Prison Reform and the Incarcerated Mentally Ill:
A Preliminary Case Study of California

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Abstract

With approximately 46,000 mentally ill offenders cycling through the state corrections system, the California Department of Corrections and Rehabilitation (CDCR) serves more of the mentally ill population than state hospitals and community treatment centers combined. However, the high demand for in-custody treatment services is unmatched by the state corrections department due to a deafening budget deficit, coupled with severe prison overcrowding and a failing prison health care system. In response to the need for prison reform, California officials and prison administrators have implemented an early release program, allowing non-violent, low-risk offenders to leave prison before completing their sentences. Because the majority of crimes committed by those diagnosed as mentally ill fall into the "level one" category, mentally ill offenders are more likely to be subjected to the early release program. It appears, however, that the CDCR has failed to take into account the challenges presented by mentally ill offenders, and, in effect, has exacerbated the problems associated with the criminalization of mental illness.

This study examines five key factors – characteristics of mentally ill offenders, recidivism rates and the revolving door phenomenon, the criminalization of mental illness, the deinstitutionalization policy, and prison and community-based treatment services – to weigh the advantages and disadvantages of early release and explores alternative means of accomplishing prison reform while recognizing the increasing complications added by mentally ill offenders.

Introduction

The Los Angeles County Jail, reputed to be the largest *de facto* "mental institution" in the United States, houses approximately 3,300 mentally disturbed inmates on any given night (The Sentencing Project, 2002). As California prison administrators face severely overcrowded facilities as well as a failing prison health care system – both due in part to the state's current budget crisis – a federal judicial panel ordered officials to develop a plan to remedy these unacceptable conditions. To accomplish such an undertaking, officials have suggested releasing mentally ill prisoners before the completion of their sentences, many of whom are incarcerated for extended or life terms as a result of California's "three strikes law." Though early release from prison clearly expands holding space for more violent criminal populations, it remains to be seen whether the means to such an end is actually a problem masquerading as a solution.

The high number of mentally disturbed inmates, the current order for prison reform, and the early release of prisoners establish a motivational foundation for examining subsequent issues of prisoner rehabilitation, reentry into society, reinstatement of civil rights, and the possibility for recidivism. More specifically, these and related factors and issues naturally lead to investigate such questions as *is rehabilitation possible in the California prison environment? Do ex-prisoners have the opportunity to be successful once reentering society? What of their housing, education, employment, and mental health needs? What are the chances that the once-incarcerated mentally ill will commit new or different crimes?*

As of January 2010, California officials began implementing solutions to these problems. Thus, the purpose of this study is to investigate whether there are more constructive means available by which to respond to the challenges posed by the incarcerated mentally ill and their environment.

Operational Terms and Definitions

While diverse definitions of "mentally ill" exist, most people agree that individuals experiencing mental illness demonstrate abnormal approaches to cognitive, emotional, and/or behavioral functioning. The symptoms presented by the mentally ill and signs of mental illness are influenced by both internal and external factors. For the purposes of this paper, the incarcerated mentally ill are classified as individuals who have difficultly adapting and adjusting to changing environmental demands and challenges.

An individual with a co-occurring disorder is considered to have both a mental disorder as well as a substance abuse disorder. "Co-occurring disorder" may also be used interchangeably with "dual diagnosis" or "co-morbidity," though the latter terms are not used as

frequently. Of the total population of mentally ill offenders, those with co-occurring disorders are among the highest risk group for arrest, violent behavior, and homelessness. Similarly, those who use drugs or alcohol and neglect to comply with physician recommendations, including prescribed antipsychotic medication, are three times more likely to be arrested as compared to other mentally ill individuals. Their risk for violent behavior increases significantly as well (Broner, et al., 2002).

Implemented in 1994, California's "three strikes law" represents a series of policies dictating the terms of incarceration for repeat offenders. Under the law, prison time doubles for a second strike and requires felons to serve at least 80 percent of the sentence given while eliminating the option of parole. Though the first two "strikes" accrue for serious felonies, the "third strike" can be imposed for any felony and carries a sentence of 25 years to life (RAND, 2005). Because the law disregards the severity of the third crime, many offenders are subject to extended or life terms after committing acts of petty theft or vandalism.

"Revolving door," a term used in reference to recidivism, alludes to the cyclical pattern of repeat arrests and incarceration. Released from prison with little to no prospects for economic autonomy – no housing, employment, or significant education – offenders tend to re-commit or commit new crimes and return to the prison system, often repeating the pattern more than once. This revolving door phenomenon is found especially among prison inmates with major mental disorders who are more likely to have been previously incarcerated and have a greater risk of multiple incarcerations than non-mentally ill inmates (Baillargeon et al., 2009).

Deinstitutionalization is a policy directive based in the exodus of patients from public mental hospitals and institutions. This trend, beginning in the latter part of the 20th century, indicated a societal shift from long-term institutionalization to short-term hospitalization.

Psychiatric care was no longer to take place in institutions or asylums with the patient subject to the whim of the psychiatrist. Instead, treatment was to be based in hospitals on an as-needed basis, with out-patient programs promoting the autonomy of the patient. Along with this new short-term care and community-based treatment came the increased prescription of and reliance on antipsychotic medication (Szasz, 1994).

The goal of criminal justice diversion is to help the mentally ill move from the criminal justice system to an environment more conducive to treatment, where they can be screened and diagnosed. Pre-booking diversion provides community-based alternatives to arrest and incarceration. When using pre-booking diversion, police officers call on community services and specialized crisis units trained to interact with the mentally ill. Post-booking diversion occurs subsequent to arrest and requires an agreement with the local court. In this case, mentally ill offenders are removed from the court docket (and are sometimes offered deferred prosecution) but are still linked to community treatment overseen by the court. Either form of criminal justice diversion is typically reserved for less serious, non-violent offenders (The Sentencing Project, 2002).

Literature Review

To introduce this debate, it is necessary to include characteristics of the mentally ill in terms of criminal tendencies and activities as well as views on the criminalization of mental illness itself. The Sentencing Project (2002), a non-profit organization dedicated to the research and advocacy of criminal justice issues, finds that prior to arrest, mentally ill offenders as compared to the general population are twice as likely to be homeless, while 40 percent are unemployed and nearly 50 percent are labeled as binge drinkers. Crimes committed by mentally

ill offenders fall into three categories: illegal acts as a byproduct of mental illness (for example, disorderly conduct, trespassing, disturbing the peace, and public intoxication), economic crimes (for example, petty theft, shoplifting, and prostitution), and serious crimes (for example, burglary, assault, and robbery).

