The Scholar: St. Mary's Law Review on Race and Social Justice

Volume 6 | Number 2 Article 6

3-1-2004

Getting the Mentally Ill Misdemeanant out of Jail.

James R. Walker

GETTING THE MENTALLY ILL MISDEMEANANT OUT OF JAIL

JAMES R. WALKER†

"The mentally ill are society's lepers."[1]
"If we are civilized, we should not allow this to happen."[2]

I. INTRODUCTION

The following story was printed in the December 6, 2002 issue of the San Antonio Express News:

---

† James R. Walker is candidate for J.D. at St. Mary's University School of Law, May 2004. Mr. Walker received his B.A. and M.B.A. from the University of Texas at El Paso and his M.A. from New Mexico State University. Mr. Walker would like to thank his parents, Edith Miles and Jimmy R. Walker.

1. SCOTT O. LILIENFELD, SEEING BOTH SIDES: CLASSIC CONTROVERSIES IN ABNORMAL PSYCHOLOGY 24 (1995).

2. Timothy Roche, *The Chief and His Ward: Too Often, When the Mentally Ill Have No Place to Go, They Go to Jail*, TIME, July 10, 2000, Special Issue: The Pulse of America (quoting Natchez, Mississippi police chief Willie Huff speaking in reference to the frustration over having to carry the burden of providing for mentally ill offenders).

> At any given time, 500 mentally ill people are incarcerated in Bexar County Jail, many for non-violent offenses such as lewd behavior, trespassing or loitering. Their average stay is typically three to four times longer than the average jail inmate, and they have a hard time getting the medication and counseling they often need.
>
> Fixing that problem will take money and changes in state laws, a coalition of Bexar County law enforcement and mental health professionals said Thursday. About 15 percent of the 75,000 booked at the jail yearly have some form of mental illness, [Bexar County] Sheriff Ralph Lopez said. A comprehensive jail-diversion program would train responding officers in recognizing mentally impaired individuals, establish more crisis intervention teams and give officers, jailers and judges more options for placing an offender in treatment rather than jail. The project would be aimed at those arrested for nonviolent offenses.[3]

Reports showing the increasingly large number of mentally ill persons represented in jails and prison populations started to emerge in the 1970's.[4] But the mentally ill represented in these facilities is not at all a new phenomenon. Statistics show that in 1999, the number of prison or jail inmates who suffer from some form of a serious mental illness was approximately 283,000[5], more than four times the number of mentally ill actually in mental healthcare facilities.[6] In contrast to today, according to the 1880 census, of the mentally ill reported, only a few hundred were actually in jail or prison with the great majority being cared for at home or in asylums.[7]

The purpose of this comment is to advocate for the release of people, who because of the symptomology associated with their mental disorder end up in jail, usually because of the commission of relatively minor crimes. This class of jailed mentally ill misdemeanants ("MIMs") suffers

---

3. Cindy Tumiel, *Illness Treatment vs. Jail Explored: Bexar Could See Pilot Program*, SAN ANTONIO EXPRESS NEWS, Dec. 6, 2002, at 5B.

4. H. Richard Lamb & Linda E. Weinberger, *Persons With Severe Mental Illness in Jails and Prisons, A Review in* DEINSTITUTIONALIZATION: PROMISE AND PROBLEMS 29 (H. Richard Lamb & Linda E. Weinberger, eds., 2001) ("This phenomenon had not been reported since the nineteenth century.").

5. Jailing the Mentally Ill, *Statistics*, *at* http://www.americanradioworks.org/features/mentally_ill/poll/stats.html (last visited January 4, 2003) (quoting Bureau of Justice Statistics, *Mental Health and Treatment of Inmates and Probationers*, 1999).

6. Jailing the Mentally Ill, *Jails: America's Mental Health Hospitals*, *at* http://www.americanradioworks.org/features/mentally_ill/stories/jails1.html (last visited January 4, 2003).

7. *Id.* (discussing Dorothea Dix's 19th century campaign for more humane treatment of the mentally ill and the construction of more mental institutions).

from severe and persistent mental disorders, usually either a psychotic or mood disorder, without symptoms of or a diagnosis of a personality disorder. For purposes of this comment, those with a serious and persistent mental disorder, without any personality disorder diagnosis, who tend to get arrested and confined because of their symptoms, will be referred to as Mentally Ill Misdemeanants (MIMs). Part II of this comment will look at the history of the treatment that our society has given its mentally ill, as well as a discussion of the differences among mentally ill persons in jail. Part III presents the legal questions and problems in the discussion of MIMs and the types of crimes they commit, their criminal responsibility, and why incarceration of MIMs does not serve the needs of society or the MIM. Part IV, the last section, is designed to offer alternatives that may serve to help those involved in the criminal justice and mental health care systems to more effectively help stop this problem from getting any worse.

II. DEFINING AND DISTINGUISHING

A. *History*

Increasing attention is being given to the topic of the mentally ill and the criminal justice system because so many people classified mentally ill are ending up in prisons and/or jails.[8] This is in large part because of the considerable growth in the number of persons with mental illnesses living in the community.[9] This has lead, over the past 40 years, to the number of individuals with psychiatric disorders actually *arrested* has increased greatly.[10] The effect: an increase in jail/prison populations. In New York jails and prisons alone, for example, 10% of those incarcerated, or 130,000 inmates, suffer from a severe and persistent mental illness, with some 24% of new inmates requiring some degree of mental healthcare.[11] Further, this increase in arrest rates of persons with mental disorders coincides with deinstitutionalization, the name given to the push for more community-based treatments necessitating discharge from state psychiatric facilities.[12] This trend over the last 30 years, combined with stricter

8. Nancy Wolff ET AL., *A New Look at an Old Issue: People with Mental Illness and the Law Enforcement System*, J. MENTAL HEALTH ADMIN., Apr. 1, 1997, at 152, *available at* 1997 WL 26129213.

9. Linda A. Teplin, *The Criminality of the Mentally Ill: A Dangerous Misconception,* 142 AM. J. PSYCHIATRY 593, 593 (1985).

10. Joseph Walsh & Dana Holt, *Jail Diversion for People With Psychiatric Disabilities: The Sheriff's Perspective*, PSYCHIATRIC REHABILITATION J., Fall 1999, at 153, 153.

11. Hon. Abraham G. Georges, *The Faceless Mentally Ill in Our Jails*, 71 MAR N.Y. ST. B.J. 52, 52 (1999).

12. Mark J. Heyrman, *Mental Illness in Prisons and Jails*, 7 U. CHI. L. SCH. ROUNDTABLE 113, 114 (2000); *see* DEREK DENCKLA & GREG BERMAN, STATE JUSTICE INSTITUTE

legal restrictions on inpatient, involuntary commitments[13] have challenged the presumption that the majority of people with schizophrenia, for example, will be located in a treatment environment.[14] Such rigid standards often lead law enforcement personnel, mental health professionals, and families, "without any way of helping people before a serious mental illness spirals into tragedy."[15] Indeed, the large number of persons with mental illnesses incarcerated reinforces the notion by many authorities that prisons and jails have developed into society's modern mental hospitals.[16] But, the mentally ill were not always filling up the jails.

In the United States, it was the Quakers in Philadelphia who started the first asylum in 1817, with others soon opening up.[17] The early asylum was usually relatively small, serving no more than 250 patients at a time, located in the country, with the grounds accented by flowerbeds and gardens, allowing for the patients to find comfort in their surroundings.[18] The treatment milieu was designed to divert the patients' thoughts from delusions and obsessions with a medley of activities, including game playing, reading, gardening, as well as educational pursuits, with "restraints used as a last resort."[19] Positive reinforcement for good behavior was

---

– CENTER FOR COURT INNOVATION, RETHINKING THE REVOLVING DOOR: A LOOK AT MENTAL ILLNESS IN THE COURTS 2 (2001) (defining 'deinstitutionalization' as a "systematic shift in resources for treating people with mental illness—from large, residential, state-run psychiatric hospitals to community-based treatment").

13. DENCKLA & BERMAN, *supra* note 12, at 2; *see generally* John Parry, *Involuntary Civil Commitment in the 90s: A Constitutional Perspective*, 18 MENTAL & PHYSICAL DISABILITY L. REP. 320 (1994) (discussing the progression and recent history of civil, involuntary legal interventions for persons with mental illnesses).

14. Samuel J. Keith ET AL., *Schizophrenic Disorders*, *in* PSYCHIATRIC DISORDERS IN AMERICA: THE EPIDEMIOLOGIC CATCHMENT AREA STUDY 33 (Lee N. Robbins & Darrel A. Reiger eds., 1991).

