

Updates Since *Brown v. Plata*: Alternative Solutions for Prison Overcrowding in California

Christopher Horne, MD, JD, and William J. Newman, MD

With the number of inmates under the care of the California Department of Corrections and Rehabilitation (CDCR) swelling over the past few decades, California faces a challenge. The U.S. Supreme Court ruled in their 2011 decision in *Brown v. Plata* that overcrowding violates inmates' Eighth Amendment rights, specifically that they are denied adequate medical and mental health care. Federally mandated release programs have historically raised some concerns regarding public safety and fiscal efficiency. Given the large number of mentally ill inmates in the United States, alternatives such as assisted outpatient treatment, mental health courts, and increased funding for substance use treatment can be used proactively to reduce the CDCR population and provide long-term solutions to the overcrowding problem. These alternatives have already shown long-term cost savings in addition to reducing the recidivism of individuals involved and would help provide appropriate diversion for mentally ill individuals.

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In 1979, the inmate population in California prisons was approximately 18,000, already at 96 percent occupancy. Between 1980 and 2006, the California Department of Corrections and Rehabilitation (CDCR) experienced a 600 percent increase in inmate population. The 2011 U.S. Supreme Court case of *Brown v. Plata*¹ highlighted the fears of many who monitored the California prison system during that period. Though the CDCR had a maximum capacity of 85,000 inmates, at the time of the Supreme Court's decision there were approximately 156,000.¹

In their 2012 article, Newman and Scott² provided an overview of the Court's decision in *Brown v. Plata*, with a focus on the potential implications of overcrowding and inmate redistribution. The Court

determined that overcrowding was the primary factor contributing to the constitutional violations and did not identify feasible alternatives to releasing thousands of inmates. However, the Court did leave open the possibility of modifying or terminating the ordered population reduction if the state could demonstrate that it was addressing the inmates' complaints of inadequate health care by means other than limiting the population.

The Court was mindful that thousands of inmates could be released prematurely and presented evidence showing that public safety had not been significantly affected by prior prison population reductions. In addition, the order allowed the state to determine who met the criteria for release. Prior strategies to help reduce the prison population had included granting additional good-time credits, diverting offenders to drug treatment programs, and providing early release to low-risk inmates. The state implemented several realignment strategies. As part of the realignment, the CDCR allowed nonviolent, nonserious, and nonsex offenders to serve their sentences in county jails rather than in prisons. By the end of 2013, the state had reduced the inmate pop-

Dr. Horne is a General Psychiatry Resident, Department of Psychiatry and Behavioral Sciences, University of California-Davis School of Medicine, Sacramento, CA. Dr. Newman is Assistant Professor of Psychiatry and Associate Training Director, Forensic Psychiatry Fellowship Program, Department of Psychiatry and Behavioral Sciences, University of California-Davis School of Medicine, Sacramento, CA. Address correspondence to: William J. Newman, MD, Department of Psychiatry and Behavioral Sciences, University of California-Davis School of Medicine, 2230 Stockton Blvd., 2nd Floor, Sacramento, CA 95818. E-mail: wjnewmanmd@gmail.com.

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ulation to 118,738, from a peak of approximately 160,000.³ In early 2014, the three-judge panel assigned to oversee the reduction granted California two additional years to reach the target population level for its prison system. However, the court also implemented interim deadlines and planned to appoint a compliance officer who would have the power to release inmates if those interim deadlines are missed.⁴ In addition, this extension did not account for new inmates or recidivism.

Inmate Redistribution

In *Plata*, both the three-judge panel and U.S. Supreme Court allowed state officials discretion on addressing prison overcrowding. The three-judge panel formed by the chief judge for the Ninth Circuit Court of Appeals considered the effectiveness of early release programs by reviewing an expert report that discussed similar programs in Canada and several U.S. states (including Washington, Wisconsin, and Colorado). After careful consideration, the CDCR decided against releasing any inmates solely in response to the Court's ruling. Instead, they worked on developing alternative approaches to decreasing the overall prison population. These alternatives included transferring inmates to other states, moving inmates back to the local jails, ceasing to incarcerate parolees for noncriminal technical violations of parole, and diverting select offenders into specialized programs.

