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ADDRESSING THE SPECIAL PROBLEMS OF MENTALLY ILL PRISONERS: A SMALL PIECE OF THE SOLUTION TO OUR NATION'S PRISON CRISIS

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INTRODUCTION

After years of neglect, policymakers must confront a crisis in our prisons created by the increasing number of mentally ill prisoners.[1] Mentally ill prisoners are both vulnerable and troublesome. Often out of control, they may need physical restraint, creating a risk to themselves and to prison guards.[2] Other prisoners fear and target the mentally ill, as well.[3]

Apart from their special needs, they are an increasing segment of the prison population.[4] While many mentally ill individuals end up in a nursing home or become homeless, their numbers have risen roughly in proportion with the release of the mentally ill from mental hospitals and the closing of those institutions.[5] Many people who received some form of mental health treatment in those settings are now in prison,[6] where they are unlikely to receive adequate mental health care.[7]

Around the nation, states are looking for ways to reduce prison costs.[8] Various mainstream organizations have been recommending a

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1. *See* Coleman v. Schwarzenegger, No. CIV S-90-0520, 2009 WL 2430820, at *12 (E.D. Cal. Aug. 4, 2009).

2. William Kanapaux, *Guilty of Mental Illness*, PSYCHIATRIC TIMES, Jan. 1, 2004, *available at* http://www.psychiatrictimes.com/display/article/10168/47631.

3. Steven K. Hoge, *Providing Transition and Outpatient Services to the Mentally Ill Released from Correctional Institutions*, *in* PUBLIC HEALTH BEHIND BARS: FROM PRISONS TO COMMUNITIES 461, 470 (Robert Greifinger ed., 2007).

4. LANCE T. IZUMI ET AL., PACIFIC RESEARCH INST., CORRECTIONS, CRIMINAL JUSTICE, AND THE MENTALLY ILL: SOME OBSERVATIONS ABOUT COSTS IN CALIFORNIA 3 (1996), *available at* http://www.mhac.org/pdf/PacificResearchStudy.pdf.

5. *See* James Ridgeway & Jean Casella, *Locking Down the Mentally Ill*, THE CRIME REPORT (Feb. 17, 2010, 10:06 PM), http://thecrimereport.org/2010/02/17/locking-down-the-mentally-ill/.

6. Te-Ping Chen, *For Many With Mental Illnesses, Jail's the Only Treatment Option*, CHANGE.ORG (May 12, 2010, 9:23 AM), http://criminaljustice.change.org/blog/view/for_many_with_mental_illnesses_jails_the_only_treatment_option.

7. SASHA ABRAMSKY & JAMIE FELLNER, HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 110 (2003).

8. *See Cost-Cutting States Reduce Prison Populations: Number of State Inmates Drops For First Time Since 1972*, MSNBC.COM (March 17, 2010, 12:02 AM), http://www.msnbc.msn.com/id/

variety of reforms.[9] In California, the prison system has been subject to federal court litigation for over 20 years.[10] In 2009, a panel of three federal judges found that overcrowding has created health risks—prompting the court to order release of over 40,000 prisoners.[11] California may represent the worst-case scenario, but it is hardly unique. As a result of this national crisis, for the first time in decades, meaningful reform may be in the air.

But if reform takes place, it should be done right. Part of the problem with sentencing generally—as well as the dramatic increase in mentally ill prisoners—is that public policy has been driven by anecdotes and headline cases. As a result, legislation is driven by exaggeration rather than by careful analysis. This is obvious in laws like Three Strikes in California that resulted from the tragic kidnapping, rape and murder of Polly Klaas.[12] Less obvious is how misinformation led to the increase in mentally ill prisoners. And so this Article discusses how the movement to release the civilly committed mentally ill has resulted in the increased number of mentally ill prisoners.[13] The point of that inquiry is to learn some lessons about how we made mistakes.[14] Thereafter I apply those lessons to today's discussions about reforming the prison system as it relates to mentally ill prisoners.[15]

I. GOOD INTENTIONS GO AWRY

So how did we get to where we are today? *One Flew Over the Cuckoo's Nest* should be assigned viewing for anyone attempting to get a quick historical view about the current state of the law governing the mentally ill.[16] In Milos Forman's film, based on Ken Kesey's novel, Jack Nicholson plays a conman who ends up in a mental institution as a way to avoid doing hard labor.[17] Central to the film is his battle against Nurse

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35903114/ns/us_news-crime_and_courts/39172744.

9. *See generally* MICHAEL E. ALPERT, THE LITTLE HOOVER COMMISSION, SOLVING CALIFORNIA'S CORRECTIONS CRISIS: TIME IS RUNNING OUT (2007), *available at* http://www.lhc.ca.gov/studies/185/Report185.pdf; Michael Vitiello & Clark Kelso, *A Proposal For A Wholesale Reform Of California's Sentencing Practice And Policy*, 38 LOY. L.A. L. REV. 903 (2004); Lauren E. Geissler, Creating and Passing a Successful Sentencing Commission in California (Jan. 27, 2006) (unpublished manuscript), *available at* http://www.law.stanford.edu/program/centers/scjc/workingpapers/LGeissler_06.pdf.

10. *See* Coleman v. Schwarzenegger, No. CIV S-90-0520, 2009 WL 2430820, at *12 (E.D. Cal. Aug. 4, 2009).

11. *See id.* at *115–16.

12. Michael Vitiello, *"Three Strikes" And The* Romero *Case: The Supreme Court Restores Democracy*, 30 LOY. L.A. L. REV. 1643, 1655 (1997).

13. *See infra* Part II.

14. *See infra* Part III.

15. *See infra* Part IV.