15. Editorial, *Helping People Off the Streets: Honoring Laura's Legacy*, L.A. TIMES, Aug. 26, 2002, at B8, *available at* 2002 WL 2499203.

16. Fox Butterfield, *Prisons Brim with Mentally Ill, Study Finds*, N.Y. TIMES, June 12, 1999, at A1, *available at* 1999 WL 30543475.

17. ROBERT WHITAKER, MAD IN AMERICA: BAD SCIENCE, BAD MEDICINE, AND THE ENDURING MISTREATMENT OF THE MENTALLY ILL 25 (2002) (noting that "[a]ll of these [early] asylums were privately funded, primarily catering to well-to-do families, but soon states began building moral-treatment asylums for the insane poor. The first such public asylum opened in Massachusets, in 1833, and by 1841, there were sixteen private and public asylums in the United States."); *Contra* JOEL BRASLOW, MENTAL ILLS AND BODILY CURES: PSYCHIATRIC TREATMENT IN THE FIRST HALF OF THE TWENTIETH CENTURY 16 (1997) (noting that some asylums existed even earlier, in the late *eighteenth* century).

18. WHITAKER, *supra* note 17, at 25-6.

19. *Id.* at 26; BRASLOW, *supra* note 17, at 35 (noting that physical restraint of patients was a topic of much debate throughout the nineteenth century, and that toward the end of the century "a number of states even attempted to abolish" the practice altogether.

used to maintain patients' display of good behavior.[20] For example, those who did not act disruptively were allowed privileges that included picking better rooms on the top floors, and being able to go into town unaccompanied, as long as the patient promised not to drink alcohol during their jaunt and to return on time.[21] This reinforcement trend would later extend into 20th century asylum life with the type of ward a patient might be assigned to dependent upon good behavior.[22] For example, with "chronically disturbed" patients receiving "a couple of hours of free movement around the hospital grounds", while the higher-functioning patients assigned to less chronic wards and having "complete independence" throughout the day.[23]

By the mid 1800's there were "twelve public asylums in the United States" whose purpose was not to enslave, but, rather, to provide treatment for the insane.[24] By this time, another 5 institutions, these being private, had been in operation for about 25 years.[25] Throughout the 19th century the number of such facilities, both public and private, grew for a couple of reasons. First, more people recognized the undeniability of the numbers of those considered insane in their societies.[26] Institutionalization was a biproduct of the industrial revolution:

> with concomitant changes in the social order, rapidly evolving complexities in social relationships, tremendous expansion of population, and closer grouping of that population in large towns and cities. The simple makeshifts of a simple community living under a simple economy were no longer possible in this increasingly complex world. The first and most logical solution that presented itself in dealing with the mentally, physically and economically disabled was to gather them together into centers of custody, care and treatment.[27]

---

20. WHITAKER, *supra* note 17, at 26; *see also* BRASLOW, *supra* note 17, at 28-9.
21. WHITAKER, *supra* note 17, at 26.
22. WHITAKER, *supra* note 17, at 26; BRASLOW, *supra* note 17, at 28-9.
23. BRASLOW, *supra* note 17, at 28.
24. THOMAS J. BROWN, DOROTHEA DIX: NEW ENGLAND REFORMER 101 (1998).
25. *Id.*
26. *See* DAVID GOLLAHER, VOICE FOR THE MAD: THE LIFE OF DOROTHEA DIX 155 (1995) (noting that the 1840 census – the first census to count the mentally disordered – revealed 978 "lunatics" in Massachusetts).
27. ALBERT DEUTSCH, THE MENTALLY ILL IN AMERICA: A HISTORY OF THEIR CARE AND TREATMENT FROM COLONIAL TIMES 186-87 (Columbia Univ. Press 2nd ed. revised and enlarged 1949).

But, the real push for the recognition of the needs of the mentally ill came, primarily, from a strong advocate.[28]

Dorothea Dix made it her personal mission to advocate for better conditions for this long-ignored group.[29] She attempted to convince those in positions to pay for mental institutions (e.g., legislatures) that a minimum level of care was needed for the mentally ill because they were incapable of self-care and that this care was a necessary responsibility of the state.[30] She also advocated against conventional medical beliefs in describing insanity as a "physical disease affecting and disturbing the natural and healthy functions of the brain", and that mental disorders were the result of "organic malconstruction[s]" and not the product of a flawed soul.[31]

Though the number of asylums had greatly increased during the twentieth century,[32] things weren't as rosy for the mentally ill in our institutions.[33] The belief that the mentally ill "posed a serious threat to the future health of American society" began to take hold.[34] In 1931, Dr. John Maurice Grimes who, along with 3 other physicians, visited 600 mental health institutions and discovered that "[*p*]*atients* [were] *hospitalized, not because they are mentally ill, but because of unsocial or antisocial manifestations*. The primary aim of the care provided is not cure, but custody."[35] Later, in 1948 the Department of Mental Hygiene would proscribe electroshock therapy for "those patients . . . in acute excitement for

---

28. *See* BROWN, *supra* note 24, at xi (noting that Dorothea Dix convinced State legislatures, the federal government, and "even the Pope to establish mental hospitals"); *see* GOLLAHER, *supra* note 26, at vii.

29. *See* BROWN, *supra* note 24, at xi, 101; *see* GOLLAHER, *supra* note 26, at vii (noting that she earned "worldwide acclaim not because she invented the asylum, but because she thrust what we have come to call mental disease and homelessness squarely into the center of public policy.").

30. GOLLAHER, *supra* note 26, at vii; Jeffrey Rubin, *Issues in the Financing and Organization of Mental Health Services*, *in* MENTAL HEALTH AND LAW: RESEARCH, POLICY AND SERVICES 219 (Bruce D. Sales & Saleem A. Shah, eds., 1996) (noting that in presenting in her "memorials" to the New York, New Jersey, and Massachusets' legislatures, Ms. Dix "often sprinkled her reports with claims of the financial benefits a state could anticipate in return for allocating additional funds to improve inpatient care for seriously mentally ill individuals").

31. BROWN, *supra* note 24, at 113.

32. BRASLOW, *supra* note 17, at 16 (noting that the number of state funded asylums had grown from 131, to 181 by 1941, and total patients served increased from 126,137 in 1903 to 419,374).

33. *See* WHITAKER, *supra* note 17, at 41 (noting how the "generous attitude toward the mentally ill disappeared in American society").

34. *Id.* at 41-2.

35. ANN BRADEN JOHNSON, OUT OF BEDLAM: THE TRUTH ABOUT DEINSTITUTIONALIZATION 161 (1990).

any cause and . . . in danger of exhausting themselves."[36] With the asylum population growing considerably, the asylums themselves seemed to be an example of a larger wrong occurring in America.[37] Insanity came to be seen as a "disease on the loose," rampant, and given that foreign immigrants accounted for almost 40% of the state mental hospital population, but only 14% of the general population, the majority white, Anglo-Saxon attitude lead to talk, and some action, of eugenics.[38] For instance, from 1911 to 1924, with the financial backing of individuals like Mary Harriman and John D. Rockefeller, Jr., and along with 258 field personnel, the Eugenics Records Office gathered "census like data" on mental health hospital patients and prison inmates to identify what percentage were foreign born and to quantify the "burden which the unfit place upon their fellow man."[39] Further, throughout the first half of the twentieth century, initiatives to sterilize asylum and state hospital patients came to fruition. By 1921, U.S. institutions had sterilized 2,700 patients, 80% of whom resided in California.[40] By 1950, this practice had consumed 23,466 victims, with California sterilizing only 11,491, nearly half of the national total.[41]

By 1945, the number of state funded mental hospitals had grown to 190, not including 33 United States government-operated psychiatric facilities for veterans, and another 192 private mental health facilities.[42] This increase in the number of facilities coincided with a debate about the capacity necessary to successfully treat mental hospital patients in these 20th century institutions.[43] For example, while some advocates in the psychiatric community supported small-sized hospitals aimed at more individualized treatment to increase rapport between patient and hospital staff, others favored much larger-capacity hospitals able to successfully accommodate 3,000 to 5,000 patients.[44] Patients in larger-capacity hospi-

---

36. BRASLOW, *supra* note 17, at 106 ("In sum, the practice of electroshock therapy reinforced physicians' ways of looking at behavior, disease, and treatment such that discipline and therapeutics were seamlessly melded together into a single practice.").

37. WHITAKER, *supra* note 17, at 46 (noting that by 1880 the number of those deemed "insane" had more than doubled to 91,997, or one out of every 554 people).

38. *Id.* at 46-8.

39. *Id.* at 48.

