Decarceration of U.S. Jails and Prisons: Where Will Persons With Serious Mental Illness Go?

H. Richard Lamb, MD, and Linda E. Weinberger, PhD

Decarceration (decreasing the number of persons incarcerated in U.S. jails and prisons) has begun. It is estimated that more than 350,000 persons with serious mental illness (SMI) are among those incarcerated in the United States and that many thousands of them will probably be among those released. Currently, the prison population in general is being reduced as a consequence of concerns about overcrowding and of policies and programs such as reclassification of drug possession, which would affect many persons with mental illness. Court-ordered diversion and changes in sentencing guidelines are also serving to reduce prison populations. In recent years, the mental health system did not have to manage as large a number of persons with SMI, especially those who were among the most difficult and expensive to treat, because many of them were incarcerated in jails and prisons. Now, with decarceration and the release of many such persons, the mental health system may be expected to assume more responsibility for them and should be prepared and funded to meet their needs. This population of persons with SMI needs structure and treatment that, depending upon their individual needs, may include 24-hour supportive housing, ACT and FACT teams, assisted outpatient treatment, psychiatric medication, and psychiatric hospitalization.

J Am Acad Psychiatry Law 42:489–94, 2014

Efforts to decrease the number of persons incarcerated in U.S. jails and prisons have begun. The United States now has the highest rate of incarceration in the world: 707 inmates per 100,000 population in 2012 (2,228,424 persons incarcerated) compared with 80 to 150 inmates per 100,000 population for Western Europe.[1] Moreover, it is estimated that more than 350,000 persons with serious mental illness (SMI) are among those incarcerated in the United States and that many thousands of them will probably be among those released.[2]

In the 20th century, we experienced deinstitutionalization, a similar release of individuals (in this case, persons with mental illness) from large institutions into the community. Although deinstitutionalization held the promise that persons with SMI would be able to live successfully in the community, that hope was not achieved for a sizeable number of individuals. Part of its failure was attributable to a lack of planning before and during deinstitutionalization and a lack of adequate funding. As a result, communities were not able to provide a sufficient care system (i.e., housing, medical and psychiatric care, social services, and social and vocational rehabilitation) for the formerly hospitalized patients.[3,4] Despite these obstacles, most deinstitutionalized patients were able to adapt successfully to living in the community; however, this was not the case for a considerable minority who were arrested and placed in jails and prisons or who became homeless (between one-fourth and one-third of homeless persons have a serious mental illness such as schizophrenia, bipolar disorder, or major depression).[5] Some of these individuals presented challenges in treatment; such as not regarding themselves as mentally ill, not taking their

Dr. Lamb is Professor of Psychiatry and the Behavioral Sciences, and Dr. Weinberger is Professor of Clinical Psychiatry and the Behavioral Sciences, and Chief Psychologist, Keck School of Medicine, University of Southern California (USC), Los Angeles, CA. Address correspondence to: H. Richard Lamb, MD, USC Institute of Psychiatry, Law, and Behavioral Science, PO Box 86125, Los Angeles, CA 90086-0125. E-mail: hlamb@usc.edu.

Disclosures of financial or other potential conflicts of interest: None.

medications, abusing substances, and in many cases, becoming violent when stressed. Many of these persons needed highly structured care to replace that which had been provided to them, albeit imperfectly, in psychiatric hospitals. Generally, the mental health system was not prepared or funded to provide the necessary treatment and support for these individuals. Will decarceration (decreasing the number of persons in prisons and jails) produce another crisis for many of those offenders with SMI who are being released?

The Rise and Fall of the State Hospitals

Before deinstitutionalization (as of 1955), 559,000 persons in the United States were in state mental hospitals, of a total national population of 165,000,000 (339 persons per 100,000 population). The commitment of persons with SMI to state hospitals was an almost unquestioned practice and reflected the policy of the time. That, together with the extremely large number of available beds, resulted in the acceptance by state mental hospitals of nearly all persons with mental illness referred to them. Often, these institutions were the settings of last resort and had to admit patients for whom less restrictive alternatives were insufficient.

