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The Path of Mentally Ill Offenders

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Abstract

Beginning with the premise that both the number and percentage of mentally ill inmates as sharply risen in recent years, this Article explores the path of mentally ill offenders in the American criminal justice system. It seeks to identify points of relief from the current crisis, in which a recent report stated that over 40% of state prisoners reported symptoms that met the criteria for mania. The challenge is exacerbated by the fact that prisons now provide a large share of the mental health treatment in the United States, taxing the resources of even the most progressive correctional systems. Part I describes three "typical" mentally ill offenders. The remaining sections discuss some of the problems these offenders face when encountering the correctional system, including: the importance of diagnosis and pre-conviction shortcomings, post-conviction shortcomings such as administrating medication and overcrowding, and issues surrounding re-entry and recidivism. The Article concludes with an assessment of opportunities for litigation and reform.

KEYWORDS: prisoner rights, mentally ill

THE PATH OF MENTALLY ILL OFFENDERS

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Introduction

Twenty years ago, prisoners around the nation challenged their unsatisfactory conditions of confinement and few states escaped the oversight of federal judges. Overcrowding compounded problems of inmate idleness, fire safety risks, insect and rodent infestations, unhygienic food, and lack of basic medical care, all of which in combination appeared like low-hanging fruit, ready for

* Professor of Law, Washburn University School of Law. I would like to thank several individuals for providing access to information that was helpful in the development of this Article, including Melissa Woodward, Mental Health/Substance Abuse Specialist, Kansas Department of Corrections; Mindy Baccus, Mental Health/Substance Abuse Specialist, Kansas Department of Social and Rehabilitation Services; Roger Hayden, Deputy Secretary, Kansas Department of Corrections; and Leslie Huss, Coordinator of Forensics, Kansas Department of Social and Rehabilitation Services.

the picking by plaintiffs seeking humane treatment.[1] Mental health care was virtually non-existent.[2] In the years that followed, many states responded by meeting minimum constitutional standards, the Supreme Court responded by limiting the scope of permissible relief, and Congress responded by doing its best to stifle the litigation itself. The context for addressing problems that prisoners faced changed accordingly.

In spite of general improvements in conditions, severe problems have continued, spurred on, in particular, by a dramatic growth in the number and percentage of mentally ill offenders who now populate our jails and prisons.[3] In the late 1980s, assessments of the mentally ill prison population were based upon limited data; reports indicated that 6% to 8% of state prisoners had "serious psychiatric illness[es] . . . while fifteen to twenty percent of all prison inmates [would] need psychiatric treatment at some point in their incarceration."[4] In contrast, a 2006 report from the Bureau of Justice Statistics reported that more than 40% of state prisoners and more than half of jail inmates reported symptoms that met the criteria for mania, 23% to 30% reported symptoms of major depression, and 15% to 24% reported symptoms that met the criteria for a psychotic disorder.[5] Furthermore, approximately three-quarters

1. *See, e.g.*, Ramos v. Lamm, 639 F.2d 559 (10th Cir. 1980); Battle v. Anderson, 564 F.2d 388 (10th Cir. 1977); Ruiz v. Estelle, 503 F. Supp. 1265 (S.D. Tex. 1980); Holt v. Sarver, 309 F. Supp. 362 (E.D. Ark. 1970).

2. *See* SASHA ABRAMSKY & JAMIE FELLNER, HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 46 (2003), *available at* http://www.hrw.org/sites/default/files/reports/usa1003.pdf.

3. Numerous definitions of mental illness appear in the literature, and differences in terminology often lead to confusion about the number of people who belong in this category and the nature of their illnesses. As used in this Article, "mental illness" will generally refer to serious "Axis I" mental disorders as described in AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 27-28 (4th ed. 2000) [hererinafter DSM IV]. This does not include categories such as anti-social personality disorders, which would apply to a much larger share of the inmate population and which generally do not respond to medication, making them more difficult to treat. It also does not include persons who suffer from addiction or substance abuse, which are recognized as mental health disorders but are referred to as co-occurring illnesses rather than being included within the term "mental illness." *See* ABRAMSKY & FELLNER, *supra* note 2, at 33 ("[There is] a convention in correctional psychiatry to identify as serious mental illnesses only certain serious Axis I disorders such as bipolar disorder, major depression, and schizophrenia, and to limit mental health treatment to prisoners with those disorders.").

4. *See* Ron Jemelka et al., *The Mentally Ill in Prisons: A Review*, 40 HOSP. & CMTY. PSYCHIATRY 481, 482 (1989).

5. DORIS J. JAMES & LAUREN E. GLAZE, U.S. DEP'T OF JUSTICE, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf. Other studies have estimated that 16% to 24%

of inmates with mental illness suffer from a co-occurring diagnosis of addiction to drugs or alcohol.[6] The challenge presented by this enlarged population of mentally ill inmates taxes the resources of even the most progressive correctional systems.

Experts have posited various theories to explain the dramatic growth in both numbers and percentage of mentally ill inmates. Part of the explanation undoubtedly comes from increased efforts to screen inmates and to diagnose mental illnesses that may be susceptible to treatment.[7] Others hypothesize that part of the explanation arises from closing of in-patient mental health facilities, limits on involuntary civil commitments, and the failure to keep pace with adequate community treatment options.[8] Additional theories include responses to the war on drugs, given that the mentally ill often have co-occurring substance abuse disorders.[9] Changes in sentencing practices place greater weight on successive convictions, and inadequately treated mentally ill offenders are often recidivists.[10] Whatever the reason, prisons now provide a substantial share of mental health treatment in the United States.[11]

This Article follows the path of mentally ill offenders as they encounter the criminal justice system, and identifies points of potential relief from the current crisis. Part I describes three "typical" mentally ill offenders. Subsequent sections describe a variety of the problems such offenders face when encountering life in our jails and prisons. Part II begins with offenders' initial encounters with the criminal justice system and discusses the importance of diagnosis as well as the various ways mentally ill offenders are

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of jail and prison inmates are "severely mentally ill." H. Richard Lamb & Linda E. Weinberger, *The Shift of Psychiatric Inpatient Care from Hospitals to Jails and Prisons*, 33 J. AM. ACAD. PSYCHIATRY L. 529, 531 (2005).

6. *See* JAMES & GLAZE, *supra* note 5, at 1, 5.

7. *See* ABRAMKSY & FELLNER, *supra* note 2, at 19.

8. *See* Lamb & Weinberger, *supra* note 5, at 531 (noting that easy access to computerized criminal records may also influence decisions by arresting officers to choose the criminal justice system over the mental health system).

9. *See* Michael D. White et al., *Co-Occurring Mental Illness and Substance Abuse in the Criminal Justice System: Some Implications for Local Jurisdictions*, 86 PRISON J. 301, 305 (2006).

10. *See infra* text accompanying notes 62-65.

11. *See* Rich Daly, *Prison Mental Health Crisis Continues to Grow*, 41 PSYCHIATRIC NEWS 20 (2006) ("[A] growing body of evidence demonstrat[es] that the criminal justice system has taken over from the public health system as the destination for many with mental illness and addictions."); H. Richard Lamb et al., *Treatment Prospects for Persons with Severe Mental Illness in an Urban County Jail*, 58 PSYCHIATRIC SERVS. 782 (2007) (concluding that a "large percentage of persons with severe mental illness received their acute psychiatric inpatient treatment in the criminal justice system rather than in the mental health system").

dealt with at the pre-conviction stage, identifying the shortcomings of each method in turn. Part III explores the shortcomings related to various post-conviction issues that mentally ill offenders face within the prison system, including "risk assessment" by prison officials, medication being administered by prison officials, overcrowding, and discipline. Part IV discusses difficult issues that mentally ill offenders face after incarceration, such as community reentry, an increased likelihood of recidivism, and perpetuation of the offense/incarceration cycle. Part V concludes with a brief assessment of opportunities for litigation and reform.

I. The People

James, Millie, and Wally are names I will use to describe three typical offender "types" who suffer from mental illness and who become enmeshed in the correctional system. All three are meant to be realistic depictions, combining national studies and reports with descriptions shared by people who work with this inmate population within the Kansas Department of Corrections.[12] James returned more than a year ago from back-to-back tours in Iraq. Millie is a mother of four children who recently lost her parental rights after enduring several years of physical and mental abuse from her ex-husband. Wally recently turned nineteen and has been in and out of hospitals, juvenile detention facilities and foster care homes for more than a decade.