40. BRASLOW, *supra* note 17, at 56 (tracing sterilization from Nazi eugenics, but ultimately arguing that doctors' implementing such medical procedures did so in an effort to alleviate suffering and not as "an instrument of the state to prevent the procreation of the insane").

41. *Id.*

42. DEUTSCH, *supra* note 27, at 456.

43. *See id.* at 456-57 (discussing a split in opinion among psychiatrists regarding the benefits of small, individualized care facilities versus the economies of scale larger institutions afforded).

44. *Id.*

tals were often assigned to wards based on their behaviors.[45] These larger facilities were able to gain more patient diversification and spread costs over this bigger inpatient census and spend more on better therapeutic equipment.[46]

Ultimately, the latter half of the Twentieth century witnessed the concept of deinstitutionalization. This "mass exodus"[47] of the mentally ill from institutions was striking, as compared to the number of people served in state hospitals and other psychiatric facilities today.[48] By 1998, the number of state hospital patients was down from 559,000 institutionalized patients out of a population of over 165 million to 57,151 patients out a population of over 275 million.[49]

This exodus occurred primarily as a result of the advent of Chlorpromazine, and other modern medications that reduced the deviant behaviors of many in-patients, as well as "the development of community psychosocial treatment and rehabilitation."[50] Chlorpromazine, with its ability to calm the psychotic patient,[51] lead to many patient discharges from the confines of their treating facilities to outpatient care.[52]

---

45. BRASLOW, *supra* note 17, at 28.

46. DEUTSCH, *supra* note 27, at 457 (noting that Central Islip State Hospital in New York, the Pilgrim State Hospital, and the Georgia State Hospital at Milledgeville had patient censuses of 7,000, 10,000 and 9,000 respectively).

47. H. Richard Lamb, *Deinstitutionalization at the Beginning of the New Millennium*, *in* DEINSTITUTIONALIZATION: PROMISE AND PROBLEMS 3 (H. Richard Lamb & Linda E. Weinberger eds., 2001); Elaine Rivera, *The Police and the EDP's: As Services for the Emotionally Disturbed Dwindle, Officers Fill the Gaps, Sometimes With Deadly Results*, TIME, Sept. 13, 1999, at 30, *available at* 1999 WL 25725298 ("Since 1969, 93% of psychiatric beds have been emptied across the country, and many of the mentally ill end up in the prison system or fending for themselves.").

48. LAMB, *supra* note 47; *see* JOHN Q. LA FOND & MARY L. DURHAM, BACK TO THE ASYLUM: THE FUTURE OF MENTAL HEALTH LAW IN THE UNITED STATES 87 (1992) (noting a sharp decline in mentally ill patients).

49. LAMB, *supra* note 47; H. Richard Lamb, *The New State Mental Hospitals*, *in* DEINSTITUTIONALIZATION: PROMISE AND PROBLEMS 21 (H. Richard Lamb & Linda E. Weinberger eds., 2001) (noting that "[b]etween 1955 and 1994 the United States reduced its number of occupied state psychiatric beds from 339 per 100,000 population to 29 per 100,000 on any given day").

50. *See* LAMB, *supra* note 47 (discussing how the discovery of Chlorpromazine affected chronically mentally ill patients); *see* LA FOND & DURHAM, *supra* note 48, at 87 (concluding that drugs like Chlorpromazine impacted the hospitalization of the mentally ill patients).

51. *See* WHITAKER, *supra* note 17, at 144 (noting the addition of the term "neuroleptic", coined by French psychiatrists Jean Delay and Pierre Deniker, taken from Greek, meaning to "take hold of the nervous system", being indicative of how drugs like Chlorpromazine was observed to be used as a chemical restraint).

52. *See Id.* at 153 (noting that U.S. News and World report described these "new wonder drugs" as revolutionary "in [the] treatment of mental disease"); *see* DENCKLA & BERMAN, *supra* note 12, at 2 (stating that "[a]dvances in the effectiveness of psychiatric

Added to this was a change in the values toward the treatment that the institutionalized were receiving.[53] In the early 1950's, some states had begun "to break down the walls between" society and mental institutions.[54] People began to see "large state institutions . . . as pathological – actually causing mental illness and prolonging dependency," further fueling reform.[55] Later, a joint commission appointed by President Kennedy would proclaim that the aim of contemporary treatment "for the seriously mentally ill" would be to deliver mental health services in the community, in an effort to avert the "debilitating effects" of institutionalized care.[56] Thus, "[w]ith community care . . . patients would be . . . released into a more natural and therapeutic environment".[57] In addition, financial motivations helped states embrace the idea of deinstitutionalization as a good thing.[58] During the 1950's, states' patient censuses were growing steadily, as was the cost to maintain the physical plant of their institutions, many of them constructed before the turn of the twentieth century.[59] With deinstitutionalization, the states were able to shift much of the cost of care over to the federal government, a supporter of the idea.[60] President Kennedy, in "unveil[ing] his plans for reforming the nation's care of the mentally ill," noted that "state hospitals. . .would be replaced with a matrix of community care". . .and, that new drugs (e.g., Chlorpromazine) "made it possible for most of the mentally ill to be successfully and quickly treated in their own communities and returned to a useful place in society."[61] These progressive-thinking states preferred state hospital discharges of patients to the community because less in-patients equated to less money spent on their in-patient care.

B. *Types of Mental Illness Classification*

Roman philosopher Philo Judaeus classified people with a mental disorder into two classes. The first, larger group, consisted of those being

---

medications since the 1950's have allowed even the most severe mental disorders to be treated on an outpatient basis.").

53. LA FOND & DURHAM, *supra* note 48, at 86.

54. *Id.*

55. *Id.*

56. *Id.*

57. *Id.*

58. *Id.*

59. *Id.*

60. *Id.*; *see* William Gronfein, *Incentives and Intentions in Mental Health Policy: A Comparison of the Medicaid and Community Mental Health Program*, 26 J. HEALTH & SOC. BEHAV. 192, 192 (1985) ("Deinstitutionalization has been the formal policy of the Federal Government with regard to mental illness since 1963".).

61. WHITAKER, *supra* note 17, at 155-6.

patient, kind and having a tender disposition.[62] The second, smaller group was made up of people whose mental illness was more ferocious and barbaric, and who were a danger to themselves and to "those who approached them".[63] Hippocrates would later separate mental illness between mania and melancholia.[64] Our recent understanding of psychoses per se is seen in the work of Emil Kraeplin and Eugen Bleuler, with Kraeplin being the first practitioner to split the concepts of "insanity," or "madness", into two separate sets of symptoms: "'dementia praecox' and manic-depressive psychosis."[65] Kraeplin believed that these syndromes were diseases with organic bases, like other diseases, and differentiated the two by "different[ ] course and outcome".[66] Bleuler actually coined the term "schizophrenia", taken from the Greek word 'schizein', (to split), and 'phren', (mind), to more accurately describe a set of symptoms that manifested itself in the breaking up of separate psychological faculties, like language and emotion.[67]

Today, a 'mental disorder' is a mental condition causing impairment in social, psychological, or educational or occupational functioning that is beyond a culturally sanctioned response.[68]

1. Psychotic Disorders

Schizophrenia, and other psychotic disorders, are typified by the presence of some combination of the following: delusions, hallucinations, disorganized speech (i.e., incoherence), and disorganized behavior.[69]

---

62. John Monahan, *Mental Disorder and Violent Behavior: Perceptions and Evidence*, 47 AM. PSYCHOLOGIST 511, 512 (1992) (quoting G. ROSEN, MADNESS IN SOCIETY: CHAPTERS IN THE HISTORICAL SOCIOLOGY OF MENTAL ILLNESS 89 (1968)).

63. *Id.*

64. DEUTSCH, *supra* note 27, at 485; Joseph D. Bloom & William H. Wilson, *Offenders With Schizophrenia*, *in* VIOLENCE, CRIME AND MENTALLY DISORDERED OFFENDERS: CONCEPTS AND METHODS FOR EFFECTIVE TREATMENT AND PREVENTION 114 (Sheilagh Hodgins & Rüdiger Müller-Isberner eds., 2000) (noting that the "classification of mental illness in Western medicine dates back to the Ancient Greeks").

65. Chris Frith & Connie Cahill, *Psychotic Disorders: Schizophrenia, Affective Psychoses, and Paranoia*, *in* ABNORMAL PSYCHOLOGY 24 (Arnold A. Lazarus & Andrew M. Colman eds., 1995) ("'Dementia Praecox' . . . almost invariably resulted in a global deterioration of the patient's mental state: from dementia praecox there was no reprieve. Manic-depressive psychosis, on the other hand, was characterized by a remitting course, with the patient experiencing a restitution of function between psychotic episodes.").