California at one point seemed to be facing the largest federally mandated prisoner release in U.S. history. In 2012, Newman and Scott² reviewed Philadelphia's federally mandated prison population cap in the early 1990s. At that time, the mayor of Philadelphia authorized the release of thousands of pre-trial detainees over several years in the setting of a federal consent decree. Although the individuals selected for release were deemed nonviolent, many of their charges involved arguably violent acts. For instance, some of the offenses of the individuals considered nonviolent included stalking, carjacking, robbery, burglary, and manslaughter. Individual factors in each case seemingly were not considered. Perhaps not surprisingly, 9,732 of these individuals were rearrested between January 1993 and June 1994 for new crimes that included 79 murders, 90 rapes, and 959 robberies.⁵ It is unclear to what extent, if at all, the results in Philadelphia would compare with the situation in California.

There were other unanticipated consequences of the mandated release and population cap that the local government implemented in Philadelphia. Alternative treatment programs (such as supervised release and substance-use treatment) were significantly less effective without the threat of incarceration. As a result, criminals who may have been rehabilitated with lower cost interventions were instead left to recidivate until their crimes necessitated a prison sentence.

Several years after the population cap was lifted in Philadelphia, in the setting of less effective alternative treatment programs, the Philadelphia prison population again swelled. Between 1999 and 2008, the prison population grew 45 percent. Spending on the prison system increased considerably as well, from \$118 million in 1999 to \$224 million in 2008.⁶ The experiences in Philadelphia remain relevant and reflect many of the potential problems associated with decreasing prison populations without bolstering the available resources for necessary support services. Statewide population caps have also been implemented in Florida (1977–1992),⁷ Louisiana (1983–1996),⁸ and Texas (1981–2001).⁹ The long-term outcomes of the statewide caps in these situations, however, have not been as well described as the outcomes in Philadelphia.

Mentally Ill Inmates

Department of Justice statistics show that approximately half of the incarcerated inmates in the United States have mental health problems.¹⁰ Of those individuals, surveys have shown that 3.7 percent of the men and 4 percent of the women have a psychotic illness, 10 percent of the men and 12 percent of the women have depression, and 47 percent of the men and 42 percent of the women have personality disorders. In addition, 70 percent of incarcerated individuals with mental illness have comorbid substance use disorders. From these statistics, it is apparent that a considerable number of inmates in the United States have psychotic and mood disorders. Some have argued that, due to factors such as inadequate community treatment and rehabilitation, many of these individuals will have higher mortality rates after release, as well as higher recidivism rates.¹¹ Focusing resources to treat these individuals may in many cases help reduce recidivism, consequently reducing prison populations and providing related cost savings.

Discussion

Plans to reduce prison overcrowding emphasize the long-term goal of reducing recidivism rates, especially among low-level criminals. In addition, legislators and policy advocates want to avoid emergency release protocols that can undermine public safety goals of incarceration, as arguably occurred with Philadelphia's federally mandated releases. Given that a large portion of incarcerated individuals have mental illness and are at a greater risk for recidivism, policies that bolster mental health resources in the community, such as assisted outpatient treatment, mental health courts, and increased funding for substance use treatment, can aid legislators in achieving long-term reductions in the incarcerated population.

Assisted outpatient treatment (AOT) is available in 44 states, including a well-developed system in New York (i.e., Kendra's Law). The policy varies by locale, but is generally a court-ordered outpatient treatment program that consists of assertive community treatment (ACT) with collaboration and coordination of law enforcement and mental health providers, as well as community integration and assistance with housing and entitlements if needed. Despite the presence of AOT laws in many states, the application of these laws remains inconsistent.¹²

There are two well-known and well-studied AOT success stories (e.g., New York and North Carolina). New York implemented AOT in 1994. After an initial three-year pilot, the state has continued to renew its program. Overall results have been positive. In the three years preceding AOT implementation, individuals who were eventually enrolled had an incarceration rate of 23 percent and an arrest rate of 30 percent. After the implementation of AOT, incarceration rates fell to 3 percent and arrest rates fell to 5 percent.¹³ In addition to incarceration and arrest rates, psychiatric hospitalization and homelessness rates fell dramatically for those enrolled in the program.