A. James, an Iraq War Veteran with PTSD

James suffers from severe depression and posttraumatic stress disorder ("PTSD"), but that condition was not clearly diagnosed prior to his discharge from the Army Reserve. His commanding officers labeled him as a malingerer, objected to his repeated failure to meet demands of the training regime that took place between tours of duty, and were happy when he did not reenlist. James had never been treated for mental illness prior to his military service, and he was discharged prior to receiving a diagnosis or treatment. After returning to the community where he grew up, he had difficulty finding a job, and his mental condition continued to deteriorate. To relieve his "demons," he chose to "self medicate,"

12. The Kansas Department of Corrections provided descriptions of specific inmates who suffer from many of the problems described in this Article. Those descriptions have been modified, however, to facilitate exploration of issues discussed in the pages that follow. As a result, the names and descriptions used should be understood as representative of real people, but not necessarily depictions of specific individuals.

beginning with alcohol and then moving on to more serious and even more addictive drugs. In order to fund his addiction, he also sold drugs, which ultimately resulted in his arrest. A first conviction for possession with intent to sell resulted in a three year prison sentence.[13]

Fallout from the Iraq war is just beginning to hit the criminal justice system. While "James" may be a mythical figure, the group that he represents is large and growing. Studies based upon questionnaires filled out by returning soldiers have shown high rates of "posttraumatic stress disorder (PTSD), major depression, substance abuse [and] functional impairment in social and employment settings . . . ."[14] These concerns rise in the months following return from deployment, with more than 20% of active duty soldiers and 42% of returning National Guard or reserve soldiers "needing referral or already being under care for mental health problems."[15]

Caring for the mental health problems of returning soldiers is complicated by related factors. Concerns about the stigma attached to those with mental health problems may suppress reporting by soldiers and reduce opportunities for effective treatment.[16] In addition, as with other populations of the mentally ill, there is a high occurrence of substance abuse, particularly with alcohol. Within the military system, however, self-reports of such problems are not confidential, must be reported to the soldier's commander, and may cause significant career problems. As a result, despite frequent identification of alcohol abuse on screening questionnaires, there is limited follow-up treatment for these problems.[17] Furthermore, it is well documented that the Department of Defense mental health system is "overburdened, understaffed, and underresourced."[18] A major additional problem is that, for reservists

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13. *See* KAN. STAT. ANN. § 21-4705 (2007).

14. Charles W. Hoge et al., *Mental Health Problems, Use of Mental Health Services, and Attrition from Military Service After Returning from Deployment to Iraq or Afghanistan*, 295 JAMA 1023, 1023 (2006).

15. Charles S. Milliken et al., *Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning from the Iraq War*, 298 JAMA 2141, 2143 (2007).

16. *See id.* at 2146.

17. *See id.*

18. *Id.* at 2145 (citing DEF. HEALTH BD. TASK FORCE ON MENTAL HEALTH, DEP'T OF DEF., AN ACHIEVABLE VISION: REPORT OF THE DEPARTMENT OF DEFENSE TASK FORCE ON MENTAL HEALTH (2007), *available at* www.ha.osd.mil/dhb/mhtf/MHTF-Report-Final.pdf). For an example of these problems, see Wade Malcolm, *Iraq Vets' Troubles Appear Long After Return*, PITT. POST-GAZETTE, Nov. 25,

like James, health insurance benefits are inadequate to start with, and expire six months after their return to civilian status.[19] Increased interpersonal conflicts and the stress of transitioning back to civilian employment further complicate the lives of returning guard and reserve soldiers.[20]

It is too early to know how many of the returning soldiers will end up among the ranks of those serving time in prison.[21] The combination of PTSD, severe depression, alcohol abuse, difficulty with relationships, and employment problems, however, leaves little doubt about the probability that the numbers will be substantial. Experience with returning veterans from prior wars underscores this prognosis.[22] For individuals like James, military service was the first step along a path that will place heavy demands upon prison mental health services.

B. Millie, an Abuse Victim Who Lost Her Children

Millie is a thirty-three-year-old woman who had her first child at age sixteen, married at age eighteen, and had three more children in the following seven years. She suffered repeated abuse from her husband, who threatened her with abandonment if she reported his violent behavior. When she finally made the break from her husband, she received short-term care from a battered women's facility. Shortly thereafter, she began experiencing mental problems. When Millie failed to secure employment, she obtained financial assistance from the state department of social and rehabilitation services. Millie's social worker identified signs of severe depression and mood disorders frequently associated with histories of abuse. The social worker's primary concern was with providing care to Millie's children; sensing a lack of care and an apparent threat of physical abuse, she removed the children from Millie's home and placed them in foster care. An unsuccessful effort was made to find community mental health treatment for Millie, but all

2007, at A-1 (describing Staff Sgt. Frederick Johnson, whose depression and PTSD led to coping methods that began with alcohol and progressed to crack cocaine).

19. *See id.* at 2146.

20. *See id.* at 2145-46.

21. The problem is already substantial enough to cause California to provide special relief from harsh sentencing policies specifically for service members with PTSD. *See* CAL. PENAL CODE § 1170.9 (West 2007).

22. *See* Timothy P. Hayes, Jr., *Post-Traumatic Stress Disorder on Trial*, 190 MIL. L. REV. 67, 76-77 (2006) (noting an estimate that more than 25% of Vietnam veterans suffered PTSD, and half of those afflicted with PTSD had been arrested or incarcerated multiple times as adults).

local mental health care facilities were filled to capacity, with waiting lists in excess of six months. Millie registered for out-patient care, but lacked either money or transportation to get to those appointments. As her mental condition deteriorated, she refused to cooperate with welfare authorities and physically assaulted her case worker. After being held briefly in jail, she was released with the stipulation that she participate in anger management classes. She not only missed those classes, but also assaulted a waitress in a local restaurant who accused Millie of attempting to leave without paying her bill. That second assault resulted in a conviction, a fifteen-month prison sentence, and, as a result of separate proceedings, the termination of her parental rights.

The picture of Millie as both a victim and offender is far from unique. Although both men and women in prison often have been scarred by histories of abuse, such experiences are most likely to be true of women.[23] A Bureau of Justice Statistics study found that 73% of mentally ill women in local jails, and more than 75% of mentally ill women in state prisons, have reported histories of abuse.[24] In comparison, approximately 30% of mentally ill male inmates in both state prisons and local jails reported abuse histories.[25] High rates of abuse histories among women inmates are a primary explanation for their correspondingly high rates of mental illness.[26]

Jail and prison settings are likely to be especially difficult for women with histories of physical or sexual abuse.[27] They have a greater likelihood than men of drug related convictions,[28] and approximately three quarters of female jail detainees have co-occur-

23. *See* Bonnie J. Sultan, U.S. Dep't of Justice, *The Insanity of Incarceration and the Maddening Reentry Process: A Call for Change and Justice for Males with Mental Illness in United States Prisons*, 13 GEO. J. ON POVERTY L. & POL'Y 357, 360-61 (2006) (noting differences between male and female prisoners).

24. PAULA M. DITTON, U.S. DEP'T OF JUSTICE, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS 6 (1999), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf.

25. *See id.*

26. *See* Bonita M. Veysey, *Specific Needs of Women Diagnosed with Mental Illnesses in U.S. Jails*, *in* WOMEN'S MENTAL HEALTH SERVICES: A PUBLIC HEALTH PERSPECTIVE 368, 371 (Bruce L. Levin et al., eds., 1998) (noting the high prevalence of PTSD among female prisoners resulting from common experiences of repeated and severe abuse).

27. *See id.* at 372 (noting the difficulty of identifying many psychiatric and emotional problems that affect women, and the risk that unidentified problems such as PTSD may result in management problems within prison).

28. *See id.* at 370.

ring substance abuse disorders.[29] Furthermore, as compared to men, they are more likely to be poor, have lower self-esteem, have more severe physiological problems, and have been victims of abuse.[30] Estimates are that approximately one quarter of all women who enter prison are either pregnant or postpartum, with medical and mental health conditions that require careful prenatal care.[31] All of these factors contribute to stress.

The most common, serious mental health diagnosis for incarcerated women is posttraumatic stress disorder, and the symptoms of PTSD include phobias, flashbacks, and uncontrollable anger or rage.[32] Their traumatic experiences are often associated with male authority figures, leading to problems interacting with men.[33] This volatile combination creates predictable problems in the prison context, including personal suffering from the mental illness itself, as well as increased disciplinary problems and lengthened terms of imprisonment.[34]

C. Wally, a Victim of Childhood Mental Illness

Wally's first institutional experience came at age seven when he was hospitalized for mental health treatment. He first encountered the legal system at age ten, and he was moved from a treatment facility to juvenile incarceration at age thirteen based on charges of battery against staff. He continued to come into conflict with local law enforcement, with charges ranging from shoplifting to drug possession. Thefts that ended with adult incarceration included stealing a show horse from the exposition grounds and riding it around town. If joyriding on a show horse had been Wally's first offense, he would have received a relatively short term of probation. Because of his juvenile record, however, Wally was placed in the highest category of repeat offenders. At this stage, all juvenile offenses are treated as if they had been committed by an adult, and Wally now faces lengthy imprisonment.