Beginning in the late 1950s, the inclination to provide hospital beds declined precipitously because of the introduction of psychoactive medications; the development of more efficacious community treatment interventions; the creation of federal programs, such as SSI (Supplemental Security Income), SSDI (Social Security Disability Insurance), Medicaid, and Medicare, that would fund community treatment and housing for persons with mental illness; the influence of the civil rights movement; and the high cost of institutionalizing persons with mental illness.[6,7] By 2010 (as a result of hospital closures and bed eliminations), the number of persons in state mental hospitals had dropped to 43,318 for a population of 308,745,538, or 14 beds per 100,000 population. This rate is similar to that in 1850, when persons with SMI received little care and concern. Their plight led to the beginning of the movement, spearheaded by Dorothea Dix and others, to provide more humane care by treating persons with SMI in hospitals.[8]

Currently, with such a reduced number of beds, the state mental hospitals have been unable to accommodate most civil commitment (nonforensic) referrals that mental health professionals and various agencies and institutions wanted to send to them, despite the fact that many of these persons probably needed the 24-hour structured care and treatment found in a hospital setting. Moreover, many of the persons with SMI who came to the attention of law enforcement, who in a previous era would have been hospitalized, were now arrested and incarcerated. It soon became clear that jails and prisons had become institutions that had to accept offenders with or without mental illness, even if the number of incarcerated persons far exceeded the correctional facility's design capacity.

The Rise and Fall of Incarceration Rates

Several factors have contributed to today's excessive incarcerated populations, both mentally ill and nonmentally ill. The war on drugs resulted in a very large number of persons incarcerated for use, sales, and other trafficking of drugs. In addition, demands of the public to be shielded from crime, especially violent offenses, as well as tough-on-crime politics, led to long and mandatory sentences.[9] In contrast, when comparing sentences across some European countries for the same types of offenses, especially violent crimes, sentences in the United States are roughly twice as long as those in the United Kingdom, 5 times longer than those in Sweden, and 5 to 10 times longer than those in France.[10]

The sheer number of persons who are incarcerated in the United States has become a financial burden that most state and county jurisdictions cannot afford, if they provide inmates with their constitutional rights, such as acceptable conditions regarding housing, clothing, food, and adequate medical and mental health care.[6] Another important factor is the belief by many that incarceration on such a large scale is not as effective in reducing crime as had been hoped.[9,11–13]

Efforts are already under way to decrease the number of persons imprisoned. For instance, many are calling for a rethinking of the war on drugs by such means as drug possession reclassification, which incidentally would affect a large number of persons with SMI. Changes would include removing imprisonment as a punishment for some categories of drug possession, increasing the use of drug courts, and redirecting resources to treatment of addiction and mental illness.[12] In fact, the Justice Department is proposing a federal clemency program so that some

incarcerated drug offenders and others may seek early release. This new program was developed as a way to correct former sentencing injustices and to relieve prison overcrowding.[14]

An examination of whether there are inequities in the imprisonment of racial and ethnic minorities may result in shorter sentences and thus a decrease in persons incarcerated. For instance, before August 2010, the federal sentence for possession of crack cocaine, which is more likely to be consumed by African Americans, was longer than that for possession of powdered cocaine.[9] However, Congress passed the Fair Sentencing Act in August 2010, reducing the 100-to-1 disparity between minimum sentences for crack and powder cocaine to 18 to 1.[15]

There are now approximately 3,000 specialized criminal courts in the United States, including those for drug charges, mental health, veterans, and reentry. These diversionary programs contribute to decarceration by assigning defendants who are otherwise most likely jail- or prison-bound to mental health and drug treatment, job and housing placement, along with other services in lieu of incarceration.[16]

There are other possible remedies that have been suggested to reduce the incarceration rate. For example, changes in sentencing policy that shorten disproportionately long sentences, especially for property and other nonviolent crimes, have been proposed.[9] Another remedy is to modify a state's determinate sentencing regimen "to reward prisoners for participating in rehabilitation programs, while allowing the system to retain prisoners who represent a continued public safety risk" (Ref. 17, p 154).

