A RESTORATIVE JUSTICE MODEL FOR MENTAL HEALTH COURTS

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ABSTRACT

Mental health courts (MHCs) are a promising forum for combating the incarceration of individuals with mental illness. This Note explains why MHCs are particularly suited for community reintegration of those suffering from severe mental illness, explores some of the more successful community treatment programs to which MHCs can link severely mentally ill persons who are accused of crimes, and models a restorative justice program for integration into MHCs. The last of these is the most controversial, as it requires that offenders with mental illness and the victims of their crimes both be treated as victims. While few to none have tested the effectiveness of a restorative justice approach specifically intended to address the crimes of offenders with mental illness, this Note considers some of the issues likely to arise in implementing such an approach and the best means of addressing them.

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I. INTRODUCTION

Individuals with mental illness, particularly those who are homeless and thus more likely to have frequent brushes with law enforcement,[1] are victims of a history of improper treatment.[2] With jails and prisons having replaced state mental hospitals as the largest purveyors of mental health services,[3] effective diversion—moving these individuals from prisons and

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[1] John Petrila & Bruce Lubotsky Levin, *Law, Services Delivery, and Policy*, *in* MENTAL HEALTH SERVICES: A PUBLIC HEALTH PERSPECTIVE 43, 58–59 (Bruce Lubotsky Levin et al. eds., 3d ed. 2010); Mary Castle White, Linda Chafetz, Gerri Collins-Bride & John Nickens, *History of Arrest, Incarceration and Victimization in Community-Based Severely Mentally Ill*, 31 J. COMMUNITY HEALTH 123, 127 (2006) (finding that individuals with mental illness who reported having no regular residence in the past six months were three times more likely to be arrested and citing a study where 71.4% of community members with mental illness reported being arrested at some point in their lives).

[2] MARY DE YOUNG, MADNESS: AN AMERICAN HISTORY OF MENTAL ILLNESS AND ITS TREATMENT 113–17 (2010) (providing details from exposés of the miserable conditions of two state asylums in 1946); *see also* MURRAY LEVINE, THE HISTORY AND POLITICS OF COMMUNITY MENTAL HEALTH 39 (1981) (describing the poor living conditions in state hospitals during the post-World War II period).

[3] *See* Sharon G. Garner & Thomas L. Hafemeister, *Restorative Justice, Therapeutic*

jails to the community—is essential. While there is still a lack of community centers and treatment resources for individuals with mental illness,[4] mental health courts (MHCs) have proven effective in reducing both recidivism and the number of individuals with mental illness in prisons and jails.[5] Such "problem-solving" courts have helped patients live independently and overcome drug problems.[6] Yet improvement is still needed. To stop the revolving door that shuffles individuals with mental illness from the streets to jails and back,[7] MHCs must connect offenders to local treatment and reintegration services, and more importantly, to the community as a whole.

This Note asserts that to ensure successful reintegration, community-based treatment should be coupled with a victim-centered restorative justice process. Combining these approaches will change communities by de-stigmatizing mental illness, heightening understanding, and encouraging community reintegration of individuals with mental illness. The restorative justice approach proposed in this Note recognizes that when individuals with mental illness encounter the criminal justice system, there are two victims: (1) the victim of the offender's acts and (2) the offender, as a victim of circumstances.

This Note models a restorative justice approach intended to divert offenders with mental illness from the criminal justice system into community treatment programs. Part II of this Note addresses the criminalization of mental illness in the context of modern history and of legal theory. Both contexts demonstrate how individuals with mental illness, especially those who are homeless, have suffered a history of

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Jurisprudence, and Mental Health Courts: Finding a Better Means to Respond to Offenders with a Mental Disorder, 22 DEV. MENTAL HEALTH L. 1, 4 (2003). In the mid-twentieth century, state mental hospitals were the largest mental health services providers. Petrila et al., *supra* note 1.

[4] H. Richard Lamb & Leona L. Bachrach, *Some Perspectives on Deinstitutionalization*, 52 PSYCHIATRIC SERVICES 1039, 1044 (2001).

