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Mentally Ill Prisoners in the California Department of Corrections and Rehabilitation: Strategies for Improving Treatment and Reducing Recidivism

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Mentally Ill Prisoners in the California Department of Corrections and Rehabilitation:
Strategies for Improving Treatment and Reducing Recidivism

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Abstract:

California prisons and jails treat more people with mental illness than hospitals and residential treatment centers combined. Mentally ill prisoners receive inadequate medical and psychiatric care, serve longer terms than the average inmate, and are released without adequate preparation and support for their return to society. As a result, these offenders are much more likely to violate parole and return to prison, cycling ever-downward. With the California prison healthcare system currently in receivership, and the state poised to spend more money on prisons than on colleges in the coming fiscal year, this paper addresses a topic that is both underreported and extremely timely.

This paper diagnoses the problems and offers solutions to the crisis in prison mental healthcare. The paper focuses on three key phases in an inmate's relationship with the prison system: intake, living in prison, and release. Currently, inmates are not adequately screened during intake for mental illnesses: any diagnosis they do receive does not travel with them through the prison system, and prisoners often go off medications as a result. While serving their sentences, prisons offer inadequate amounts of counseling and medication, and tend to treat "acting out" as a discipline problem, rather than a symptom of mental illness. As a result, mentally ill inmates face much greater rates of administrative segregation, which leads to further mental deterioration and expensive stays in mental hospitals. Finally, mentally ill prisoners are often released without adequate treatment programs or housing support. As a result, the mentally ill face much higher parole revocation rates than inmates in the general population.

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Mentally Ill Prisoners in the California Department of Corrections and Rehabilitation:
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I. Introduction: California is Failing its Mentally Ill Prisoners

Thousands of people with mental illness are currently serving terms in California state prisons.¹ These individuals receive inadequate medical and psychiatric care, serve longer terms than the average inmate, and are released without adequate preparation and support for their return to society. As a result, mentally ill offenders are more likely than general-population offenders to violate parole and return to prison. The poor treatment of California's mentally ill prisoners burdens the judicial system, drains the state's budget, and causes needless inmate suffering. Reform of the California correction system's mental health treatment system is both urgent and necessary.

California treats more of the mentally ill inside prison than out: prisons and jails treat more people with mental illness than hospitals and residential treatment centers combined. Ten-and-a-half percent of California state prisoners—approximately 17,000—are treated with psychotropic medications, while 12.5% receive in-custody therapy from a trained professional on a regular basis.² Only 4778 people with mental illness were treated in state-funded (Medi-Cal) residential programs in Fiscal Year

¹ For the purposes of this paper, I treat sex offenders and substance abusers as part of the mentally ill population only when these individuals also have an underlying mental illness, and, where noted, certain statistics include these populations.

² Allen J. Beck & Laura M. Maruschak, Bureau of Justice Statistics, U.S. Dept. of Justice, Mental Health Treatment in State Prisons 6 (2001) (reporting 2000 data) [hereinafter Beck BJS Study]. These figures are for enrollment in programs, not overall demand. Given the staffing problems in California prisons, discussed infra at 13-15, the figures are likely to underestimate demand. Human Rights Watch puts the population of California state prisoners with mental illness at 23,439 as of 2003. Human Rights Watch, III- Equipped: U.S. Prisons and Offenders with Mental Illness 18 (2003) [hereinafter Human Rights Watch, III- Equipped].

2002-03,³ while a staggering 197,184 inmates received outpatient mental health services in California jails.⁴ A 2005 state report concluded that “jails have become the primary source of treatment for [California’s] mentally ill”⁵; California spends more than \$300 million a year on jail and probation costs for mentally ill prisoners.⁶ Nationally, the situation is equally serious: prisoner mental illness rates are double to quadruple the rate for the U.S. population at large.⁷ The U.S. Bureau of Justice Statistics (“BJS”) estimates that 283,000 of the two million incarcerated people in the U.S. (approximately 16 %) suffer from serious mental illnesses such as schizophrenia, major depression and bipolar disorder.⁸

Prisoners with mental illness are more likely to face discipline than inmates in the general population. Inmates with serious illnesses are ill-equipped to abide by the myriad

³ Cal. Dept. of Mental Health, Medi-Cal Trend Report for FY 1998-99 through FY 2002-03 (2003), <http://www.dmh.ca.gov/SADA/SDA-Medi-Cal.asp>. These are unduplicated numbers—that is, they count individuals receiving treatment, not program enrollment.

⁴ Cal. Dep’t of Mental Health, Involuntary Detention Reports, Involuntary Detentions in Cal. Fiscal Year 2002-03 (2003), <http://www.dmh.ca.gov/SADA/SDA-Inv-Dtmt.asp>. Residential programs include Adult Crisis Residential and Adult Residential Services. These figures include some duplication—“since the involuntary detention is done on a quarterly basis and this report is summarized by fiscal year.” *Id.* at 2.

⁵ Cal. Board of Corr. and Rehab., Mentally Ill Offenders Crime Reduction Grant Program: Overview of Statewide Evaluation Findings (March 2005), http://www.bdcrr.ca.gov/cppd/miocrg/reports/miocrg_report_presentation.doc [hereinafter 2005 MIOCRG Statewide Eval.].

⁶ Cal. Board of Corr. and Rehab., Mentally Ill Offenders Crime Reduction Grant: Annual Rep. to the Legislature 2 (June 2004), http://www.bdcrr.ca.gov/cppd/miocrg/2004_annual_report/miocrg_2004_annual_report.doc [hereinafter 2004 MIOCRG Annual Rep. To Legis.].

⁷ See President’s New Freedom Comm’n on Mental Health, Achieving the Promise: Transforming Mental Health Care in America 2 (2003), <http://mentalhealthcommission.gov/reports/Finalreport/downloads/FinalReport.pdf> (finding that five to seven percent of adults have a serious mental illness); see also William Kanapaux, Guilty of Mental Illness, *Psychiatric Times*, Jan. 2004, at 1 (finding that U.S. prisoners have rates of mental illness that are up to four times greater than rates for the general population).

⁸ Paula M. Ditton, Bureau of Justice Statistics, U.S. Dep’t of Justice, Mental Health and Treatment of Inmates and Probationers 2 (1999) [hereinafter Ditton BJS Study]. The figure was based on prisoners who either reported a current mental or emotional condition or who had spent at least one night in a mental hospital or treatment program. The figures are higher for women: the study estimates that 24% of female inmates are mentally ill. 547,800 people with mental illness are estimated to be on probation. These figures exclude mentally ill prisoners in jail; while jail populations are important, see supra note 5, given

rules of prison life, resulting in higher rates of disciplinary action: “While mental illness may not technically violate prison rules, a number of the all but inevitable concomitants of mental illness do.”⁹ The BJS reported in 2005 that 62.2% of mentally ill state prison inmates had been formally charged with breaking the rules since admission, compared to 51.9% of the general population.¹⁰ At the same time, the mentally ill are more vulnerable to physical and sexual assault, exploitation, and extortion from other inmates:¹¹ for example, 36% of mentally ill prisoners reported being involved in altercations, compared to 25% of other inmates.¹²

Mentally ill prisoners are more likely to end up in administrative segregation than general-population inmates, both for punitive reasons (following disciplinary infractions) and protective reasons (following victimization at the hands of fellow inmates). Administrative segregation, in turn, tends to exacerbate (or, in some cases, precipitate) mental illness.¹³ Mentally ill prisoners can therefore find themselves in a vicious circle: mental illness leads to discipline/victimization problems, which leads to solitary confinement, which leads to decompensation,¹⁴ which worsens mental illness, which results in further discipline/victimization and further segregation. Mentally ill prisoners

the number of prisoners who are on trial and eventually transfer to state prison, the focus of this paper is on state corrections.

⁹ Human Rights Watch, Ill-Equipped, supra note 2, at 59 (citing aggression, disruptive behavior, and a refusal to follow orders due to an inability to conform one’s conduct).

¹⁰ Ditton BJS Study, supra note 8, at 9.

¹¹ Human Rights Watch, Ill-Equipped, supra note 2, at 56-58. Contributing factors include slower reaction times as a side-effect of medication and social isolation from the stigma of mental illness.

¹² Ditton BJS Study at 9. A New York Correctional Association Study found that 54% of prisoners in intermediate care mental health units reported victimization, “including having property stolen and physical and/or sexual assaults.” Human Rights Watch, Ill-Equipped, supra note 2, at 57.

¹³ Madrid v. Gomez, 889 F. Supp. 1146, 1216 (N.D. Cal. 1995). “For some, SHU [secure housing unit] confinement has severely exacerbated a previously existing mental condition’, while other inmates developed mental illness symptoms not apparent before confinement in the SHU.” Id.

¹⁴ Decompensation is “the inability to maintain defense mechanisms in response to stress, resulting in personality disturbance or psychological imbalance.” Am. Heritage Dictionary of the English Language 309 (4th ed. 2000).

have longer to suffer these harms since they serve, on average, fifteen months longer for the same crimes than the non-mentally ill.¹⁵ Because their illnesses often prevent them from engaging in prison programming that results in the acquisition of “good time” credits, they also serve a greater percentage of their sentences.¹⁶

California fails its mentally ill prisoners at every step. Prisons fail to adequately screen inmates for mental illness during intake, fail to offer special programming or housing, fail to provide basic treatment for many prisoners, and fail to address special needs upon release, as described infra at 8 et seq. The result is that mentally ill prisoners get sicker, stay longer, suffer more—and wind up back in prison soon after their release.

These failures have long been apparent. In 1995, the federal district court in Coleman v. Wilson held the treatment of the mentally ill in the California corrections system so inadequate that it violated the Eighth Amendment’s prohibition on cruel and unusual punishment.¹⁷ The Coleman court found that the following deficiencies violated the Eighth Amendment of the U.S. Constitution: (1) the lack of any screening mechanism for mental illness; (2) inadequate mental health staffing levels; (3) the lack of quality-assurance mechanisms for evaluating mental health staff; (4) delays and denials of medical attention; (5) inappropriate use of punitive measures; and (6) an “extremely deficient” records system.¹⁸ Ten years later, the same problems continue to plague mental health administration in prison, as discussed infra at 12-13.

¹⁵ Ditton BJS Study, supra note 8, at 8.

¹⁶ Human Rights Watch, Ill-Equipped, supra note 2, at 126.