16. ONE FLEW OVER THE CUCKOO'S NEST (Fantasy Films 1975); *see also* David Pescovitz, *Cuckoo's Nest Hospital to be Demolished*, BOINGBOING (July 16, 2008, 9:32 AM), http://boingboing.net/2008/07/16/cuckoos-nest-hospita.html (explaining that the author of the original story, Ken Kesey, got many of his ideas from working in a mental institution earlier in his life).

17. ONE FLEW OVER THE CUCKOO'S NEST, *supra* note 16.

Ratched, the person effectively in charge of the mental institution.[18] The film captures several themes: it raises questions about whether those in mental institutions in fact are insane; it suggests that the diagnosis of insanity is in part used to suppress rebels, like Nicholson's character, Randall McMurphy; and it shows the debilitating effects of mental health treatments, including McMurphy's lobotomy.[19]

The film's view of mental illness was hardly unique to Kesey or Forman. It reflected powerful themes that had serious backing in the psychiatric community during that era. Emerging as a serious intellectual force in the 1960s, the "anti-psychiatry" movement challenged the most fundamental assumptions and practices of psychiatry.[20] Many prominent figures led an attack on psychiatry as it was then practiced.[21] Central to their claims were a number of premises. For example, they believed that definitions of many psychiatric disorders are vague and arbitrary, leaving too much room for interpretation by the observer and to too many misdiagnosed patients.[22] And the anti-psychiatrists could point to notorious failures and misuses of psychiatry.[23] The modern anti-psychiatrists argued that illnesses like schizophrenia reflected healthy attempts to cope with a sick society.[24] In effect, the diagnosis of mental illness was society's way to control and limit dissent.[25]

Another premise of the anti-psychiatry movement was that available treatments were far more damaging than helpful.[26] Treatment could be brutal. Existing techniques included electric shock therapy, involuntary

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18. *Id.*

19. *Id.*

20. *See* EDWARD SHORTER, A HISTORY OF PSYCHIATRY: FROM THE ERA OF THE ASYLUM TO THE AGE OF PROZAC 277 (1997).

21. *Id.* at 274–276 (explaining that among the leaders in the movement were Michael Foucault, Ronald D. Laing, and Erving Goffman).

22. Heap v. Roulet (*In re* Estate of Roulet), 590 P.2d 1, 10–11 (Cal. 1979).

23. *See, e.g.*, THOMAS SZASZ, SCHIZOPHRENIA: THE SACRED SYMBOL OF PSYCHIATRY 152–53 (1976) (citing the ability of husbands to have their wives committed for disobedience despite their wives' sanity); SHORTER, *supra* note 20, at 303–04 (explaining that anti-psychiatrists could also point to the American Psychiatric Association's inclusion of homosexuality as a form of mental illness until the 1970's); Richard J. Bonnie & Svetlana V. Polubinskaya, *Unraveling Soviet Psychiatry*, 10 J. CONTEMP. LEGAL ISSUES 279, 279 (1999) (explaining the Soviet's use of mental institutions to deal with political opponents of the state); Ariela Gross, *Pandora's Box: Slave Character on Trial in the Antebellum Deep South*, 7 YALE J.L. & HUMAN. 267, 293 (1995) (explaining the 18th century diagnosis of a mental disease afflicting some slaves whose symptoms included their tendency to escape their masters).

24. SHORTER, *supra* note 20, at 276.

25. Bonnie & Polubinskaya, *supra* note 23, at 279 (explaining that the anti-psychiatry movement coincided with opposition to the Vietnam War and to civil rights and women's rights movements); *see* E. FULLER TORREY, OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS 142 (1997) [hereinafter OUT OF THE SHADOWS] (explaining that a new generation of lawyers emerged with an interest in civil liberties and borrowed strategies from other civil rights litigation as well); Michael E. Staub, *Madness is Civilization: Psycho Politics and Postwar America* 4 (School Soc. Sci., Occasional Paper No. 34, 2008), *available at* http://www.sss.ias.edu/files/papers/paper34.pdf (explaining that as a result, claims that the mentally ill were victims of a sick society gained credibility).

26. *See* SHORTER, *supra* note 20, at 208.

commitment for long periods of time with few constraints, and lobotomies—often leaving the patient catatonic.[27] Combine those invasive practices with famous cases of misdiagnosis of different kinds. In some instances, a patient suffering from one mental illness was diagnosed with a different illness.[28] Even more frightening were cases where a perfectly sane individual was involuntarily committed and kept committed for a prolonged period of time.[29]

The system was certainly broken. Peaking in 1956, the population housed in state and local public mental health hospitals was about 560,000.[30] Many were warehoused in state institutions described as "snake pits," where they were at the mercy of poorly trained staff, which lacked adequate resources.[31] Back when Geraldo Rivera was a serious investigative reporter, he, among others, got the public's attention with exposés of the terrible conditions in mental institutions.[32]

This period was the setting for a dramatic expansion of the rights of the mentally ill and for the movement that led to deinstitutionalizing mental health care. Change came through various legislation and many lawsuits, several of which ended in the Supreme Court.[33] Several important principles emerged that expanded the rights of the mentally ill.[34] The net result was that involuntary civil commitment and compelled medica-

27. Sheldon Gelman, *Looking Backward: The Twentieth Century Revolutions in Psychiatry, Law, and Public Mental Health*, 29 OHIO N.U. L. REV. 531, 531–32 (2003).

28. *See* Heap v. Roulet (*In re* Estate of Roulet), 590 P.2d 1, 10–11 (Cal. 1979).

29. *See* SZASZ, *supra* note 23, at 149–51.

30. MICHAEL PUISIS, CLINICAL PRACTICE IN CORRECTIONAL MEDICINE 33 (2d ed. 2006) (stating that by comparison, today, there are about 80,000 people committed to such institutions).