Throughout his childhood, juvenile authorities and community service agencies attempted to provide appropriate treatment for Wally. He received separate assistance from agencies offering substance abuse treatment, special conditions victim services, group

29. *See id.* at 373.
30. *See id.* at 373-74.
31. *See id.* at 376.
32. *See id.* at 372.
33. *See id.*
34. *See* James & Glaze, *supra* note 5, at 9-10 (noting that mentally ill offenders serve longer sentences and commit more disciplinary infractions while in prison).

therapy, individual therapy, housing assistance, Medicaid general assistance, vocational rehabilitation, and Social Security disability assistance.[35] One of the problems with juveniles is that diagnosis of their mental illness is often difficult, complicated by shifting assessments as the child matures. In Wally's case, the different agencies separately diagnosed his problem as "schizo affective disorder," "polysubstance dependence," "alcohol dependence," "Axis II borderline personality disorder," "Axis II deferred," and "major depressive disorder." Unfortunately, the agencies generally failed to communicate with each other, and separate plans to treat different problems never became integrated.[36]

Like James and Millie, Wally's problems are indicative of a much larger problem. Mental illness among juveniles caught up in the criminal justice system appears to be even more prevalent than among adult men or women. Although large-scale studies have not been reported, researchers in a major Chicago study found that, after excluding conduct disorders, more than 60% of detained youth "met diagnostic criteria and had diagnosis-specific impairment for one or more psychiatric disorders."[37] The move from a rehabilitative model to a punitive model for treatment of juveniles only exacerbates this problem.[38]

When James, Wally, and Millie were transferred to prison, all were diagnosed with severe Axis I mental illness. Their stories illustrate problems encountered within the prison system that are unique to persons with mental illness.

II. Pre-Conviction Issues

A. Crisis Intervention Teams and Mental Health Courts

The three people described above will all be spending substantial time in prison, which is not where they belong. In each case, timely and appropriate intervention by mental health professionals might

35. Wally's name was derived from Waldo; no one knew where to find him in the "system" of disconnected service providers.

36. Telephone Interview with Melissa Woodward, Mental Health/Substance Abuse Specialist, Kan. Dep't of Corr. (July 7, 2008) (noting that by the time of his incarceration, the real "Wally" had received treatment from nineteen different agencies, which had formulated thirteen different treatment plans).

37. Jessica A. Garascia, *The Price We Are Willing to Pay for Punitive Justice in the Juvenile Detention System: Mentally Ill Delinquents and Their Disproportionate Share of the Burden*, 80 Ind. L.J. 489, 505 (2005) (citing Linda A. Teplin et al., *Psychiatric Disorders in Youth in Juvenile Detention*, 59 Archives Gen. Psychiatry 1133, 1137 (2002)).

38. *See id.* at 506.

have resulted in alternatives to either jail or prosecution. In the long term, these alternatives could have improved the lives of the individual offenders, reduced costs to the communities in which they live, and improved public safety.[39]

Millie's case illustrates the need for evaluation and diversion at the time of initial arrest. Communities that have studied this issue, searching for realistic alternatives to criminalizing conduct influenced by mental illness, have developed "crisis intervention teams" ("CIT") that respond to the kind of disturbance Millie caused at the restaurant where she became embattled.[40] Such teams are comprised of specially trained police officers, social workers, and mental health professionals. The CIT model was developed by the City of Memphis, which continues to offer training to police and community mental health departments from around the country.[41]

The key to CIT intervention or alternative co-responder programs is coordination among criminal justice and social service providers.[42] Providing immediate diversion for individuals who need mental health treatment, rather than waiting for custodial evaluation in county jails, offers a number of advantages. First, in terms of cost, the CIT approach eliminates the unproductive time and expense related to incarceration. Elimination of jail time also has the benefit of avoiding the trauma of that process and the related psychological harm likely to be caused by such trauma. Furthermore, provision of immediate diversion speeds the delivery of necessary psychological services and avoids the bureaucratic costs and delays caused by lawyers, judges, and court services officers.[43] In Millie's case, immediate diversion at a time of apparent mental health crisis may also have resulted in long-term treatment and successful restoration of full custodial parental rights.

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39. *See* COUNCIL OF STATE GOV'TS, CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT (2002) [hereinafter CONSENSUS PROJECT], http://consensusproject.org/downloads/Entire_report.pdf (noting the goal of diversion to the mental health system without a threat to public safety, while preventing cycling of offenses and incarceration).

40. *See* MELISSA REULAND & JASON CHENEY, NAT'L GAINS CTR, ENHANCING SUCCESS OF POLICE-BASED DIVERSION PROGRAMS FOR PEOPLE WITH MENTAL ILLNESS (2005), http://www.gainscenter.samhsa.gov/pdfs/jail_diversion/PERF2.pdf.

41. *See* Crisis Intervention Team web site, http://cit.memphis.edu.

42. *See* CONSENSUS PROJECT, *supra* note 39, at 40-41.

43. *See* REULAND & CHENEY, *supra* note 40, at 6 (noting that the use of CIT approach results in fewer people with mental illness entering the criminal justice system, and more receiving appropriate and effective treatment). Reuland and Cheney also note improved safety of officers and civilians and improved relationships between police and community resulting from the CIT approach. *Id.*

Women's prisons are disproportionately composed of women with mental illnesses brought about by personal histories comparable to Millie, who was a victim of physical and psychological abuse.[44] The last best chance for correcting, rather than compounding, such problems occurs when decisions are made either to provide mental health treatment or initiate criminal justice proceedings. By linking police departments directly with mental health providers, communities increase the likelihood of treating mental illnesses, and avoiding inappropriate criminal prosecutions.

Either as an alternative or as a substitute for the crisis intervention approach, many states have created alternative courts that focus on treatment rather than incarceration.[45] These "mental health courts" or "drug courts" respond directly to the illness or addiction that may have been the underlying cause of criminal conduct. Depending upon existing jurisdictional rules, James, Millie, and Wally might all have been diverted to such an alternative if it existed. Much like the crisis intervention teams, effective implementation of this "therapeutic approach" to criminal justice depends upon coordination among criminal justice, mental health, and social services programs within a given community.[46]

Variations of the mental health court model may perform comparable functions. Thus, the driving force behind the mental health court is likely to be a judicial commitment to implement such a program. Judges who preside over such courts must be trained to understand the illnesses they are dealing with, the treatment modalities that exist within the community, and ways in which orders from a court might enhance prospects for a favorable outcome.[47] In communities lacking judicial leadership, a district attorney's office may be able to bring about similar reforms, using discretion to

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44. *See supra* text accompanying notes 23-34.

45. *See Developments in the Law—The Law of Mental Illness,* 121 HARV. L. REV. 1114, 1168 (2008); LeRoy L. Kondo, *Advocacy of the Establishment of Mental Health Specialty Courts in the Provision of Therapeutic Justice for Mentally Ill Offenders*, 28 AM. J. CRIM. L. 255 (2001). Note, however, criticism of mental health courts. *See, e.g.*, Stacey M. Faraci, *Slip Slidin' Away? Will Our Nation's Mental Health Court Experiment Diminish the Rights of the Mentally Ill?*, 22 QUINNIPIAC L. REV. 811 (2004); Tammy Seltzer, *A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illnesses*, 11 PSYCHOL. PUB. POL'Y & L. 570 (2005).

46. *See* Susan Stefan & Bruce J. Winick, *Forward: A Dialogue on Mental Health Courts*, 11 PSYCHOL. PUB. POL'Y & L. 507, 520-21 (2005) (noting the importance of a "team approach" to mental health courts).

47. *See* Shauhin Talesh, *Mental Health Court Judges as Dynamic Risk Managers: A New Conceptualization of the Role of Judges*, 57 DEPAUL L. REV. 93, 111-21 (2007).

defer prosecution or recommend diversion as alternatives to immediate prosecution.[48]

Specific approaches will vary from one community to another, depending in part on whether leadership comes from police departments, community mental health programs, judges, or prosecutors. In the best case, all participants understand the need and the benefit of providing treatment alternatives to using the criminal justice system as a dumping ground for the mentally ill.

B. Jails

The three largest mental institutions in the United States are jails in Los Angeles, Chicago, and New York City.[49] The problems in dealing with individuals within this population are compounded by their variety and transient nature. By its nature, diagnosis and treatment of mental illness requires time, stability, and sustained therapy. In contrast, jail confinement is normally short-term, high-stress, and disruptive of any element of stability that offenders may have previously established.