[5] Virginia A. Hiday & Bradley Ray, *Arrests Two Years After Exiting a Well-Established Mental Health Court*, 61 PSYCHIATRIC SERVICES 463, 465–67 (2010) (finding that offenders who completed MHC programs had the greatest reductions in re-arrests and recidivism); Henry J. Steadman & Michelle Naples, *Assessing the Effectiveness of Jail Diversion Programs for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders*, 23 BEHAV. SCI. & L. 163, 168 (2005) (reviewing a study comparing diverted and non-diverted groups, and finding that diversion connects the offender with community-based services and reduces the time an offender spends in jail without increasing the public safety risk).

[6] Steadman et al., *supra* note 5, at 165.

[7] *See* KAMALA MALLIK-KANE & CHRISTY A. VISHER, URBAN INST., HEALTH AND PRISONER RE-ENTRY: HOW PHYSICAL, MENTAL, AND SUBSTANCE ABUSE CONDITIONS SHAPE THE PROCESS OF PRISONER REINTEGRATION 7 (Feb. 2008), *available at* http://www.urban.org/UploadedPDF/411617_health_prisoner_reentry.pdf.

victimization that has carried over into the criminal justice system. Part III introduces the role of MHCs by examining their early successes in diversion and recidivism reduction, and their present deficits in administering criminal justice. Part IV recommends that community treatment regimens and restorative justice be integrated into MHCs. First, Part IV discusses some of the promising community treatment programs already in place and possible impediments to creating new, effective programs. Second, it proposes a restorative justice approach that revolutionizes society's conception of a victim by acknowledging that many offenders with mental illness are de facto victims. Last, Part V provides some concluding thoughts on the topic.

II. FRAMING OFFENDERS WITH MENTAL ILLNESS AS VICTIMS

A. HISTORICAL, SOCIETAL, AND PERSONAL VICTIMIZATION OF INDIVIDUALS WITH MENTAL ILLNESS

During the early part of the twentieth century, an increasing number of individuals with mental illness were sent to state asylums as a result of federal legislation that held states responsible for such individuals.[8] By the mid-1900s, state asylum populations had more than tripled.[9] However, starting in the 1950s, reports of overcrowded facilities and miserable conditions prompted lawmakers to adopt various initiatives, which eventually led to a significant decrease in patient populations.[10] Several groups, including the Council of State Governments, the American Psychiatric Association, and the Joint Commission on Mental Illness and Health, independently recommended that treatment of patients with mental illness shift from state asylums to community-based approaches.[11] Subsequently, President John F. Kennedy worked with a task force to draw up a mental health proposal, which he submitted to Congress in

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[8] GROB & GOLDMAN, THE DILEMMA OF FEDERAL MENTAL HEALTH POLICY: RADICAL REFORM OR INCREMENTAL CHANGE? 7–9 (2006) (noting that the passage of the State Care Act of 1890 required individuals with mental illness to become state wards in New York).

[9] DE YOUNG, *supra* note 2, 103–04. In the mid-twentieth century, state mental hospitals were the largest mental health services providers. Petrila et al., *supra* note 1.

[10] DE YOUNG, *supra* note 2, at 114–17; PATRICIA E. ERICKSON & STEVEN K. ERICKSON, CRIME, PUNISHMENT, AND MENTAL ILLNESS: LAW AND THE BEHAVIORAL SCIENCES IN CONFLICT 27 (2008) ("Approximately ninety-two percent of the people who would have been living in public psychiatric hospitals in 1953 were not living in them in 1994.").

[11] DE YOUNG, *supra* note 2, at 117.

1963.[12] In his message to Congress, President Kennedy emphasized the inadequacy of state institutions, their overcrowding, and their understaffing.[13] He recommended that mental health services be concentrated in comprehensive community mental health centers, where individuals could "be successfully and quickly treated in their own communities and returned to a useful place in society."[14] His hope was to reduce asylum populations by fifty percent or more.[15] Kennedy also recommended that Congress authorize grants to the states to fund forty to seventy-five percent of the costs of community mental health centers.[16] Although the Mental Retardation Facilities and Community Mental Health Centers Construction Act was signed into law in 1963, the House of Representatives never appropriated the funds authorized under the Act.[17] Thus, President Kennedy's dream of community-centered reform was never fulfilled.[18] Rather, twenty years after Kennedy's proposal, less than half the number of community centers needed had been built.[19]