66. *Id.*

67. *Id.* at 24-5.

68. *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS – TEXT REVISION xxx-xxxi (4th ed. 2000).

69. *Id.* at 297-98, 312 (noting that "in Schizophrenia . . . the term *psychotic* refers to delusions, any prominent hallucinations, disorganized speech, or disorganized or catatonic behavior").

> The actual experience of being in the grip of a psychotic episode has been likened to the experience of dreaming. In dreams our minds are flooded by thoughts and sensations whose logical connections and meaning may elude us. In dreams[,] the chaotic and the fantastical are real to us just as the experiences of the psychotic may feel intensely real to the individual experiencing them.[70]

Aside from the diagnostic descriptors and the dream analogy, schizophrenia, at its most basic level, "afflicts thinking, . . . mak[ing] it hard for affected people to organize thoughts and feelings."[71]

2. Mood Disorders

There are two main mood disorders: depression and bipolar disorder. Major Depressive Disorder, the technical name given to depression, is characterized by the presence of Major Depressive Episode(s), during which time, five of the following have been present in a two-week time frame: a depressed mood most of the day, most every day; notably reduced interest in things once considered pleasurable; significant weight loss, absent dieting, or weight gain; an inability to sleep or over-sleeping every day; observable psychomotor agitation or retardation most every day; fatigue nearly every day; "feelings of worthlessness or excessive or inappropriate guilt"; a reduced ability to think or concentrate; and lastly, "recurrent thoughts of death."[72]

Someone suffering from Major Depressive Disorder experiences the above symptoms by way of a "dysphoric mood whose intensity far outweighs the ordinary ups and downs of everyday life."[73] One suffering from depression may also have "a low self-esteem and feeling that they deserve punishment" as a part of the syndrome.[74] Sometimes these cognitive symptoms may take the form of dwelling on past mistakes, thereby creating guilt leading to a feeling that they will never really be able to do well, culminating into a paralysis over the ability to resolve even unimportant decisions.[75]

---

70. ALESSANDRA LEMMA, INTRODUCTION TO PSYCHOPATHOLOGY 157-58 (1996).

71. J. ALLAN HOBSON & JONATHAN A. LEONARD, OUT OF ITS MIND: PSYCHIATRY IN CRISIS, A CALL FOR REFORM 180 (2001).

72. AM. PSYCHIATRIC ASS'N, *supra* note 68, at 349-51.

73. A CASEBOOK IN ABNORMAL PSYCHOLOGY: FROM THE FILES OF EXPERTS 167 (Richard P. Halgin & Susan Krauss Whitbourne eds., 1998) (noting that this dysphoria "may appear as extreme dejection or a dramatic loss of interest in most aspects of life").

74. *Id.*

75. *Id.*

Another mood disorder, Bipolar Disorder, also known as manic-depression, is typified by alternating periods of mania and depression.[76] Symptoms of mania may include: cycling between extreme moods, dramatically increased energy levels and activity, increased thought activity and faster thinking than is normal for the person, increased rate of speech, ambitious plans, increased sexual activity and a decreased need for sleep.[77] This disease affects about 2.3 million Americans and is a serious brain disorder that is often chronic, usually beginning "in adolescence or early adulthood," and often necessitates ongoing treatment.[78]

3. Personality Disorders

Personality disorders, although technically "mental disorders", are in a class to themselves. They are even coded separately for diagnostic purposes.[79] Unlike mental disorders, personality disorders are a part of the patient's personality, intrinsic in nature, as opposed to delusional thinking that might accompany Schizophrenia for example, which is known to be apart from the patient's inherent make-up.[80]

The differences of these disorders, while important in helping to shape one's understanding of why persons with a particular disorder end up in jail or prison, are further magnified when one considers the staggering number of mentally ill persons diagnosed as having a personality disorder in jails and prisons.[81] A study looking at the incarceration rates of those

---

76. National Alliance for the Mentally Ill, *Bipolar Disorder*, *at* http://www.nami.org/helpline/bipolar.htm (last visited Jan. 4, 2003).

77. *Id.*

78. *Id.*

79. Richard P. Halgin & Susan Krauss Whitbourne, *The Therapeutic Process*, *in* A CASEBOOK IN ABNORMAL PSYCHOLOGY: FROM THE FILES OF EXPERTS 3-4 (Richard P. Halgin & Susan Krauss Whitbourne eds., 1998); *see* AM. PSYCHIATRIC ASS'N, *supra* note 68, at 28-9.

80. *See* HALGIN & WHITBOURNE, *supra* note 79, at 4 (characterizing mental disorders as illnesses and personality disorders as "part of the underlying 'fabric' of the individual's disposition or intellectual capacity").

81. James R.P. Ogloff, Ronald Roesch, & Stephen D. Hart, *Mental Health Services in Jails and Prisons: Legal, Clinical, and Policy Issues*, 18 LAW & PSYCHOLOGY REV. 109, 109, 116 n.28 (1994), 18 LPSYR 109 (Westlaw)(noting in their review of "empirical research concerning mentally ill offenders" that "over 90% [of inmates] have some form of diagnosable mental disorder . . . [with] 50% to 75% of all offenders . . . diagnosed with antisocial personality disorder"; The Health Report with Norman Swan, *Personality Disorders (Part One): A Special Feature by John Merson*, Mon. 17, Feb. 1997, http://www.abc.net.au/rn/talks/8.30/helthrpt/stories/s2029.htm (last visited Mar. 28, 2004)(noting that, in Australia, "[i]t's estimated that around 60% to 70% of the inmates . . . have some form of personality disorder."; *contra* Eulon Ross Taylor, *Using Algorithms and Protocols in Diagnosing and Treating Offenders with Mental Health Disorders*, CORRECTIONS TODAY, Vol. 63, Issue 5 (Aug. 2001), 2001 WL 14891799 ("The mentally ill population in

with serious mentally illnesses in Western countries found that between men & women, respectively, 3.7% and 4.0% had a psychotic disorder, 10% and 12% depression, and a staggering 65% and 42% with a personality disorder.[82] These numbers are important in that the theme of this commentary is that most jails and prison systems do little to differentiate mentally ill misdemeanants, with psychotic disorders for example, and antisocial personality disordered individuals who are more prone to violence and the commission of much more serious crimes. Further, this lack of differentiation results in the same "mental health treatment" being given to all persons classified as having a mental disorder, including both groups just mentioned. However, before we can fully appreciate why giving the same treatment to all persons labeled as having a mental disorder in jail or prison is important, we need to understand the basic difference between the two disorder groups.

Individuals with a serious and persistent mental psychotic or mood disorder often endure more impairment in basic, everyday life functioning. For example, an individual with a Global Assessment of Functioning[83] ("GAF") of 40 to 50 would most likely have difficulties in reality testing or communication (e.g., speech might be illogical or irrelevant) or have major deficits in being able to develop and keep friendships, as well as an inability to find and keep a job.[84] This impairment in functioning is what often times results in these persons having to be hospitalized to stabilize their symptoms to the point that participating in life is more successful and probable.[85]

Persons who develop a personality disorder, on the other hand, exhibit pathological behavior that they consider to be a part of their character and, for them, usual.[86] And, while a personality disorder can also result

---

prisons is not well-studied. It is estimated that between 20 percent and 30 percent of individuals in jails or prisons have diagnosable mental illnesses. The literature does not document the number of offenders who have personality disorders[.]".

82. Seena Fazel & John Danesh, *Serious Mental Disorder in 23,000 Prisoners: A Systematic Review of 62 Surveys*, 359 LANCET 545, 545 (2002).

83. AM. PSYCHIATRIC ASS'N, *supra* note 68, at 34. Global Assessment of Functioning is used "for reporting the clinician's judgment of the individual's overall level of functioning . . . with respect only to psychological, social, and occupational functioning". *Id.* at 32.)

84. *Id.*

85. Richard L. Munich & William H. Sledge, *Providing a Continuum of Care for Patients with Schizophrenia or Related Disorders*, *in* TREATMENTS OF PSYCHIATRIC DISORDERS 1113, 1116-18 (Glen O. Gabbard ed., 2001) (noting that "psychiatric inpatient treatment is useful and at times absolutely essential, particularly for patients . . . who are in the midst of florid psychotic decompensation"); *see* AMERICAN PSYCHIATRIC ASS'N, *supra* note 68, at 34 (listing GAF ranges and corresponding deficits).