Furthermore, the Treatment Advocacy Center (1999) believes many individuals in the mentally ill population are responsible for increasing episodes of violence, due to their apparent inability to understand their disorders and their lack of awareness of the consequences of their actions on the surrounding environment. In a similar sense, Feder (1991) describes mentally ill offenders as economically unstable in that they are severely lacking employment, housing, and financial resources. As opposed to other mentally disordered offenders who are found incompetent to stand trial or not guilty by reason of insanity, mentally ill offenders require psychiatric hospitalization during their incarceration. In her comparison of the post-prison adjustment of mentally ill offenders to that of the general prison population, Feder finds that mentally ill offenders tend to have a more "marginal existence" and demonstrate significantly greater instability both in their pre and post prison adjustments (1991: p. 486). However, a lack of research inhibits a thorough analysis of mentally ill offenders even though they represent one of the largest mentally disordered groups and require a vast amount of prison resources.

Addressing the effects of criminalizing mental illness, Torrey et al. (2010) blame deinstitutionalization for the multitude of problems the United States correctional system is currently experiencing. Mental illness is criminalized by decreasing the hospitalization of psychiatric patients and increasing incarceration. According to Torrey et al., approximately three times more people with serious mental illnesses are held in prisons rather than hospitals. California has witnessed the adverse consequences of deinstitutionalization, more so than other

states, as prison administrators and corrections officers do not have the proper and necessary training and resources to manage the vast number of mentally ill inmates. This frequently results in mistreatment and neglect of the incarcerated mentally ill. Concurrently, Quanbeck et al. (2003) reference a California-based study concerning mentally ill patients with no history of arrests before release from psychiatric institutions. This population was likely to be arrested three times more often after their release, as compared to the general population. The authors hold that a greater number of arrestees are manifesting symptoms of mental illness at the time of arrest and during their terms of incarceration since the implementation of deinstitutionalization.

Attributing the problems surrounding deinstitutionalization to an overall lack of planning for alternative treatments and mental health services, Talbott (1979) criticizes the lack of follow-up and aftercare available to deinstitutionalized patients. As a result, two new syndromes, "falling between the cracks" and the "revolving door," emerged not long after patients were first removed from hospitals and abandoned in the surrounding communities. Similarly, Szasz (1994) recognizes the challenges created by deinstitutionalization and the subsequent effects on mentally ill patients. As patients struggled to receive treatment and care after discharge from state hospitals, they developed the "I will make you take me back" mentality to be re-admitted. Looking at the mentally ill who spent the majority of their lives in hospitals, Szasz categorizes these patients into three groups: those who want to leave the hospital, those who want to stay in the hospital, and those who want neither to leave nor to stay in the hospital.

Focusing on the internal environment of the prison system post-deinstitutionalization, Fellner (2006) identifies an inherent tension between prisons and mental illness, of which is perpetuated primarily by prison overcrowding, violence, lack of privacy and meaningful activities, and inadequate health services. The prison environment offers little room for change

while rules and regulations dictating prison operations are difficult to adapt to the needs of the mentally ill. From the opposite perspective, Ball (2007) looks at the external relationships found in the criminal justice system, and explains that inmates cycle through three phases while in the system: intake, living in prison, and release. During incarceration, mentally ill inmates experience greater rates of administrative segregation, which leads to further mental deterioration. When released, mentally ill inmates are left without adequate treatment programs or housing support, and as a result, face higher parole revocation rates than inmates in the general population. Finally, Ball proposes a thorough overhaul of prison mental health care to redress the imbalances found between mentally ill inmates and the prison system.

A pressing topic in the area of criminal justice research centers on recidivism rates after incarceration and rehabilitation. Rich (2009) explains that after encountering and being released from the prison system for the first time, mentally ill inmates have a greater tendency to cease mental health treatments and, as a result, face reconviction and exasperate their disorders and trouble with the law. Baillargeon et al. (2009) investigate the "revolving door phenomenon" – attributing offenders' constant flow in and out of prison to under and untreated psychiatric disorders. Looking at the connection between psychiatric problems and recidivism rates, the authors find that released inmates with major mental disorders (bipolar disorders, schizophrenia, major depressive disorder, and non-schizophrenic psychotic disorders) to be more likely to relapse into previous criminal behavior.

Contrary to the suggestions offered by the aforementioned scholars, Gagliardi et al. (2004) believe that mentally ill inmates are at no significantly greater risk of felony and violent-crime recidivism than the non-mentally ill inmate population. As a result, the authors recommend using the least costly method to forecast recidivism – institutional databases and

ordinary correctional records that review variables, such as age at first offense, age at release, past misdemeanors and past felonies, instead of state-of-the-art assessment tools that require professional administration.

For the mentally ill inmate population that does face recidivism, a study conducted by Ventura et al. (1998) investigates the ability of case management to reduce recidivism after release from prison. The authors found that mentally ill offenders who received case management during incarceration were more likely to receive community-based case management post-release. Those who received the community-based services were also less likely to be re-arrested and more likely to last for longer periods of time before any re-arrest. Continuing the discussion of services offered to mentally ill offenders, Lovell et al. (2002) suggest that despite the high number of mentally ill offenders, surprisingly little is known about their adjustment after release from prison into the community. The authors find that reconviction is most likely to occur within the first forty months after release from prison, while a pattern of arrests for minor offenses often precedes an arrest for a major felony. Thus, services are most important during the first year after release. However, studies show that only half of mentally ill offenders receive financial assistance and community-based mental health services. Interruptions to or delays of services is also common within this time period while very little is done for offenders facing substance abuse problems.

Offering recommendations on how to reconcile the problems surrounding the incarcerated mentally ill, Broner et al. (2002) find that relying solely on the pre-release planning does little to impact recidivism for mentally ill offenders, especially those with co-occurring disorders. On the other hand, post-release coordination of mental health care, financial assistance, and housing services significantly lower the risk. The authors find that intense

community involvement during the first weeks after prison release to somewhat decrease the risk of recidivism, but pre-release planning combined with post-release efforts served as the most effective method to lower the chance of recidivism. Conly (1999) recognizes that efficiency and effectiveness of services improves once efforts are coordinated between prisons, treatment centers, housing facilities, and any other involved organizations. Even more beneficial is strong leadership and guidance from state and local authorities on how to fit the needs of mentally ill offenders. Conly believes training in crisis intervention, concentration on post-booking diversion, services for co-occurring disorders, and routine counseling and community planning serve as productive forms of intervention. The Sentencing Project (2002) calls for expansion of community services, special training programs for police, better mental health care, and improved transitions from prison back to the community. According to the organization, jail diversion programs also serve to help mentally ill offenders move from the criminal justice system to community-based treatment services.