Rural jails may pose even greater challenges than their urban counterparts. Part of the problem is obvious: rural areas often lack community mental health treatment alternatives. An even more basic aspect of this problem, however, is the lack of training to recognize mental illness and the costs and logistical problems associated with transferring an individual to a distant urban area or mental health hospital for evaluation when signs of mental illness are suspected.[50] In a survey of jails in rural Kansas, a large percentage of administrators believed that they did not have a problem because, in most small jails, fewer than 5% of their inmates suffered from mental illness.[51] One can imagine James in such an environment, sitting silently in the corner of a cell, perhaps showing outbursts of anger or resistance, but not outwardly delusional. He remains well aware of his own identity and appreciates (or even

48. *See* CONSENSUS PROJECT, *supra* note 39, at 83-84 (noting pretrial diversion programs specifically designed for persons with mental illness).

49. *See* Mark R. Munetz & Jennifer L. S. Teller, *The Challenges of Cross-Disciplinary Collaborations: Bridging the Mental Health and Criminal Justice Systems*, 32 CAP. U. L. REV. 935, 939 n.16 (2004) (citing CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT, COUNCIL OF STATE GOV'TS, FACT SHEET: MENTAL ILLNESS AND JAILS (2004), http://consensusproject.org/infocenter/fact-sheets/fact_jails.

50. *See* CONSENSUS PROJECT, *supra* note 39, at 85 (noting the "chief problem" for rural jails is lack of mental health professionals).

51. *See* LESLIE HUSS, STATE OF KANSAS JAIL MENTAL HEALTH SURVEY SUMMARY 6 (March 2004).

magnifies within his own mind) the problems he faces. Millie is also likely to withdraw into depression without other outward manifestation of her illness. For both James and Millie, diagnosis of their mental illnesses may not take place until after convictions and transfers to prison authorities. Rural jails are particularly likely to avoid dealing with the issue rather than attempting to provide diagnosis in advance of treatment which was not realistically available.[52]

C. Formularies

Wally's problems with mental illness were diagnosed long before his adult conviction. A major component of attempts to provide him with appropriate treatment involved assessment of whether his problems were susceptible to treatment with psychotropic medications. Because of his age, the range of available tested drugs was limited. At least some of the drugs came with high risks of suicidal behavior. Mental health professionals working with the juvenile justice system tried a number of alternatives, and finally arrived at a treatment protocol that appeared to work. For the five months prior to his arrest, Wally had been taking one of the most current and effective medications. After his nineteenth birthday, however, his prescription for that drug had lapsed, and Wally was off of his medication at the time of his arrest.

During screening at the county jail, officers interviewed Wally and discovered that he had a history of treatment for mental illness. They contacted Wally's parents, and learned the name of the drug that Wally had been taking. Unfortunately, that drug was not on the approved formulary for the jail, as the cost was considered too high and medical providers recommended use of lower-cost alternatives.[53] If the officials had reviewed Wally's records, they would have discovered that Wally had already been placed on the low-cost alternatives and it had already been established that they were ineffective. However, those records were sealed and without a release, could not be obtained, even by the mental health treatment provider at the jail who attempted to provide assistance.[54] As a result, Wally was placed on an anti-psychotic drug that failed to

52. *See* Fred Cohen, *Correctional Mental Health Law & Policy: A Primer*, 7 D.C. L. Rev. 117, 133 (2003) (noting that "[m]any jail administrators . . . actually have no acceptable arrangements for mental health care").

53. As noted by the Consensus Project, "correctional health officials are often unable to fill a prescription prepared by a doctor outside the facility." Consensus Project, *supra* note 39, at 107.

54. *See* Kan. Stat. Ann. § 75-7023(b) (1997) (making such records confidential).

treat his condition, and he remained on this ill-suited regimen for the entire time that he was in jail.

After his transfer to prison, problems with finding appropriate psychotropic medications were compounded. In most states, prisons and jails operate under state and county auspices, respectively. Their budgets and their health care providers are unrelated to each other, and therefore formularies for prescription drugs often do not match. Even if Wally had been able to maintain a successful medication regime after his arrival in jail, there is a good chance that it would have been changed immediately upon his transfer to prison. Lacking clear medical record guidance to the contrary, both systems begin by trying to use the lowest cost drugs available, and will only move to higher cost alternatives when deemed necessary.[55] In the meantime, the shifts from one drug regimen to another cause both trauma and potential long-term harm to the mentally ill patient.[56] Abrupt termination or changes in medication also result in deterioration of mental stability that is likely to lead to disciplinary infractions, prolonging terms of incarceration.[57]

D. Sentencing

Sentencing reform has been a common component of the criminal justice reform agenda for at least the last century. Every state legislature likely includes some individuals who recognize the unfairness, the waste, and the expense of existing sentencing policies, and others who seek to toughen sanctions with increased terms of imprisonment. For one generation, indeterminate sentences appeared to be the answer, with parole board authority to measure "progress" in prison and to decide when individual prisoners were sufficiently contrite to be ready for release.[58] That approach com-

55. *See* Anasseril E. Daniel, *Care of the Mentally Ill in Prisons: Challenges and Solutions*, 35 J. AM. ACAD. PSYCHIATRY L. 406, 408 (2007) ("[A]commonly used tactic to control cost is to establish a restricted formulary of older generation psychotropics and generic agents that are less expensive and then insist that the psychiatrist preferentially prescribe medications from this restricted formulary instead of the newer, generally more expensive medications that are often included in the nonformulary list.").

56. *See* ABRAMSKY & FELLNER, *supra* note 2, at 118-20 (noting that as prisoners move from jail to prison and from one prison to another, medication may be discontinued, leading prisoners to act out and become disruptive as well as triggering other serious side effects).

57. CONSENSUS PROJECT, *supra* note 39, at 107.

58. *See* FRANCIS A. ALLEN, THE DECLINE OF THE REHABILITATIVE IDEAL: PENAL POLICY AND SOCIAL PURPOSE 6-7 (1981); Charlton T. Lewis, *The Indeterminate Sentence*, 9 YALE L.J. 17 (1899).

pounded problems of prison management, with corrections officials unable to predict population size or individual dates of release.

Lack of clear sentencing guidelines leads to gross unfairness in sentencing policies. In one county in Kansas, the length of a sentence was more likely to be affected by the floor on which the elevator stopped on the way to trial (signifying the judge who had been assigned to the case), than by the seriousness of the crime that had been committed.[59] Sentence length also appeared to be directly correlated with race.[60] All of these factors became cause for reform.

The era of the use of sentencing guidelines in Kansas ushered in what many considered to be a correction to this range of problems, including the unfairness of the indeterminate sentence as well as the difficulty of managing unpredictable growth of the prison population. But sentencing guidelines came with their own set of difficulties. Unfairness did not disappear from the system. Police and prosecutor discretion increased in the guidelines era, and to the extent that law enforcement focused upon poor and minority communities, discrimination against those residents continued.[61] Furthermore, because prior criminal history became the key determinate for sentencing, those with prior criminal records ended up with longer and longer terms of imprisonment.[62]

While these problems were generally predictable, guidelines reform advocates generally did not predict the harsh impact that would fall upon the mentally ill, especially those with juvenile records. While individual states may answer these questions differently, Kansas chose to treat juvenile crimes as equivalent to adult crimes when assessing criminal records and calculating new sentences.[63] Furthermore, multiple convictions resulting in concurrent sentences were treated as separate crimes even though they may have been part of a single pattern of conduct at the time the

59. *See* William J. Rich, *Prison Conditions and Criminal Sentencing in Kansas: A Public Policy Dialogue*, 11 KAN. J.L. & PUB. POL'Y 693, 699 (2002).

60. *See id.* at 698 (citing BEN COATES, KAN. SENTENCING COMM'N, RECOMMENDATIONS OF THE KANSAS SENTENCING COMMISSION 24 (1991)).

61. *See* Robert Weisberg & Marc L. Miller, *Sentencing Lessons*, 58 STAN. L. REV. 1, 29 (2005) (noting the standard "mantra" that "[g]uidelines produced a great 'transfer of power' to prosecutors").

62. Virtually all sentencing guidelines regimes increase incarceration in response to increases in records of criminal convictions. *See, e.g.*, KAN. STAT. ANN. § 21-4704b (2007).

63. *See id.* § 21-4709.

crimes were committed.[64] All of this means that the mentally ill who failed to control their behavior on multiple occasions and who, in the absence of treatment were particularly prone to recidivism,[65] ended up at the far end of the criminal history scale and became the persons most likely to receive long terms of imprisonment.

Wally could be a poster child for the harsh treatment under sentencing guidelines. His juvenile convictions all reflected problems associated with mental illness, and at least some of the convictions were plea agreements entered into with an eye towards obtaining treatment. Those explanations disappeared, however, when confronted with the stark context of adult sentencing. Prison was the inevitable result.