31. *Psychiatry: Out of the Snake Pits*, TIME, Apr. 05, 1963, *available at* http://www.time.com/time/magazine/article/0,9171,830082-1,00.html.

32. *See* WILLOWBROOK: THE LAST DISGRACE (ABC 1972).

33. *See, e.g.*, O'Connor v. Donaldson, 422 U.S. 563 (1975).

34. *See* Wyatt v. Stickney, 325 F. Supp. 781, 785–86 (1971). For example, mentally ill patients who are involuntarily committed have due process interests in conditions of reasonable care and safety and reasonably nonrestrictive confinement conditions. They have the right to a range of services, including the right to treatment in a community setting. *O'Connor*, 422 U.S. at 574–76. Further, the Court has found that it is unconstitutional to detain someone involuntarily if that person is not a danger to himself or to others. Thus, a finding of mental illness, without more, does not justify continued confinement even if appropriate treatment is available. *Id.* at 575. Both lower federal courts and the Supreme Court have limited the state's ability to administer psychotropic medication in any setting. Involuntarily committed mental patients have a right to make their own treatment decisions and may not be forcibly medicated (subject to limited circumstances, notably emergencies and periods of incompetence). *See* Washington v. Harper, 494 U.S. 210, 221 (1990). An institution's decision to medicate is not justified solely on a finding that the patient is incompetent. The decision to medicate requires additional litigation and a specific finding that the patient is incompetent to make that decision for herself. *Id.* at 228. In the more recent past, some states have cut back on the rights of the mentally ill, often in reaction to a violent crime committed by a mentally ill individual. For example, New York enacted "Kendra's Law," N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2010), after a schizophrenic man pushed a young woman onto subway tracks, leading to her death. PATRICIA E. ERICKSON & STEVEN K. ERICKSON, CRIME, PUNISHMENT, AND MENTAL ILLNESS: LAW AND THE BEHAVIORAL SCIENCES IN CONFLICT 23–25, 45–46 (2008).

tion became far more difficult.[35] Many of the same protections apply to mentally ill prisoners as well.[36]

Not only have the mentally ill gained legal protection, but at the same time, we experienced a movement away from publicly funded state mental institutions.[37] That change was not inevitable, but flowed from the horrible exposure of conditions in those institutions. Even those revelations may not have resulted in the closing of many of those institutions. After all, revelations about horrible prison conditions did not lead to closing those facilities.[38] But as indicated earlier, inspired in part by the anti-psychiatry movement, numerous reformers believed, in effect, that many mentally ill individuals were rebels against an oppressive society and that the state used mental institutions to suppress dissent.[39]

And not all of those interested in closing mental institutions were disability rights activists. In California, in the late 1960s, then-Governor Ronald Reagan signed legislation that paralleled developments elsewhere, and made involuntary commitment extremely difficult.[40] Mentally disabled rights activists called the California legislation "the Magna Carta of the mentally ill" and saw it as a step towards an eventual goal of eliminating involuntary commitment altogether.[41] As a result of the deinstitutionalization movement, mentally ill patients who were released from mental health facilities were sent back into their communities.[42]

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35. *See* CAL. WELF. & INST. CODE § 5150 (West 2010). For example, under California's law, commitment was no longer justified simply based on a showing of the need for treatment but instead required a showing that the person was a danger to himself or to others. *Id.*

36. In 1990, the Supreme Court held that correction officials can administer such medication in compelling circumstances but cannot do so arbitrarily. *Washington*, 494 U.S. at 221. Thus, the state must show that the prisoner is gravely disabled or is a danger to himself or others. Under the Court's case law, an inmate has a right to refuse psychotropic medication under most circumstances. The net result of these various cases is a set of important procedural rights that make involuntary commitment and treatment difficult to compel.

37. Alfred Auerback, *The Short-Doyle Act: California Community Mental Health Services Program: Background and Status After One Year*, CAL. MED., May 1959, at 335, *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1577700/pdf/califmed00113-0095.pdf.

38. *See* Margaret Winter & Stephen F. Hanlon, *Parchman Farm Blues: Pushing for Prison Reforms at Mississippi State Penitentiary*, 35 LITIG. 1, 1–8 (2008), *available at* http://www.aclu.org/images/asset_upload_file829_41138.pdf (explaining that instead, for example, in prison litigation in the south, court supervision led to markedly improved conditions in notorious prisons like Parchman and Angola prisons in Mississippi and Louisiana).

39. Bonnie & Polubinskaya, *supra* note 23, at 279.

40. CAL. WELF. & INST. CODE § 5150 (West 2010).

41. E. Fuller Torrey & Kenneth Kress, *The New Neurobiology of Severe Psychiatric Disorders and Its Implications for Laws Governing Involuntary Commitment and Treatment* 51 (Bepress Legal Series Working Paper No. 423, 2004), *available at* http://law.bepress.com/expresso/eps/423; *see also* OUT OF THE SHADOWS, *supra* note 25, at 143–144. As with many political coalitions, not all of those who supported making civil commitment more difficult did so out of concern for the mentally ill. Some proponents of the legislation saw it as a way to reduce costs to the state.

42. *See* Antonia Moras, *Human Rights Watch: The Mentally Ill in U.S. Prisons*, ALASKA JUST. F., Spring 2004, at 2, 2, *available at* http://justice.uaa.alaska.edu/forum/21/1spring2004/b1_mentallyill.html. As observed by one author:

> State incentives for cost-shifting to the federal government reside almost exclusively in the discharge of patients from state hospitals, who then become eligible for SSI, Medicaid, food stamps, and other federal benefits. States gain nothing by ensuring that patients

The promise at the time was that community-based care would allow the mentally ill greater freedom without abandoning them to their own devices.[43]

So what went wrong? Closing institutions seemed humane and community-based care seemed like a sound way to treat the mentally ill. Adequately funded community based programs have worked: many patients see a dramatic improvement in their quality of life; many are able to hold steady employment and find housing.[44] However, in most places the development of the community-based programs lagged far behind the demand created by the release of the mentally ill.[45] The lack of adequate resources for community-based care has only grown worse over time—especially since states have confronted serious budget crises brought on by the recession.[46] As described below, these reforms, even with the best intentions, have come at a high cost to many mentally ill persons.