Though it offers an insight to the incarcerated mentally ill, the existing literature does not, however, provide adequate and realistic proposals for how to manage the challenges brought forth by mentally ill offenders and their environment nor does it account for the major policy implications California's early release proposal may bring. Many scholars suggest solutions to the prison crisis, but they fail to account for the financial burden such reforms would bring. As the ongoing prison and economic crises overwhelm California, the need for a better understanding of mentally ill offenders, the benefits and disadvantages to pre and post-release services, the financial impact of services, and the availability of resources is imperative.

Discussion

To comprehend the breadth of the controversy surrounding the early release of the incarcerated mentally ill, it is necessary to delve into the background of the California budget crisis. Though the state has practiced deficit spending for several decades, the most recent and ongoing financial shortfalls were first recognized in 2007 and have caused officials and administrators to reevaluate state policies and prison procedures. Also during this time period, California became involved in legal matters questioning the constitutionality of the prison mental health care system. The amalgamation of these factors lay ground for the debate of the incarcerated mentally ill.

The California Budget Crisis and the Need for Prison Reform

With the economy reeling and revenues plummeting, Governor Arnold Schwarzenegger described California as "headed toward a financial Armageddon" (The Associated Press, 2008: para. 3). His description of the state's budget woes in December 2008 was all too accurate – the deficit was estimated at $14.8 billion with a projected loss of $40 billion over two years. At this point, California was losing $470 every second, $28,000 every minute, $1.7 million every hour, and $40 million every day (The Associated Press, 2008). By January 2010, California fared no better as the governor declared a fiscal state of emergency and called for a special legislative session to take action against the now $19.9 billion budget shortfall (Yamamura, 2010). Thus, in order to maintain any operating power, officials enacted cutbacks of state-based jobs, wages, and services.

When implementing budget cuts, state legislatures looked to an area in which so many state funds were allocated – the correctional system. California's corrections expenditures have repeatedly been among the highest in the country, with more than 10 percent of general fund

spending going towards inmates' daily needs, staff compensation, and rehabilitation programs and services. In fiscal year 2009-2010, the state corrections budget was $8.2 billion, while the annual cost of housing a prisoner was $49,500 (Petersilia, 2010). But even with such high spending, California currently leads the nation with the highest offender recidivism rate. Seventy percent of parolees return to prison after violating their terms of release (Muradyan, 2008). In effect, the more it puts into its correctional system, California gets back less. Thus, the current economic crisis has also become a catalyst for prison reform as the budget deficit forces officials to pull funds from the state prison system.

The need for prison reform in California is an issue that has not gone unnoticed. Since the early 1990s, facility overcrowding and understaffing coupled with a state-wide "tough on crime" mentality have forced state prisons to operate at double capacity (Muradyan, 2008). Recent statistics show that the 33 California state prisons are designed to hold 84,271 inmates but actually house close to 167,000 (Stateman, 2009). In fact, California's prison overcrowding is currently so severe that nearly 16,000 inmates reside in hallways, classrooms, gyms, and laundry facilities. If left unaddressed until 2012, any major increase in the inmate population will result in a shortage of approximately 35,000 beds (Muradyan, 2008).

Moreover, prison health care programs are described as horrendous while health care workers exhibit "incompetence and at times outright depravity," (qtd. in Udesky, 2005: para. 1). On average, one inmate kept in a California state prison facility dies every six to seven days as a result of malpractice, negligence, or overall deficiency. During a 2005 court-ordered investigation, the physical conditions of several prison medical centers were found to be filthy and coated in standing water, while lacking hand washing equipment and exam tables (Udesky, 2005).

California's Pelican Bay State Prison Security Housing Unit (SHU), a specialized unit used for security lockdowns, gives host to conditions so horrendous that inmates have filed hundreds of complaints claiming cruel and unusual punishment. SHU is described as grim, as prisoners are secluded in their cells for approximately 22.5 hours per day and are distanced from windows, natural sunlight, and, for the most part, other prisoners. A Harvard Medical School professor of psychiatry found one third of SHU inmates to have acute, emergent psychiatric needs that require medical monitoring every two hours. The SHU inmates receive no such care (Ball, 2007).

Though overcrowding, inadequate health services, and grim prison conditions exist for all inmates, the consequences of such problems are much greater on the incarcerated mentally ill. As a result, legal attention and federal oversight of the prison system now supplement traditional state-run monitoring led by the California Department of Corrections and Rehabilitation (CDCR). Litigation involving California's prison system began almost two decades ago when a mentally ill inmate, Ralph Coleman, in Pelican Bay State Prison filed a civil rights lawsuit in order to continue his mental health treatment while incarcerated. The 1995 *Coleman v. Wilson* district court ruling determined that prison mental health care failed to meet minimum standards as defined by the Constitution (*Coleman v. Wilson*, 1995). At this time, an estimated 13,000 – 18,000 inmates experienced a mental disturbance severe enough to need treatment (Ball, 2007).

In over 10 years, that number more than doubled, with the state reporting more than 46,000 of the approximately 160,000 inmates suffer from serious mental illnesses that require intervention. As the demand for mental health care services grew, the *Coleman* case merged with *Plata v. Schwarzenegger* in 2007 to fight prison overcrowding, understaffing, and

inadequate health care. This class action civil rights suit against California was granted cert[1] by a three-judge district court (*Plata v. Schwarzenegger*, 2009). However, by 2010, the litigation has still not ended as the CDCR struggles to remedy the problems in the midst of a budget crisis.

The Condition of the Mentally Ill Offender

Characteristics of the mentally ill in terms of criminal tendencies, adjustment to incarceration, and recidivism allow one to better understand the impact of the mentally ill on the criminal justice system as well as the effects of the criminal justice system on the mentally ill.

Prior to incarceration, many mentally ill offenders have previous contact with mental health agencies, usually in the form of institutionalization or community-based treatment programs. Also during this period, mentally ill individuals display signs of transient behavior, are responsible for increasing episodes of violence, and lack awareness of their disorders and the consequences of their actions on the surrounding environment[2]. In such cases, mentally ill individuals consistently refuse to take any anti-psychotic medication and will only do so if it is administered under some form of assisted treatment. They were often homeless, unemployed, have a limited educational background, and experience co-occurring disorders (Feder, 1991; Treatment Advocacy Center, 1999; The Sentencing Project, 2002). Individuals with co-occurring disorders are particularly at risk of incarceration. According to a survey issued by the National GAINS Center, a research division of the Substance Abuse and Mental Health Services Administration, approximately 60 percent of mentally ill offenders in state prisons reported using drugs or alcohol in the month preceding their arrest (The Sentencing Project, 2002). However,

[1] "Certiorari," Latin meaning "to be more fully informed," is used when an appellate court can choose to review cases at its discretion. The court can either grant or deny cert and either hear to let the lower court ruling stand, respectively (Cornell University Law School, 2010).