Answers to these problems are not difficult to identify. First and foremost, any system of sentencing guidelines should provide exceptions for those suffering from mental illnesses that may be safely treated without endangering the public. This is especially important in the context of drug and alcohol offenses where the co-occurring disorders may reflect self-medication of mental illness.[66] In addition, when evaluating past criminal history, there should be a willingness to look behind the list of convictions and to identify behavior that could be best understood as the manifestation of untreated mental illness. When prior criminal behavior resulted in concurrent sentencing, judges should be able to determine whether multiple convictions should be dealt with as a single pattern of behavior rather than as multiple separate crimes.[67] Juvenile records in particular should be subject to increased scrutiny when relied upon as a basis for imposing incarceration rather than probation.[68]

III. Post-Conviction Issues

A. Risk Assessment

One of the first issues that James, Wally, and Millie all confront will involve a "risk assessment" by prison authorities to determine appropriate treatment alternatives. Risk assessment tools are not specifically geared to diagnosis or treatment of mental illness. In-

64. *See id.* § 21-4710(c).

65. *See infra* note 123 and accompanying text.

66. *See supra* text accompanying notes 14-22 (describing the decision to self-medicate that is frequently made by James and other returning veterans).

67. *See* Rich, *supra* note 59, at 713 (noting that when judges impose concurrent sentences, they are treating the crimes involved as a single instance of criminal behavior).

68. *See id.* (noting the difficulty in assessing juvenile "adjudications").

stead, they are used as a screening device for all inmates in order to match their placement in prison with the most appropriate security levels, programs, training, or treatment so that upon eventual release from prison the offenders will pose reduced risks to the community they reenter.[69]

When used as intended, risk assessment tools provide a relatively reliable method of identifying aspects of an individual's family background, education, employment history, neighborhood associations, personal values, outlook, and mental health that may contribute to high risk of future criminal activity.[70] In theory, those aspects of the individual's background that are amenable to treatment or modification become the target of prison officials who seek to reduce factors that contribute to risk during a term of incarceration. Red flags, however, should accompany any tools designed for risk assessment.[71]

First and foremost, risk assessment procedures must *not* be channeled into the criminal sentencing process. The temptations on this score are substantial. Standardized risk assessment measures provide numbers that can be used to quantify the degree of risk that individual offenders may pose when released back into the community. Judges and parole authorities make difficult decisions regarding incarceration, and could easily be influenced by an individual's "number" that represents risk. This could become a convenient way to hide behind the work of social scientists, thereby attempting to avoid liability for the inevitable "mistakes" that occur when prisoners receive short prison sentences or early release on parole. Such misuse of risk assessment devices should never be tolerated.[72]

Mental illnesses highlight reasons for maintaining a cautious approach to risk assessment measures. Individuals with mental ill-

69. *See, e.g.*, D. A. ANDREWS & JAMES L. BONTA, THE LEVEL OF SERVICE INVENTORY—REVISED (LSI-R) USER'S MANUAL (1999) (describing the purpose of risk assessment as identifying "risk/need that may be addressed by programming in order to reduce risk").

70. *See* Stephen C. P. Wong & Audrey Gordon, *The Validity and Reliability of the Violence Risk Scale: A Treatment-Friendly Violence Risk Assessment Tool*, 12 PSYCHOL. PUB. POL'Y & L. 279, 290 (2006) ("The LSI-R has been validated on various offender samples in predicting violent and nonviolent recidivism."); *see also* Lina Girard & J. Stephen Wormith, *The Predictive Validity of the Level of Service Inventory—Ontario Revision on General and Violent Recidivism Among Various Offender Groups*, 31 CRIM. JUST. & BEHAV. 150 (2004).

71. *See* CONSENSUS PROJECT, *supra* note 39, at 155 ("[N]o known risk assessment instrument has been validated by research to predict accurately the nexus between mental illness and risk.").

72. *See* ANDREWS & BONTA, *supra* note 69, at 3 (explaining that the LSI-R "was never designed to assist in establishing the just penalty").

ness also have a relatively high likelihood of unemployment backgrounds and experiences with family conflict or instability.[73] If they happen to have been recently homeless or to have lived in low-income, high-crime neighborhoods, that combination of factors will push assessment of the offender into "high risk" categories.[74] If, for example, James is poor, has a limited education, lives in an inner city "ghetto," and suffers from mental illness, then his risk assessment number will be high. If that number were to be misused to determine whether he should spend time in prison, then states would be using a combination of a poverty background (often affiliated with race) and mental illness as determinants of imprisonment, even when the underlying mental health concerns may be most amenable to successful community treatment. If mental illness becomes a synonym for "high risk," and therefore a basis for imprisonment, states will effectively have criminalized that illness.

B. Prison Medication

The issue of medication in prison has multiple dimensions. There appears to be a growing consensus that modern psychotropic medications increase prospects of recovery for those with mental illness.[75] Newer, more effective (and more expensive) medications, however, are not used as frequently in prisons and jails as in the general community.[76] Furthermore, there continue to be jails and prisons which fail to properly screen new inmates, fail to diagnose mental illness, and fail to provide appropriate medication where needed. According to one Bureau of Justice Statistics study, more

73. *See* JAMES & GLAZE, *supra* note 5, at 4-5 (noting that homelessness, foster care, unemployment, physical or sexual abuse and family problems are all correlated with mentally ill prison and jail inmates).

74. *See* Anthony W. Flores et al., *Predicting Outcome with the Level of Service Inventory-Revised: The Importance of Implementation Integrity*, 34 J. CRIM. JUST. 523, 524 (2006) (noting that the ten "domains" included within the LSI-R include criminal history, education/employment, financial status, familial relationships, accommodations, alcohol and drug use, emotional health, and attitudes/orientation). Problems in the domains targeted by the LSI-R are often correlated with mental illness. *See, e.g.*, JAMES & GLAZE, *supra* note 5, at 4-6 (noting the relationship between offenders with mental illness and problems such as homelessness, substance abuse, low income, and strained interpersonal relationships).

75. *See* CONSENSUS PROJECT, *supra* note 39, at 137.

76. *See id.*

than a quarter of state correctional facilities do not distribute psychotropic medications to inmates.[77]

On the other hand, there is a long and sordid history of misuse and over-reliance upon psychotropic medications, used at times for their sedative properties to pacify disruptive inmates whether or not they were being treated for mental illness.[78] The term "chemical restraints" has been used to characterize such use of medications in the absence of medical justification.[79] The problem appears to be most acute for female inmates; Millie is more likely than James to fit the stereotype of the "sick" criminal.[80]

Because of problems associated with both underuse and overuse of psychotropic medications in prison, data merely reporting such use does not provide a satisfactory picture for evaluating prison health care. A report that large numbers of prisoners are receiving medication may reflect conscientious efforts to treat mental illness. It may also reflect abuse of the same medications as control agents, used to simplify inmate management. A complete picture will only emerge based upon expert assessment of both staffing and records. In the best case, those records will indicate that medication is provided as one element of therapy, carefully combined with medical oversight and other elements of therapeutic case management.[81] Poorly monitored distribution of drugs, without corresponding therapy, may be the worst of all alternatives, compounding underlying mental illness while triggering harmful side effects.[82]

C. Overcrowding

The class action law suit that resulted in improved mental health treatment for Kansas inmates began with complaints about over-

77. ALLEN J. BECK & LAURA M. MARUSCHAK, U.S. DEP'T OF JUSTICE, MENTAL HEALTH TREATMENT IN STATE PRISONS 2 (2000), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtsp00.pdf.

78. *See* CONSENSUS PROJECT, *supra* note 39, at 136; ABRAMSKY & FELLNER, *supra* note 2, at 109 (noting use of psychotropic medications "simply to pacify and to control inmates").

79. *See* Kathleen Auerhahn & Elizabeth D. Leonard, *Criminology: Docile Bodies? Chemical Restraints and the Female Inmate*, 90 J. CRIM. L. & CRIMINOLOGY 599, 604 (2000) (citing PETER BREGGIN, TOXIC PSYCHIATRY (1991) as the originator of this term).

80. *E.g.*, *id*. at 615 (explaining that "prevailing view of the female criminal as 'sick' has resulted in a criminal justice system response oriented towards treatment").

81. *See* CONSENSUS PROJECT, *supra* note 39, at 136.