The Duke Mental Health Study (DMHS) analyzed North Carolina's AOT law with a randomized controlled study from 1993 to 1996. The results showed that the AOT program reduced the risk of arrest by 74 percent. In addition, the arrest rate for participants in long-term AOT was 12 percent compared with 47 percent for those who were not in AOT.¹⁴

In the groups studied, violent behaviors that often led to incarceration were also reduced in patients engaged in AOT. In New York, patients involved in AOT had 47 percent fewer incidents of physically harming others, 46 percent fewer incidents of damaging or destroying property, and 43 percent fewer incidents of threatening physical harm to others. Patients in New York were found to be four times less likely to perpetrate serious violence after engaging in AOT.¹⁵ North Carolina had similar results. The DMHS showed that long-term AOT in combination with outpatient services reduced the predicted probability of violence by 50 percent.¹⁶

In 2002, the California Legislature and Governor Gray Davis enacted their own version of AOT, Laura's Law. The implementation of California's AOT law was left to individual counties and placed much of the onus for funding and coordination on county governments. Most counties initially chose not to fund the law, and only a single county chose to enact the law right away; Nevada County fully implemented Laura's Law in 2008. A pilot program has also been initiated in Los Angeles County. Thus far, data from Nevada County have continued to show that AOT can reduce psychiatric hospitalizations, homelessness, and most notably (pertinent to prison overcrowding), incarcerations. Incarceration days were reduced by 67 percent in Nevada County in the first three years of implementation of the program. In addition, actual jail costs were reduced by approximately \$75,000 following implementation of AOT, and AOT provided a total cost savings of approximately \$500,000 in the 3-year period following implementation. The savings mainly came from the reductions in incarcerations and hospitalizations (especially involuntary) of individuals enrolled in AOT.¹⁷ With the caveat that not all incarcerated individuals with mental illness qualify for AOT, encouraging broader implementation of AOT for municipalities has been shown to reduce the total burden that such people place on jails and prisons.

Mental health court is another alternative program to help reduce the number of incarcerated mentally ill individuals. Like other problem-solving courts, such as drug courts and domestic violence courts, mental health courts seek to address the underlying problem contributing to criminal behavior.¹⁸ Mental health courts have been implemented since the late 1980s and use a problem-solving approach through judicially supervised, community-

based treatment plans to divert mentally ill defendants from the normal incarceration process. Often, there are regular status hearings as well as both incentives and sanctions for the defendant for adhering to the program.¹⁹ Whereas there are basic components found in all mental health courts, there is significant variation in models and it is important to understand the full spectrum of these models.²⁰

Research has demonstrated that mental health courts can be effective. Several studies have shown a range of positive results, from reduced recidivism to general improvement in outcomes for individuals who complete mental health court programs.^{21,22} In one study involving San Francisco Behavioral Health Court graduates, there was a reduction in new charges for violent crimes and a longer period before re-arrest. At 18 months, enrollees in the San Francisco Behavioral Health Court showed a 26 percent reduction in the probability of any new charges and a 55 percent reduction in the probability of new violent charges compared with results in those not enrolled.²³ Similarly, in Portland, Oregon, mental health court graduates showed a reduction in post-enrollment recidivism, with a 400 percent reduction in the crime rate in the year following enrollment. Enrollees also had a 62 percent reduction in re-arrest for probation violations.²⁴ Seattle demonstrated a reduction in recidivism, as well as a reduction in jail days for mental health court participants.²⁵ The King County (Seattle) mental health court program showed a 75.9 percent decrease in the number of offenses committed among graduates, as well as a 90.8 percent reduction in jail time.²⁶ Most of these studies compared mental health court participants and graduates against individuals with mental illness who navigated the criminal justice system through the traditional route.

Given that mental health courts are a fairly recent innovation, there are challenges in gathering data on long-term outcomes. Not all mental health court systems have shown significant benefits like King County or San Francisco. In a 2005 study of Broward County's (Florida) mental health court, Christy *et al.*²⁷ found that the mean number of arrests was not significantly lower for enrollees than control nonenrollees. However, their study also showed that enrollees had a significantly lower mean arrest rate in the year following enrollment than in the year before entering the program. Mental health courts have shown potential for helping divert indi-

viduals with mental illness away from incarceration. Increased funding for research will provide clearer guidance on methods and outcomes.