[2] The inability of the mentally ill to understand their disorders and their lack of awareness of the consequences of their actions is scientifically referred to as anosognosia. This "lack of insight" causes individuals to believe their delusions and hallucinations are real. At times, individuals can be partially aware of their disorders but lose awareness when they relapse (Treatment Advocacy Center, 2009).

an even greater preponderance, 72 percent, meets the criteria for co-occurring disorders upon admittance to the criminal justice system (The GAINS Center, 2004).

Though most crimes committed by the mentally ill are relatively minor, research suggests that crimes fall into three groups. The Sentencing Project believes that with more community involvement, crimes, such as trespassing, public intoxication, shoplifting, and prostitution that comprise the first two groups – illegal acts and economic crimes – would be easily avoidable or at least reduced. Illegal acts are explained to be a byproduct of mental illness, while economic crimes occur because mentally ill offenders attempt to obtain money for subsistence. The third group, more serious offenses such as assault and robbery, continue to lead to incarceration. The vast majority of mentally ill offenders commit non-violent illegal acts and economic crimes (The Sentencing Project, 2002).

Once placed into the corrections system, mentally ill offenders continue to show signs of psychiatric and behavioral problems. A study conducted at the Los Angeles County Jail indicates a high prevalence of mental illness within the corrections system, with 28 percent of male and 31 percent of female arrestees having a significant history of mental illness (Quanbeck et al., 2003). Furthermore, mentally ill offenders tend to experience problems adjusting to the prison environment and, on average, face more prison disciplinary infractions per year (Feder, 1991; Treatment Advocacy Center, 1999; Fellner, 2006; Ball, 2007; Rich, 2009). They do not have the same capacity to comply with the rules and regulations of the corrections system as do other prisoners. Hallucinations, delusions, and other psychotic signs or dysfunctions lead mentally ill offenders to exhibit "disruptive behavior, belligerence, aggression, and violence" (Fellner, 2006: p. 395). Such problems perpetuate the inherent tension between prisons and the mentally ill (Fellner, 2006).

This "poor prison performance" contributes to the fact that mentally ill offenders are less likely to receive parole release (Feder, 1991: p. 482). According to a study of 546 inmates in a state prison facility, while 78 percent of the general prison population received parole, only 21 percent of mentally ill offenders were granted the same release status. Because they typically enter prison at an older age and they are less likely to receive parole, mentally ill offenders are also significantly older when released from prison as compared to non-mentally ill offenders (Feder, 1991).

Following reentry into the community, mentally ill offenders once again have difficulties adjusting to community life and often face repeated re-hospitalizations and/or re-incarcerations. Research also indicates that approximately one third or more of mentally ill offenders fail to adjust while abiding by the law in the community setting. Of the same sample of 546 inmates, approximately one out of every five mentally ill offenders was civilly committed to a psychiatric center directly after release from prison. When finally released into the community after an additional 18 months of institutionalization, these offenders were 24 percent less likely than the general population to receive support or assistance from family or friends. Also in the 18 month follow-up period, almost half of the mentally ill offenders faced at least one psychiatric hospitalization, while 64 percent were formally arrested at least once (Feder, 1991).

After their release from prison, mentally ill inmates have a greater tendency to stop taking medication and recommit crimes, exasperating their disorders and trouble with the law. Given the difficulties mentally ill offenders face during adjustment to the prison environment, it should not come as a surprise that they experience similar difficulties while attempting to enter back into the community. These difficulties manifest in high rates of recidivism in the mentally ill population (Ventura et al., 1998; Lovell et al., 2002; Ball, 2007; Rich, 2009; Torrey et al.,

2010). Repeat offenders are often renamed "frequent flyers." Ninety percent of the mentally ill offenders in the Los Angeles County Jail are these "frequent flyers," with 31 percent having been incarcerated ten or more times (Torrey et al., 2010).

The added stress outside the prison environment is likely to trigger anger and compulsive behavior in mentally ill offenders. For the portion of mentally ill offenders that already have co-occurring substance abuse problems, the stress coupled with the discontinuation of medication will likely result in a return to drug use. If under parole supervision, drug use will be detected, and these offenders will return to prison and be considered recidivists (Rich, 2009). Furthermore, the prevalence of repeat incarcerations increases among mentally ill offenders with major mental disorders such as schizophrenia, major depressive disorder, bipolar disorders, and non-schizophrenic psychotic disorders. Overall, research shows that mentally ill offenders have a substantially heightened risk of recidivism and are likely to move continuously between hospitalization, homelessness, and the corrections system, also known as the "revolving door" (Baillargeon et al., 2009).

"The "revolving door" between jail and the street is propelled largely by untreated mental illness and co-occurring substance abuse disorders among individuals who have committed relatively minor crimes. This population includes homeless and mentally ill people whose untreated mental illnesses lead to repeated "nuisance crimes" and jail" (The Sentencing Project, 2002: p. 7). Data collected in Los Angeles County suggests that mentally ill offenders experience a significantly different revolving door pattern than do mentally ill individuals who have not committed crimes. Bipolar offenders as compared to non-offenders utilized inpatient services twice as much and were hospitalized three times as often, but the duration of the

hospitalization was only half as long (Quanbeck et al., 2003). In this sense, the revolving door of deinstitutionalization replaced by the revolving door of incarceration.

Shown to reduce recidivism and hamper the cycle of the revolving door post-incarceration, court ordered and monitored treatment while on parole provides mentally ill offenders with the oversight necessary to comply with reporting and employment rules or other related demands. Such treatment, however, requires increased financial resources, and many corrections departments simply cannot afford to enact these methods (Ventura et al., 1998; Lovell et al., 2002; Quanbeck et al., 2003). As a result, local and state agencies are reluctant to establish outpatient treatment programs for mentally ill offenders released from prison. To the extent monitored treatments can aid mentally ill offenders and reduce recidivism, the inability of corrections departments to implement such programs actually increases the likelihood of opposite outcomes. If offered treatment programs, mentally ill offenders have a reduced risk of recidivism that is similar to the rate found in the general inmate population (Gagliardi et al., 2004). However, if corrections departments do not have the necessary funding to supplement parole with monitored treatment programs, such as the case in California, and the recidivism rate is contingent upon such treatment, then mentally ill offenders will be at a greater risk of recidivism than the general inmate population.