¹⁷ Coleman v. Wilson, 912 F. Supp. 1282 (E.D. Cal. 1995). Coleman dealt with the mental health system for all prisons except Pelican Bay; a companion case, Madrid v. Gomez, 889 F. Supp. 1146 (N.D. Cal. 1995), was also successful in establishing the unconstitutionality of the level of care at the Pelican Bay supermax prison. See discussion infra pp. 11-13.

¹⁸ Coleman, 912 F. Supp. at 1296-97.

Problems with mental health care are symptomatic of problems within California's prison health care system as a whole. Judge Thelton Henderson of the Northern District of California placed the entire prison health care system into receivership in October 2005:¹⁹ he described the system as "broken beyond repair" and stated that the California Department of Corrections and Rehabilitation ("CDCR") was "incapable of successfully implementing systemic change".²⁰

California must provide more effective treatment for mentally ill prisoners and, at the same time, prepare for their release in a way that will minimize recidivism. Reforms must focus on the three critical stages in the penal system's relationship with mentally ill prisoners: intake, living in prison, and release.

II. Intake

During intake, the prison system processes and evaluates prisoners before transferring them to the prisons where they will serve their sentences. Intake begins when prisoners are taken from county jails to one of several state reception centers, such as the California Institution for Men (CIM) and the California Institution for Women.²¹ Prisoners are housed at these reception centers for at least sixty days, although stays can last as long as several months.²² Officials at the reception centers screen for any health

¹⁹ Plata v. Schwarzenegger, CV01-01351, 2005 WL 2932253, at *1 (N.D. Cal. Oct. 3, 2005).

²⁰ Id. at *5.

²¹ Cal. Dep't of Corr. and Rehab., CDCR Facilities Map, <http://www.corr.ca.gov/Visitors/facilities.html>. Other Reception Centers include San Quentin, Wasco State Prison, and North Kern State Prison.

²² There are no good data on the average stay in a reception center, nor are there statutory or judicial mandates limiting the amount of time inmates may spend there. Because placements depend, in part, on the level of overcrowding at destination prisons, time in reception centers is difficult to estimate. North Kern State Prison claims that it "usually" places reception center inmates "within a 60 to 90 day period." Cal. Dep't of Corr. and Rehab., North Kern State Prison homepage, http://www.cdcr.ca.gov/Visitors/fac_prison_NKSP.html. In one infamous case, Jon Blaylock, a reception center inmate, murdered Corrections Officer Manuel Gonzalez after six months at a reception center. Cal. State Board of Corr., Independent Operations and Incident Review Panel on the Cal. Institutions for Men, March 2005, http://www.bdcrr.ca.gov/special_reports/operational_incident_review_cim/Final%20Report.pdf. Blaylock

problems, including mental health, and assess other needs in order to recommend appropriate placement and programming for each inmate.²³ In theory, prisoners transferred from county jail to prison should be accompanied by their intake screen, health, and disciplinary records.

Prisoners are classified according to a series of factors, each of which is given a numerical weight.²⁴ The scores for each factor are then added; the resulting number determines classification.²⁵ Certain factors require particular placements that might result in an inmate being housed in a facility “which is not consistent with the inmate’s placement score”²⁶—e.g., “an inmate with a history of arson shall not be housed in a facility constructed primarily of wood.”²⁷ Most importantly, placement scores can be overridden if the inmate requires special psychiatric treatment.²⁸

Ideally, diagnoses, programming recommendations, and medication would accompany prisoners both as they arrive at reception centers from county jail and as they leave the centers to travel to their destination facility. In fact, however, prescriptions, medications, and diagnoses often fail to accompany prisoners at intake.²⁹ Pursuant to California law, county jails are required to evaluate the mental health of their prison population, but very few of these records get transferred from the jails to the state prison

was sent to CIM on June 23, 2004, referred for placement on November 19th, and was still in the reception center on January 10, 2005. Id.

²³ See Cal. Code Regs. tit. 15 §3075.1 (2006) (outlining the basic process); Cal. Code Regs. tit. 15 §3375 (2006) (outlining the classification process).

²⁴ See Cal. Code Regs. tit. 15 §3375.3 (2006). For example, the inmates are scored according to personal background factors (such as age at first arrest, age at incarceration, and length of current sentence) and prior incarceration behavior (such as disciplinary problems or possession of a deadly weapon). Id.

²⁵ See Cal. Code Regs. tit. 15 §3375.1 (2006) (detailing which scores result in detention at which level of facility).

²⁶ See Cal. Code Regs. tit. 15 §3375.2(a) (2006).

²⁷ See Cal. Code Regs. tit. 15 §3375.2(a)(2) (2006).

²⁸ See Cal. Code Regs. tit. 15 §3375.2(b)(15) (2006).

²⁹ Marcus Nieto, Cal. Research Bureau, Health Care in Cal. State Prisons 17 (June 1998).

system.³⁰ Because so few records are transferred, state prison reception centers must administer redundant tests. One study estimated that 30% of all reception center medical screens are needless duplications of county screens, costing up to 5 million dollars per annum.³¹ As of this writing, county jails and the state prison system have yet to work out an orderly and reliable system for transferring records, even though this failing was identified at least as early as 1995, during the Coleman v. Wilson litigation.³²

California's mental health screening process, developed in response to the Coleman lawsuit, is inadequate, notwithstanding court orders to improve it. The current screen is designed to give mentally ill prisoners a "red flag" during intake interviews; a more detailed psychiatric screening no more than seventy-two hours later; and a full psychiatric evaluation within eighteen days.³³ In 2005, however, the Plata court found that "the reception center intake process ... fails to adequately identify and treat the health care problems of new prisoners."³⁴ An adequate screen should take at least fifteen minutes to administer; "[h]owever, prisoners' exams in CDCR reception centers typically last no more than seven minutes."³⁵ Inmates are often screened in groups without regard to confidentiality; the examinations are therefore unlikely to be accurate.³⁶ Screens

³⁰ Id. at 1.

³¹ Id. at 16. These figures are for all tests, not just those for mental health.

³² Coleman v. Wilson, 912 F. Supp. 1282, 1314 (E.D. Cal. 1995).

³³ Nieto, supra note 29, at 19.

³⁴ Plata v. Schwarzenegger, CV01-01351, 2005 WL 2932253 at *12 (N.D. Cal. Oct. 3, 2005). Note that this refers to all screens, not just those for mental health; mental health screens are, however, part of the general health screen administered during prisoner intake.

³⁵ Id. Again, this refers to all health screens, not just mental health screens. A "Suicide Prevention Assessment Form" provides some insight into the types of questions asked during mental health screens: health problems, suicidal ideation, and history of hospitalization. Cal. Dep't of Corr. and Rehab., Corrections Standards Authority, Suicide Prevention Assessment Form,

<http://www.bdcrr.ca.gov/stc/stc.htm>. All answers are self-reported. Additionally, the form asks the screener to note signs of depression ("Inmate feels hopeless"), psychosis (agitated, responding to voices), the seriousness of criminal charges, and indications of being under the influence of alcohol or drugs. Id.

³⁶ Plata, 2005 WL 2932253, at *13.

should also incorporate objective factors as well as self-reporting, since inmates with acute mental illness are often unable to communicate their symptoms and/or diagnoses.³⁷

Screens must also account for co-occurring disorders—that is, mental illness coterminous with drug abuse. Co-occurring disorders present particular problems in penal mental health screening because symptoms of mental illness can be masked by or misdiagnosed as the result of drug or alcohol abuse.³⁸ Screening for drug abuse alongside mental illness is crucial in the penal context, however: a state study estimated that chemical reactions in the brain cause seventy percent of California prisoners' major mental disorders, the primary cause of which is use of mind-altering drugs.³⁹ Nationwide, six in ten mentally ill state prison inmates report being under the influence of alcohol or drugs at the time of their offense.⁴⁰ Drug use is a critical factor in predicting violence: the incidence of violent crime committed by mentally ill prisoners is no greater than that of the general prison population, but the incidence of violent crime by the mentally ill who also abuse drugs and alcohol is far greater.⁴¹ Yet there are few drug treatment programs in county jails, and no drug treatment programs at all at CDCR reception centers.⁴²

The shortcomings of California's intake screens are compounded by their low rate of administration. A national BJS study analyzed mental health screening for prisoners at state-operated facilities, facilities under joint state and local authority, and private

³⁷ Coleman, 912 F. Supp. at 1305.

³⁸ National Comm'n on Corr. Health Care, Position Statements: Mental Health Services in Correctional Settings (adopted Sept. 27, 1992), <http://www.ncchc.org/resources/statements/mentalhealth.html>.

³⁹ Nieto, supra note 29, at 20.

⁴⁰ Ditton BJS Study, supra note 8, at 7.

⁴¹ Eric Silver et al., Assessing Violence Risk Among Discharged Psychiatric Patients: Toward an Ecological Approach, 23 Law and Human Behavior 237, 238 (1999), [http://www.springerlink.com/\(a3z4blvb5zk2ze4534j1yr3h\)/app/home/contribution.asp?referrer=parent&backto=issue,5,8;journal,41,138;linkingpublicationresults,1:104390,1](http://www.springerlink.com/(a3z4blvb5zk2ze4534j1yr3h)/app/home/contribution.asp?referrer=parent&backto=issue,5,8;journal,41,138;linkingpublicationresults,1:104390,1).

facilities at which at least 50% of patients were inmates held for state authorities.⁴³ 67.7% of such facilities nationwide (1055 of 1558 facilities) conducted mental health screening at intake, while only 58.1% (50 of 86) of California facilities did.⁴⁴ 63.5% (990 facilities) of national facilities conducted psychiatric assessments, while only 40.7% (35 facilities) of California facilities did.⁴⁵

A functional intake process would also provide mentally ill prisoners with any necessary care during their stay at reception centers. Early identification of mental illness enables early treatment, and early treatment is a hallmark of effective treatment. Early treatment is also constitutionally required: the Eighth Amendment’s prohibition against cruel and unusual punishment requires the prison system to provide mental health care “before inmates suffer unnecessary and wanton infliction of pain.”⁴⁶ Inmates are typically held at reception centers for at least two months, but efforts to increase the number of reception center mental health treatment beds has met with stiff local opposition.⁴⁷

Finally, conditions at reception centers must be improved and overcrowding reduced. Conditions at the CIM’s Sycamore Hall, for example, are “deplorable”, according to a 2005 independent panel investigating the murder of a corrections officer by an inmate.⁴⁸ “The Panel observed heavy cobwebs, broken windows, fecal matter on

⁴² Nieto, *supra* note 29, at 2.

⁴³ Beck BJS Study, *supra* note 2, at 5.

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ *Coleman v. Wilson*, 912 F. Supp. 1282, 1305 (E.D. Cal. 1995).