II. THE REVOLVING DOOR

Today, most state mental hospitals have closed or dramatically reduced available beds.[47] But what happens to the mentally ill? Since the elimination of most beds in state-run facilities, and the cutting of community health care resources offers a dramatic contrast to the world envisioned by the anti-psychiatrists and mental health care advocates, the result of many of the reformists' efforts have come at a cost to the mentally ill.

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receive follow-up care following their hospitalization because readmission of the patients can be deflected to the psychiatric wards of general hospitals, where federal Medicaid will cover much of the costs.

OUT OF THE SHADOWS, *supra* note 25, at 102. Thus, the way in which federal funds are made available to the states provides states an incentive to discharge patients whether or not they are able to function on their own and to do so without regard to available aftercare.

43. *See* PHIL BROWN, THE TRANSFER OF CARE: PSYCHIATRIC DEINSTITUTIONALIZATION AND ITS AFTERMATH 67 (1985).

44. *See, e.g.*, *Direct Access to Housing*, CORP. FOR SUPPORTIVE HOUSING, http://www.csh.org/index.cfm?fuseaction=Page.viewPage&pageId=501 (last updated Aug. 2005).

45. H. Richard Lamb & Leona L. Bachrach, *Some Perspectives on Deinstitutionalization*, 52 PSYCHIATRIC SERVICES 1039, 1044 (2001), *available at* http://psychservices.psychiatryonline.org/cgi/reprint/52/8/1039. Some of the additional freedoms that the mentally ill gained have exacerbated the problem. Many mentally ill persons refuse medication that might otherwise enable them to live more stable lives and to stay out of trouble with the law. *Id.* at 1041.

46. *See* Rusty Selix, *State Budget Memorandum*, CAL. COUNCIL COMMUNITY MENTAL HEALTH AGENCIES (Jan. 10, 2008), http://www.cccmha.org/public_policy/state_budget.html; *see also* CAL. COUNCIL CMTY. MENTAL HEALTH AGENCIES, PRESERVE AB 2034 FUNDING: A MODEL PROGRAM THAT WORKS AND HAS CHANGED LIVES (2008), *available at* http://www.cccmha.org/documents/AB2034FACTSHEET--ProgramthatWorks.pdf. For a period of time, legislation made available federal matching grants for community health programs, including mental health care. California initially followed suit, but in the 1990's, it shifted the burden of responsibility for funding to local governments. For a time, it had in place pilot programs that were highly successful in reducing incarceration and homelessness among the mentally ill. But those programs were eliminated when budget cuts were made in 2007.

47. Hitesh C. Sheth, *Deinstitutionalization or Disowning Responsibility*, 13 INT'L J. PSYCHOSOCIAL REHABILITATION, no. 2, 2009 at 11, *available at* http://www.psychosocial.com/IJPR_13/Deinstitutionalization_Sheth.html.

The effect has been a change of venue for the mentally ill from mental hospitals to prisons, not just to nursing homes or the streets. While there are few data on incarcerations of mentally ill people prior to the deinstitutionalization movement,[48] evidence suggests that, since deinstitutionalization, the rate of incarceration of mentally ill people has increased significantly.[49] While estimates vary, studies are consistent that large numbers of those admitted to prison are mentally ill.[50] When states closed or reduced the population of mental health facilities, the prison system took in those mentally ill patients who required twenty-four hour supervision.[51] Due to the lack of community programs and adequate and affordable housing for the mentally ill patients who were released from the institutions, many of those released wound up homeless.[52] Because of a general public fear of those with mental illness, law enforcement was pressured into arresting and incarcerating the homeless mentally ill for petty crimes, such as public intoxication.[53] Further, illegal drug use among mentally ill people is common.[54] Mentally ill individuals often self medicate.[55] As a result, many of the mentally ill people living in a community—who would have once been institutionalized—are arrested for behavior that they engage in as a result of their illness.[56]

Further, unable to get adequate resources for mental health care treatment in state run institutions or community health care facilities, mentally ill individuals in prison have their symptoms exacerbated by being put in jail or prison, causing them to act out.[57] Prisons are seldom good places to receive mental health care treatment.[58]

Mentally ill inmates who are released have a difficult time getting into community mental health programs and public housing because of their criminal records.[59] Thus, for those who are released from prison, it becomes a vicious cycle of homelessness, to imprisonment, and back to homelessness. Without adequate treatment to allow the mentally ill to adapt to living in the community, many end up back in prison.[60]

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48. Lamb & Bachrach, *supra* note 45, at 1042.

49. *Id.*

50. *Human Rights at Home: Mental Illness in U.S. Prisons and Jails, Hearing Before the Subcomm. on Human Rights and the Law of the S. Comm. on the Judiciary*, 111 Cong. (2009) (statement of Gary Maynard, Secretary of the Maryland Department of Public Safety and Correctional Services).

51. Lamb & Bachrach, *supra* note 45, at 1042.

52. *Id.* at 1040.

53. *See id.* at 1042.

54. *Id.* at 1041.

55. *Id.*

56. *See id.* at 1042.

57. Allan Schwartz, *Imprisoning the Mentally Ill*, MENTALHELP.NET, http://www.mentalhelp.net/poc/view_doc.php?type=doc&id=14284 (last updated Jan. 14, 2008).