A New Policy in California: Early Release

Tensions between the California budget crisis and the needs of mentally ill offenders surfaced with the involvement of the federal court system in the corrections system. In 2009, after the *Coleman* litigation and the consolidation of *Coleman* with *Plata*, a three-judge district court panel found that overcrowding in California's prisons was the primary cause of the state's failure to deliver constitutionally adequate mental health care to its prison inmates. With the

Plata v. Schwarzenegger ruling, the judicial panel ordered California officials to develop a plan to remedy and upgrade the unacceptable prison conditions (*Plata v. Schwarzenegger*, 2009). To adhere to the ruling, the state must reduce the prison population over a span of two years. This large-scale reduction would result in the cutback of approximately 40,000 inmates and decrease the prison population from 196 percent to 137.5 percent design capacity (Denniston, 2010).

Ideally, while reducing the prison population, the California state legislature will also allocate more money to provide for the building of new prisons, to purchase more beds, to sanitize prison medical facilities, and to increase the number of health care staff (Moore, 2009). The financial deficit and subsequent budget cuts, however, does not allow for such measures. At the time of this writing, the CDCR has yet to work out a comprehensive plan for reducing prison overcrowding and improving the mental health care system as ordered by the three-judge panel, even though these problems were identified at least as early as 1995 during *Coleman v. Wilson*. This delay in state action is a result of the progress of the *Plata* litigation through the court system; California officials appealed the *Plata* ruling to United States Supreme Court. Though the appeal was heard on November 30, 2010 by the Supreme Court in *Schwarzenegger v. Plata*, the final ruling is pending announcement in 2011 (Denniston, 2010).

Nonetheless, California officials and prison administrators have begun to implement several steps to comply with the judicial order as well as reduce the amount of funds allocated to the corrections system. To help reduce the overall cost of housing inmates in state prisons, the CDCR has suggested enacting an "early release" program, allowing low-risk offenders who are in the last year of their sentences to leave prison before the completion of their sentences (Stateman, 2009). More violent criminals, such as sex offenders or gang members, are not eligible for early release. The program was made into California law in October 2009 and put

into effect on January 25, 2010. By enacting early release, the CDCR estimates that the cost-saving measure will affect approximately 3,000 inmates over the next two years (Littlefield, 2010).

To save at least $500 million in the first full year of implementation, California officials are combining early release with "non-revocable parole" (NRP). Similarly to early release, low-risk offenders can be considered for NRP in which they do not receive traditional oversight previously given to parolees. As another new program to reduce overcrowding, NRP parolees cannot be returned to prison for simple or technical parole violations. Rather, they must commit a new crime and be re-arrested. Early release coupled with NRP is predicted to reduce the overwhelming inmate population by 6,500 (Watkins, 2010).

In practice, the early release adjusts the way in which inmates can earn "custody credits" through good behavior and completion of vocational and rehabilitation courses. By accumulating credits, inmates can earn up to six weeks per year off their sentences. Once inmates have earned enough weeks off their sentences, they can be considered for early release. In its beginning stages, the program starts by releasing incarcerated parole violators, who were sent back to state prisons after minor or technical offenses (i.e., failing to attend a meeting with a parole officer) (Littlefield, 2010). With time, the program could expand to include prisoners who have been incarcerated as a result of California's "three strikes law." Because the law disregards the severity of an offender's third crime, many offenders are subject to extended or life terms after committing acts of petty theft or vandalism. The implementation of such a law has contributed to the prisoner surplus in California and, along with failures in rehabilitation and substance abuse programs, costs the state millions of dollars in prison operating expenses per year (Stateman, 2009). Because the early release program has the potential to save the state a

substantial amount of money, Governor Schwarzenegger has categorized the plan as non-revocable (Littlefield, 2010; Watkins, 2010).

Mentally ill offenders will be considered for early release due to the nature of their crimes. The majority of offenses committed by the mentally ill are non-violent and low-level illegal acts and economic crimes. Also, because the mentally ill are also likely to recidivate, many of these offenders are incarcerated for extended or life terms as a result of the three strikes law. In actuality, the CDCR serves to benefit from releasing mentally ill offenders early. Due to their need for increased staffing needs, prescription drugs, and psychiatric examinations, mentally ill inmates require a greater allotment of funds and resources from the CDCR. Mentally ill inmates also subject to longer periods of incarceration, and thus need more services for a greater amount of time. Though prison administrators may attempt to transfer mentally ill inmates from prison to treatment programs, such transfers often do not occur because no beds are available in state psychiatric hospitals. Lastly, mentally ill inmates are more difficult for corrections officers to manage. These inmates can be more aggressive towards staff, spitting on them and throwing bodily waste. Several reports describe inmates as either refusing to eat altogether or consuming everything in their cells, including Styrofoam food containers and paper clothing. The response of the staff members is to lock these mentally ill inmates in isolation (Torrey et al., 2010). Now, a new option for corrections staff is to recommend the mentally ill inmate for early release. Nonetheless, it remains unknown how many of the early released inmates are mentally ill.

A major problem associated with early release is the misclassification of offenders as "level one," meaning they fall into the lowest-risk category. Since the implementation of the early release program, the CDCR has admitted that they have incorrectly classified and released

656 inmates who now pose a threat to public safety. For example, in July, 2010, a 34-year-old male California inmate with a long and detailed criminal history was released early from prison, taking advantage of the state's parole reform. Post-release, the felon broke into a woman's home and brutally murdered her as she was preparing for her upcoming wedding (Blankstein, 2010; Los Angeles Police Protective League, 2010). Such an incident raises red flags for corrections and police officers. According to the Los Angeles Police Protective League, a police officers' union, inmates on the new early release terms are sent to local communities without any supervision or notification to local authorities. This lack of oversight brings into questions public safety. However, because early release has not yet been in effect for an entire year, it is difficult to predict how many more misclassified and threatening releases will occur (Los Angeles Police Protective League, 2010).

The Effects of Early Release: History Repeats Itself

Though California officials and the CDCR believe early release will give rise to a reduced inmate population and an improved prison health care system, they neglect to account for the policy implications of the new prison program. By implementing early release, the state strips the mentally ill offender of his primary environment. By forcibly removing him from his assumed home, prison, to relocate him into unfamiliarity, the community, early release "frees" the mentally ill offender but does not prepare him to live successfully outside of prison walls. The CDCR has replaced more beneficial treatment and rehabilitation programs with shortcut "custody credits" earned through good behavior to gauge whether an inmate is ready and stable enough for release.

In fact, early release is reminiscent of a previously enacted and highly controversial policy – deinstitutionalization. Based on the principle that severe mental illness should be

treated in the least restrictive setting, deinstitutionalization set to provide mentally ill patients with a greater degree of freedom by releasing them from state hospitals and psychiatric institutions. This policy, however, quickly escalated beyond control when mentally ill patients were removed from hospitals without the necessary medications and rehabilitation services they received while institutionalized. Torrey et al. describe deinstitutionalization as "one of the greatest social disasters of the 20th century" (2010: p. 11).