⁴⁷ Mason Stockstill, *Chino Prison Mentally-Ill Inmate Plan Reintroduced*, Inland Valley Daily Bulletin, Mar. 30, 2006, at A5, http://www.dailybulletin.com/news/ci_3661249.

⁴⁸ Independent Operations and Incident Review Panel on the California Institutions for Men, at 12, available at www.bdcorr.ca.gov/special_reports/operational_incident_review_cim/Final%20Report.pdf.

the walls, [and] accumulated filth and food on the floor.”⁴⁹ The “cramped and dilapidated conditions” have led to operational practices that violate security; despite these conditions, “the staff continues to process over 600 inmates per week.”⁵⁰ The panel recommended that the CDCR “evaluate the number of inmates being processed to determine how many inmates can be safely processed and housed at CIM.”⁵¹

III. Living In Prison

Once prisoners with mental illness are assigned to prisons, they must receive necessary counseling and medication. At a minimum, mentally ill prisoners need to get their prescribed medications regularly: too often drug treatment is interrupted when prisoners are transferred between prisons or when lockdown interferes with medication delivery. Prisons should also be responsive to changes in prisoners’ mental health and should screen for possible late onset of mental illness. Finally, special disciplinary procedures, housing, and programming should be considered in order to improve diagnostic and behavioral outcomes.

Mentally ill prisoners are currently classified into three categories in an attempt to match levels of service to medical needs. First, inmates who are capable of living in the general population are placed in the Correctional Clinical Case Management System (“CCCMS”). CCCMS inmates are prescribed medication and counseling⁵² and meet with their clinical case manager at least once every ninety days.⁵³ Second, prisoners “who are unable to function or care for themselves” in the general prison population “or who are acutely ill or decompensating” are placed in the Enhanced Outpatient Program, or

⁴⁹ Id.

⁵⁰ Id.

⁵¹ Id. at 16.

⁵² Nieto, supra note 29, at 39.

“EOP”.⁵⁴ The EOP provides regular medication review, meetings with a case manager at least once a week, and ten hours of structured therapy activities per week.⁵⁵ Finally, “patients in crisis” are housed in a Mental Health Crisis Bed in an infirmary on a short-term basis (ten days maximum).⁵⁶ Acutely ill patients who continue to remain “in crisis” beyond ten days are transferred to the custody of the Department of Mental Health, which provides residential treatment to prisoners until they are ready to return to prison.⁵⁷

While this classification system could, in theory, be useful in delivering resources where they are most needed, in practice the system fails to deliver adequate care to prisoners who need it. The EOP, for example, currently serves 1-2% of the state prison population but falls far short of the demand.⁵⁸ In 2002, San Quentin’s EOP was operating at 385% of capacity, while the Valley State Prison for Women was at 156% capacity.⁵⁹ Prison policies require transfers into the EOP to be completed within thirty days of a recommendation by medical staff, but “most administrators acknowledge transfers can be delayed far longer”.⁶⁰

Over the past decade, the courts in several lawsuits have found that the CDCR’s grossly inadequate health care provision violates the Eighth Amendment’s prohibition on cruel and unusual punishment.⁶¹ In 1995, two class action suits were filed on behalf of mentally ill prisoners: Madrid v. Gomez and Coleman v. Wilson. Madrid’s plaintiff class

⁵³ Steven Fama et al., Prison Law Office, California State Prisoners Handbook 262 (3d ed. 2001).

⁵⁴ Id.

⁵⁵ Id.

⁵⁶ Id.

⁵⁷ Id.

⁵⁸ Human Rights Watch, Ill-Equipped, supra note 2, at 131.

⁵⁹ Id.

⁶⁰ Id.

⁶¹ The grim picture is also substantiated by a number of both state- and privately-funded studies of the system. See, generally, Human Rights Watch, Ill-Equipped, supra note 2; Nieto, supra note 29; Milton Marks “Little Hoover” Comm’n on Cal. State Gov’t Org. and Economy, Rep. No. 157, Being There:

was limited to mentally ill inmates at the “supermax” facility at Pelican Bay while Coleman’s plaintiff class represented mentally ill prisoners in the rest of the prison system. The state lost both suits. As a result, mental health reforms were ordered but not adequately implemented: the CDCR recently lost another suit, Plata v. Schwarzenegger, alleging that the provision of prison health care is so grossly inadequate as to constitute cruel and unusual punishment.⁶²

The prison healthcare system thus finds itself preparing to be administered through court-supervised receivership. Without addressing the serious and systemic problems with the administration of mental health care, the CDCR faces a future of more lawsuits and further judicial control. The prison mental health system must address its chronic staffing shortages; the lack of quality control and managerial oversight of mental health care providers; an emphasis on security over treatment that is counterproductive for both security and treatment; a badly outdated and unusable data system; and a dysfunctional medication disbursement system. Correcting these problems will help stabilize the conditions of mentally ill prisoners which, in turn, will both reduce suffering and improve long-term prognoses.

Staff Shortages. California prisons suffer from inadequate hiring and inadequate retention, each of which contributes to the other. Understaffing drives people from the workforce; high turnover makes recruiting more difficult.

Psychiatric staff levels have been inadequate for decades. The 1995 Coleman decision found not only that current psychiatric positions were understaffed, but that

Making a Commitment to Mental Health (2000), <http://www.lhc.ca.gov/lhcdir/report157.html> [hereinafter Little Hoover, Making a Commitment to Mental Health].

⁶² CV01-1351, 2005 WL 2932253 (N.D. Cal 2005).

several studies for the decade prior had noted shortages as well.⁶³ A 1998 study found system-wide vacancies of 14% in the EOP.⁶⁴ Pelican Bay State Prison, which houses the CDCR's most incorrigible offenders, opened in December of 1989 without a single psychiatrist on staff.⁶⁵ Anecdotally, a staff psychiatrist at the California Medical Facility said that "turnover is huge" and "asserted that the average stay for mental health staff in the prison was a mere six months."⁶⁶ Staff shortages extend to the prison health care system as a whole: some prisons have an 80% vacancy rate for nursing staff.⁶⁷ According to one federal district court, the 15% vacancy rate for physicians does not account for "the additional significant percentage of incompetent doctors who need to be replaced."⁶⁸

The remote location of most prisons makes recruitment difficult, as does the low quality of services and the unprofessional environment.⁶⁹ Pay is also an issue: nurses working in the prison system make between 20 and 40% less than they would in the private sector⁷⁰ and 29% less than Medical Technical Assistants, corrections officers who do jobs "that could be performed by licensed nurses."⁷¹ The pay differential between medical staff and corrections officers has also been cited as another barrier to recruitment of qualified medical staff.⁷² Insufficient staff levels not only degrade care, they also increase costs. If no care is available in prison, inmates are sent to hospitals,

⁶³ Coleman v. Wilson, 912 F. Supp. 1282, 1306-7 (E.D. Cal. 1995).

⁶⁴ Nieto, supra note 29, at 39.

⁶⁵ See Madrid v. Gomez, 889 F. Supp. 1146 at 1214.

⁶⁶ Human Rights Watch, Ill-Equipped, supra note 2, at 98. The California Medical Facility in Vacaville is a "centrally-located medical and psychiatric institution for the health care needs of the male felon population in California's prisons." Cal. Dep't of Corr. and Rehab., California Medical Facility homepage, http://www.cdcr.ca.gov/Visitors/fac_prison_CMF.html.

⁶⁷ Human Rights Watch, Ill-Equipped, supra note 2, at 98.

⁶⁸ Plata v. Schwarzenegger, CV01-01351, 2005 WL 2932253, at *11 (N.D. Cal. Oct. 3, 2005).

⁶⁹ Nieto, supra note 29, at 44.

⁷⁰ Plata, 2005 WL 2932253 at *11.

accompanied by corrections officers. The transportation costs alone of sending prisoners to hospitals was \$875 per prisoner per trip in 1998.⁷³

Lack of Quality Control and Management. Despite ample evidence that prisoners are getting grossly substandard care, there is very little management or supervision of the provision of medical care. This lack of management makes it almost impossible to fire, retrain, or reassign poorly performing staff.

The court in Plata v. Schwarzenegger found that the CDCR “lacks an adequate system to manage and supervise medical care”.⁷⁴ There is “a culture of non-accountability and non-professionalism” in the Health Care Services Division (“HCSD”);⁷⁵ in September 2004, the HCSD was ordered to implement quality management of physicians but “failed to come close” to doing so.⁷⁶ The system suffers from “organizational silo” syndrome: that is, there is no comprehensive, system-wide oversight, but rather a series of prisons accountable only to their individual wardens.⁷⁷ Further, the CDCR has a staggering 80% vacancy rate in the higher level of management of its HCSD.⁷⁸ Receivership is the court’s attempt to improve the situation; the medical service workers’ union, which is unaffiliated with the prison guards’ union, supports receivership.⁷⁹

⁷¹ Nieto, supra note 29, at 45.

⁷² Human Rights Watch, Ill-Equipped, supra note 2, at 131.

⁷³ Nieto, supra note 29, at 32.

⁷⁴ Plata, 2005 WL 2932253, at *3.

⁷⁵ Id. at *10.

⁷⁶ Id. at *2.

⁷⁷ Id. at *3.

⁷⁸ Id. at *5.

⁷⁹ Id. at *33.

Inadequate Information Technology. Data management in the HCSD is “practically non-existent,”⁸⁰ yet patient treatment, quality control, and management are almost impossible to implement without adequate information. Systems to track patient follow-up don’t work,⁸¹ and medical records in most prisons are “either in a shambles or non-existent.”⁸² Doctors often have to open new patient files because they can’t find existing records.⁸³ Medical records are not transferred from jails, parole, or from other prisons (in the case of inter-prison transfers).⁸⁴ Doug Peterson, head of health care at the California State Prison at Sacramento, states that the data deficit is “horrible as a management tool, which affects inmate care. It’s harder to monitor whether they’re getting what they’re supposed to be getting.”⁸⁵ That is, not only are prisoners not getting the care they need, managers are unable to diagnose and correct problems with incompetent staff. At a minimum, adequate records would help administrators to give prisoners timely access to drugs and treatment.

The CDCR’s information technology has been notoriously inadequate for years. In 1992, the CDCR committed itself to the legislature to improve health care delivery, standardization, and automation via, inter alia, a Health Information Project.⁸⁶ CDCR officials later blamed their failure to implement these reforms on the state procurement process.⁸⁷ Coleman in 1995 noted “extremely deficient” record keeping in the system at

⁸⁰ Id. at *4.