Nonetheless, subsequent decades continued to produce a mass release of individuals with mental illness from asylums into the community, with some asylums releasing patients and others closing their doors altogether.[20] This trend—now known as deinstitutionalization[21]—was accelerated by a number of outside pressures. Among these were the federal government's funding of Medicaid and Supplemental Security

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[12] *Id.* at 118. Robert H. Felix, director of the National Institute of Mental Health, was an influential proponent of the task force's proposal and believed that in twenty-five years, state mental hospitals in their then-existent form would be replaced by specialized care and treatment institutions. GROB ET AL., *supra* note 8, at 20, 37.

[13] John F. Kennedy, *Message from the President of the United States Relative to Mental Illness and Mental Retardation*, 120 AM. J. PSYCHIATRY 729, 729 (1964).

[14] *Id.* at 730.

[15] *Id.* at 731.

[16] *Id.*

[17] PETE EARLEY, CRAZY: A FATHER'S SEARCH THROUGH AMERICA'S MENTAL HEALTH MADNESS 69, 71 (2007); Amy Carter, *Fixing Florida's Mental Health Courts: Addressing the Needs of the Mentally Ill by Moving Away from Criminalization to Investing in Community Mental Health*, 10 J.L. SOC'Y 1, 6 (2009) (noting that Kennedy authorized three billion dollars under the Act).

[18] *See* LEVINE, *supra* note 2, at 84, 92.

[19] DE YOUNG, *supra* note 2, at 122–23.

[20] GROB ET AL., *supra* note 8, at 15 ("Between 1955 and 2000 the number of patients in American public mental hospitals declined from a high of 558,000 to 55,000."); Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 CARDOZO L. REV. 1, 8–10 (2012) ("[S]tates have closed hundreds of their institutions, and they have downsized many others.").

[21] GROB ET AL., *supra* note 8, at 14–15.

Income (SSI), and pharmaceutical companies' marketing of purported miracle antipsychotic drugs, principally Thorazine.[22] In addition, a patients' rights movement, corresponding with the filing of "right to treatment" cases against states, prompted legislatures and courts to favor treating individuals with mental illness in the "least restrictive" environment.[23] These legal developments led to further reductions in the number of state mental hospital patients.[24]

Then, in the early 1980s, attempts to renew efforts to provide federal funding for community mental health services failed.[25] Deinstitutionalization led to widespread homelessness and what has been called "transinstitutionalization"[26]: instead of ending up in the least restrictive environment, many individuals with mental illness ended up in the most restrictive environment—behind bars.[27] Former asylum patients were arrested up to three times as much as members of the general population,[28] indicating that as more individuals were released from asylums, more of them were also being incarcerated.[29]

Today, individuals with mental illness still heavily populate prisons and jails.[30] Whereas state mental hospitals were once the largest providers of mental health services,[31] jails and prisons now function as de facto mental hospitals and are the largest providers of mental health services.[32] Unfortunately, those who are incarcerated are unlikely to receive adequate

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[22] DE YOUNG, *supra* note 2, at 118–19 (describing how federal Medicaid and SSI programs, in addition to development of psychotropic medications, served as financial incentives for states to accelerate deinstitutionalization); SANDRA J. JOHNSON, ASSERTIVE COMMUNITY TREATMENT: EVIDENCE-BASED PRACTICE OR MANAGED RECOVERY 26 (2011).

[23] ERICKSON ET AL., *supra* note 10; Aubrey L. Cunningham, Comment, *Toward a System of Least Restrictive Care:* Brown v. Plata *and the Eighth Amendment Right to Adequate Mental Health Care for the Incarcerated*, 56 HOW. L.J. 253, 257 (2012).

[24] Carter, *supra* note 17, at 7.

[25] GROB ET AL., *supra* note 8, at 114–16.

[26] Allegra M. McLeod, *Decarceration Courts: Possibilities and Perils of a Shifting Criminal Law*, 100 GEO. L.J. 1587, 1638 (2012).

[27] *Id.*

[28] White et al., *supra* note 1, at 124.