The relationship between early release and deinstitutionalization stems from the criminalization of mental illness. Though not a new concept,[3] criminalization can be considered a consequential effect of deinstitutionalization. Along with the closure of state hospitals came the expectation that deinstitutionalized patients would enter into community mental health programs. However, this expectation was never realized as shown by California studies. For example, the county jail mentally ill inmate population increased by 300 percent after the close of California's Agnews State Hospital in the early 1970s. By the end of the 1970s, deinstitutionalized patients were three times more likely to be arrested even if they had no prior history of arrest as compared to the general population (Quanbeck et al., 2003). Thus demonstrating an inverse relationship, mentally ill persons who engage in delinquent activities are increasingly subject to arrest and prosecution rather than treatment or hospitalization. As the number of mentally ill patients in hospitals decreases, the number of mentally ill offenders in prisons increases (Torrey et al., 2010).

Since the criminalization of mental illness, the corrections system has become the primary source of treatment for the mentally ill in California. As a result, pre-release planning

[3] The "criminalization of the mentally ill" was a term first coined by Marc F. Abramson, a psychiatrist for a California Courts and Corrections Unit, in 1972. He observed that mentally ill person who committed minor criminal offenses were, more often than not, no longer being placed into and cared for by community mental health treatment programs or hospitals and instead were placed into the criminal justice system (Ball, 2007).

programs that link mentally ill offenders to housing, employment, and heath and drug services would ideally encourage the offenders to stabilize their conditions outside prison as to avoid the possibility for recidivism. But as the state remains billions of dollars in debt, the CDCR can no longer afford to provide offenders with adequate mental health screening, medication, treatment, and other pre-release programs. Also, many California corrections officers are not trained in how to handle mentally ill offenders who have difficulty adapting to changing demands, and thus, the officers fail to establish a prison environment that cultivates stability. As a result, once mentally ill offenders are released from prison, they are much less likely to continue to receive any post-release support services and more likely to return to their transient tendencies and criminal activities (Ball, 2007).

Seemingly, early release gives greater support to the idea that the revolving door of deinstitutionalization has been replaced by the revolving door of incarceration. Recidivism-related problems created by deinstitutionalization are currently being replicated by the California criminal justice system. During the preliminary stages of deinstitutionalization, the "lack of planning for alternative facilities and services (especially for a population with notable social and cognitive deficits" proved to be a vital error (Talbott, 1979: p. 621). The same can be said for early release as prison administrators have failed to offer adequate transition and post-release services to mentally ill offenders. More specifically, the similarities between early release and deinstitutionalization are comparable on four main points: re-admittance, "falling between the cracks," the revolving door, and extended stays/sentences.

Re-admittance: After the start of deinstitutionalization, a mentally ill patient could not be readmitted to a state hospital simply upon request nor could he apply for any state-based mental health or substance abuse treatment services after removal from such services. Instead, he had to

pose a threat to himself or others to guarantee admission. Though attempting to reduce the number of institutionalized patients, these anti-re-admittance policies created the "I will make you take me back" mentality first coined by Thomas Szasz, a leading critic of the scientific and moral foundations of psychiatry, (1994: p. 185). The deinstitutionalized patient used this strategy to regain entry to a hospital or institution and may engage in destructive or self-destructive behaviors to do so (Szasz, 1994).

In a similar sense, with the enactment of early release, once a mentally ill offender is released from prison, he can no longer be re-arrested on traditional parole violations, such as failure to meet with his parole officer. With NRP, he is no longer monitored by a parole officer, and he must be arrested for a new crime if he is to be sent back to prison. Though this method attempts to both reduce the prison population and save money by cutting operating costs, it has the potential to cause mentally ill offenders to commit new crimes in order to be sent back prison and a more stable environment.

"Falling between the cracks": From deinstitutionalization came a new issue, "falling between the cracks," characterized by lack of follow-up and aftercare. At the start of deinstitutionalization, hospitals and community organizations attempted to expand alternative treatment programs. State hospital staff believed that fewer patients would result in better and more individualized treatment and care. However, because these treatment programs lacked additional support and funding, they became ineffective and actually proved detrimental as they overtaxed staff and diluted resources. As a result, local communities became inundated with deinstitutionalized patients who were ill-equipped to survive in the community on their own (Talbott, 1979).

With the implementation of early release and even more so with NRP in which parolees do not receive traditional oversight, mentally ill offenders can very easily "fall through the cracks" and find themselves in a state of neglect. Because the CDCR has failed to establish structured post-release planning programs beyond that of "custody credits," released inmates struggle to re-acclimate and assimilate into their new communities. Such poor planning places a greater burden on local communities as they must develop and manage new treatment programs in hopes that mentally ill offenders do not "fall through the cracks."

Revolving-door: A byproduct of "falling between the cracks," the revolving door, as previously discussed, indicates a cycle of continued readmissions. Though patients spent fewer total days in hospitals after the start of deinstitutionalization, they were accounting for many more admissions and readmissions to a greater number of hospitals. With each admittance came a shorter length of stay before the patient was again released. Deinstitutionalization forced the chronic mentally ill patient to live in a series of hospitals and institutions instead of one primary treatment facility (Talbott, 1979).

Already rampant within California's criminal justice system, recidivism and the revolving door will likely increase with the implementation of early release. As mentally ill offenders exit prison devoid of effective community reentry training, they have a heightened risk of recidivism (Baillargeon et al., 2009). Early release sets the groundwork for repeated encounters with the corrections system whether they are in the form of parole violations or newly committed crimes. In either circumstance, mentally ill offenders will fall victim to the revolving door of incarceration.

Extended stays/sentences: The effects of deinstitutionalization were even greater for those who spent most of their lives in state hospitals. By residing in psychiatric institutions for

so long, mentally ill patients became de-socialized. Once they were forcibly discharged from institutions and returned to the community, they had little to no sense of how to operate under "free" conditions. Thus, these patients became dependants who continued to require care from the outside community. Szasz categorizes psychiatric patients into three groups. Using his descriptions, one can relate the groups of patients to groups of mentally ill inmates. The first group includes mentally ill offenders who prefer to remain in prison and go to great lengths to stay in, the second group loathes incarceration and goes to great lengths to be "free," and inmates in third group are not drawn to either option (Szasz, 1994). There is a paucity of professional studies or polls that give statistics detailing the specific preferences of mentally ill inmates or indicate whether inmates subject to longer periods of incarceration eventually learn to cope with the prison environment. However, similar to how Szasz describes psychiatric patients, anecdotes illustrating inmates' actions, as opposed to statistics, serve as better indicators of their preferences.