⁸¹ Id.

⁸² Id. at *14. Indeed, the lack of basic record keeping means that the problem is not just a lack of information technology, but a lack of information gathering itself.

⁸³ Id.

⁸⁴ Nieto, supra note 29, at 16.

⁸⁵ Human Rights Watch, Ill-Equipped, supra note 2, at 102.

⁸⁶ Nieto, supra note 29, at 43.

⁸⁷ Id.

large⁸⁸, while the Pelican Bay records were described as “nothing short of disastrous” and “outrageously disorganized.”⁸⁹ A 1998 study found that medical records were compiled by hand.⁹⁰ In 2004 the Corrections Independent Review Panel—convened by Governor Schwarzenegger and chaired by former Governor Deukmejian—deemed the system’s information technology “inadequate.”⁹¹

Lack of Coordination with and Cooperation from Corrections Officers.

Corrections officers (“COs”) are an untapped resource in an area that desperately needs more resources. COs not only administer medications and accompany prisoners to medical clinics, but can also serve as a potential early warning system for changes in prisoners’ behavior and mental health. Improvements in mental health treatment will be much easier with cooperation from COs, but, at the very least, COs should not make things worse.

Corrections officers currently play too large a role in determining treatment for mentally ill prisoners, making medical decisions based primarily on security considerations. According to Dr. Michael Friedman, director of medical care at Soledad Prison, “[t]he system, in my view, is totally corrupted” because “[n]onmedical staff are making medical decisions, because everything is about security, not how we look after the inmates.”⁹² Because corrections officers have daily contact with inmates, they could provide timely referrals for mental health treatment; however, COs fears that prisoners are just faking their symptoms (“malingering”) means that referrals often are not made

⁸⁸ Coleman v. Wilson, 912 F. Supp. 1282, 1314 (E.D. Cal. 1995).

⁸⁹ Madrid v. Gomez, 889 F. Supp 1146, 1203 (N.D. Cal. 1995).

⁹⁰ Nieto, *supra* note 29, at 46.

⁹¹ Report of the Corrections Independent Review Panel, Cal. Performance Review, Reforming Corrections 233 (presented to Governor Schwarzenegger June 2004), <http://cpr.ca.gov/report/indrpt/corr/pdf/from7to11.pdf>.

⁹² James Sterngold, Grim Reality of Prison Health Care, S.F. Chron., Oct. 16, 2005, at A15.

until prisoners are grossly psychotic.⁹³ The Madrid decision noted that mentally ill inmates who were not displaying violent or disruptive behavior could remain untreated for “months” despite regular contact with COs.⁹⁴ Madrid also found that corrections officers tended to impose “a higher referral threshold than appropriate... [C]ustody staff essentially make medical judgments that should be reserved for clinicians, and some inmates are not given appropriate early treatment that could prevent or alleviate a severe psychiatric disorder.”⁹⁵ Corrections officers are insufficiently trained to make these judgments about treatment: COs get a mere three-hour training in “unusual inmate behavior” which is occasionally supplemented by discretionary programs administered by their local prisons.⁹⁶ Medical caregivers also report that COs display a lack of respect for them that interferes with their ability to make decisions in the clinical context.⁹⁷

While COs are reluctant to refer mentally ill inmates for treatment, they are overly ready to commit mentally ill inmates to administrative segregation. Mentally ill prisoners are disproportionately represented in administrative segregation: in July 2002, 31.85% of the California administrative segregation population was on the mental health caseload.⁹⁸ At Mule Creek State Prison, half of acute-care “crisis beds” came from the EOP administrative segregation population—in other words, mentally ill prisoners who were placed in administrative segregation for protective or disciplinary purposes then decompensated to a point requiring “crisis bed” treatment.⁹⁹ At the Valley State Prison for Women, the figures were higher: 65.91% of the prisoners in secure housing were

⁹³ Human Rights Watch, Ill-Equipped, *supra* note 2, at 76.

⁹⁴ Madrid at 1217.

⁹⁵ Id. at 1219.

⁹⁶ Human Rights Watch, Ill-Equipped, *supra* note 2 at 77.

⁹⁷ Plata v. Schwarzenegger, CV01-01351, 2005 WL 2932253, at *15 (N.D. Cal. Oct. 3, 2005). Note that this refers to all medical treatment, not psychiatric treatment in particular.

⁹⁸ Human Rights Watch, Ill-Equipped, *supra* note 2 at 148.

mentally ill.¹⁰⁰ Mental health care in administrative segregation is limited to drug treatments only: without therapy, face-to-face contact, and exposure to normalcy, recovery is difficult. “The requirement of isolation [imposed by administrative segregation] flies in the face of the medically accepted fact that most mentally disordered people need to interact with others.”¹⁰¹ This cycle leads to the mentally ill being “trapped at the bottom”¹⁰², never getting out of secure housing because “most people in isolation will fall apart.”¹⁰³

Decompensating prisoners sometimes become violent; one defense attorney reported that mentally ill clients of hers received third-strike convictions (hence life in prison) for in-prison offenses caused by untreated mental illness.¹⁰⁴ Fear of decompensating prisoners can also result in horrifying overreactions on the part of corrections officers. Madrid cited the example of a psychotic inmate being placed in water hot enough to give him severe burns.¹⁰⁵ COs took the prisoner, who was African-American, into the infirmary and said in the presence of a nurse, “we’re going to have a white boy before this is through.”¹⁰⁶ After the prisoner was removed from the water, the nurse testified that “his skin had peeled off and was hanging in large clumps around his legs, which had turned white with some redness.”¹⁰⁷ The Madrid court concluded that the use of force was not isolated but “an affirmative management strategy to permit the use

⁹⁹ Id. at 160.

¹⁰⁰ Id.

¹⁰¹ Id. at 155.

¹⁰² Id. at 154.

¹⁰³ Id. at 149.

¹⁰⁴ Id. at 66.

¹⁰⁵ Madrid v. Gomez, 889 F. Supp. 1146, 1166-67 (N.D. Cal. 1995).

¹⁰⁶ Id. at 1167.

¹⁰⁷ Id.

of excessive force for the purposes of punishment and deterrence.”¹⁰⁸ The evidence presented “paint[ed] a picture of a prison that all too often uses force, not only in good faith efforts to restore and maintain order, but also for the very purpose of inflicting punishment and pain.”¹⁰⁹

Medications Problems. Abrupt withdrawal from psychotropic medications can lead to relapses, panic attacks, and psychosis,¹¹⁰ yet many prisoners face precisely these terrifying symptoms because the medication delivery system in California prisons is broken. Management of medication is “unbelievably poor.”¹¹¹ There are no timely refills for prisoners with chronic conditions;¹¹² unmedicated prisoners can eventually grow “too far gone” to request their medications.¹¹³ Prison policies state that prescriptions must travel with prisoners who are being transferred from one facility to another, but “in practice, however, the prisons do not consistently transfer prescriptions along with the inmates, resulting in large quantities of medication being thrown out rather than administered.”¹¹⁴ Prescriptions from other prisons are, in fact, routinely disregarded.¹¹⁵

For those prisoners who do get their medications, the system provides disincentives to continued medical treatment. Certain medications, for example, induce anxiety as a side effect unless taken just before sleep, yet nighttime deliveries for these medications are not permitted.¹¹⁶ California also prevents prisoners on psychotropic

¹⁰⁸ Id. at 1199.

¹⁰⁹ Id. at 1200.

¹¹⁰ Human Rights Watch, Ill-Equipped, supra note 2, at 118-9.

¹¹¹ Plata v. Schwarzenegger, CV01-01351, 2005 WL 2932253, at *16 (N.D. Cal. Oct. 3, 2005).

¹¹² Id.

¹¹³ Human Rights Watch, Ill-Equipped, supra note 2, at 120.

¹¹⁴ Plata at *16.

¹¹⁵ Id.

¹¹⁶ Human Rights Watch, Ill-Equipped, supra note 2, at 117-8.

drugs from participating in work-furlough programs; this creates an incentive for prisoners to discontinue use precisely as they increase contact with society at large.¹¹⁷ Given that these drugs are medically necessary and readily available outside prison, such a policy is completely nonsensical. Side effects to some psychotropic medications are quite substantial, even when taken as directed, but California has done little¹¹⁸ to monitor and ameliorate side effects other than those relating to heat-sensitivity.¹¹⁹ Prisoners who opt out of taking drugs cannot be forced to take them without officials following a byzantine process,¹²⁰ yet COs and health officials make little effort to convince prisoners who have decided to stop taking their medicine to reconsider.¹²¹ Once again, systemic problems with refill delays, the lack of medication continuity upon transfer, and a failure to monitor side effects were identified as early as 1995 in the Coleman litigation.¹²²

IV. Release

For nearly all mentally ill prisoners, release is inevitable; the CDCR should therefore plan for re-entry of these prisoners as early as possible.¹²³ Approximately 66,000 prisoners are released in California each year, all of whom are placed on parole. Of these 66,000 parolees, approximately 12,000 have “a documented history of psychiatric problems.”¹²⁴ Parole Outpatient Clinics (“POCs”) provide assistance to 9000

¹¹⁷ Id. at 126.

¹¹⁸ Id. at 120.

¹¹⁹ Id. at 124.

¹²⁰ California State Prisoners Handbook, supra note 53, at 265-66.

¹²¹ Human Rights Watch, Ill-Equipped, supra note 2, at 125.

¹²² Coleman v. Wilson, 912 F. Supp. 1282, 1309 (E.D. Cal. 1995).

¹²³ Prison release dates are known with some degree of certainty. Unfortunately, jails do not lend themselves as easily to careful release planning, since so many mentally ill inmates are there as a part of pretrial detention—either because they have failed to post bail or because they pose a danger to the community. Accordingly, many mentally ill inmates are released from jail with little or no advance notice—either as a result of posting bail or as a result of getting credit for “time served” at an arraignment.

¹²⁴ Cal. State Legis. Analyst’s Office, Annual Analysis of Budget Bill, Judiciary & Criminal Justice: Linking Mentally Ill Offenders to Community Care D-14-15 (2000), http://www.lao.ca.gov/analysis_2000/crim_justice/cj_2_cc_mentally_ill_anl00.html_1. Data are somewhat

of these individuals.¹²⁵ If intake is about diagnosis and life in prison is about holding the line, release prepares prisoners so that they can stabilize their condition outside prison and, one hopes, avoid recidivism. Recidivism can be reduced if re-entry is planned, intervention is front-loaded and addresses multiple issues, and if parole officers embrace the harm reduction principle (a public-health-oriented rather than criminal-justice-oriented approach to dealing with parole infractions). Investments in release programs ultimately reduce strains on the prison system and its budget—by decreasing prisoner recidivism, more resources are freed up within the system, and society as well as individual prisoners pay far less in other costs.