[29] George B. Palermo, Maurice B. Smith & Frank J. Liska, *Jails Versus Mental Hospitals: A Social Dilemma*, 35 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 97, 103 (1991).

[30] Ursula Castellano & Leon Anderson, *Mental Health Courts in America: Promise and Challenges*, 57 AM. BEHAV. SCIENTIST 163, 164 (2012) (noting that an estimated sixteen percent of inmates suffer from severe mental illness); White et al., *supra* note 1, at 124.

[31] Petrila et al., *supra* note 1, at 43.

[32] Garner et al., *supra* note 3.

treatment.[33]

While there are higher proportions of individuals with mental illness in jails than in prisons or the general population,[34] most jails lack sufficient staff for even basic screening or crisis intervention.[35] Inmates with mental illness often experience unreasonable delays in their requests for mental health care, including mental health examinations.[36] This raises legal issues about inmates' constitutional rights to health care, which the United States Supreme Court addressed in *Estelle v. Gamble* in 1973.[37] In its decision in *Estelle*, the Court emphasized three basic constitutional rights guaranteed to inmates: the right of access to care, the right to care that is ordered, and the right to professional medical judgment.[38] It also held that "deliberate indifference" to inmates' serious medical needs was "cruel and unusual" under the Eighth Amendment.[39] Since *Estelle*, circuit courts have considered treatment of mental illness a serious medical need.[40] Nevertheless, treatment behind bars remains subpar.[41]

Inadequate care for inmates with mental illness has unfortunate consequences. The longer inmates with mental illness are left untreated, the more likely they are to violate prison and jail rules and be held responsible for their violations.[42] The higher rates of noncompliance by

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[33] Alina Perez, Steven Leifman & Ana Estrada, *Reversing the Criminalization of Mental Illness*, 49 CRIME & DELINQ. 62, 65 (2003).

[34] Linda A. Teplin & James Swartz, *Screening for Severe Mental Disorder in Jails: The Development of the Referral Decision Scale*, 13 LAW & HUM. BEHAV. 1, 2 (1989).

[35] Allison D. Redlich, Siyu Liu, Henry J. Steadman, Lisa Callahan & Pamela C. Robbins, *Is Diversion Swift?: Comparing Mental Health Court and Traditional Court Processing*, 39 CRIM. JUST. & BEHAV. 420, 421 (2012).

[36] ERICKSON ET AL., *supra* note 10, at 41.

[37] *See generally* Estelle v. Gamble, 429 U.S. 97 (1976) (holding that the government has an obligation to provide medical care to inmates).

[38] *Id.* at 101–05.

[39] *Id.*

[40] *See, e.g.*, Hall v. Ryan, 957 F.2d 402, 404–05 (7th Cir. 1992) (recognizing that the "deliberate indifference" standard applies to jail detainees suffering from mental illness); Langley v. Coughlin, 888 F.2d 252, 254 (2d Cir. 1989) ("[F]rom the legal standpoint psychiatric or mental health care is an integral part of medical care."); Ohlinger v. Watson, 652 F.2d 775, 778 (9th Cir. 1980) (holding that inmates with mental illness are constitutionally entitled to "such individual treatment as will give each of them a realistic opportunity to be cured or to improve his mental condition" (citing Wyatt v. Stickney, 325 F. Supp. 781, 784 (M.D. Ala. 1971))).

[41] Perez et al., *supra* note 33.

[42] ERICKSON ET AL., *supra* note 10, at 41; *see also* DORIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 10 (2006), *available at* http://www.bjs.gov/index.cfm?ty=pbdetail&iid=789.

inmates with mental illness is a potential explanation as to why, on average, they spend longer periods of time behind bars than other inmates.[43] In light of evidence that many inmates with mental illness are responsive to treatment,[44] the inadequate treatment they receive becomes even more intolerable.