As a consequence of all these factors, the incarcerated population, which seems to have reached its peak in 2009, has now shown small decreases (for example, state and federal prison populations decreased 0.1% in 2010, 0.9% in 2011, and 1.7% in 2012)[18,19] and will probably continue to decline. One example of the pressure to reduce incarceration rates is the situation in California.

Brown v. Plata

In October 2006, California reached its all-time prison population record of approximately 163,000[17] inmates for a system designed for a maximum of 79,650, resulting in state adult prisons that were operating at slightly more than 200 percent of design capacity. In May 2011, the U.S. Supreme Court[15] upheld a lower U.S. district court three-judge panel's[17] ruling that the constitutional rights of prisoners to adequate medical and mental health care were violated in California's prisons and that overcrowding was the primary cause of the violation. Consequently, the U.S. Supreme Court concurred with the district court panel that a reduction to 110,000 inmates in the prison population (137.5% of design capacity) must occur within two years. (It should be noted that the state has been given an extension to February 2016 to reach this goal.)

The ruling left the state with only two choices: build more prisons and increase the quality of care in this expanded system or simply release a large number of current prisoners while limiting the number entering prison. California could not realistically afford to do the former, but decided it could do the latter. Thus, prisons in California are no longer institutions that can incarcerate as many individuals as they previously accepted and housed. To illustrate, as of May 21, 2014, the population in California's prisons had been reduced to approximately 116,600[20] which represents a reduction of almost 46,400 inmates since the prison population record was set in 2006. These released individuals are living in the community, although some may be homeless, incarcerated in jail, or hospitalized for medical or psychiatric conditions.

Reducing the Incarcerated Population

An illustration of a way that the incarcerated population, including inmates with SMI, has been reduced is the 2011 Public Safety Realignment Act (realignment) passed in California.[21] Included in the bill were provisions to shift the responsibility of certain convicted felons from the state correctional system to the counties.

Based on the Realignment Act, two major changes were implemented: the first addressing persons in the community convicted of new crimes and the second focusing on inmates currently in state prison. The first change was that some persons generally convicted of felony offenses punishable by incarceration for three years or less (with specified exceptions) would now be placed in local jails instead of sent to prison to serve their sentences. The second change was that most inmates in prison who were eligible for parole would now be released to their local county department of probation instead of being released on state parole. If these county probationers violated

their conditions of probation (but without committing a new crime), they could not be returned to prison, but could be placed in jail.

Thus, realignment resulted in local jails having to absorb a greater number of felony inmates under these new mandates and having to house many for longer periods. As a result of this, some local jails have been operating above 100 percent capacity, which has forced them to prioritize whom they can incarcerate.[22] Consequently, jails are having to deny admission (or at minimum, substantially reduce the length of incarceration) to many persons they previously could accept, including many with SMI charged with or convicted of low-level crimes, such as disturbing the peace.

Further, it is believed that the social control formerly exerted on state prison parolees has been lessened to the point that many county probationers, who before the Realignment Act would have been state prison parolees (including those with SMI), are relatively unsupervised. In fact, the Chief Probation Officer for Los Angeles County stated recently that approximately 15,000 inmates who were sent to jail instead of prison as a result of realignment, have served their sentences and are now living in the community without any conditions, such as reporting to a probation officer, undergoing substance abuse rehabilitation and mental health treatment, or seeking any other support services.[23] In this California experiment, the previous seemingly limitless acceptance of incarceration, as well as adequate community control, has now become curtailed and may indeed have a profound effect on where and how persons with SMI will be treated.