The most effective post-release programs concentrate on the period immediately following release and address multiple issues such as mental health, parole, therapeutic treatment, housing, and/or employment—the “integrated services” model.¹²⁶ For example, prisoners about to be released should have an adequate supply of medication (at least seventy-two hours’ worth), some form of housing, and contacts with a coordinated team of correctional and social services staff to help them as they enter parole, seek

difficult to come by, since the state changed parole databases within the last five years. A 2004 study commissioned by the CDCR provides another estimate: 48,291 parolees were under some sort of mental health supervision between July 2001 and December 2003, for an average of 19,316 per year (of whom 79.8% were CCCMS, 14.2% EOP, and 6% unclassified). See Neuropsychiatric Inst., Univ. of Cal., Los Angeles, Third Annual Report on the Mental Health Servs. Continuum Program of the Cal. Dep’t of Corr. and Rehab.—Parole Div. 14 (2005) [hereinafter 2005 Annual MHSCP Report].

¹²⁵ 2005 MHSCP Report, supra note 124, at 14. These numbers must be taken with a grain of salt: sex offenders are required to report to POCs, even if they are at low risk of reoffending. Assuming that the released prisoners reflect the general incidence of mental illness found in the prison population—10.5%, to use the most conservative estimate—that means almost 7000 prisoners with serious mental illnesses will be released on average per year. Of the non-serviced individuals, one can only hope that they are high-functioning. According to a 2004 report, parolees released from the EOP program are given highest priority for treatment, followed by those from Mental Health Crisis Beds, inmates released from the Department of Mental Health (e.g. inmates from the CONREP program), and inmates classified as CCCMS. Id. at 8.

¹²⁶ Milton Marks “Little Hoover” Comm’n on Cal. State Gov’t Org. and Economy, Rep. No. 172, Back to the Community: Safe & Sound Parole Policies x (2003), available at <http://www.lhc.ca.gov/lhcdir/report172.html> [hereinafter Little Hoover, Safe & Sound Parole Policies].

permanent housing, pursue job training and employment, enroll in drug and alcohol abuse counseling, and restore government benefits (Temporary Aid to Needy Families, Medi-Cal, Medicaid, Social Security, State and Social Security Disability Insurance).¹²⁷

Treatment should employ cognitive behavioral techniques, emphasize positive reinforcement, use actuarial (population-based) assessments of risk and be based in the community.¹²⁸ It's not enough to threaten to be "tough" on parolees—threats don't seem to work "because they do not target for change the known predictors of recidivism."¹²⁹

Some release programs for mentally ill prisoners have shown promising results, but, system-wide, too many mentally ill parolees are returning to prison, and too many of those are returning for reasons unrelated to the commission of new crimes. According to a national 2002 study, 22% of parolees self-reported that their parole was revoked for failure to report, 16% said their parole was revoked for drug violations, and 18% reported other reasons such as failure to meet financial or employment conditions.¹³⁰ In San Francisco, a staggering 94% of mentally ill offenders on parole have their parole revoked and are returned to prison.¹³¹ Ironically, more intense supervision without treatment has been shown to lead to higher rates of revocation, but when more supervision is coupled with treatment, recidivism has been shown to drop 20-30%.¹³² A zero-tolerance policy

¹²⁷ Mentally ill prisoners report high rates of homelessness, unemployment, and drug use prior to incarceration. Ditton BJS Study, *supra* note 8, at 5.

¹²⁸ Joan Petersilia, What Works in Prisoner Re-Entry: Reviewing and Questioning the Evidence, Fed. Probation, September 2004, at 3-4, available at http://uscourts.gov/fedprob/September_2004/whatworks.html.

¹²⁹ *Id.* at 4.

¹³⁰ Joan Petersilia, When Prisoners Come Home: Parole and Prisoner Reentry 149 (2003); see also Sonja Shield, Ctr. on Juvenile and Criminal Justice, Addressing Gaps in Post-Release Services for Mentally Ill Offenders: One Community's Response 4 (2003), http://www.cjcj.org/pdf/mentally_ill.pdf at 4.

¹³¹ Shield, Addressing Gaps, *supra* note 130, at 2.

¹³² Petersilia, When Prisoners Come Home, *supra* note 130, at 84.

of drug abstinence could be the common thread: parolees need treatment, not just supervision, if they are to avoid relapses into drug abuse.¹³³

The CDCR should aim to reduce parole revocations that are a function of untreated mental illness, with an understanding that this focus in no way jeopardizes its mission to protect public safety. A number of statutes already give parole officers authority to send dangerous mentally ill parolees back to prison. Mentally ill parolees can obviously be sent back to prison for committing new crimes, and those who decompensate to the point where their illness is acute can also have their parole revoked: as the standard form for conditions of parole states, “When the Board of Prison Terms determines, based upon psychiatric reasons, that you pose a danger to yourself or others, the Board may, if necessary for psychiatric treatment, order your placement in a community treatment facility or state prison or may revoke your parole and order your return to prison.”¹³⁴ Parolees can be temporarily returned to prison under an “Emergency Transfer” if they meet the criteria for mental illness and if they “cannot receive necessary psychiatric treatment pending a hearing”.¹³⁵ Parole Officers are required to report to the Parole Board if a parolee’s mental condition deteriorates “such that the parolee is likely to engage in future criminal behavior.”¹³⁶ Parolees must then be returned to prison upon a finding of future criminal behavior. Finally, parolees can be returned to prison if they have a mental disorder “which substantially impairs his or her ability to maintain himself

¹³³ Shield, Addressing Gaps, *supra* note 130, at 5.

¹³⁴ California State Prisoners Handbook, *supra* note 53, at app. 10-A (Supp. 2004).

¹³⁵ Cal. Code Regs. tit. 15 §2605(c) (2006).

¹³⁶ Cal. Code Regs. tit. 15 §2616(a)14 (2006).

or herself in the community” and “necessary psychiatric treatment cannot be obtained in the community.”¹³⁷

At the same time, prisoners with acute mental illness should continue to be released into treatment, not parole, through the Mentally Disordered Offender (“MDO”) program. A prisoner is classified as an MDO if (1) he or she has a severe mental disorder that is not in remission, (2) the disorder was either one of the causes of or an aggravating factor in a crime involving force or violence, and (3) he or she poses a substantial danger of physical harm to others.¹³⁸ When an MDO’s prison term expires, he or she is released into inpatient treatment at a state mental hospital as a condition of parole.¹³⁹

Once an MDO’s hospital treatment team and officers of the Conditional Release Program (“CONREP”) believe the patient can be safely and effectively treated on an outpatient basis, the Department of Mental Health will recommend treatment in CONREP.¹⁴⁰ CONREP provides full mental health services (including individual and group therapies, substance abuse screenings and psychological assessments) and provides a return mechanism to state hospital inpatient status for participants who do not comply with their CONREP treatment plan.¹⁴¹ MDO participants can be forced to continue treatment at the end of their parole terms if they continue to have severe mental disorders, if these disorders are not in remission or cannot be kept in remission without treatment,

¹³⁷ Cal. Code Regs. tit. 15 §2637(b)6 (2006). Note, however, that the legality of the portions of §2637 that apply to sexually violent predators are in dispute. A California state Court of Appeals held that it is a violation of due process to hold a prisoner beyond his release date based solely on a finding that he has a mental disorder and is in need of treatment. See Terhune v. Superior Court, 65 Cal. App. 4th Supp. 864 (Cal. App. Dept Super. Ct. 1998).

¹³⁸ Cal. Penal Code §2960 *et seq.* (West 2000).

¹³⁹ California State Prisoners Handbook, *supra* note 53, at 407.

¹⁴⁰ Cal. Welf. & Inst. Code §4360 (West 1998).

¹⁴¹ See Forensic Conditional Release Program Home Page, Cal. Dep’t of Mental Health, <http://www.dmh.ca.gov/Forensic/conrep.asp>.

and if they continue to pose a substantial danger of physical harm to others.¹⁴² In such circumstances, the DMH will refer the case to the District Attorney, who will then initiate proceedings for civil commitment.¹⁴³

The following programs demonstrate some of the key features of a successful post-release approach, although none operates on the scale necessary to meet the statewide demand. California should therefore either take a few programs and implement them statewide, or expand existing grant-making programs so that local jurisdictions receive funding for programs they develop. In either case, the state should require regular reports on parolee outcomes from local jurisdictions. More information is necessary to diagnose shortcomings and to shift managerial and material resources to where they are most needed.

The Mental Health Services Continuum Program (“MHSCP”): Transition from Prison to Parole. MHSCP is a statewide program designed to ease mentally ill inmates’ transition from prison to parole and thereby reduce recidivism.¹⁴⁴ It serves parolees released on or after October 1, 2000.¹⁴⁵ The program aims to assess inmates’ pre-release needs, assist with eligibility and applications for public assistance, provide enhanced post-release mental health treatment, improve continuity of care from prison to the community, assist participants with re-integration into the community, and standardize care across all four of California’s parole regions.¹⁴⁶

¹⁴² Cal. Penal Code §2970 (West 2000). See also People v. Beeson, 99 Cal. App. 4th Supp. 1393 (Cal. App. Dep’t Super. Ct. 2002) (describing an MDO commitment proceeding).

¹⁴³ California State Prisoners Handbook, *supra* note 53, at 411.

¹⁴⁴ 2005 Annual MHSCP Report, *supra* note 124, at 1.

¹⁴⁵ Id.

¹⁴⁶ Id.

Social workers under the aegis of the regional Transitional Case Management Program coordinate the care of program participants, beginning with an in-prison face-to-face assessment within ninety days of the inmate’s Earliest Possible Release Date (“EPRD”).¹⁴⁷ The assessment is then updated within thirty days of the EPRD and the information is entered into the Parole Automated Tracking System database.¹⁴⁸ A first post-release appointment is also scheduled—within three business days for EOP parolees and seven business days for stable, functioning CCCMS parolees.¹⁴⁹

A 2005 study of MHSCP participants from July 1, 2001 to December 31, 2003 showed promising results. Participants in the program were much more likely than non-participants to attend Parole Outpatient Clinics (POCs) and less likely to return to prison. Pre-release assessment alone appeared to be an important factor in improving post-release POC attendance: 66.2% of assessed inmates attended at least one POC session, compared to 50.8% of non-assessed inmates.¹⁵⁰ Assessed inmates also attended more POC sessions, on average, than non-assessed inmates did: a mean of 4.4 versus 3.3.¹⁵¹ Most significantly, pre-release assessments were associated with a 19% reduction in the likelihood of being returned to custody in the first twelve months of release, and having at least one POC contact was associated with a 37% reduction in recidivism risk.¹⁵² The 2005 study estimated that cost savings from the program are substantial: based on reduced incarceration days, pre-release assessments save \$2194 for each EOP parolee and

¹⁴⁷ Id.