86. JEROLD S. MAXMEN & NICHOLAS G. WARD, ESSENTIAL PSYCHOPATHOLOGY AND ITS TREATMENT 390 (2d ed. 1995).

in social occupational deficits, these persons are not always in emotional misery, and "impairment in functioning is seldom as profound" compared to "major depressive disorder and schizophrenia".[87] Rather, it is those around the personality-disordered individual that usually have the most difficulty.[88] For example, someone diagnosed with Antisocial Personality Disorder (APD) usually encounters, beginning in childhood, long-term problems in school and at home, and these problems carryover into adulthood affecting relationships at work, with family, and other relationships.[89] These people "tend to be aggressive and impulsive and are thought to lack normal capacities for love, guilt, and cooperation with authority figures . . . [with] [m]any of them com[ing] into conflict with the legal system."[90] The antisocial personality, in general, has can be described as one showing little consistency in work habits, frequent law breaking, with irritability and physical aggression, and, overall, with a tendency towards recklessness.[91] Further, they are usually impulsive and don't plan ahead, with no regard for honesty or "remorse for misdeeds."[92]

There is a common misconception that both mental disorders and personality disorders are illnesses, but, in fact, a "personality disorder" is actually a misnomer, and not an "illness", in the way that schizophrenia is.[93] Although mental illnesses are usually diagnosed by their behavioral manifestations, it is increasingly accepted that these syndromes (e.g., schizophrenia, major depression, etc.) respond more favorably and predictably to medications.[94] Further, personality disorders, in general, are not disorders "in the medical sense," but, instead, are "reified constructs employed to represent varied styles or patterns in which the personality system functions *maladaptively* in relation to its environment."[95]

---

87. *Id.* at 391.

88. *Id.* at 389.

89. Lee N. Robins ET AL., *Antisocial Personality, in* PSYCHIATRIC DISORDERS IN AMERICA: THE EPIDIMEOLOGIC CATCHMENT AREA STUDY 258 (Lee N. Robins & Darrel A. Regier eds., 1991).

90. *Id.*

91. THOMAS OLTMANNS ET AL., CASE STUDIES IN ABNORMAL PSYCHOLOGY 298 (5th ed. 1999).

92. *Id.*

93. LEMMA, *supra* note 70, at 181.

94. Bruce J. Winick, *Ambiguities in the Legal Meaning and Significance of Mental Illness*, 1 PSYCHOL. PUB. POL'Y & L. 534, 562 (1995).

95. LEMMA, *supra* note 70, at 181.

III. CRIMINALIZATION OF THE MENTALLY ILL

The subject of the mentally ill should be of interest to the legal community because of the challenge that they bring to the criminal justice system in general and, specifically, to the matter of criminal responsibility.[96]

A. *Why It's Easy for MIM's To Get 'Picked Up'*

'Criminalization of the Mentally Ill', is a term coined to describe how increasing numbers of people with mental illnesses, who commit minor crimes, become more frequently subject to arrest, prosecution, and confinement in a jail system.[97] This topic of the mentally ill ending up in the criminal justice system isn't new.[98] A 1939 study looking at the relationship between mentally ill and prison populations found the two to have an inverse relationship;[99] when one form of confinement increased, the other was reduced.[100] Under this theory, when prison populations are vast, mental institution-population and mental hospital censuses will be in decline.[101]

From the law enforcement perspective, it is easy to see why MIM's are arrested and taken to jail and not to a mental health facility that could better deal with their needs.[102] First of all, a MIM is "picked up" not for being mentally ill, but for breaking the law.[103] Especially for more serious offenses, the criminal justice system, which is directed by society with the assignment for removing from public people under suspicion of having committed serious crimes, perceives no options but to place the accused in custody in a secure environment *first* and *then* arrange or accommodate any psychiatric care if needed.[104] If a mentally ill person is believed "to have committed a serious crime," law enforcement and the criminal justice system do not want to leave a person in a mental hospital, where security is slack, and the criminal transgression possibly seen by hospital staff as subordinate to the patient's illness—the reason necessi-

---

96. Ugo Leone, *Preface to* UNITED NATIONS INTERREGIONAL CRIME AND JUSTICE RESEARCH INSTITUTE, PATHWAYS TO THE MANAGEMENT OF MENTALLY ILL OFFENDERS IN THE CRIMINAL JUSTICE SYSTEM iii (Adelmo Manna, Ryosuke Kurosawa, and Koichi Hamai eds. 1993).

97. Lamb & Weinberger, *supra* note 4, at 30.

98. *See id.* at 30-31.

99. *Id.*

100. *Id.*

101. *Id.*

102. *See* Richard H. Lamb, *The Mentally Ill in an Urban County Jail*, 39 ARCHIVES OF GENERAL PSYCHIATRY 17, 17 (1982).

103. *Id.* at 20.

104. *Id.*

tating the hospitalization in the first place – which may lead to a discharge back "to the community in a relatively short time".[105]

Another factor aiding the arrest of MIMs is the difficulty faced by law enforcement agents during the investigation & arrest process, when discerning the cause of criminal behavior.[106] The signs of mental illness can go unnoticed.[107] For example, some mentally ill arrestees prefer to see themselves as criminal, rather than mentally ill, and, thus, act and behave accordingly.[108] To compound this, if a MIM has taken drugs or alcohol prior to the arrest, to the arresting officer the mental illness may very well be masked, making it even more unreasonable to expect a police officer to conclude that someone's criminal behavior is due to their mental illness.[109] And, even if a police officer knows that a MIM's criminal behavior is due to their symptoms, society at large may not be so understanding.

While it is frustratingly clear to understand why a MIM is arrested, it is equally as frustrating to understand society's reluctance to be so understanding.[110] For example, stores and businesses often have policies dictating that those individuals caught stealing have charges filed against them and, accordingly, be taken to jail.[111] Another example, bus stations, are especially attractive to homeless MIMs, because they tend to be open all night, provide haven from the elements. Unfortunately, station managers can get easily frustrated, and want eliminated the presence of such persons when and if they beg or harass station customers.[112] Last, what if someone who was mentally ill attacked you? How would you even know that they were mentally ill? And, if you did, would you care? Would you care that this MIM was taken to jail? In the face of an assault would you or could you be sympathetic to the fact that your assailant was mentally ill and that they *not* be taken to jail but instead be sent to a psychiatric facility for care and treatment of the very symptoms that caused them to smack you?[113] These examples make clear that the jailing of MIMs is a societal problem because of the zeitgeist.

As the title of this article suggests, we are concerned with the mentally ill misdemeanant. As such, we need to appreciate the fact that the vast majority of crimes that MIMs commit aren't grave crimes against human-

105. Lamb & Weinberger, *supra* note 4, at 30.
106. Lamb, *supra* note 102, at 20.
107. *Id.*
108. *Id.*
109. *See id.*
110. *See id.*
111. *See id.*
112. *See id.*
113. *See id.*

ity; they're petty crimes.[114] A much simpler example of how easy it is for a MIM to enter the criminal justice system is demonstrated by a simple theft of ice cream sandwich from a convenience store. In this example, once arrested, the MIM is taken to jail but, unfortunately, ends up staying in jail much longer than necessary because they most likely lack the money to post bail and secure release, thereby helping to fill up the jail's capacity.[115]

B. *Why We Punish In the First Place: A Theoretical Look*

"A diseased or disordered mind cannot entertain or formulate a criminal purpose, or know that the act is wrongful."[116]

A look at the basic philosophy of criminal justice as it relates to punishment is necessary at this point. A discussion on the involvement of the mentally ill in the criminal justice system necessarily leads to a re-examination of the purpose of punishment, theories of punishment, intent, and criminal responsibility.

Any punishment, whether handed down as an expression of societal anger, familial, or from an organization, has seven features that comprise the actual punishment.[117] The punishment is the infliction of something, we presume, undesirable to the person receiving it, such as a disqualification or incarceration.[118] This infliction is given for a purpose, is not accidental, and is applied by those considered as having the license to do so.[119] The happening of the infliction of punishment is in response to a *voluntary* commission or omission by the accused that violates a criminal statute or rule.[120] The reasoning for offering the punishment is "such as to offer a justification for doing so"; it is not doled out at or for the mere whim of the punisher.[121] Further, a pretext is called for because of the fact that the punishment being imposed is unwanted no matter the wishes of its recipient, versus a voluntary unpleasantness like enduring a dental visit or a surgery that will evoke some benefit.[122] Last, it is the aim of the person ordering the sentence, and not the assent of the recipient, which

---

114. LeRoy L. Kondo, *Advocacy of the Establishment of Mental Health Specialty Courts in the Provision of Therapeutic Justice for Mentally Ill Offenders*, 24 SEATTLE U. L. REV. 373, 373-74 (2000).