The number of persons with SMI who have been affected by realignment is sizeable. Recent studies estimate that at least 16 percent of persons in prisons have SMI.[24] If we assume that this is correct and that this percentage of persons with SMI holds for those who have been released, then approximately 7,424 fewer persons with SMI are incarcerated in California prisons (i.e., 16% of the 46,400 fewer inmates now incarcerated compared with California's 2006 all-time prison population record).

Since the passage of the Realignment Act, probation officers have found that some persons with SMI who have been released from prison and placed on probation are in need of treatment services and some of the officers have expressed frustration in not being able to find appropriate community treatment resources. Even with available resources, some offenders with mental illness have not been willing to receive treatment. For example, in Los Angeles County, more than 30 percent of persons with mental illness released from prison were unwilling to meet with a clinician or attend treatment.[25] Thus, many offenders with SMI residing in the community will present great challenges, not only for the criminal justice system, but for local mental health systems and the community generally.

The Need for Structure

An important modality that enables persons with SMI to live successfully in the community is structure. Given current trends, it is essential to ask who will provide the structure for many of these persons when they are released from jails and prisons. What constitutes structure? In mental health settings, structure is provided by such means as assigning mental health staff a manageable caseload whereby they can provide frequent and continuing contact with clients as well as closely monitoring medication adherence; offering therapeutic activities to clients that may add structure to much of their day; and housing that is adequate and staff that is willing and able to set limits on inappropriate and violent behavior.

How much structure persons with SMI require varies widely. Some need a minimum degree and can live quite well in the community. Others may need more structure and support, often in a residential setting, such as a board-and-care home or with family, to reach an approximation of independent living.

In our opinion, one of the most important deficiencies for those who do not respond successfully to community treatment is the failure to provide sufficient structure. One approach that has proven effective is intensive, structured treatment.[13] In fact, a recent report of prisoners released to Los Angeles County under realignment, stated that, "their higher levels of mental health treatment needs. . .indicate the need to expand intensive residential treatment services."[26] Other ways of adding structure in the community include such modalities as treatment as a condition of probation or parole and assisted outpatient treatment. Some persons may need a high degree of external structure and control on an intermediate or long-term basis, such as placement in an intensive community program like Assertive Community Treatment (ACT) or Forensic Assertive

Community Treatment (FACT) or possibly, a locked intermediate care facility or a psychiatric hospital.

What Will the Mental Health System Do?

In light of decarceration, important concerns will now emerge regarding persons with SMI. For example, who should assume responsibility for persons with SMI who commit nonserious crimes? What do we do about people with SMI released from prison? Departments of mental health will be expected to accept responsibility for them; in doing so, they must be able to provide sufficient structure and effective community treatment.

Moreover, having local mental health systems assume responsibility for offenders with mental illness is not without its problems. In our discussions with mental health professionals in California, many clinicians already report feeling extremely uncomfortable and even overwhelmed by this shift. Clinicians in the community who have seen offenders with SMI have noted that many clients have few support services; that is, a lack of a supportive family, social network, or ancillary system (such as social service case workers), few vocational skills, and little access to adequate and supportive housing. Consequently, clinicians may feel that an excessive burden is placed on them to assure their clients' well-being in the community.

Many clinicians practicing in the community never expected to be working with offenders with mental illness, some of whom arouse fear or have histories of violence. Clinicians may have little or no experience with such a population and may feel unprepared to face the challenges of working with these individuals. However, clinicians should expect to work with persons with SMI, regardless of whether they become involved with the criminal justice system or not, rather than viewing them as offenders who happen to have SMI.