¹⁴⁸ Id.

¹⁴⁹ Id. at 1-2. Again, Correctional Clinical Case Management System (“CCCMS”) parolees are diagnosed with mental illness but stable functioning; Enhanced Outpatient Program (“EOP”) parolees are diagnosed with acute onset of a serious mental disorder with delusional thinking, hallucination, etc. See discussion supra at 10-11.

¹⁵⁰ 2005 Annual MHSCP Report, supra note 124, at 2.

¹⁵¹ Id.

¹⁵² Id. at 3.

\$712 for each CCCMS parolee.¹⁵³ Parolees attending at least one POC session saved the CDCR \$5998 per EOP parolee and \$3224 per CCCMS parolee.¹⁵⁴

MHSCP's main shortcoming is that not all eligible prisoners are actually reached by the program. Only 57% of the eligible pool of released prisoners were assessed in a face-to-face meeting prior to release.¹⁵⁵ The earlier an inmate appears on the Offender Information Services ("OIS") list of soon-to-be-released inmates, the more likely he or she will be assessed face-to-face.¹⁵⁶ 63.5% of MHSCP-eligible inmates appearing on the OIS list more than forty-five days before their release date were assessed face-to-face,¹⁵⁷ while only 17.8% of MHSCP-eligible inmates who appeared on the OIS list within forty-five days of release got a face-to-face assessment.¹⁵⁸ Assessment rates have been improving recently, but it remains to be seen whether the program can continue to reach more and more prisoners.

Mentally Ill Offender Crime Reduction Grant Programs. In 1998, the California Legislature authorized the Mentally Ill Offender Crime Reduction Grant ("MIOCRG") program to fund innovative local programs targeting mentally ill offenders. MIOCRG currently provides 80 million dollars to thirty projects in twenty-six of California's fifty-eight counties.¹⁵⁹ To set the program's priorities, county service providers and law enforcement officials were asked what their needs were in dealing with mentally ill offenders; their responses included (1) better prison discharge planning, (2) more housing

¹⁵³ Id.

¹⁵⁴ Id.

¹⁵⁵ Id. at 2 (hopefully observing that "the percentage of inmates who are assessed has increased over time").

¹⁵⁶ Id.

¹⁵⁷ Id.

¹⁵⁸ Id.

¹⁵⁹ 2005 MIOCRG Statewide Eval., supra note 5, at 1.

options, (3) increased treatment capacity, and (4) interagency coordination.¹⁶⁰ The MIOCRG programs are funded with these priorities in mind.

Though the funding is disbursed at the state level, all MIOCRG programs are administered at the county level: this allows counties to tailor programs to their needs without engendering resource differentials between counties. Because mental health services are provided through counties, local administration allows community stakeholders a greater opportunity to coordinate care. Two-thirds of county programs draw on the Assertive Community Treatment model,¹⁶¹ employing a multidisciplinary group of providers that service clients as a team, with availability around the clock. A study aggregating data from the programs showed positive results.¹⁶² Participants scored higher on the improved Global Assessment of Functioning (“GAF”)¹⁶³ and lowered rates of criminal bookings, convictions, drug and alcohol usage, and homelessness.¹⁶⁴ The strategies common to the most successful programs were interagency collaboration, intensive case management, assistance in securing housing and government benefits, use of a center or clinic, assistance with transportation, and peer support for participants.¹⁶⁵

Unfortunately, most counties exclude violent offenders from their MIOCRG programs.¹⁶⁶ This makes little sense. Violent offenders, if still violent, will be treated under existing programs for Mentally Disordered Offenders or the Conditional Release Program—no county program needs to account for currently dangerous mentally ill

¹⁶⁰ 2004 MIOCRG Annual Rep. to Legis., supra note 6, at 4.

¹⁶¹ 2005 MIOCRG Statewide Eval., supra note 5, at 1. ACT criteria include multidisciplinary staffing, integration of services, low client-staff ratios, 24-hour access, and time-unlimited services (that is, ongoing treatment on an as-needed basis, even after participants’ conditions have stabilized).

¹⁶² 2004 MIOCRG Annual Rep. to Legis., supra note 6, at 3.

¹⁶³ 2005 MIOCRG Statewide Eval., supra note 5, at 5. The GAF is a common psychiatric assessment tool which measures social, occupational, and psychiatric functioning.

¹⁶⁴ Id. at 4.

¹⁶⁵ Id. at 7. Many of these factors track closely with the ACT criteria; see supra note 161.

parolees.¹⁶⁷ Ex-offenders who are not currently dangerous but who were sentenced on a violent offense need treatment to ensure that they remain non-violent. In short, violent offenders will not go away or spontaneously heal themselves; ignoring the problem will not eliminate it. Denying violent ex-offenders care does not make the public safer but, instead, increases the likelihood that ex-offenders will relapse, forcing the prison system to absorb them at greater expense.

Programs Targeting the Mentally Ill Homeless. California has targeted the mentally ill homeless through a variety of state initiatives, commonly referred to as “AB 2034 programs” after state assembly bill 2034, passed in 2000, which provides funding for a variety of community mental health programs.¹⁶⁸ These programs serve, but do not specifically target, ex-offenders among the homeless mentally ill population, although a “large number” of participants “came directly out of jail or prison.”¹⁶⁹ Over three years, participants in AB 2034 pilot programs reduced days spent in incarceration by 72.1% and the number of incarcerations by 45.9%.¹⁷⁰ Participants’ ability to secure housing was a foundation for successful treatment: “What has become apparent to most providers and stakeholders is the therapeutic significance of having a stable place to live, and the foundation this provides for individuals’ ability and desire to make progress in other aspects of their lives.”¹⁷¹

AB 2034 programs also treat co-occurring substance abuse—61.9% of program participants had a co-occurring substance abuse disorder, and the results of the test

¹⁶⁶ 2005 MIOCRG Statewide Eval., *supra* note 5, at 2.

¹⁶⁷ See *supra* text at 24.

¹⁶⁸ Stephen Mayberg, *Effectiveness of Integrated Servs. for Homeless Adults with Serious Mental Illness*, i (2003), available at http://www.dmh.cahwnet.gov/AOAPP/Int_Services/docs/AB2034_may2003.pdf.

¹⁶⁹ *Id.* at 8.

¹⁷⁰ *Id.* at 10.

¹⁷¹ *Id.* at 2.

programs show “that to be effective it is necessary to treat the mental illness and the substance abuse issues simultaneously rather than separately.”¹⁷² The program also emphasizes the importance of collecting data, particularly for outcome-based assessments of effectiveness: “The requirements for data collection and reporting ... send a universal message to all.... that what we care about is not limited to what type of mental health service someone is receiving, but rather where people are living, whether they are working, avoiding incarcerations and inappropriate hospitalizations, and generally improving the quality of their lives.”¹⁷³ Outcome measurements for programs include current housing and employment—an outcome focus unique to this program.¹⁷⁴ As of 2003, AB 2034 programs served 5000 people, about 10% of the estimated 50,000 mentally ill homeless people in California.¹⁷⁵

Graduated Sanctions and Harm Reduction. One San Francisco program funded by AB 2034 uses graduated sanctions within a harm reduction philosophy: recognizing that abstinence is the ultimate goal, but “accept[ing] that not everyone is ready or able to cease all drug use immediately.”¹⁷⁶ Under harm reduction, drug abuse is treated according to a disease model, not a criminal one. When a client relapses, the graduated sanctions approach allows administrators to respond by adjusting treatment first, rather than immediately revoking parole.¹⁷⁷ As one program administrator says, “Everyone

¹⁷² Id. at 8.

¹⁷³ Id. at 22. Note that the importance of collecting data is addressed to providers of the services. The message of data’s importance “resounds from line staff to program administrator, from county mental health director to State mental health director, from the Legislature to the Governor.” Id.

¹⁷⁴ Id.

¹⁷⁵ Id. at 36.

¹⁷⁶ Id. at 5.

¹⁷⁷ Id. at 7.

agrees abstinence is the ideal. But that is not going to happen, so let's not make them flee from treatment."¹⁷⁸

One method of getting patients to reduce dependence on illegal drugs is to educate them about symptom management and about the benefits of legal medications.¹⁷⁹ The theory behind this policy is that many mentally ill homeless self-medicate through use of illegal drugs and will make healthier decisions if they are better informed. Program administrators also build bridges to the criminal justice system, "which increases the likelihood that judges will release clients to treatment programs, or probation officers will defer to case managers [sic] treatment recommendations."¹⁸⁰

California's official parole policies must be amended if harm reduction and graduated sanctions are to be rolled out on a large-scale basis. Parole officers are currently constrained by Parole Board policies in their ability to participate in such programs, because officers are still officially required to report certain offenses.¹⁸¹ Parole officers are also hindered by the prospect of legal liability, which affects their willingness and ability to bend the rules for a given client.¹⁸² State indemnification of parole officers who participate in certain programs might improve treatment outcomes; the cost of indemnification could easily be paid for out of the savings from implementing graduated sanctions. The 2003 Little Hoover report on parole recommended both graduated sanctions and shorter revocation sentences as a way of cutting costs "without jeopardizing public safety": treating drug abuse with graduated sanctions was estimated

¹⁷⁸ Id. at 6.

¹⁷⁹ Id. at 6-7.

¹⁸⁰ Id. at 8-9.

¹⁸¹ Id. at 10. See, e.g., Cal. Code Regs. tit. 15 §2616 (2006).

¹⁸² Petersilia, When Prisoners Come Home, supra note 130, at 85 et seq.

to save \$151 million immediately, while reducing the average revocation sentence from 140 days to 100 days was estimated to save \$300 million per year.¹⁸³

V. Policy Recommendations

Without a change in the culture of the CDCR health care system, policy recommendations are meaningless. The problems with California prison health care in general and mental health care in particular are both well-documented and well entrenched. No policy recommendation has the power to reform the system; any attempt to fix the unconstitutional and embarrassing state of the prison mental health care system must begin by repairing the system's culture of failure. Once the CDCR's culture of failure is replaced with accountability and responsibility, several other specific changes must also be implemented: (1) some form of diversion from the penal system; (2) flexible, fully-funded, coordinated provision of care in prisons, including information systems and managerial oversight designed to ensure compliance with standards of care; (3) an expansion of programs targeting the mentally ill and specific subgroups therein; and (4) an expansion of post-release programs as outlined above.