115. *See id.* (noting how one mentally ill homeless man stole a $1.16 ice cream sandwich for which he did jail time because he couldn't afford the $25 bail).

116. C. RAY JEFFERY, CRIMINAL RESPONSIBILITY AND MENTAL DISEASE 14 (1967).

117. NIGEL WALKER, WHY WE PUNISH? 1-3 (Oxford University Press, 1991).

118. *Id.* at 1.

119. *Id.* at 1-2.

120. *Id.* at 2.

121. *Id.*

122. *Id.*

answers any inquiry as to whether or not such a punishment is to be determined a 'punishment'.[123]

Criminal law exists to compel people to do what the larger society regards as beneficial and, at the same time, to deter or stop people from doing things society deems undesirable.[124] To this end, some theories of criminal law have a focus on the particular offender, while others concentrate more on the nature of the crime and the community.[125] More specifically, the end goals of criminal sentencing, which relates to why punishments are given, are: retribution (an eye for an eye), deterrence (stopping people, both individually and specifically, from committing crimes in the future), denunciation (i.e., reinforcing societal views on lawbreaking), incapacitation, and, finally, rehabilitation.[126] Further, the extension of or denial of criminal responsibility to the mentally ill comes down to two sides of a debate: the basic liberal and the more hard-line, conservative stance.[127] According to the liberal view, because mental illness as applied to a crime negates the mens rea requirement, one of the two requirements of any crime (actus rea and mens rea) cannot be met, therefore no criminal sanctions should ensue. The conservative perspective in this debate is more closely associated with being averse to the use of the insanity plea in criminal cases.[128]

C. *Why Incarcerating MIMs Does Not Help Them*

Once someone with a mental disorder enters the criminal justice system, it is unlikely that their mental health will improve.[129] In her plea to the legal and mental health community for better treatment of the mentally ill in jail via improved, specialized, and educated courts, Debra Baker notes that long wait times for trials, for petty offenses or commitment hearings exposes the mentally ill defendant to corrections officers untrained in the basics of dealing with the mentally ill and, often, abuse as the hands of other inmates.[130] This problem is further compounded by

---

123. *Id.* at 3.

124. WAYNE R. LAFAVE & AUSTIN W. SCOTT, HANDBOOK ON CRIMINAL LAW, HORNBOOK SERIES 22 (1986).

125. *Id.* at 23.

126. WAYNE R. LAFAVE, MODERN CRIMINAL LAW: CASES, COMMENTS, AND QUESTIONS 24 (2d ed. 1998).

127. *See* generally JEFFERY, *supra* note 116, at 30-5 (discussing both the liberal and conservative perspectives).

128. *Id.* at 34.

129. Debra Baker, *A One-of-a-Kind Court May Offer the Best Hope for Steering Nonviolent Mentally Ill Defendants Into Care Instead of Jail*, 84-JUN A.B.A. J. 20, *21(1998), *available at* 84-Jun ABAJ 20, Westlaw.

130. *Id.*; *See How Are Problems of Mental Illness Being Handled in the Prison System?*, 17 HARV. MENTAL HEALTH LETTER 1, at 8, July 2000 (noting that as a result of

the fact that in-jail medication compliance versus out-of-jail medication compliance is different, because the inmates are less likely to take prescribed psychotropic medications.[131]

Given that jail, essentially, warehouses persons away from society, why shouldn't jails and prisons serve as a great substitute for mental hospitals?[132] The quick answer to this question is that the treatment afforded the mentally ill in jails and prisons, is usually worse than what they might, or would, receive in an actual mental health facility.[133] This boils down to the basic fact that a prison's mission is to separate criminals from society and, perhaps, reform them, not to prescribe psychotropic medications, assure that good treatment is delivered, and, then, evaluate the effectiveness of the treatment.[134] As such, a prisoner's day is usually filled with harsh rules and punishments doled out for disobeying those rules, something that someone with a severe and persistent mental disorder, like schizophrenia, is going to have a very difficult time doing.[135]

IV. PROPOSAL

> "[Y]ou have to bear in mind that mental illness is just that, it is an illness, and many of the people caught up in our criminal justice system are there largely because of that mental illness."[136]

What are the costs of criminalizing the mentally ill? One cost that is easy to appreciate, given that police have had to respond to the lack of proper services in the community for the mentally ill, is the cost to the police department.[137] Given that more and more mentally ill released from facilities since deinstitutionalization's inception are going to be on the streets, with more and more opportunities to commit petty crimes, it is the police who are on the front-line, so to speak. As such, the number

---

placing mentally ill inmates among the general population has caused "increased rates of violence, mental breakdown, and suicide in prisons and jails. [And that] prisoners with mental illnesses are often victimized by other prisoners . . . spend[ing] most of their time confined to their cells.").

131. Walsh & Holt, *supra* note 10, at 154.

132. HOBSON & LEONARD, *supra* note 71, at 29.

133. *Id.*

134. *Id.* at 29-30.

135. *Id.* at 30.

136. Martin Karopkin, *The Changing Face of Justice: The Evolution of Problem Solving, Eleventh Annual Symposium on Contemporary Urban Challenges*, 29 FORDHAM URB. L.J. 1790, 1801 (2002) (Judge Martin Karopkin, of Kings County Criminal Court, speaking on mentally ill misdemeanants and how the justice system should best approach them.).

137. *See* Nancy Wolff, *Interactions Between Mental Health and Law Enforcement Systems: Problems and Prospects for Cooperation*, 23 J. HEALTH POL. POL'Y & L. 133, 138 (1998).

of functions that police have to be responsible for only increases.[138] Hence, a larger share of police resources is going to the care of the mentally ill who are in the community and not receiving the treatment they need thus bringing them into contact with law enforcement eating into the traditional job of law enforcement: crime fighting.[139]

Given that jailing these individuals doesn't seem to meet anyone's needs, what alternatives are available to the criminal justice system in general and, specifically, to the courts to stop, or at least, slow this growing trend?

A. *Jail Diversion*

'Jail Diversion' is, basically, what the name implies: an attempt to divert those people (especially MIMs) that shouldn't be in jail from going there and into an appropriate treatment setting.[140] Jail diversion programs involve the interplay between the courts, prosecutors, local law enforcement officials and local mental health service providers in the community to better meet the offender's needs.[141] There are two types of jail diversion programs available: pre-booking and post-booking.[142] Pre-booking diversion, as the name implies, occurs before any consideration of arrest during initial contact with law enforcement officials.[143] The idea is simple: if a police office or other law enforcement official can identify someone with a mental illness who has committed some petty offense, most likely because of their illness, then all these people can work together with the goal of getting the right kind of help to reduce the chances that a particular MIM will break future laws or come into further contact with the police. Unfortunately, most diversion occurs post-booking.[144] Post-booking diversion occurs at an arraignment court or a jail where a screening commences to detect the possibility of a mental illness.[145] Upon verification of a mental illness, a process of negotiation begins among "prosecutors, defense attorneys, community-based mental health providers, and the courts to produce a disposition outside the jail

---

138. *See id.*

139. *See id.*

140. TEX. HEALTH & SAFETY CODE ANN. § 533.101.

141. Alissa Riker, *The Homeless Pretrial Release Project: An Innovative Pretrial Release Option*, 65-Jun FED. PROBATION 9-10 (2001) (discussing how San Francisco dealt with the jail-overcrowding problem caused by homeless misdemeanants).

142. *Impact of Mentally Ill Offenders on the Criminal Justice System: Hearing Before the Subcommittee on Crime of the Committee on the Judiciary House of Representatives*, 106th Cong., Second Sess. 15 (2000) (prepared statement of Bernard S. Arons, M.D., Director, Center for Mental Health Services, Dept. of Health and Human Services).

143. *Id.*

144. *Id.*

145. *Id.*

in lieu of prosecution to get a disposition out of jail in lieu of prosecution."[146]

The ability to defer prosecuting someone if they enter some type of rehabilitation or treatment has long been used on an informal basis.[147] Texas's foray into the more formal implementation of diversion, for example, was seen in the 1990's, with the Texas legislature specifically addressing the issue.[148] Prior to 1994, a Texas judge was "precluded . . . from issuing a commitment order for . . . mental health services . . . to a proposed patient who faced charges for *any* criminal offense."[149] As such, those in the law enforcement community had to decide whether to drop all charges in the hope "that an alleged offender obtain mental health services pursuant to the Mental Health Code."[150] In 1993, the Texas Legislature responded to this by adding changes to the Texas Code of Criminal Procedure, as well as amending the Mental Health Code.[151] The Texas legislature, acknowledging that "[mentally ill individuals] await trial without the benefits of treatment," removed the limitation on the "transfer of suspected mentally ill . . . defendants who are in jail" in order to obtain such help by limiting the prohibition to any alleged mentally ill defendant charged with committing an offense that involves serious bodily injury to another.[152]

The main condition that needs to occur before any discussion of jail diversion takes place is decriminalization.[153] Decriminalization is necessary because the practice of immediately arresting someone known to be mentally ill for a non-violent misdemeanor needs to stop, and this can only happen when all involved realize that, sometimes, the low-function-

---

146. *Id.*

147. Debra T. Landis, Annotation, *Pretrial Diversion: Statute or Court Rule Authorizing Suspension or Dismissal of Criminal Prosecution on Defendant's Consent to Noncriminal Alternative*, 4 A.L.R. 4th 147, 151 (1981).