Take, for example, a depiction of Freddie Gilbert by Pete Earley, former Washington Post investigative reporter. Gilbert, a homeless, chronic schizophrenic, was originally arrested for panhandling, trespassing, and being a "sanitary nuisance." Caught in the revolving door of incarceration, Gilbert was arrested twenty times within the span of six years. When corrections officers could no longer keep him in the critical "suicide watch" wing of the Miami-Dade County jail, Gilbert was placed into an intensive treatment program in which he received regular cognitive therapy and counseling and was required to take antipsychotic medication. When Gilbert was deemed mentally stable enough to survive in the community, he was released for what was to be the last time. However, outside of prison, he lacked housing and employment and stopped taking his medication or attending therapy sessions. One year after his release

Gilbert was rearrested on the same three charges and returned to the jail's mental health wing in a nearly catatonic state (Early, 2006).

The problem for Gilbert and many other mentally ill offenders is that incarceration becomes the lifestyle to which they grow accustomed and prison becomes the only environment with which they understand. Because they have been in the hands of the corrections system for an extended number of years, mentally ill offenders lose their already fragile ability to cope with and survive under changing or even typical societal circumstances. In effect, prison takes on the characteristics of a home for offenders and provides them with a routinized environment. Early release disrupts mentally ill offenders' perception of home and forces them into an outside community where they can easily fall back into poor mental health and criminal activities.

In essence, all one has to do is replace "deinstitutionalization" with "early release" as the consequences of both policies are shockingly parallel. As mentally ill offenders flounder without a highly structured environment, they tend to experience even greater mental deterioration when denied such structure (Feder, 1991). In its current state, however, the California criminal justice system only perpetuates the further mental decomposition of its inmates. With severe overcrowding and a virtually nonexistent prison mental health care system, inmates are forced to reside in triple-bunked hallways, gyms, and laundry facilities. On average, one state prisoner dies every six to seven days as a result of medical malpractice, negligence, or overall deficiency. These factors provide the reasoning as to why a district judge found the CDCR incapable of correcting the systemic failures in prison health care and placed the entire system under receivership[4] (Ball, 2007). Though first the *Coleman* and then the *Plata* litigation attempt to

[4] As a representative of court by which he was appointed, a federal receiver serves as a court-to-government agency liaison. He displaces the officials of the government agency and takes on all decision-making responsibility,

reconcile these maladies, the lack of support services and reentry planning makes early release take even one step closer to deinstitutionalization.

Recommendations for and Alternatives to Early Release

It is clear that reform of the California corrections system is both urgent and necessary. However, because the state is embedded in such a financial deficit, California cannot afford to implement new and expensive treatment programs. Thus, state officials and prison administrators must be careful in the types of reform they consider implementing. At this point, solutions to the problems can only be, at best, reactionary. Though an inherent tension between the corrections system and the mentally ill will always exist, steps can be taken to diminish the problems associated with the incarcerated mentally ill (Fellner, 2006). Among the solutions are the following:

Pre-release planning and case management: Case management integrates community-based services with in-custody pre-release planning. The purposes of case management are to foster independence in mentally ill offenders by linking them to community services and to lower the risk of recidivism or re-hospitalization. To implement a case management program, prison administrators bring on a collection of case managers from community mental health centers to work directly in the prison as staff. These case managers begin re-entry planning with the mentally ill inmates and work to help them understand the criminal justice system and use mental health services. Case managers also educate attorneys and court officials about the needs, disorders, and disabilities of mentally ill offenders (Ventura et. al, 1998).

After release from prison, offenders are to receive new community-based case managers who oversee prison-to-community transition, treatment programs, medication maintenance, and

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including major financial and hiring/firing decisions. In California, the receiver oversees the prison health care system in attempt to bring medical care up to constitutional standards (Udesky, 2005).

other support services (Ventura et. al, 1998; Conly, 1999). However, according to a study conducted by Ventura et al., the number of offenders who receive case management services post-incarceration dramatically decreases because such services are voluntary once released from prison. Of the 261 mentally ill offenders observed for the study, 188 (72 percent) were re-arrested (Ventura et al, 1998).

Post-release planning and criminal justice diversion: To account for the gaps left by pre-release planning and case management, criminal justice diversion redirects mentally ill offenders from prison to community-based services. Diversion works in two ways – offenders can be diverted from the criminal justice system at initial contact or during incarceration. At either time, offenders are linked to treatment services with special attention given to those with co-occurring disorders who often do not respond well to traditional community mental health interventions. To be effective, diversion and post-release programs require the coordination and cooperation of a multitude of sources: law enforcement officers and personnel, probation and parole officers, correctional facility staff, judges and court officials, state officials, mental health service providers, substance abuse service providers, housing providers, and lastly, the mentally ill offenders who are most impacted by the program (Conly, 1999; Broner et al, 2002; The Sentencing Project, 2002).

If implemented successfully, the positive results of diversion are threefold; it helps to alleviate over-crowding, helps consumers get access to appropriate services (especially those with co-occurring disorders), and helps end the cycle of repeated incarcerations and crisis care (Conly, 1999; Broner et al., 2002). However, corrections departments must be wary that poorly organized diversion programs that lack a mental health infrastructure produce short-term results that may, in the long run, harm the client as well as the community (Conly, 1999).

Absent from these two recommendations is consideration of financial implications and operating costs. Case management and criminal justice diversion are based upon a simplistic view of California's prison crisis and fail to realize the constraints added by the $19.9 billion deficit. Thus, as an alternative to early release and costly treatment and community programs, California officials and prison administrators should focus on reducing prison overcrowding instead of improving community-based care. Improved treatment and mental health care services can come only after the prison population is decreased to a manageable level.

However, plausible alternatives to early release are contingent upon the November 30, 2010 hearing of *Schwarzenegger v. Plata*. The issue before the Supreme Court questions whether a federal court can require California to reduce its prison population to remedy unconstitutional conditions within its state prisons (Denniston, 2010). Pending the Court's ruling, two different courses of action can be taken by California officials and prison administrators. If the Court upholds the federal judicial order, then the state should call on the federal government to provide supplemental funds to the corrections system for the purpose of enacting prison population reduction. This option is considered only because the federal government should be required to bear a level of responsibility for the federal judicial order. On the other hand, if the Court rules in favor of California, then state officials should consider a method that reevaluates the relationship between the state prisons and the county jails with respect to the handling of criminal offenders. Although both alternatives work primarily in the short-term, an improved state prison and county jail relationship is much more practical in the long-term than relying on federal funding.