58. *See* Kanapaux, *supra* note 2.

59. *Id.*

60. *See id.*; *see also* OUT OF THE SHADOWS, *supra* note 25, at 108.

III. LESSONS LEARNED?

California may be forced to reduce its overcrowded prison population. Reform may be possible for the first time in years because a three-judge panel has ordered California to reduce its prison population by about 40,000 inmates.[61] That may force California to come to terms with its bloated prison system.[62]

The Supreme Court has granted certiorari to review the order of the three-judge panel.[63] As is typical of this closely divided Court, predicting how it will resolve the dispute is a crapshoot. But we may be in familiar territory. As Adam Liptak wrote, the Constitution means what Justice Kennedy says it means.[64] Despite strong conservative leanings, Justice Kennedy may vote to uphold the order. For example, even after voting to uphold two sentences under California's Three Strikes law,[65] Justice Kennedy has been a vocal critic of mandatory minimum sentencing and the overuse of prisons.[66] He also authored a number of majority opinions striking down the death penalty[67] and, more recently, an opinion striking down true life sentences for offenders who were juveniles when they committed offenses other than homicide.[68] As a result, the conservative wing of the Court cannot count on his vote on criminal justice issues.

If the Supreme Court upholds the federal district court order, reform will have to take place, and California will need to find less expensive ways to handle prisoners generally and the mentally ill specifically.

So what lessons should policy-makers take from history? The reforms of the past several decades were suitable if the then-popular assumptions were true. As discussed above, those assumptions included the

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61. Coleman v. Schwarzenegger, No. CIV S-90-0520, 2009 WL 2430820, at *115–16 (E.D. Cal. Aug. 4, 2009).

62. *See id.* The state has taken an aggressive litigation posture. It attempted to have the prisoner receiver removed, but was rebuffed by the Ninth Circuit. Julie Small, *Court Upholds Federal Oversight of California's Prison Medical Care*, S. CAL. PUB. RADIO (Apr. 30, 2010), http://www.scpr.org/news/2010/04/30/receiver-stands/. The state has also petitioned, now twice, to have the three judge panel's order overturned. Schwarzenegger v. Plata 130 S. Ct. 1140, 1140 (2010). If the Court finds that the three judge panel exceeded its authority, reform may be dead. The litigation may be the state's last-best hope for meaningful reform of its prison system. The legislature's response to prison overcrowding and massive spending on its prison system has been discouraging. For example, the senate passed a bill that included a sentencing commission, but the Democratic-controlled assembly refused to go along. Jack Chang, *Sentencing Panel Sets Off Alarms*, SACRAMENTO BEE, Aug. 20, 2009, at 1A, *available at* http://www.sacbee.com/2009/08/20/2124062/sentencing-panel-sets-off-alarms.html.

63. Schwarzenegger v. Plata, 130 S. Ct. 3413, 3413 (2010).

64. Adam Liptak, *Anthony M. Kennedy*, N.Y. TIMES, http://topics.nytimes.com/top/reference/timestopics/people/k/anthony_m_kennedy/index.html (last updated July 1, 2009).

65. Ewing v. California, 538 U.S. 11, 14, 30–31 (2003); Lockyer v. Andrade, 538 U.S. 63, 66, 77 (2003).

66. Pete Williams, *Justice Anthony M. Kennedy: End Minimum Sentences*, THE NOVEMBER COALITION (Aug. 9, 2003), http://www.november.org/stayinfo/breaking/Kennedy.html.

67. *See, e.g.*, Kennedy v. Louisiana, 554 U.S. 407 (2008); Roper v. Simmons, 543 U.S. 551 (2005).

68. Graham v. Florida, 130 S. Ct. 2011, 2034 (2010).

belief that diagnoses were routinely wrong,[69] that the mentally ill were capable of easy integration into the community,[70] and that psychotropic drugs and other treatments were dehumanizing,[71] and that institutions were so bad that they had to be abandoned.[72]

And all of those assumptions were true, but only to a point. Those who work with the mentally ill and the families of the mentally ill will tell you that the diseases are real and that adequate care can improve the quality of their lives.[73] And ask any family member of a mentally ill person whether today's system works well—many would describe their frustration in getting access to basic mental health care services.[74] Further, policymakers were unable to work through the unintended consequences of their decisions. That is, they did not recognize that they were basing policy on an incomplete view of the mentally ill and made overly optimistic assumptions about the ability for the mentally ill to live on their own without state supervision. They did not recognize the revolving door from homelessness to jail and prison to homelessness and back.[75]

Reformers should focus on these lessons of experience. As developed below, we have learned a great deal about mental illness and the needs of the mentally ill.[76] Applying current data should allow a more realistic approach to caring for the mentally ill.

IV. THE SHAPE OF REFORM

As indicated above, California may be forced to affect a reform of its prison system.[77] Part of that reform should focus on the special problems of mentally ill prisoners. Because of California's budget crisis,[78] anyone who comes forward with a proposal for reform must demonstrate that it will save the system money. Even given that constraint, this section argues that meaningful reform is possible.

As currently delivered, mental health care for prisoners is expensive and ineffective.[79] Treating the mentally ill in a variety of settings, like

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69. Heap v. Roulet (*In re* Estate of Roulet), 590 P.2d 1, 10–11 (Cal. 1979).

70. *See* BROWN, *supra* note 43, at 67.

71. *See supra* text accompanying notes 26–27.

72. *See supra* text accompanying notes 31–32.

73. *Mental Illnesses*, NAT'L ALLIANCE ON MENTAL HEALTH, http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm (last visited Dec. 29, 2010).

74. *See* MARY BETH PFEIFFER, CRAZY IN AMERICA: THE HIDDEN TRAGEDY OF OUR CRIMINALIZED MENTALLY ILL 159–160 (2007).