1. Promote Alternatives to Prison.

Because people with mental illness tend to get sicker in prison, all efforts should be made to divert them from incarceration where practical. These efforts should include implementation of programs encouraging diversion from the criminal justice system, expansion of treatment resources outside the penal context, and, perhaps most radically, treating mental illness as a public health problem whether the person with mental illness is in prison or outside it.

¹⁸³ Little Hoover, Safe & Sound Parole Policies, supra note 126, at iii. These figures are for parolees in general, not just mentally ill parolees.

Diversion saves money and improves outcomes. Imprisoning the mentally ill is a very expensive proposition; California can either spend taxpayers' money incarcerating the mentally ill or serving a larger number of patients more efficiently and effectively in a non-penal context. Whenever the mentally ill come into contact with the criminal justice system, diversion should always be an option. Police should be trained to de-escalate conflicts with the mentally ill and should be encouraged to refer the individuals they encounter to the DMH; 911-emergency dispatchers should also send trained mental health professionals to respond to calls believed to have a mental health component.¹⁸⁴ Before trial, some mentally ill defendants should be diverted from prosecution into treatment or from criminal court to a mental health court.¹⁸⁵ Mental health courts in particular, by combining law enforcement and social services in a therapeutic approach, have proven particularly effective. According to the California court system, as of 2002, thirteen trial court systems had established mental health courts;¹⁸⁶ additional courts will be funded as a result of Proposition Sixty-three (discussed infra at 35).

Non-penal forms of mental health treatment must receive greater resources than they do now if diversion is to work; currently, the non-penal mental health infrastructure is vastly underfunded and underutilized. California's mental health treatment system began to atrophy during the 1950s, when the deinstitutionalization movement proposed to treat people with mental illness in the least restrictive setting.¹⁸⁷ From 1955 to 1994, the population of mentally ill patients in California state hospitals dropped 89.8%; adjusting

¹⁸⁴ See Council of State Gov'ts, Criminal Justice/Mental Health Consensus Project, 34-70 (2002), available at http://consensusproject.org/downloads/Entire_report.pdf.

¹⁸⁵ See id. at 72-124.

¹⁸⁶ Judicial Council of California, Mental Health Courts: Of Current Interest (2006), <http://www.courtinfo.ca.gov/programs/collab/mental.htm>.

¹⁸⁷ See generally E. Fuller Torrey, Out of the Shadows: Confronting America's Mental Illness Crisis (1997).

for the boom in California's population during that time, however, yields a figure closer to 96%.¹⁸⁸ In other words, California state hospitals do not treat 96% of the target population they treated in 1955; 96% of people who would have received inpatient treatment in state mental hospitals must now turn elsewhere.

At the same time, California's civil commitment laws make it difficult for local officials to force a person with mental illness to get treatment. The Lanterman-Petris-Short Act ("LPS") enables the state to commit individuals adjudged to be either a danger to others or "gravely disabled"—unable to provide food, clothing, and shelter for themselves—as a result of mental illness.¹⁸⁹ Commitment, known as a conservatorship, lasts for a year; conservatorships can be renewed but, if challenged by the patient, must be supported in court with updated diagnoses. The LPS provides important civil rights to the mentally ill, but limits treatment: first, the law enables individuals to initially refuse treatment even if they might be too mentally ill to exercise sound judgment (making "voluntary" refusals to accept treatment potentially more suspect¹⁹⁰), and second, the law permits commitment only after the illness has reached a crisis point.¹⁹¹ Intermediate treatment for those unable to consent is needed: "We do not tell cancer patients to come back if and when their disease has metastasized. But we turn mental health clients away

¹⁸⁸ PBS Frontline website, *The New Asylums, Deinstitutionalization: A Psychiatric Titanic* (2005), <http://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html>, citing generally Torrey, *Out of the Shadows*, *supra* note 187.

¹⁸⁹ Cal. Welf. & Inst. Code §5000-5129 (West 1998).

¹⁹⁰ Advance directives about mental health care can preserve individual preferences about treatment even when an individual is too incapacitated to express them. See John Monahan et al., *Mandated Community Treatment for Mental Disorder*, *Health Affairs* 34 (Sept.-Oct. 2003).

¹⁹¹ Cal. Treatment Advocacy Coalition, Fact Sheet, *Talking Points: Why LPS Must Be Reformed* 1 (n.d.), available at <http://www.psychlaws.org/StateActivity/California/factsheet1.htm> (last visited Dec. 19, 2005).

and tell them to return when their symptoms are so severe and persistent that they cannot meet their own needs, and may no longer recognize that they need care.”¹⁹²

Some observers refer to the “balloon theory” of mental illness treatment: by squeezing the mentally ill out of civil treatment, they have shifted to a place where treatment both must be provided and cannot be refused—prison.¹⁹³ Untreated mental illness may manifest itself in behavioral problems that result in arrest and imprisonment,¹⁹⁴ and often the only treatment available is in jail. Anecdotal reports even indicate that judges sometimes put the mentally ill in prison to give them access to mental health services.¹⁹⁵ This might explain why the incidence of extreme recidivism among inmates—those inmates with eleven or more prior offenses—is twice as high for the mentally ill.¹⁹⁶ The ironic result is that a deinstitutionalization policy borne of a desire to treat the mentally ill using the least restrictive alternative now puts them in the most restrictive environment possible.¹⁹⁷ For diversion to work, there must ultimately be greater resources devoted to non-penal alternatives and better legal mechanisms for steering people with mental illness toward treatment.

One path towards getting greater resources for prisoners might be to tap into the money generated by various state and federal initiatives. In November 2004, California voters passed Proposition Sixty-three (codified as the Mental Health Services Act, or

¹⁹² Little Hoover, Making a Commitment to Mental Health, *supra* note 61, at iii.

¹⁹³ That is, push down on one part of the balloon—hospitalization—and the needs of people with mental illness will arise in a different location—prison.

¹⁹⁴ Kanapaux, Guilty of Mental Illness, *supra* note 7, at 2.

¹⁹⁵ See *id.* at 6; see also PBS Frontline Website, The New Asylums, Frequently Asked Questions (2005) <http://www.pbs.org/wgbh/pages/frontline/shows/asylums/etc/faq.htm> (quoting Reginald Wilson, director of the Ohio prison system: “I’ve actually had a judge mention to me before that, ‘We hate to do this, but we know the person will get treated if we send this person to prison.’”).

¹⁹⁶ Frontline Frequently Asked Questions. See The New Asylums, Frequently Asked Questions, *supra* note 195.

“MHSA”).¹⁹⁸ The MHSA, which raises money for the treatment of the mentally ill via a tax on Californians with incomes greater than one million dollars, has not yet been used to fund programs relating to mentally ill prisoners in particular.¹⁹⁹ It is unclear whether this is a result of a policy decision or simply the lack of knowledge on the part of corrections officials—the information provided to potential applicants identifies the treatment of co-occurring mental illness and drug addiction as a funding goal, but it does not list corrections anywhere.²⁰⁰ The language most favorable to the potential funding of offender and ex-offender programs is the MHSA’s goal “to reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness.”²⁰¹ The funds available through the MHSA are significant—in excess of \$600 million a year,²⁰² or about a 26% increase over current funding levels.²⁰³

Perhaps the most radical reform would be to treat mental illness as a public health problem—not as a criminal problem—regardless of the custodial status of those involved. Such an approach would encompass graduated sanctions and harm reduction in parole,

¹⁹⁷ This phenomenon—the transition from inpatient treatment in hospitals to incarcerated treatment in prisons—is known as transinstitutionalization. See Ralph Slovenko, The Transinstitutionalization of the Mentally Ill, 29 Ohio N. U. L. Rev. 641 (2003).

¹⁹⁸ Initiative Measure (Prop. 63, approved Nov. 2, 2004), Mental Health Services Act of 2004, available at http://www.dmh.cahwnet.gov/MHSA/docs/Mental_Health_Services_Act_Full_Text.pdf.

¹⁹⁹ Sadly, this oversight is not uncommon. The recent report published in 2003 by the President’s New Freedom Commission on Mental Health makes no mention of the mentally ill behind bars. See generally President’s New Freedom Comm’n on Mental Health, Final Report, *supra* note 6. Apparently reducing the stigma of mentally ill is a goal only if the mentally ill in question are not further stigmatized by their criminal records.

²⁰⁰ Judicial Council of Cal., Proposition 63 Info. Kit 3 (2005), <http://www.courtinfo.ca.gov/programs/collab/documents/prop63infopack.pdf>. In contrast, the federal Mentally Ill Offender Treatment Crime Reduction Act (Public Law 108-414 (Oct. 30, 2004)) provides \$50 million in grants for, *inter alia*, improving mental health and substance abuse care to prisoners and those re-entering society.

²⁰¹ Mental Health Services Act of 2004 §3(b) (“Purposes and Intent”); http://www.dmh.cahwnet.gov/MHSA/docs/Mental_Health_Services_Act_Full_Text.pdf, last visited 1/26/06.

²⁰² Judicial Council of Cal., Proposition 63 Info. Kit, *supra* note 200, at 1.

²⁰³ See Kara Bambauer, Proposition 63: Should Other States Follow California’s Lead?, 56 Psychiatric Services 642 (June 2005).

but would extend to other factors as well. For example, if prisoners who suffer from mental illness were treated through Medi-Cal or Medicaid, just as they were before and/or after incarceration, administration costs would decrease and continuity of care would improve. Prisoners would no longer need to face medication and therapeutic shortages as they got lost in the shuffle. Given the high rates of communicable diseases such as AIDS and hepatitis in the prison community,²⁰⁴ coupled with the fact that most prisoners do eventually return to society whether their diseases are contagious or not, an epidemiological approach that treats prison populations as a subset of the larger population could gain traction.

To implement such an approach, California must move away from certain entrenched ideas. Treatment of mental illness is a sound investment in public safety, the public fisc, and reduction of suffering—not a luxury. Recent mental health initiatives, many of which exclude mentally ill offenders, indicates that there is a great need for leadership and education on this issue. The mentally ill do not somehow stop being ill once they are incarcerated; the fact that some people with mental illness commit crimes as a result of their mental illness does not make them less deserving—or less in need of—treatment. Focusing on the treatment needs of mentally ill offenders does not mean they should be “let off” and released from prison: they should not be and are not. California’s MDO program, which covers violent mentally ill prisoners, provides a well-established regime for treating and civilly committing violent mentally ill offenders.