82. *See* Washington v. Harper, 494 U.S. 210, 229-30 (1990) (describing the side effects of psychotropic medications and concluding that inmates have liberty interests restricting involuntary treatment with such drugs); ABRAMKY & FELLNER, *supra* note 2, at 110 (noting the need for a multifaceted treatment approach).

crowding.[83] Inmates who filed *pro se* petitions in 1977 and 1978 lived in the old part of a prison that was built in the 1860s and never renovated.[84] When the litigation began, most inmates had independent cells with reasonable square footage.[85] Because of a lean administrative structure, however, inmate management often consisted of confining individuals to their cells without access to either jobs or programs.[86] With five tiers of open cells and minimal air circulation, inmates suffered from extreme heat or cold.[87] Inmates and management agreed that with renovations, increased opportunities for activity, and improved health care and related services, the deficiencies could be corrected. A consent decree reflecting that agreement was filed in 1980.[88]

Several years later, however, Kansas inmates (like those in many other states at the time)[89] discovered what real overcrowding was like.[90] With a doubling of the prison population, targets for renovation could not be met, and goals established by the consent decree became unrealistic dreams.[91] The overcrowding that existed in 1988 meant that, throughout the old penitentiary, two inmates were housed in cells designed in the nineteenth century for just one person.[92] Growth in the number of mentally ill inmates paralleled growth of the inmate population, but additional treatment space for those inmates with heightened mental health needs had not

83. *See* Amended Complaint at 3, Olson v. Bennett, No. 77-3045 (D. Kan. Sept. 15, 1978).

84. *See* Rich, *supra* note 59, at 695-96.

85. *See id.* at 695. Cells with approximately sixty square feet of space were considered normal. *See* Rhodes v. Chapman, 452 U.S. 337, 341-43 (1981) (comparing many studies' findings that approximately sixty square feet of living space was normal with an Ohio prison's practice of placing two inmates in sixty three square foot cells).

86. *See* Rich, *supra* note 59, at 695.

87. *See id.*

88. *See* Consent Decree, Arney v. Bennett, No. 77-3045 (D. Kan. May 2, 1980), *enforced sub nom.* Arney v. Hayden, No. 77-3045 (D. Kan. filed Apr. 1, 1988). The only provision for mental health care in the 1980 consent decree was a provision requiring the Secretary of Corrections to "make an active, good faith effort to procure such funds as may be necessary to enable compliance with American Correctional Association standards for medical and mental health care services in prisons." *Id.* at 7. While that provision seemed innocuous at the time of agreement, and was ultimately unenforceable when Kansas later failed to meet other provisions of the decree, it nevertheless provided a set of standards to aid in establishing long-term relief. *See* Rich, *supra* note 59, at 697.

89. *See, e.g.*, Ramos v. Lamm, 639 F.2d 559 (10th Cir. 1980); Battle v. Anderson, 564 F.2d 388 (10th Cir. 1977).

90. *See* Rich, *supra* note 59, at 696-97 (describing overcrowded conditions in the Kansas State Penitentiary).

91. *See id.* at 695.

92. *See id.* at 697.

been created.[93] Limited space in a single treatment facility meant that only the most severe cases received long term professional care.[94] In order to make room for inmates in crisis, those receiving treatment were often returned to their cells before their conditions had stabilized, and conditions in overcrowded prison cells exacerbated their illnesses.[95] Rapid deterioration of these inmates' conditions triggered need for a return to intensive treatment, and resulted in an endless cycle of movement in and out of the state hospital.[96]

As the percentage of mentally ill inmates living in the general population increased, lack of treatment to stabilize those inmates or to help them adjust to living in the general population created enormous management problems for resource-strapped prison officials.[97] One alternative adopted by the Kansas State Penitentiary was to place mentally ill inmates into the population of inmates who needed "protective custody," thus separating them from the general population.[98] But even those inmates were forced to live in overcrowded conditions, and because of their protective custody status, they were denied freedom of movement to jobs or activities outside of their cells.[99]

Although litigation reduced the overcrowding in Kansas prisons, many states continue to battle with this issue, and many prisons in the United States operate with inmate populations that are one hundred fifty to two hundred percent above capacity.[100] Imagine either James, Wally, or Millie living in a cell with less than sixty square feet of floor space, a toilet and bunk-beds taking up much

93. *See* Arney v. Hayden, No. 77-3045, slip op. at 28-29 (D. Kan. Apr. 1, 1988).

94. *See id.* at 28.

95. *See* TERRY A. KUPERS, PRISON MADNESS 47-53 (1999) (discussing the relationship between crowding and mental illness).

96. *Id.* at 49. The cycle of movement between specialized psychiatric units and other prison facilities, especially prison segregation units, has been documented in a number of states. *See* ABRAMSKY & FELLNER, *supra* note 2, at 162 (referring to a "ping pong effect").

97. *See Arney*, No. 77-3045, slip op. at 23-24.

98. *See id.* at 24 ("The percentage of inmates in segregation (28.5%) could be substantially reduced if those inmates in protective custody due to mental health problems could be removed to a living unit where they could receive treatment instead of simply being locked down.").

99. *See* Rich, *supra* note 59, at 697. Conditions that used to exist in Kansas were far from unique, and still persist in other states; c*f.* Sultan, *supra* note 23, at 375 (describing "Segregated Housing Units" that represent a "grotesque and inhumane practice that actually precludes recovery for [persons currently incarcerated ("PCI")] with mental illness").

100. *See* Sultan, *supra* note 23, at 366.

of that space (with the toilet just inches away from the bed), confined to that cell for twenty-three hours per day, and with a cellmate whose personal hygiene and mental illness contribute to virtually unbearable aromas and noise. Overcrowded conditions create especially difficult coping problems for people with mental illness who are prone to decompensate under such conditions.[101] When preparing for trial against the Kansas State Penitentiary, attorneys for the plaintiffs compared inmates' living conditions to standards for housing primates in zoos.[102] However, the disparity was so enormous—primates in zoos were given so much more space and opportunities for exercise—that the comparison to zoological standards would have been futile in court. To solve the problem, it would be necessary to both relieve the overcrowding and to provide treatment alternatives for the mentally ill.

At the time when these issues were raised in court, it was not enough to claim that overcrowding per se was unconstitutional, because the United States Supreme Court had already closed that door.[103] The Court had ruled, however, that conditions of confinement violate "contemporary standards of decency" when "alone or in combination . . . [they] deprive inmates of the minimal civilized measure of life's necessities."[104] A combination of overcrowding and failure to provide reasonable treatment for mental illness could meet that standard.[105]

D. Discipline and Segregation

One of the reasons why people like James, Millie, and Wally end up in prison in disproportionate numbers is that their mental illness directly contributes to illegal behavior. It happens when they self-medicate, resorting to alcohol or drugs as a response to their depression or psychosis. It also happens when their response to

101. *See* KUPERS, *supra* note 95, at 49 (noting that the extreme duress of such conditions makes it difficult to cope). Decompensation occurs when mentally ill individuals are unable to maintain defense mechanisms needed to keep their mental disorders in check. *See* THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE (4th ed. 2004) (defining "decompensation").

102. Personal communications, William Rich, lead counsel for plaintiffs, with Dwight Corrin and Roger Theis, co-counsel for plaintiffs, in Topeka, Kan. (Dec. 1988).

103. *See* Rhodes v. Chapman, 452 U.S. 337 (1981) (concluding that overcrowding per se did not violate Eighth Amendment standards).

104. *Id.* at 347.

105. *See* ABRAMSKY & FELLNER, *supra* note 2, at 53-54 (noting risks of "serious psychological harm" resulting from onerous, overcrowded conditions of confinement).

others is viewed as inappropriate, especially when "inappropriate" reactions include an element of violence. When Millie argued with the waitress about payment of a bill, and when Wally engaged in frequent combative behavior, both were responding in ways that could be the result of untreated mental illness. Similarly, poor impulse control and increased interpersonal conflicts are common affects of the PTSD that James suffers.[106]

The fallout from these problems with personal interaction does not end with incarceration. As noted previously, the stress caused by living in crowded conditions and sharing small spaces with other people who may themselves suffer from personality disorders magnifies the manifestations of mental illness.[107] Pathological behavior patterns can be directly linked to punishment within the prison context where rigid disciplinary systems treat all incidents of assaultive behavior in the same manner, and where repeated violations of rules result in escalation of punishment and eventual segregation, isolation, and loss of "good time" credit.[108] As Bonnie Sultan notes, correctional officers often lack the training needed to distinguish behavior that results from mental illness from infractions by those who are not ill, and "assaultive acts coupled with disturbed behavior" are likely to be punished more severely than other assaults.[109] She concludes that, "[t]hough their acts of aggression fit their symptomatic psychoses and illnesses, the ill are met with more and harsher punishment instead of treatment."[110]

Harsh punishment and loss of "good time," of course, mean that the mentally ill also spend more time in prison than their non-ill counterparts. In a Department of Justice study, people who were mentally ill received longer sentences and served a higher percentage of their sentence in prison, averaging fifteen months more behind bars for their crimes.[111]

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106. For a complete description of symptoms associated with PTSD, see DSM IV, *supra* note 3, at 467-68 (including in the "Criteria for Posttraumatic Stress Disorder" references to "markedly diminished interest or participation in significant activities" and "irritability or outbursts of anger").

107. *See supra* text accompanying note 101.