75. I assume that they did not recognize those consequences because who would have chosen today's response to the mentally ill had they been able to foresee where we have ended up?

76. *See infra* Part VI.

77. Aaron Rappaport & Kara Dansky, *State of Emergency: California's Correctional Crisis*, 22 FED. SENT'G REP., no. 3, 2010, at 133.

78. Dan Walters, *Overview of California's Budget Crisis*, SACRAMENTO BEE (July 21, 2009, 12:50 PM), http://www.sacbee.com/2009/07/21/2044072/overview-of-californias-budget.html.

79. RISDON N. SLATE & W. WESLEY JOHNSON, THE CRIMINALIZATION OF THE MENTALLY ILL: CRISIS AND OPPORTUNITY FOR THE JUSTICE SYSTEM 289–296 (2008).

community-based facilities, is far less expensive than is warehousing them in prison and even less expensive than maintaining them in prison with adequate mental health care services.[80] Thus, using alternative settings for the mentally ill may be an effective alternative to incarceration.

If state officials adopt reforms that would enable a shift of mentally ill prisoners from prisons to community care facilities, they must do so in ways that protect the public. Here, they must fully appreciate the lessons from the past. As discussed above, policy makers and the public in the 1960s and beyond had a naïve view of mental illness.[81] They bought into stereotypes about the ability of the mentally ill to live independent lives. When many mentally ill failed to conform to reformers' hopes, we experienced a backlash that has resulted in the current situation where a person is more likely to receive mental health care in prison than in the community.[82] In effect, society replaced one stereotype of the mentally ill with other stereotypes. Thus, today many members of the public view the mentally ill as incapable of cure[83] or as malingerers,[84] individuals in need of punishment.

Any change in policy towards the mentally ill must be grounded in reality, rather than stereotypes. While providing care for the mentally ill in community-based treatment facilities can save the state money, not all mentally ill prisoners are capable of being reintegrated into society.[85]

To this point, I have spoken of mentally ill prisoners without making an essential distinction between two distinct kinds of mentally ill prisoners. Many criminals suffer from an assortment of mental illnesses, but would continue to violate the law even if they received adequate treatment.[86] Indeed, one suspects that treatment might make them more capable of carrying out criminal acts. By comparison, our prisons now house many prisoners whose mental illness has led to their criminal conduct.[87]

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80. Mental Health Servs, Oversight & Accountability Comm'n, *Commission Meeting Minutes*, CA.GOV, 9 (June 26, 2008), http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2008/Jul/MHSOAC_June08MeetingMinutes_2.pdf.

81. ERICKSON & ERICKSON, *supra* note 34, at 25.

82. John Gunn, *Future Directions for Treatment in Forensic Psychiatry*, 176 BRIT. J. PSYCHIATRY 332, 333 (2000).

83. Rohan Ganguli, *Mental Illness and Misconceptions*, POST-GAZETTE.COM (Mar. 18, 2000), http://www.post-gazette.com/forum/20000318gang1.asp.

84. SLATE & JOHNSON, *supra* note 79, at 290.

85. *Human Rights at Home: Mental Illness in U.S. Prisons and Jails, Hearing Before the Subcomm. on Human Rights and the Law of the S. Comm. on the Judiciary*, 111 Cong. (2009) (statement of Harley G. Lappin, Dir. of Fed. Bureau of Prisons).

86. Historically, mental health experts considered sociopaths and psychopaths as difficult, if not impossible to treat. CHARLES H. KNICKERBOCKER, HIDE-AND-SEEK: THE EFFECT OF MIND, BODY, AND EMOTION ON PERSONALITY AND BEHAVIOR IN OURSELVES AND OTHERS 90 (1967). Today, some researchers contend that even those mental illnesses are treatable. Randall Parker, *Psychopathic Brain Driven to Seek Rewards*, FUTUREPUNDIT (March 14, 2010, 11:14 AM) http://www.futurepundit.com/archives/007018.html.

87. OUT OF THE SHADOWS, *supra* note 25, at 39–40.

Many mentally ill individuals enter the criminal justice system because of drug abuse, often their way of self-medicating.[88] They may commit petty property crimes to feed themselves or to get money to buy drugs.[89] When delusional or disoriented, they may act in ways that frighten members of the public.[90] The literature is full of accounts of mentally ill individuals who end up in conflict with law enforcement agents.[91] Those confrontations may result from the person urinating in public or engaging in other antisocial conduct.[92] Otherwise non-violent, the mentally ill individual may resist arrest or otherwise challenge the police officer's authority.[93] Assaulting an officer may result in serious felony charges.[94]

In addition, these offenders are less able to deal with prison. Prisons require rigid rules and adherence to those rules.[95] They are more likely than other offenders to be written up for violations of prison rules.[96] But disoriented mentally ill inmates cannot understand the rules leading to what guards see as defiance and sometimes leading to guards using physical force against them.[97] They often end up in solitary confinement, making their illness worse.[98] As a result of their disruptive behavior, they tend to serve longer prison sentences than other offenders.[99] They may also be victimized by fellow inmates.[100] Suicide rates for mentally ill prisoners are high.[101] As quoted by one author, "the bad and the mad just don't mix."[102]

Reform efforts should focus on this group of mentally ill prisoners. As a matter of decency, the state should not subject them to the brutal conditions of prison, so ill-suited to their needs. Placing them in community-based care facilities would serve their needs far better than they are served in prison and the state would save money by doing so.

Such a proposal, however, begs other questions. First, one might appropriately ask about high rates of recidivism among mentally ill[103]

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88. *Id.* at 35

89. MARCUS NIETO, CAL. RESEARCH BUREAU, MENTALLY ILL OFFENDERS IN CALIFORNIA'S CRIMINAL JUSTICE SYSTEM 4 (1999).

90. *See* OUT OF THE SHADOWS, *supra* note 25, at 38.