Conclusions

In recent years, the mental health system did not have to deal with as large a number of persons with SMI and especially those who were among the most difficult to manage and expensive to treat, because many of these persons were incarcerated in our jails and prisons.[27] As many of these persons are released from correctional facilities, mental health systems should be expected to assume more responsibility for them. Consequently, there will be a need for more community outpatient psychiatric services with the capability of treating these individuals, as well as clinicians who are willing to treat them and have the training to do so. Moreover, those individuals who may need more intensive treatment than that which can be provided on an outpatient basis should be identified. These services may take the form of residential treatment facilities, with various degrees of structure, including psychiatric hospitals, which are capable of housing and treating offenders with SMI.

Although the U.S. Supreme Court decision in *Brown v. Plata* was limited to the state of California, given the severe prison overcrowding in other states, it is likely that many mental health systems nationwide will be expected to embark on a new era of undertaking care for many persons with SMI who were formerly incarcerated. How will mental health systems respond, and what changes in policy, practice, and ideology will result? Will those interventions that are effective but controversial be more widely accepted, such as assisted outpatient treatment?[28]

It is our belief that the mental health system should embrace the treatment of those persons with SMI who populated our jails and prisons and are now being released. The mental health system should be given the funding for the treatment and facilities necessary for this population. We believe that there should be a general recognition that this population needs structure and treatment, which may take the form of 24-hour supportive housing, an adequate number of ACT and FACT teams, assisted outpatient treatment when indicated, and a recognition of the need for a considerable increase in the number of psychiatric beds for those who must have this degree of structure to avoid being at risk for reoffending and being placed in jails and prisons. Of great importance is psychiatric medication, which should be an integral part of treatment.

If these modalities are not provided, where would these persons receive the care they need; to what degree would they simply be allowed to live in situations where they might well decompensate and reoffend? The answer to this question is particularly important, because if a large number of these individuals are inadequately treated and commit new crimes, especially aggressive ones, it is likely that many will not be tolerated in the community and will

be returned to the criminal justice system. Thus, we may very well be consigning some persons with SMI to the criminal justice system, not because they have criminal characteristics, but because of inadequate treatment. We hope that in this time of decarceration of persons with SMI, we will not repeat the disasters of deinstitutionalization.