On a related note, the state (and federal government) must stop excluding drug offenders from receiving government benefits and programming. An insistence on drug

²⁰⁴ See, e.g., Laura Maruschak, Bureau of Justice Statistics, U.S. Dep’t of Justice, HIV in Prisons and Jails 1999 1 (2001) (finding nationwide rates of HIV infection in prison to be 5 times the rate of the population

abstinence—and the revocation of parole—is more expensive and ultimately less effective than graduated sanctions. Incarceration interrupts therapeutic programs which work; zero tolerance policies provide, at best, minimal deterrence for addicts and even less for mentally ill parolees. Excluding drug offenders from government subsidized Section Eight housing destabilizes their lives and makes them more likely to wind up homeless or in jail, at a cost that is greater both financially and in terms of human suffering.²⁰⁵ If the state’s goal is public safety and economy, excluding drug offenders from housing and other benefit programs for life makes very little sense and actually makes funding residential drug and alcohol treatment much more difficult.²⁰⁶ Graduated sanctions for parolees, as mentioned infra at 31, could save California \$151 million immediately.²⁰⁷

2. Implement a Flexible, Fully-Funded, Coordinated Mental Health Program in Prisons That Uses Data and Management Oversight to Ensure Quality Care is Provided.

Medical and therapeutic care programs must be flexible enough to accommodate the diverse needs of prisoners, funding must be secured to ensure that prison health care and programming is fully staffed, corrections officers must coordinate their priorities and operations to ensure that needless suffering is avoided, and information technology and management systems must ensure that programs are providing positive outcomes.

First, the state’s information technology and data collection needs to be revamped. Without better information, an accurate diagnosis of the system’s ills is

as a whole).

²⁰⁵ See discussion supra at 29.

²⁰⁶ Petersilia, When Prisoners Come Home, supra note 130, at 125.

²⁰⁷ Little Hoover, Safe & Sound Parole Policies, supra note 126, at iii.

impossible. In general, more data needs to be standardized and shared, both within the prison system and among social service providers. Sharing information avoids duplication of effort and can realize efficiency gains in a resource-strapped system; it also means that prisoners don't have to wait for treatment. Jails and prisons in particular must integrate their information, since there is so much population migration between the two systems. The state should consider funding mental health screenings in county jails: this would eliminate the need for duplicate tests at reception centers and would help to standardize the information collected.²⁰⁸ Standardized information is of great assistance in maintaining effective release programs.²⁰⁹

For those prisoners with pre-existing diagnoses, information must be shared between jails and prisons, or between social service providers and prisons. If the prisoner has been on medications outside the prison, every effort should be made to continue the identical medication; though many drugs perform the same function, side effects can be different. Since most patients' dissatisfaction with psychotropic medications focuses on the side effects of drugs, not their intended effects, changing drugs is both disorienting (in an already disorienting environment) and may lead to a decreased willingness to take medication.

California needs to track mentally ill county inmates, state prisoners and parolees across jurisdictions. The state should consider piggybacking mental health information onto one of the existing criminal justice databases—e.g. the Parole Automated Tracking System or the California Law Enforcement Telecommunications System (which tracks

²⁰⁸ Nieto, supra note 29, at 47.

²⁰⁹ John Monahan, Violence Risk Assessment [11 Forensic Psychology] Comprehensive Handbook of Psychology 25-30 (§6, Ch. 24) (Feb. 9, 2001) (unpublished on file with author).

criminals across jurisdictional lines)²¹⁰—or apply for funds from the National Criminal History Improvement Program to computerize criminal history records.²¹¹ Any attempt to reform the state’s antediluvian correctional information technology must standardize databases and have a central administrator oversee the project, as recommended in 2004 by the Corrections Independent Review Panel.²¹² Ultimately, the information should be used to assess program effectiveness on an outcome basis.

The prison system must also screen prisoners already in custody to account for late-onset mental illness. Prison can trigger mental illness in some inmates who do not present symptoms at the time of intake, and protocols should be developed to ensure that late onset mental illness is identified and treated. Finally, California must revamp its prison health system in order to comply with the rulings of Judge Henderson in Plata. This will include (1) streamlining administrative procedures to ensure prisoners easier access to treatment and (2) implementing systems for more accountability on the part of service providers.

Second, more resources for mental health treatment and programming in prison must be provided. It is clear that the mentally ill, once imprisoned, do not get the care that they need. One collateral effect of resource scarcity is that there are fewer resources to address inmates with non-acute psychological needs. “Inmates who need treatment for lesser problems, such as anger management and borderline personality disorders, rarely get it. That contributes to the great stress within the prison, and it frustrates inmates’

²¹⁰ Nieto, supra note 29, at 47.

²¹¹ Petersilia, When Prisoners Come Home, supra note 130, at 108. Given that many states make criminal records publicly available online, however, there might be medical privacy issues under the Health Insurance Portability and Accountability Act of 1996.

²¹² Report of the Corrections Independent Review Panel, Reforming Corrections, supra note 91, at 1.

opportunities for parole."²¹³ One ingenious solution proposed to deal with staffing shortages would be to condition state medical education grants (or reduced rates on student loans) on recipients' agreeing to work in prison health care for a set period of time.²¹⁴ In addition to providing needed services, the community at large would benefit as young doctors returned from their prison residencies with firsthand knowledge of what is really happening inside California's prisons.

Third, treatment can be improved by decentralizing its provision; prisoners are less likely to fall through the cracks if they do not have to be transferred from prison to prison. California concentrates mental health treatment in a few facilities, such as the California Medical Facility in Vacaville (42.3% of inmates are in twenty-four-hour psychiatric care, receive therapy/counseling and take psychotropic medications) and the California Institution for Women (46.1% of inmates in therapy/counseling, 30.7% on psychotropic medications).²¹⁵ Decentralization of treatment may yield better results: local treatment facilities capable of handling mental illness might provide greater flexibility to prison administrators and less disruption to mentally ill inmates, although decentralization might simply strain already scarce resources.

Fourth, health care providers should enlist corrections officers to be the first line of treatment for mentally ill prisoners. COs should receive more support and training for dealing with mentally ill prisoners, including training on mental health symptomology and pharmaceutical treatment. Jurisdictions outside California have experimented with different ways of imposing discipline on mentally ill prisoners to positive effect: behavior modification techniques engender order without as much confrontation as traditional

²¹³ Sterngold, Grim Reality of Prison Health Care, supra note 92, at A16.

²¹⁴ Nieto, supra note 29, at 48.

techniques and seem to work better with mentally ill inmates, whose impulse control is not well established.

3. Tailor Programs to the Mentally Ill Population.

Programming must be expanded for mentally ill prisoners, and alternatives to standard policies, where appropriate, should be developed. This includes the possibility of separate housing for the mentally ill, separate disciplinary procedures, and an expansion of tailored post-release programs. Furthermore, individual subpopulations of mentally ill prisoners, particularly female prisoners with mental illness, need programming tailored to their particular needs.

Existing programs for the general population that are particularly effective for the mentally ill must be identified and mentally ill prisoners should be placed in them. At the same time, programming that is designed specifically for the mentally ill needs to be developed and implemented. These programs must address not only post-release needs (self-care, job skills, information about federal and state post-release programs) but deeper psychological needs as well. Prisoners with co-occurring drug and alcohol abuse must be specifically targeted, since their rate of recidivism is much higher than that of either the mentally ill or the general prison populations. Moreover, many mentally ill prisoners have suffered from emotional, physical, and sexual abuse; counseling to address the legacy of abuse and help prisoners avoid becoming abusers themselves should also be developed and implemented.

Safety, discipline, and housing also need to be modified to reflect the reality of mentally ill prisoners. First, mentally ill prisoners are more likely to be victimized by other inmates and also more likely to violate prison rules. The result in both cases, as

²¹⁵ Ditton BJS Study, supra note 8, at 7.

discussed supra at 4, is often solitary confinement—either as punishment or protective custody. Given the harsh, decompensating effects of solitary confinement, alternatives to solitary confinement must be developed. Second, on a more general level, housing of the mentally ill should be done with their needs in mind. Some inmates should not be housed with the general population, both for their safety and for the safety of those around them. They might benefit from a regime in which somewhat less traditional disciplinary rules prevail—this would avoid the cycle of violations and solitary confinement without sacrificing officer safety.

Female prisoners are particularly susceptible to depression as a result of separation from children and family: 10-15% of women entering reception centers suffer from depression alone.²¹⁶ Women prisoners with mental illness report more disciplinary violations than male prisoners with similar diagnoses: women on psychotropic medication have infraction rates twice that of other women prisoners, and higher than that for medicated men.²¹⁷ Programs and training should focus on the particular needs of women prisoners in the penal context.

4. Transform the Culture of Failure.

All parties with any involvement in the corrections system need to acknowledge openly that these problems have existed for many years, and that the system needs a major overhaul. Every few years, new reports document the lack of record keeping, the inadequacy of mental health care, and the needless duplication of effort and expense that goes into the wasteful system, and yet year after year, nothing seems to change except the dates on the latest atrocious review of CDCR policies. Ten years ago, Coleman described

²¹⁶ Nieto, supra note 29, at 22.

²¹⁷ Human Rights Watch, Ill-Equipped, supra note 2 at 39.

the prison mental health system in words that could apply with equal force today: “Defendants have been confronted repeatedly with plain evidence of real suffering caused by systemic deficiencies of a constitutional magnitude. Their responses have frequently occurred only under the pressure of this and other litigation.”²¹⁸ Litigation of these issues is expensive and removes any discretion from corrections officials—while this is a better alternative than keeping control in the hands of incompetent officials, it would be better still to address the problems proactively. Perhaps the department could begin publishing a shame table of the worst facilities, in terms of untreated prisoners and abuses. Or the system could provide incentives for honesty in reporting mental health problems so that accurate information—the predicate to any solution—can finally be obtained. But even these suggestions have been made before.

It is therefore with some frustration that I conclude this paper, by noting that none of these recommendations is particularly novel. All that is lacking is the administrative skill and political will to implement them. As the system undergoes another stinging rebuke from the justice system and a period of receivership, one can hope that lessons will finally be learned. The citizens of California—not merely its mentally ill prisoners—certainly deserve no less.

²¹⁸ Coleman v. Wilson, 912 F. Supp. 1282, 1311 (E.D. Cal. 1995).

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