91. SLATE & JOHNSON, *supra* note 79, at 83, 109–177.

92. OUT OF THE SHADOWS, *supra* note 25, at 37–38.

93. *See* PFEIFFER, *supra* note 74, at 120–121.

94. *See* CAL. PENAL CODE § 243(c)(2) (West 2010).

95. SLATE & JOHNSON, *supra* note 79, at 60.

96. *Id.* at 60–61.

97. OUT OF THE SHADOWS, *supra* note 25, at 31.

98. SLATE & JOHNSON, *supra* note 79, at 295.

99. *Id.* at 60-61.

100. JOHN PARRY, CRIMINAL MENTAL HEALTH AND DISABILITY LAW, EVIDENCE AND TESTIMONY 27 (2009).

101. OUT OF THE SHADOWS, *supra* note 25, at 33.

102. *Id.* at 32.

103. SLATE & JOHNSON, *supra* note 79, at 197.

and why we should risk continued criminality among this group of offenders.

Here, a close look at how this group of individuals ends up in a cycle of release from prison back to the streets and back to prison helps to explain how adequate follow-up care can reduce recidivism. Unlike the overly optimistic view of the mentally ill that led to deinstitutionalization,[104] many mentally ill persons cannot function adequately merely left to their own devices. Currently, many mentally ill prisoners are stabilized on medication before their release from prison.[105] At discharge, they are given a small supply of medication and told to follow up with public health officials to receive more.[106] That may be the extent of follow-up that they receive upon release.

Even if they find some kind of housing, many recently released prisoners run out of medication and are too disorganized to continue treatment[107] or choose to go off medication.[108] As a result, they may be evicted from their housing or otherwise choose to go back on the street.[109] Once homeless, they often find themselves in conflict with law enforcement again and back into the criminal justice system.[110]

At least for individuals who are going to be placed on parole, one obvious solution is to make continued compliance with a regimen of therapy and medication a condition of release.[111] Further, the state needs to stop releasing the mentally ill back into the community without resources. Instead, it needs to expand various housing options for the mentally ill where their compliance with terms of release can be enforced.[112] For individuals not yet in prison, similar rules should be put in place that would allow alternative disposition of charges against the mentally ill.[113] That is, the state should expand the options open to sentencing judges to place the mentally ill in appropriate facilities where they can be monitored, but where they are not subject to the dehumanizing conditions that they would otherwise face in prison.[114]

Some advocates for the mentally ill might object to restrictive terms of release.[115] But given the current state of the law, the options are lim-

104. ERICKSON & ERICKSON, *supra* note 34, at 25.
105. THE RELEASED (PBS Home Video 2009).
106. *Id.*
107. *Id.*
108. *See* PFEIFFER, *supra* note 74, at 25.
109. THE RELEASED, *supra* note 105.
110. *Id.*
111. OUT OF THE SHADOWS, *supra* note 25, at 160–61. Studies demonstrate that conditional release increases individuals' compliance with treatment plans, including continued use of medication, and reduces their violent behavior. *See id.*
112. SLATE & JOHNSON, *supra* note 79, at 183–97.
113. *Id.* at 131–34, 156. Some jurisdictions already have in place mental health courts. Studies suggest that these courts have better outcomes than would occur otherwise.
114. PARRY, *supra* note 100, at 191–92.
115. OUT OF THE SHADOWS, *supra* note 25, at 162.

ited: untreated, the individual is likely to end up in prison again. That option is far less desirable than imposing lesser limitations on the individual's autonomy.

My proposal begs two additional closely related questions. Does such a proposal adequately protect the public? And can we really distinguish between the bad and the mad or those who are mentally ill who would continue to commit dangerous criminal act and those whose untreated mental illness is responsible for their criminal conduct?

A great deal is at stake. As I developed above, misperceptions about the mentally ill led to the current state of affairs, with large numbers of mentally ill persons in prison.[116] If policymakers fail to learn the lessons from our earlier experience with deinstitutionalization, we will simply end up with the inhumane and costly alternative of dealing with the mentally ill in our prisons. Releasing dangerous mentally ill persons into the community who commit violent crimes will quickly undo any reform efforts.[117]

In partial answer to the first question, the mentally ill are not typically violent, despite sensationalized reports in the media.[118] And that is especially true if the individual receives adequate follow-up care.[119]

The related question is whether we are able to distinguish between those who get involved in the criminal justice system as a result of inadequately treated mental illness and those who are likely to continue to pose a risk of harm even if treated. Or, as argued by the anti-psychiatrists, is the state of the art inadequate to make accurate diagnoses of mental illness?

A great deal has changed over recent decades. At a minimum, data collection is more sophisticated than in the past. In the area of criminal sentencing, for example, advocates of evidence-based sentencing have demonstrated that predictions about future criminal conduct are increasingly reliable.[120] Researchers have developed testing instruments that measure traits like the inability to feel remorse and the individual's level of impulsivity.[121] Researchers have also been able to determine factors

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116. Gunn, *supra* note 82, at 333.

117. *Sacramento Early Release Inmate Kevin Peterson Arrested for Attempted Rape: Said Release Wasn't A "Bad Deal"*, NEWS 10 (Feb. 3, 2010), http://www.news10.net/news/local/story.aspx?storyid=74615.

118. PARRY, *supra* note 100, at 23–24.

119. Liesel J. Danjczek, *The Mentally Ill Offender Treatment and Crime Reduction Act and Its Inappropriate Non-violent Offender Limitation*, 24 J. CONTEMP. HEALTH L. & POL'Y 69, 103 (2007).