Another option to help reduce prison overcrowding is increased funding for substance use disorder (SUD) treatment. Approximately one-quarter of the over 2 million individuals incarcerated in the United States have been convicted of a drug offense.^{28,29} In addition, substantial research supports the idea that SUDs can worsen rates of other criminal activity.³⁰ Drug courts have demonstrated short-term reductions in rates of future criminal behavior and substance use versus traditional adjudication. They have also demonstrated reduced rates of reconviction and reincarceration. However, data remain mixed on re-arrest rates for drug court participants.³¹

In response to the positive data on drug courts, California citizens approved Proposition 36, which voters enacted as the Substance Abuse and Crime Prevention Act of 2000 (SACPA).³² Individuals who meet the SACPA criteria may receive up to one year of drug treatment and six months of aftercare, in addition to probation, in lieu of incarceration. SACPA also provides that offenders may petition the court for dismissal of their charges following successful completion of the program. The intended goal of SACPA was to divert offenders from the incarceration system into the treatment system where an emphasis is placed on adequate treatment for SUDs and includes funding for that treatment.

Data on the SACPA initiative have thus far been positive and have shown another potential advantage to the program. Anglin *et al.* estimated a cost savings of \$2,317 per offender after a 30-month follow-up (Ref. 30, p 1099). With 42,000 offenders affected by SACPA in the first year, they estimated a total cost savings of \$97.3 million over the life of the program. These savings accounted for the increased costs of supervision and probation as well as the cost of treating SUDs.

SACPA initially demonstrated an increase in re-arrest rates for individuals in the program, but research illustrated that some of this could be attributed to the placement of clients with severe SUDs in outpatient settings, as opposed to residential treatment programs.³³ County agencies attempted to meet this challenge by reallocating resources for better alignment of the treatment needs of the enrollees with services offered. The most recent report of SACPA findings in 2009 demonstrated that offend-

ers enrolled in the program had reduced drug use and reduced criminal activity and were less likely to be homeless. The report also showed that prisons in California were incarcerating fewer drug offenders and a larger percentage of violent offenders after SACPA's passage. While re-arrest rates decreased for offenders enrolled in SACPA programs compared with nonenrollees, re-arrest rates increased when compared with those of a similar control group before SACPA's passage. In addition, patients with dual-diagnoses or severe mental illness were more difficult to retain in the program.³⁴ With recent budget cuts, many county agencies have had to cut funding for SACPA programs and have significantly inhibited full engagement of offenders in the program.³⁵ The effects of these cuts remain to be seen on SACPA's effectiveness. Both SACPA and drug courts have shown that increased funding for treatment of SUDs can reduce recidivism and criminality for individuals who would otherwise be incarcerated.

As of October 2013, with the U.S. Supreme Court having recently rejected another appeal by Governor Jerry Brown, California faced a mandatory reduction of 10,000 inmates in less than six months. However, as of February 2014, this deadline has now been extended to April 2016, but the extension brings its own drawbacks with interim deadlines, more oversight, and the addition of more inmates through new arrests and recidivism.³⁶ The deadline extension also freed up \$70 million, which Governor Brown had previously earmarked for housing inmates in out-of-state prisons. Instead, Governor Brown has since proposed spending \$81 million on long-term solutions to recidivism.⁴

Conclusion

Prison overcrowding has become and will continue to be a problem some states face due to rising incarceration rates coupled with shrinking budgets. Since the 1970s, the United States has seen a steady rise in incarceration rates at local, state, and federal levels. While incarceration rates plateaued and slightly decreased over the past four years, data suggest that these rates may again be on the rise.^{37,38} This challenge presents an opportunity for legislators and policy advocates. Given the significant percentage of inmates with mental illness, increased funding for their treatment would be one beneficial approach.

The \$81 million proposed by Governor Brown could help support assisted outpatient treatment programs, mental health courts, and adequate substance use disorder treatment, all of which can help reduce prison populations with a long-term strategy of reducing recidivism and strengthening coordination between law enforcement and mental health providers. Many of these programs have demonstrated their cost effectiveness and offer savings in the long-term for state governments and local municipalities. The CDCR is the largest system ever to incur a federally mandated decrease in inmate population. Observation of the long-term outcomes of the redistributed inmates of California is likely to provide valuable information over the coming years.

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