148. Brian D. Shannon, *Diversion of Offenders with Mental Illness: Recent Legislative Reforms*, 59 TEX. B.J. 330, 332 (1996).

149. *Id.*

150. *Id.*

151. *Id.* at 332-33.

152. *Id.* at 333 (quoting bill analysis).

153. *See* David Kelly, *Ventura County News: Flynn Seeks Mental Health System Revamp County*, L.A. TIMES, Dec. 19, 2000, *available at* 2000 WL 25928453 (reporting on Ventura County, California's supervisor, John Flynn, in his efforts to introduce reforms in the Behavioral Health Department, as well as his desire to "come up with new ways of dealing with [Ventura County's] mentally ill population"); *see also* Laura Beil, *A Holding Pattern: Criminal justice system – with jails caught in the middle – have become custodians of the mentally ill. Series: Illness in the System*, THE DALLAS MORNING NEWS, Nov. 2, 1997, *available at* 1997 WL 11532568 (noting that criminalization occurred, de facto, because of a lack of mental health services available in the community).

ing mentally ill are going to commit these petty offenses because of the very illness that makes them low functioning.

Lastly, successful jail diversion programs of either type usually have five characteristics in common: (1) all necessary community mental health, substance abuse and criminal justice agencies are dedicated from the beginning, (2) regular meetings are held between and among these groups, (3) liaison personnel are employed to circumnavigate all systems involved, (4) the programs embody strong leadership, and (5) the programs utilize more non-traditional case management methods by staff who are hired more for their experience across these systems than for academic credentials.[154]

B. *Mental Health Courts*

The mental health court started as an outgrowth of drug treatment courts that were set up to handle mostly felony drug cases, usually dealing with adults who were not violent but had dependence problems.[155] These drug courts reflected the belief by many in the criminal justice field that customary processes, like street-level police crackdown and interdiction, have, in large measures, failed to diminish drug usage among offenders.[156] Drug courts help the problem of recidivism of non-violent drug-offenders by offering a mixture of alternatives to jail, such as accelerated case processing, intensive case management, urine analyses, outpatient services, and assistance with community reintegration (i.e., enhancing employment skills), and, usually, working with the probation officer.[157] This entire approach is couched in the philosophy that a therapeutic justice approach is better able to handle and deal with a chronic, relapse-prone disorder, like an alcohol addiction, for example, instead of jail.[158]

This same strategy was applied to the problem of MIMs repeatedly ending up in jail and repeatedly before the same judge.[159] The goals of

---

154. *Impact of Mentally Ill Offenders on the Criminal Justice System, supra* note 142; Videotape: Diverting the Mentally Ill from Jail (Films for the Humanities & Sciences 1996) (on file with the St. Mary's University Blume Library).

155. Arthur J. Lurigio et al., *Therapeutic Jurisprudence in Action: Specialized Courts for the Mentally Ill*, 84 JUDICATURE 184, 185 (2001).

156. *Id.* (noting that growth in the use and creation of these specialized courts represents a recognition of the public health component as well as the criminal justice/legal aspect of the problem).

157. *Id.*

158. *See* Teresa W. Carns et al., *Therapeutic Justice in Alaska's Courts*, 19 ALASKA L. REV. 1, 6 (2002). 'Therapeutic justice' as "the use of social science to study the extent to which a legal rule or practice promotes the psychological and physical well-being of the people it affects." *Id.* at 2.

159. *See* Lurigio, *supra* note 155, at 186 (describing how, in San Bernardino County, California, the same judge can preside over both drug treatment and mental health cases);

such unique courts are to process MIM cases more quickly, to increase the MIMs access to needed mental health care, to deal with the underlying mental illness that is causing criminal behavior[160] and ultimately, to reduce the recidivism of MIMs to the criminal justice system.[161] And, while a drug court may look more prominently towards cessation of substance use and/or abuse, a mental health court is more concerned with improving the quality of its defendants' lives instead of finding a cure.[162] In addition, families of MIMs can find satisfaction in this process because of the closer association between the mental health courts and more effective outpatient treatment approaches, such as Assertive Community Treatment (ACT).[163]

An example of the way in which a mental health court might typically operate is as follows. The court must first make certain that the defendant in competent enough to participate in the program; these decisions are often made by a judge who has special training in mental health issues.[164] Next, the defendant is given an explanation of the mental health court process and what participation entails.[165] To be accepted in the

---

America's Law Enforcement and Mental Health Project, Pub.L.No. 106-515, 114 Stat 2399 (2000) (*See* Part 5, 'Mental Health Courts'); Arthur J. Lurigio, *Federal Legislation Establishes a National Mental Health Court Demonstration Program*, 84 JUDICATURE 185, *185 (2001) (noting that President Clinton signed this law Nov. 13, 2000 authorizing funds for mental health court training for court officials and for mental health services).

160. *See Unique Court Helps Mentally Ill Offenders*, 64 TEX. B.J. 724, 724 (2001) (discussing a newly created mental health court in Dallas, Texas).

161. Lurigio, *supra* note 155, at 187; Sue Ellen Christian, *Special Court for Mentally Ill in Talking Stage Concept Working in Other Cities*, CHI. TRI., Nov. 7, 1999, *available at* 1999 WL 2929846; *see* Paul Stavis, *Why Prisons Are Brim-Full of the Mentally Ill: Is Their Incarceration a Solution or a Sign of Failure?*, 11 GEO. MASON U. CIV. RTS. L.J. 157, 199 (2000) (arguing for the creation of mental health courts as one of a few recommendations to effectively counter the increasing number of mentally ill persons incarcerated); Mental Health Court, King County District Court website, *at*http://www.metrokc.gov/kcdc/mh-home.htm (last visited Oct. 22, 2002) (describing King County, Washington's Mental Health Court, its goals and processes); George F. Moriarty, Jr., *Department Reviews of the Professional Periodicals*, 63-JUN FED. PROBATION 84, *84 (1999) (noting the creation of mental health courts in Cook County, Illinois and Bernalillo County, New Mexico, in addition to San Bernardino County, California, as a tool against recidivism of mentally ill defendants).

162. Carns, *supra* note 158, at 5-6, 26 (noting that because MIM's are chronically ill, the likelihood of a complete cure is unlikely).

163. M. Susan Ridgely et al., *The Effectiveness of Involuntary Outpatient Treatment Empirical Evidence and the Experience of Eight States*, INST. CIV. JUSTICE 2001 Monograph/Report, *available at* MR-1340-CSCR-ICJ, *7 (on Westlaw) (discussing a Duke University study that found a reduction of overall system recidivism, with the "two most salient factors . . . be[ing] intensive mental health treatment and enhanced monitoring for a sustained period of time", along with a court order.).

164. Carns, *supra* note 158, at 26; Lurigio, *supra* note 155, at 186.

165. Carns, *supra* note 158, at 26-27.

process, the defendant must voluntarily agree to participate, which equates to a plea of guilty or no contest, and accept treatment in exchange for a suspended sentence,[166] with participation, in some instances, occurring as a stipulation of probation.[167] To this end, suggestions from empirical study of community-program effectiveness have surfaced. These include, first and foremost, the reduction of recidivism along with conditional release; expanded outpatient (case) management; specific, skill-based training for the severely mentally ill; and, a special focus on the reduction and cessation of substance abuse.[168] One manager of a special needs offender program in Dallas, Texas, for example, noted that, in her view, it is the ability to leverage probation and/or court ordered treatment that helps lead to success.[169] She further added that, "once you get people taking their medication, understanding their illness, understanding the impact that medication's going to make after they begin to stabilize psychiatrically, that in turn helps them to stabilize in their living situation, then they begin to see the benefits."[170]

C. *Assertive Community Treatment*

There appear to be a number of reasons why persons with mental illnesses come into contact with law enforcement officials and end up in jail.[171] The most widely accepted reason being the failure of the mental health system in furnishing satisfactory services in the first place, which, ideally, would reduce the chances of the people under discussion from becoming MIMs.[172] The way in which this happens is that, without needed services (e.g., psychiatric medication and follow-up, case management, etc.), persons with a severe and persisting mental illness decompensate, thereby increasing the chance of displaying violent or illegal behavior.[173] Hence, what is needed is an outpatient model of care that helps to meet these persons' needs in the community. This is called "ACT".