120. ROGER K. WARREN, NAT'L CTR. FOR STATE COURTS, EVIDENCE BASED PRACTICE TO REDUCE RECIDIVISM: IMPLICATIONS FOR STATE JUDICIARIES 2 (2007); Richard E. Redding, *Evidence Based Sentencing: The Science of Sentencing Policy and Practice*, 1 CHAPMAN J. CRIM. JUST. 1, 5–6 (2009).

121. *See generally* Kent A. Kiehl et al., *An Event Related Potential Investigation of Response Inhibition in Schizophrenia and Psychopathy*, 48 BIOLOGICAL PSYCHIATRY 210 (2000).

that predict violent behavior among the mentally ill.[122] Further, studies of the brain through various kinds of measurements have generated knowledge that we have lacked in the past. For example, using an MRI allows measurement of changes in the structure and function of the brains of the mentally ill, allowing a health care professional to determine objectively that the person is suffering from mental illness.[123]

Not only has our ability to diagnosis mental illness improved, but treatment has improved as well. Lobotomies and electric shock treatments as administered up until the 1970s are no longer routine.[124] The availability of Thorazine in the 1950s aided the movement to deinstitutionalize the mentally ill,[125] but proved less effective than hoped for the mentally ill because of its debilitating effects.[126] While some individuals experience side effects from psychotropic drugs,[127] they may be reduced by adjusting the dosage[128] or by finding an alternative medication.[129] Further, newer medications may be more acceptable because of different side effects.[130]

It would also be a mistake to think that medication alone is the answer to the problem posed by mentally ill prisoners. Some studies raise questions about the effectiveness of many medications that have been touted by psychiatrists and the pharmaceutical companies as miracle cures.[131] Many mental health care professionals recognize that the best outcomes require treatment in combination with medication.[132] Availability to adequate therapy, as envisioned when our society began closing state hospitals, remains an essential component to any meaningful reform.

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122. OUT OF THE SHADOWS, *supra* note 25, at 53 (stating that "overwhelming evidence" demonstrates that "a small subgroup of the mentally ill have a propensity toward violence," and also that "a persons' past history of violence, concurrent abuse of drugs and alcohol, and failure to take medications are risk factors for violent behavior").

123. *Id.* at 4.

124. M. PADOLINA & C. SANCHEZ, COUNSELING AND PSYCHOTHERAPY: THEORIES, TECHNIQUES AND APPLICATIONS 197 (1997); LINDA GASK, A SHORT INTRODUCTION TO PSYCHIATRY 18 (2004). Since almost disappearing as a method of treatment, electric shock therapy reemerged in the 1990's. In 1999, the Surgeon General endorsed it. About one-hundred thousand patients a year receive electric shock therapy in the United States. As one author states, "the treatment has been refined and made gentler by lowering the amount of electricity delivered and changing where the scalp the leads are placed." DANEIL J. CARLAT, UNHINGED 167 (2010).

125. OUT OF THE SHADOWS, *supra* note 25, at 8.

126. ROBERT WHITAKER, MAD IN AMERICA 147–159 (2010).

127. SLATE & JOHNSON, *supra* note 79, at 58 (noting that side effects include, "dry mouth, weight gain, tiredness, and depression . . . [a]ntipsychotic medications may also cause Akathisia, Dystonia, Parkinsonianism, Tardive Dyskinesia, and Arganulocytosis").

128. NAT'L INST. OF MENTAL HEALTH, MENTAL HEALTH MEDICATIONS 12 (2010).

129. *Id.*

130. *See* OUT OF THE SHADOWS, *supra* note 25, at 5–6.

131. For a particularly disturbing view of America's belief in the silver bullet theory of such drugs, see generally ROBERT WHITAKER, ANATOMY OF AN EPIDEMIC (2010).

132. *See, e.g.*, CARLAT, *supra* note 124.

Thus, as part of a larger reform of California's prison system, addressing the special problems of the mentally ill may be a way to save the state money and improve the quality of the lives of many individuals who would otherwise do hard time in prison.

CONCLUSION

At the outset, I argued that the deinstitutionalization movement began with some truths, like the dehumanizing conditions in state institutions and inaccurate diagnoses, but that reforms were based on exaggerations of those truths.[133] As a result, the cure created a new set of problems that now confront policymakers.[134] Today's policymakers should avoid the same kind of naiveté that led to the current dilemma.

As a result, I must underscore that releasing or diverting some mentally ill individuals from prison is only one measure to address prison over-crowding and to reduce expenditures. All mentally ill prisoners are not suitable candidates for conditional release.[135] Not all mentally ill individuals respond to treatment; and some may pose a risk of violence that justifies their continued incarceration.[136] Releasing mentally ill prisoners who make headlines by committing violent acts will undo any reform that may be in place.[137]

Despite that, meaningful, if incremental, reform is possible. It requires careful risk assessment of whether a prisoner can be successfully integrated into the community,[138] and devotion of resources for follow-up care, including finding or creating housing, and for assuring that they comply with a regimen of treatment.[139] Critics of compelled treatment should recognize that the alternative currently is incarceration, a cruel option for a person who may have difficulty making an informed choice for herself. Critics of prison reform must recognize that years of get-tough-on-crime has bloated our prisons beyond our ability to afford them and that when applied to the mentally ill, those sentences are particularly cruel and often unnecessary.

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133. *See supra* Part II.
134. *See* Coleman v. Schwarzenegger, No. CIV S-90-0520, 2009 WL 2430820, at *12 (E.D. Cal. Aug. 4, 2009).
135. Kobley, *supra* note 117.
136. *See supra* notes 85–86.
137. OUT OF THE SHADOWS, *supra* note 25, at 54–56.
138. *See supra* notes 120–23.
139. SLATE & JOHNSON, *supra* note 79, at 183–197.