108. *See* Sultan, *supra* note 23, at 370. In one study, mentally ill federal prisoners were more than twice as likely to have engaged in fights compared to their non-ill fellow prisoners. *See* Ditton, *supra* note 24, at 9.

109. Sultan, *supra* note 23, at 371 (citing Hans Toch & Kenneth Adams, Acting Out: Maladaptive Behavior in Confinement 118 (2002)).

110. *Id.*; *see also* Patricia A. Streeter, *Incarceration of the Mentally Ill: Treatment or Warehousing?*, 77 Mich. B.J. 166, 166 (1998) (noting that "pathological behavior patterns lead to repeated and escalating levels of punishment often culminating in segregation").

111. *See* Ditton, *supra* note 24, at 8; Sultan, *supra* note 23, at 371-72.

To complicate matters, prison officials are not required to provide procedural protection in the context of disciplinary proceedings that result in punitive isolation, at least when that treatment lasts for a relatively short period of time.[112] Such transfers do not constitute deprivations of "liberty" interests as currently recognized by the Supreme Court.[113] Even the fact that misconduct reports are likely to result in increased periods of incarceration will not be enough to warrant procedural protection.[114]

IV. After Incarceration

A. Reentry into Society

Problems with reentry to the community are difficult for almost everyone being released from prison, but the challenges are especially hard to overcome for the mentally ill. For most mentally ill prisoners, reentry planning should begin at the time of incarceration. Transition specialists need to realistically assess community options and resources and to prepare individual prisoners for options they will face upon release.[115]

Community treatment options that are not tailored to the individual are likely to be prescriptions for failure. For example, if Wally is placed into a community based substance abuse treatment program that does not also treat his co-occurring mental illness, the placement may quickly terminate if he "acts out" while participating in group therapy; this manifestation of mental illness will be recorded by the treatment provider as uncooperative or disruptive behavior, and it is likely then to be treated by authorities as failure to abide by conditions of parole. Similarly problematic, many substance abuse treatment programs force mentally ill participants to discontinue their medication during treatment, believing that use

112. *See* Sandin v. Conner, 515 U.S. 472, 486 (1995).

113. *See id.* at 487.

114. *See id.* (claiming that parole decisions are based upon a "myriad of considerations," and that prisoners will presumably be able to explain the circumstances behind their disciplinary record at parole hearings).

115. Kansas is one of the few states that have developed reentry programs specifically designed for mentally ill offenders. *See* Kan. Criminal Justice Recodification, Rehabilitation & Restoration Project, 2006 Committee Report to the Kansas Legislature: Behavioral Health Subcommittee Recommendations 5 (2006) (explaining the COR-Pathways program, which prepares inmates with mental illness for reentry into society following release from incarceration).

of such drugs by some participants will undermine therapy for others.[116]

One of the first problems likely to be faced upon release is maintenance of medication. Many states fail to help incarcerated persons apply for medical benefits prior to their release from prison,[117] and the mentally ill often have little prospect of being able to cross the bureaucratic hurdles that will be needed to maintain medication. There will generally be at least two basic steps that need to be taken. They need to arrange for either public or private insurance coverage that will cover the cost of both medications and professional treatment, and they also must arrange for a prompt appointment with community mental health programs that will provide professional oversight. If the mental illness is disabling, they may be able to establish both Social Security and Medicaid eligibility prior to leaving prison, but doing so takes cooperation between corrections officers and outside government bureaucrats. In the absence of such planning, however, there is likely to be a gap in coverage.

All of the standard difficulties of reentry are compounded for those with mental illness. Compared with the general population, they are more likely to have histories of homelessness[118] and to face difficulty in finding and maintaining suitable housing.[119] Mental illness is often linked to past conflict with family members, including high incidence of prior abuse, and therefore the mentally ill are less likely to return to a supportive family unit.[120] Mental

116. Telephone Interview with Melissa Woodward, *supra* note 36 (noting that a majority of substance abuse treatment programs in Kansas have such policies).

117. *See* ABRAMSKY & FELLNER, *supra* note 2, at 199.

118. State prisoners with mental health problems were twice as likely to have been homeless in the year prior to arrest than those without. *See* JAMES & GLAZE, *supra* note 5, at 4.

119. *See* CONSENSUS PROJECT, *supra* note 39, at 7 ("[A] lack of affordable, practicable housing options for individuals with mental illness compounds the difficulty of providing successful treatment.").

120. *See* JAMES & GLAZE, *supra* note 5, at 4-5 (noting that mentally ill prison and jail inmates were more likely to have lived in foster care, more likely to have been abused, and more likely to have family members suffering from substance abuse and incarceration than non-mentally ill inmates); JUSTICE CTR., COUNCIL OF STATE GOV'TS, REPORT OF THE RE-ENTRY POLICY COUNCIL: CHARTING THE SAFE AND SUCCESSFUL RETURN OF PRISONERS TO THE COMMUNITY 168 (2005) (noting that mentally ill prison inmates are more likely to have "histories of physical and sexual abuse, often perpetrated by family members or intimate partners"), *available at* http://reentrypolicy.org/report/download.

illness is also linked to difficulty in sustaining employment,[121] and these problems become even more difficult for those in transition from prison.

Even under ideal circumstances, transition is likely to induce stress, with new housing arrangements, new work possibilities, and new people to interact with. Loss of medication coupled with this stress will likely be destabilizing, and that combination will complicate all other plans for transition. In such an environment, it is essential that parole officers understand the effects of mental illness, and be in a position to either provide direct services necessary to restore stability, or maintain a relationship with social service providers who can take over that responsibility. In a national survey, however, less than one quarter of responding parole administrators indicated that they provided special programs for mentally ill parolees.[122] In the absence of coordinated efforts, there is little chance of successful transition.

B. Recidivism

Given the problems that mentally ill offenders face during transition, it should not come as a surprise that they experience high rates of recidivism.[123] Progressive states may address these issues with trained parole officers who recognize signs of mental illness and the need for treatment.[124] In most cases, however, parole officers without that training will have difficulty distinguishing between symptoms of mental illness and incorrigible behavior. The mentally ill, especially when undergoing dramatic transitions including the loss of stabilizing medication, will have difficulty complying with reporting rules, employment rules, or other related demands associated with unrealistic reentry plans. While non-compliance with rules may not lead directly to parole revocation, it is almost certain to create stress that will have revocation as an inevitable secondary consequence. Thus, stress outside of the prison is

121. *See* ABRAMSKY & FELLNER, *supra* note 2, at 26 (citing an unpublished survey by NAMI revealing that only fourteen percent of consumers of mental health services had full-time employment, and only seventeen percent had part-time employment).

122. Arthur J. Lurigio, *Effective Services for Parolees with Mental Illnesses*, 47 CRIME & DELINQUENCY 446, 453 (2001).

123. *See* JUSTICE CTR, *supra* note 120, at 168 (noting that "untreated mental illness (or mental illness and a co-occurring substance abuse disorder) is a strong predictor of recidivism").

124. Telephone Interview with Melissa Woodward, *supra* note 36 (noting that parole and probation officers in Kansas will be receiving CIT training, helping them to both recognize mental health issues and to coordinate their efforts with community mental health agencies).

again likely to be a cause for bursts of anger and compulsive behavior. For the large percentage of mentally ill offenders with co-occurring substance abuse problems, stress and a lack of proper medication and therapy will be likely to result in a return to drug use. Parole supervision will detect such changes with urinalysis, and these offenders will quickly join the ranks of recidivists.

Assume that James, Millie, and Wally all received excellent care during their time in prison, including both appropriate medication and therapy. If that treatment comes to an abrupt halt when they are released, if medication is cut off, or if follow-up care within the community is not available, then benefits of prison treatment will quickly dissipate. Under such circumstances, even the most effective prison treatment programs will be assessed as failures when measured in terms of recidivism rates. Prison and community programs need to be coordinated in order to avoid repetition of the cycle described in the preceding pages.

V. Reform or Litigation

There *should* be a receptive audience for those seeking reform in the criminal justice system to meet the needs of mentally ill offenders. As described in preceding pages, ample evidence exists to demonstrate that the United States is incarcerating large numbers of people because they are mentally ill. A growing body of evidence also demonstrates the existence of treatment programs that work.[125] Failure to screen offenders prior to sentencing results in missed opportunities for appropriate diversion and community treatment. Failure to treat jail or prison inmates causes deterioration in mental health, making eventual treatment more difficult or even impossible. Failure to prepare inmates for reentry, and failure to provide supervised medication, trained staff and related housing, and social services to paroled inmates almost assures repetition of the cycle of crime and punishment.

Reform advocates should begin with a focus on the lives of the offenders. While the California legislature apparently understands the need to address the problems faced by people like James, who return from combat in Iraq or Afghanistan with psychological problems brought on by their war time experience,[126] hundreds of

125. *See* Consensus Project, *supra* note 39, at 251 (describing "evidence-based practices" including appropriate use of psychotropic medications, supported employment, family psychoeducation, illness self-management, and integrated treatment for co-occurring illnesses and disorders).