---

166. *Id.* at 27.

167. Lurigio et al., *supra* note 155, at 187.

168. Kirk Heilbrun & Lori Peters, *Community-Based Treatment Programmes, in* VIOLENCE, CRIME AND MENTALLY DISORDERED OFFENDERS: CONCEPTS AND METHODS FOR EFFECTIVE TREATMENT AND PREVENTION 208 (Sheilagh Hodgins & Rüdiger Müller-Isberner, eds., 2000).

169. *See* Laura Beil, *Legal Treatment: Courts are Overseeing Mentally Ill Patients by Default*, Series: Illness in the System – Court-Ordered Psychiatry, DALLAS MORNING NEWS, Nov. 5, 1997, at A1, *available at* 1997 WL 11533356.

170. *Id.*

171. Wolff, *supra* note 8, at 3.

172. *Id.*

173. *Id.*

Created as a reaction to ever-increasing recidivism in the late 60s and 70s, ACT was designed to be a hospital without walls;[174] to bring the level of intensity of care that in-patients get to those persons living in the community. As applied, ACT takes into account all of the aspects of care that tend to promote success (i.e., less inpatient admission and less jail time) and deliver, in the community,[175] intensive psychiatric rehabilitation and case management services via a multi-disciplinary treatment team.[176] Further, while the whole goal of ACT is to reduce the amount of times that someone with a severe and persisting mental illness goes back to the hospital or jail, it also has another advantage: lower cost. Yearly estimates of inpatient psychiatric treatment hover around $100,000 per patient, versus treating a person in the community, via ACT for example, which would cost between $9,000 and $14,000,[177] with the most profound "cost offset" being the reduction in actual hospital usage.[178]

Specifically, the way that ACT is helpful as a treatment alternative for MIMs is in the multi-disciplinary, team format driven care which is available 24 hours a day (i.e., a hospital without walls), 365 days a year, and

---

174. *See* Phillip Tibbo, *Global Assessment of Functioning Following Assertive Community Treatment in Edmonton, Alberta: A Longitudinal Study*, 46 CAN. J. PSYCHIATRY 144, 144 (2001); Elizabeth Edgar, *The Role of PACT in Recovery*, at http://www.nami.org/content/contentgroups/programs/PACT1/The_Role_Of_PACT_In_Recovery.htm (last visited Oct. 6, 2003); ACT Association Homepage at www.actassociation.org (last visited Oct. 6, 2003); National Alliance for the Mentally Ill (NAMI), *What About Assertive Community Treatment? An Interview with PACT's William H. Knoedler, M.D.*, THE ADVOCATE, *at* http://www.nami.org/about/interview.html (last visited Oct. 22, 2002); Johnson, supra note 35, at 199. Note that this service is also referred to 'Program for Assertive Community Treatment', or PACT.

175. JAY NEUGEBOREN, TRANSFORMING MADNESS: NEW LIVES FOR PEOPLE LIVING WITH MENTAL ILLNESS 305-08 (1999) (describing a New York City ACT Team that spends at least 75% of the time out of the office and in the clients' homes, the courts, on job sites, in schools, and in doctors' offices).

176. Elana H. Margolis, *The Failure of Civil Confinement: How Russell E. Weston, Jr. Slipped Through the Cracks and the Potential for Many More to Follow*, 26 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 129, 152 (2000); *see* David E. Anderson, *Virginia's Mental Health Trust Fund: A Proposal to Financially Secure and Modernize Services Provided to the Seriously Mentally Ill in Virginia*, 11 GEO. MASON U. CIV. RTS. L.J. 135, 139-40 (2000); *see* Jennifer Honnig and Susan Fendell, *Meeting the Needs of Female Trauma Survivors: The Effectiveness of the Massachusetts Mental Health Managed Care System*, 15 BERKLEY WOMEN'S L.J. 161, 176 (2000).

177. Edgar, *supra* note 174; *see* M. Susan Ridgely & Howard H. Goldman, *Putting the "Failure" of National Healthcare Reform into Perspective: Mental Health Benefits and the "Benefit" of Incrementalism*, 40 ST. LOUIS U. L.J. 407, 426 (1996) (describing the need for more lower cost alternatives to hospitalization).

178. Eric A. Latimer, *Economic Impacts of Assertive Community Treatment: A Review of the Literature*, 44 CAN. J. PSYCHIATRY 443, 443 (1999).

even during after-hours for crisis management.[179] Thus, ACT Teams, as they are called, are able to deliver services more aggressively and more often than traditional case management, office-based mental health services.[180] This allows for many more opportunities for medication compliance, psychiatric follow-up, and rehabilitation all aimed at the increasing the individual's tenure in their community . . . and not in a hospital, state facility, or worse, jail.[181] The way to do this is to teach people the life skills that they once had and have now lost or never had at all.[182] For example, ACT Teams spend most of their time in the community rehabilitating and teaching their clients in how to successfully go about day-to-day living. This includes teaching them how and when to shower and change into new clothing; teaching them how to go to the doctor's office; teaching them how to go shopping for groceries; or, how to behave more appropriately in social settings.[183] This is good for the clientele because ACT is considered one of the more effective treatments for those with severe and persistent mental illness who are also at risk for homelessness, something that tends to occur with this population.[184]

What this has to do with getting MIMs out of jail is that with this kind of aggressive, more assertive treatment delivered in the community, the person with a severe and persisting mental illness has fewer opportunities

---

179. Edgar, *supra* note 174; Frank Holloway & Jerome Carson, *Case Management: An Update*, 10/1/01 INT'L J. SOC. PSYCHIATRY 21, at 5, *available at* 2001 WL 21047798; Rüdiger Müller-Isberner & Sheilagh Hodgins, *Evidence-Based Treatment for Mentally Disordered Offenders* 12 *in* VIOLENCE, CRIME AND MENTALLY DISORDERED OFFENDERS: CONCEPTS AND METHODS FOR EFFECTIVE TREATMENT AND PREVENTION (Sheilagh Hodgins & Rüdiger Müller-Isberner, eds., 2000) (noting that patients with 'major mental disorders' (e.g., schizophrenia, major depression, bipolar disorders and atypical, but non-toxic psychoses) require a treatment regimen inclusive of multiple components "designed to address the various aspects of the major mental disorder and to reduce antisocial behavior and substance abuse").

180. Halloway & Carson, *supra* note 179, at 3 (noting that the "core mission of the majority of mental health case management programs in the US is the prevention of hospitalization" and defining 'case management' as "the enhancement of the continuity of mental health care and its accessibility, accountability and efficiency"; MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL *available at* www.surgeongeneral.gov/library/mentalhealth/chapter4.sec5.html#case (last visited October 9, 2003) (listing case management's purpose as the coordination of "service delivery and to ensure continuity and integration of services".

181. Edgar, *supra* note 174; Holloway & Carson, *supra* note 179, at 5; Tibbo, *supra* note 174, at 144 (noting that in the largest longitudinal study ever performed on the effectiveness of ACT, overall GAF scores increased in person with chronic mental illness, especially those diagnosed with schizophrenia).

182. *See* JOHNSON, *supra* note 35, at 199.

183. *See* NEUGEBOREN, *supra* note 175, at 155-58, 305-08.

184. Sidney D. Watson, *Discharges to the Streets: Hospitals and Homelessness*, 19 ST. LOUIS U. PUB. L. REV. 357, 361 (2000).

to get involved with the criminal justice system to begin with. This equates to higher and more effective abilities and skills learned and reinforced to help with the difficulties they often have in living in the community given their history of treatment and, often, medication noncompliance.

V. CONCLUSION

Despite whatever treatment alternatives are available to people with severe and persistent mentally illnesses, the fact remains that they are being continually subjected to the harshness that the criminal justice system has to offer. And, while more hardened criminals who commit more serious crimes deserve to be incarcerated, there are too many instances of such people who, because of their illness commit simple, non-violent offenses and end up in jail. It is this population that everyone, no just the legal community, needs to give more attention to. This disparate treatment would not be tolerated in our society if such treatment were happened upon a racial minority. But because it occurs to a group of people that society is either unaware of, or unconcerned with, it is, de facto, accepted.