References

1. Entire World Prison Population Rates per 100,000 of the National Population. London, UK: International Centre for Prison Studies. Available at http://www.prisonstudies.org/info/worldbrief. Accessed May 19, 2014
2. Lamb HR, Weinberger LE: Some perspectives on criminalization. J Am Acad Psychiatry Law 41:287–93, 2013
3. Talbott JA: Deinstitutionalization: avoiding the disasters of the past. Hosp Community Psychiatry 30:621–4, 1979
4. Okin RL. Expand the community care system: deinstitutionalization can work. Hosp Community Psychiatry 36:742–5, 1985
5. Folsom DP, Hawthorne W, Lindamer L, *et al*: Prevalence and risk factors for homelessness and utilization of mental health services among 10,340 patients with serious mental illness in a large public mental health system. Am J Psychiatry 162:370–6, 2005
6. Harcourt BE: Mass incarceration: causes, consequences, and exit strategies: reducing mass incarceration: lessons from the deinstitutionalization of mental hospitals in the 1960s. Ohio St J Crim L 9:53–88, 2011
7. Torrey EF, Entsminger K, Geller J, *et al*: The shortage of public hospital beds for mentally ill persons. Arlington, VA: Treatment Advocacy Center, 2008. Available at http://www.treatmentadvocacycenter.org/storage/documents/the_shortage_of_publichospital_beds.pdf/. Accessed July 15, 2014
8. Torrey EF, Fuller DA, Geller J, *et al:* No room at the inn: trends and consequences of closing public psychiatric hospitals 2005–2010. Arlington, VA: Treatment Advocacy Center, 2012
9. Cole D: Mass incarceration: causes, consequences, and exit strategies: turning the corner on mass incarceration? Ohio St J Crim L 9:27–51, 2011
10. Clear TR: Imprisoning communities: how mass incarceration makes disadvantaged neighborhoods worse. New York: Oxford University Press, Inc., 2007
11. Morrison CM: Criminal justice responses to the economic crisis. Ga St U L Rev 28:953–63, 2012
12. Simons MA: Sense and sentencing: our imprisonment epidemic. J Civ Rights Econ Dev 25:153–68, 2010
13. Doob AN, Webster CM: Sentence severity and crime: accepting the null hypothesis. Crime Just 30:143–57, 2003
14. Phelps TM: Justice department invites thousands of inmates to seek clemency. Los Angeles Times. April 23, 2014. Available at http://www.latimes.com/nation/la-na-justice-clemency-20140424,0,1617703.story#axzz2zphKVOrp. Accessed April 24, 2014
15. Brown v. Plata, 131 S. Ct. 1910 (2011).
16. McLeod AM: Decarceration courts: possibilities and perils of a shifting criminal law. Geo L J 100:1587–674, 2012
17. Coleman v. Schwarzenegger, CIV S-90–0520 LKK JFM P (E.D. Cal. 2009); Plata v. Schwarzenegger, No. C01–1351 TEH (N.D. Cal. 2009). Available at http://www.caed.uscourts.gov/caed/Documents/90cv520o10804.pdf. Accessed May 26, 2014
18. Carson EA, Sabol WJ: Prisoners in 2011. U.S. Department of Justice, Bureau of Justice Statistics, Office of Justice Programs, December 2012. Available at http://bjs.gov/index.cfm?ty=pbdetail&iid=4559. Accessed May 26, 2014
19. Carson EA, Golinelli D: Prisoners in 2012: advance counts. U.S. Washington, DC: Department of Justice, Bureau of Justice Statistics, Office of Justice Programs, July 2013. Available at http://www.bjs.gov/content/pub/pdf/p12ac.pdf. Accessed May 26, 2014
20. Estimates and Statistical Analysis Section. Offender Information Services Branch. Monthly Report of Population as of May 21, 2014. Sacramento, CA: Department of Corrections and Rehabilitation, State of California Data Analysis Unit. http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/WeeklyWed/TPOP1A/TPOP1Ad140521.pdf. Accessed May 28, 2014
21. Assembly Bill No. 109, Chapter 15 (Cal. 2011)
22. Lofstrom M, Raphael S: Impact of realignment on county jail populations. San Francisco: Public Policy Institute of California, June 2013. Available at http://www.ppic.org/content/pubs/report/R_613MLR.pdf. Accessed February 5, 2014
23. Villacorte C: Releasing prison inmates without supervision could increase crime, probation chief says. Los Angeles Daily News. February 4, 2014. Available at http://www.dailynews.com/general-news/20140204/releasing-prison-inmates-without-supervison-could-increase-crime-probation-chief-says. Accessed February 5, 2014
24. Torrey EF, Kennard AD, Eslinger D, *et al*: More mentally ill persons are in jails and prisons than hospitals: a survey of the states. Arlington, VA: National Sheriffs Association and the Treatment Advocacy Center, 2010
25. Gorman A: State convicts arrive in L.A. County with costly mental illnesses, Los Angeles Times. January 8, 2012. Available at http://www.destroypsychiatry.org/Articles/la-me-prisoners-mentalhealth.html. Accessed May 26, 2014
26. Public Safety Realignment Team: Public Safety Realignment Year-Two Report. Los Angeles: Countywide Criminal Justice Coordinating Committee, December 2013. Available at http://ccjcc.lacounty.gov/PublicSafetyRealignment.aspx. Accessed February 6, 2014
27. Lamb HR, Weinberger LE: Meeting the needs of those persons with serious mental illness who are most likely to become criminalized. J Am Acad Psychiatry Law 39:549–54, 2011
28. Swartz MS, Wilder CM, Swanson JW, *et al*: Assessing outcomes for consumers in New York's assisted outpatient treatment program. Psychiatr Serv 61:976–81, 2010