126. *See supra* note 21.

thousands of others continue to be caught by the criminalization of mental illness. Millie's problems were brought on by physical and mental abuse and an unresponsive system. Wally's illness developed while he was a child; he may have received *too much* care from multiple agencies and institutions that expended substantial resources but failed to effectively coordinate their services. State officials should understand their responsibility for meeting the needs of all three of these individuals and those of others who share similar problems.

A second reason for reforming the system is based upon concern for public safety. Some legislators inevitably argue for lengthy imprisonment out of a legitimate desire to safeguard their communities. Recidivism rates alone, however, demonstrate that incarceration is not a cure for crime. Especially when dealing with the mentally ill, failure to reform the system and to provide meaningful community support and treatment means that criminal conduct will be repeated.[127] Behind the recidivism statistics is the harm to third parties who have been victimized because of the lack of treatment. Adoption of a reform agenda based upon "best practices" leading to successful treatment is a better answer for those who genuinely care about protecting the public.

Finally, reform should be embraced on purely monetary grounds. A Washington State study compared costs and benefits of four hundred "crime reduction projects."[128] The report found that investment in treatment programs for juvenile offenders offered the greatest long term return on the dollar, with several programs for juveniles that would return more than twenty dollars in benefits for every dollar invested in the programs.[129] Programs for adults, while not as dramatically cost efficient as those designed for juveniles, nevertheless provided substantial returns on investments, with the greatest returns resulting from community based programs rather than from programs within prisons.[130] Efficient re-

127. *See supra* text accompanying notes 123-24124.

128. STEVE AOS ET AL., WASH. STATE INST. FOR PUB. POLICY, THE COMPARATIVE COSTS AND BENEFITS OF PROGRAMS TO REDUCE CRIME 1 (2001), http://www.wsipp.wa.gov/rptfiles/costbenefit.pdf.

129. *See id.* at 17-19 (describing "multi-systemic therapy," "functional family therapy," "aggression replacement training," "multidimensional treatment foster care" and an "adolescent diversion project").

130. *See id.* at 23-32; *see also* PAUL W. SPAITE & MARK S. DAVIS, NAT'L ALLIANCE FOR THE MENTALLY ILL, THE MENTALLY ILL AND THE CRIMINAL JUSTICE SYSTEM: A REVIEW OF PROGRAMS 2 (2005) (describing programs and reviewing their efficacy in view of their costs).

form requires shared information and coordination of services,[131] and breaks the costly cycle of crime and punishment. Unfortunately, it costs money in order to save money; community mental health resources that were promised at the time of deinstitutionalization still need to be developed.[132] In the long term, maintaining those resources will reduce the need for incarceration. On the other hand, failure to address basic needs of the mentally ill will expose states to liability and the potential long term costs of judicial oversight of their correctional systems.

In the absence of reform led by a combination of legislators and administrators, litigation remains the only viable alternative for addressing the needs of mentally ill offenders. Others have addressed the prospects and difficulties of litigation in detail.[133] Congress created barriers through the enactment of the Prison Litigation Reform Act of 1995.[134] Based upon that act, judicial remedies are to be narrowly fashioned and limited to resolving specific constitutional complaints.[135] As a result, broad and systemic relief is now more difficult to obtain than it had been previously.

The Supreme Court created major substantive hurdles with decisions that limit instances in which relief will be granted for mistreatment of the mentally ill.[136] Prison administrators will only be liable if they "acted or failed to act despite . . . knowledge of a substantial risk of serious harm."[137] This "deliberate indifference" standard puts a premium on ensuring that prison officials are aware of serious medical needs; for them, ignorance may be bliss. Proving awareness of the serious nature of mental illness poses ad-

131. *See* W. David Ball, *Mentally Ill Prisoners in the California Department of Corrections and Rehabilitation: Strategies for Improving Treatment and Reducing Recidivism*, 24 J. CONTEMP. HEALTH L. & POL'Y 1, 22 (2007) (describing the "integrated services model," which coordinates mental health, parole, therapeutic treatment for drug and alcohol addiction, housing, and employment).

132. *See* THE PRESIDENT'S NEW FREEDOM COMM'N ON MENTAL HEALTH, ACHIEVING THE PROMISE: TRANSFORMING MENTAL HEALTH CARE IN AMERICA 3 (2003), http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf (describing the mental health delivery system as "fragmented and in disarray").

133. *See generally* FRED COHEN, THE MENTALLY DISORDERED INMATE AND THE LAW (2d ed. 2008).

134. Prison Litigation Reform Act of 1995, Pub. L. No. 104-134, §§ 801-802, 110 Stat. 1321, 1321-66 (1996) (codified as amended in scattered sections of 11 U.S.C., 18 U.S.C., 28 U.S.C., 42 U.S.C.).

135. *See* 18 U.S.C. § 3626(a)(1)(A) (2007).

136. *See generally* CHESTER J. ANTIEAU & WILLIAM J. RICH, MODERN CONSTITUTIONAL LAW § 41.47 (2d ed. 1997).

137. Farmer v. Brennan, 511 U.S. 825, 842 (1994).

ditional problems where lack of a proper diagnosis makes it difficult for "reasonable persons" to understand the pain suffered by the mentally ill, especially given the lack of trust accorded to inmate complaints.[138] For these reasons, relief may be difficult to obtain. As Fred Cohen has noted, "[p]sychological stress and possible deterioration often are accepted as an inherent aspect of imprisonment and thus beyond the realm of legal protection."[139]

The difficulty in obtaining remedies in individual cases does not preclude systemic relief, especially given the prevalence and awareness of mental illness in the prisons. Every prison warden *knows* that a high percentage of inmates are mentally ill, and given that notice, basic screening, evaluation, and diagnostic programs staffed with qualified professionals must be available.[140] Minimal components of a treatment program must also be provided;[141] the extent of judicial relief is likely to be affected by other problems of confinement including such factors as overcrowding or inadequate out-of-cell activities.[142] Such conditions independently add stress and contribute to deteriorating mental health.[143] Attention to the needs of the mentally ill, therefore, becomes a focal point of virtually any challenge to conditions of confinement.

The biggest barrier to obtaining reform through litigation is the cost imposed both on prisoners and on the public. The Supreme Court's "deliberate indifference" standard means that relief will not be ordered until individual inmates have experienced immeasurable suffering. Untreated prisoners released to the community will often be in worse condition than when they were sentenced, and subsequent treatment costs as well as risks to public safety will increase as a result.

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138. *See* Lori A. Marschke, *Proving Deliberate Indifference: Next to Impossible for Mentally Ill Inmates*, 39 VAL. U. L. REV. 487, 538 (2004) (noting a distrust of inmate motivations and truthfulness).

139. Fred Cohen, *Correctional Mental Health Law & Policy: A Primer*, 7 D.C. L. REV. 117, 120 (2003).

140. *See id.* at 124.

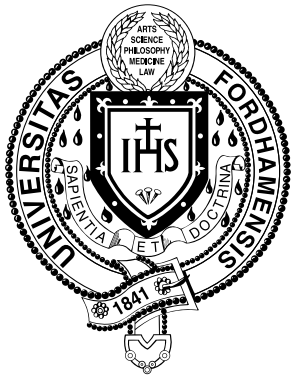
141. *See id.* at 125-26 (listing minimal components, including screening, supervision, trained professionals, adequate record keeping, supervised medication, and suicide prevention).

142. The Supreme Court has noted that, while over-crowded conditions will not independently violate the Eighth Amendment, over-crowding combined with other factors may have that affect. *See* Rhodes v. Chapman, 452 U.S. 337, 348-49 (1981). The Court has also noted, however, that "[*s*]*ome* conditions of confinement may establish an Eighth Amendment violation 'in combination' when each would not do so alone . . . ." Wilson v. Seiter, 501 U.S. 294, 304 (1991).

143. *See* ABRAMSKY & FELLNER, *supra* note 2, at 53-54 (noting "particularly onerous" risk of psychological harm resulting from such conditions).

Conclusion

Discussion of prison conditions in the United States would be incomplete without attention to the needs of the mentally ill. Reasons for growth of the mentally ill prison population may be traced to our communities, and our collective failure to provide coordinated community treatment as an alternative to invoking the criminal justice system. By offering inadequate community mental health care, we have progressively criminalized mental illness; the ghastly insane asylums of a prior generation have been replaced by equally pernicious overcrowded prison cells. Failure to treat prisoners leads to disciplinary problems, lengthy incarceration, and the cycle of recidivism. The path of mentally ill offenders, however, does not need to lead in that direction. Communities that provide training, coordination, treatment, and community services can meet the needs of the mentally ill and break the cycle of violence.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