Reflecting the second outcome, a state prison to county jail inmate transfer would shift the responsibility for low-level, non-violent inmates from the state to the counties, rather than

early releasing inmates into the community. In this manner, the state could both begin to fix its prison overcrowding problem and save money by decreasing the overall number of prison inmates. Such a move is contrary to the last thirty years, in which state prisons housed a significantly higher number of inmates than local jails, and therefore, bore the bulk of the financial burden. Recent statistics show that California state prisons keep approximately 167,000 inmates while county jails only house about 75,000 (Petersilia, 2010). But by gradually shifting the responsibility for low-level inmates to the counties, the burden on state prisons can be reduced along with the prison population.

For this method to work, a portion of state prison inmates would have to be relocated to county jails. Though relocation would alter mentally ill inmates' environment and has the potential to instigate compliance and adjustment issues, such action would be less of a disruption than total removal from prison and would allow mentally ill inmates to ease into any changes within the county system. State-to-county population shift can also decrease the chance for the "not in my back yard" syndrome apparent in many communities after deinstitutionalization. Because local organizations opposed the establishment of community-based care and services, deinstitutionalized patients were discharged into communities that lacked mental health resources and services. As a result, the needs of mentally ill patients were not met, and many exchanged institutionalization for incarceration (The Sentencing Project, 2002).

An example of a successful corrections population shift to the counties is found within the California juvenile justice system. As a result of a dramatic policy change, juvenile offenders can no longer be held in state facilities. To comply with the reforms, state prisons were required to transfer all but the most serious juvenile offenders back to the counties. In doing so, the state was able to close two of its largest juvenile facilities and save more than $100

million (Petersilia, 2010). The success and savings of the juvenile justice reform relied upon a major change in state policy, an act that may be more different to relate to the adult corrections system. However, if California officials can use similar tactics to negotiate the release of low-risk offenders to local jails, they very well may be able to restore the balance between state and local responsibilities and reduce the expenses of the state prison system.

Summary and Conclusion

With California in the midst of budget and prison crises, the purpose of this study was to question the use of early release and investigate whether there were more effective and financially responsible methods by which to achieve prison reform while responding to the challenges presented by mentally ill offenders. Even now, state officials and prison administrators are faced with the tasks of reducing the prison population in severely overcrowded facilities as well as improving the failing prison health care system. When considering possible remedies for these unacceptable conditions, officials must bear in mind mentally ill offenders, as approximately 46,000 of the 167,000 California state prisoners experience some degree of mental disturbance. In addition to the typical challenges posed by mentally ill offenders – inability to adapt to changing environments, refusal to take medication, high recidivism rates, and overall poor prison performance – this cohort requires increased medical, treatment, and counseling services. However, by implementing early release, California has neglected to account for these challenges, forced mentally ill offenders from their environment, exasperated the revolving door phenomenon, and resorted to a policy reminiscent of deinstitutionalization.

In analyzing the benefits and drawbacks of early release, the author investigated five factors affecting mentally ill offenders – characteristics of the mentally ill in terms of criminal tendencies and activities, criminalization of mental illness, deinstitutionalization, recidivism and the revolving door, and prison and community-based services available for mentally ill offenders. After reviewing the literature, it was clear that researchers and scholars unequivocally agree on the first factor. Prior to incarceration, the majority of mentally ill offenders exhibit homelessness, unemployment, violence, and a lack of understanding about their disorder. During incarceration, mentally ill offenders have difficulty adapting to the prison environment and thus face more disciplinary infractions and are less likely to receive parole. Following incarceration, mentally ill offenders experience an unstable adjustment back into the community, tend to stop taking their medications, and often return to hospitals or prisons.

Looking beyond the characteristics of mentally ill offenders, the scholarship varies regarding recidivism rates and services available. While some researchers find that the recidivism rate is higher in offenders with major mental disorders, others conclude that the mentally ill are at no greater risk of recidivism than the general inmate population. The latter viewpoint, however, holds that for mentally ill offenders to have a similar recidivism rate to non-mentally ill offenders, they must receive monitored treatment. The most effective type of treatment services is also a point of contention between researchers as some recommend the use of case management that closely monitors mentally ill offenders both during and after incarceration, while others call for criminal justice diversion to direct offenders away from prisons and into community-based treatment programs. Consistent across the research is the reliance upon a partnership between the criminal justice system and the community that

coordinates services offered by police and corrections officers, court officials, mental health and substance abuse providers, and the mentally ill offenders themselves.

The scholarship, however, falls short of addressing the financial implications of prison and community-based treatment services. After examining the economic predicament in California, it was determined that the state's budget deficit simply does not allow for the enactment of such treatment and diversion recommendations. Because a successful early release program requires the use of such services for mentally ill offenders, California cannot effectively implement the new corrections policy. Instead, the state should concentrate on the relationship between state prisons and county jails with respect to the handling of criminal offenders. By shifting the responsibility for low-level, non-violent inmates from the state to the counties, California could both begin to fix its prison overcrowding problem and save money by decreasing the number of prison inmates.

At this point, the author finds it important and necessary to tell you what this study is not. This is not a list of best practices for diverting mentally ill individuals from prisons and jails or for establishing community mental health and substance abuse treatment centers. California, with its current budgetary shortfall, is not in a condition to enact such practices. This is not a detailed blueprint for how to reconcile the problems rampant in the California corrections system. State official and prison administrators must work to develop a series of short-term resolutions that feed into the long-term goal of comprehensive prison reform to have any chance of reducing the prison population and improving the prison health care system. Quite simply, this is an essay meant to provoke debate that allows the reader to make his or her own predications on how California will ultimately address overcrowding and prison health care reform as well as on how the state will fare during the upcoming November 30, 2010 Supreme

Court hearing. Lastly, whether categorized as a strength or a weakness, the author has not faced the painful experience of personally being or having a family member institutionalized or incarcerated as a result of mental illness, and thus has attempted to take an objective approach to the impact of the California budget and prison crises on the incarcerated mentally ill.

Before concluding, it is important to note that there are several shortcomings in this study which future research could address to better examine the question at hand. Currently, no professional studies or polls exist that elucidate whether mentally ill offenders prefer to remain in prison or be released into the community early. With this lack of resources, it was rather difficult to thoroughly analyze the issue while relying only on anecdotal evidence. Furthermore, this essay cannot fully answer the questions initially posed in the introduction because California's early release program has been implemented for less than one year. Thus, future data collection efforts need to address this issue by including more detailed information on the possibility for rehabilitation within the California prison environment as well as offender re-entry into society and access to housing, education, employment, and medical services. Lastly, because the state prison-to-county jail inmate population shift has yet to be tested in any other state, it is uncertain whether this alternative would produce a significant number of additional problems for mentally ill offenders. Unfortunately, this goes beyond the scope of this particular analysis and must be left for subsequent research efforts. But as prison reform and early release in California are extremely timely and germane topics, it is only due time before new research will be available to close the gaps.

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