Treatment issues aside, individuals with mental illness are likely to be victimized within the criminal justice system in other ways. For instance, in police interrogations, individuals with mental illness are more likely to confess to crimes they did not commit, resulting in wrongful convictions.[45] Inmates with mental illness, especially those suffering from schizophrenia and bipolar disorder, are also significantly more likely to be sexually assaulted than are members of the general prison population.[46] And even once released from incarceration, these individuals are often stigmatized by their "criminal record and the resulting denial of housing or employment or treatment services—even if charges are dropped."[47]

Individuals with mental illness are also more likely to be victims of crimes themselves.[48] Not only is victimization a contributing cause of mental illness;[49] in addition, given their vulnerabilities, individuals diagnosed with mental illness have been shown to fall victim to violent crimes two-and-a-half times more often than do members of the general

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[43] *See* JAMES ET AL., *supra* note 42, at 8–9. Another potential explanation is that public servants are reluctant to release them. EARLEY, *supra* note 17, at 55.

[44] Liesel J. Danjczek, *The Mentally Ill Offender Treatment and Crime Reduction Act and Its Inappropriate Non-Violent Offender Limitation*, 24 J. CONTEMP. HEALTH L. & POL'Y 69, 77 (2007).

[45] ERICKSON ET AL., *supra* note 10, at 178–79.

[46] Nancy Wolff, Cynthia L. Blitz & Jing Shi, *Rates of Sexual Victimization in Prison for Inmates with and Without Mental Disorders*, 58 PSYCHIATRIC SERVICES 1087, 1089–92 (2007) (noting a study where 1 in 12 male inmates with mental illness reported having been sexually victimized at least once over a six-month period versus 1 in 33 male inmates without mental illness, and noting that there were higher rates of victimization as between female inmates with mental illness versus male inmates with mental illness regardless of race or ethnicity).

[47] JUDGE DAVID L. BAZELON CTR. FOR MENTAL HEALTH LAW, CRIMINALIZATION OF PEOPLE WITH MENTAL ILLNESSES: THE ROLE OF MENTAL HEALTH COURTS IN SYSTEM REFORM 2 (2003) [hereinafter BAZELON], *available at* http://www.floridatac.org/files/document/mentalhealthcourts.pdf.

[48] For instance, suffering childhood abuse may be more prevalent among individuals with mental illness. Nahama Broner, Stacy S. Lamon, Damon W. Mayrl & Martin G. Karopkin, *Arrested Adults Awaiting Arraignment: Mental Health, Substance Abuse, and Criminal Justice Characteristics and Needs*, 30 FORDHAM URB. L.J. 663, 700 (2003).

[49] BAZELON, *supra* note 47, at 18–19 (noting that abuse is a risk factor for psychiatric disorders and, likewise, psychiatric disorders are risk factors for criminal victimization).

population.[50] These patterns suggest that individuals with mental illness have been and still are victimized in society, while also carrying personal histories and susceptibilities that heighten their need for community-based treatment over incarceration.

B. ANALOGIZING VICTIMIZATION OF INDIVIDUALS WITH MENTAL ILLNESS WITH PUNISHMENT OF STATUS CRIMES

In many senses, the criminalization of mental illness is comparable to the punishment of status crimes, crimes that are based on an individual's status or a quality that cannot be avoided.[51] As such, status crimes represent crimes of "being," not crimes of "doing."[52] *Robinson v. California* is an early case that established that punishing an individual for a status crime, specifically drug addiction, is unconstitutional.[53] The majority compared drug addiction to mental illness, noting:

> It is unlikely that any State at this moment in history would attempt to make it a criminal offense for a person to be mentally ill . . . a law which made a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments.[54]

By suggesting that mental illness should be treated as an illness, not punished as a crime, *Robinson* supports the contention that individuals with mental illness should be diverted from the criminal justice system as early as possible, perhaps during the pre-booking stage, if not altogether.[55]

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[50] Virginia Aldigé Hiday, Marvin S. Swartz, Jeffrey W. Swanson, Randy Borum & Ryan Wagner, *Criminal Victimization of Persons with Severe Mental Illness*, *in* ISSUES IN COMMUNITY TREATMENT OF MENTAL ILLNESS: A COMPENDIUM OF ARTICLES FROM PSYCHIATRIC SERVICES 18, 21–22 (1999).

[51] *See* Walter W. Steele, Jr., *The Status of Status Crime*, 52 JUDICATURE 18, 18 (1968).

[52] *See id.*

[53] *See generally* Robinson v. California, 370 U.S. 660 (1962) (holding that criminalizing the status of drug addiction inflicted cruel and unusual punishment and was therefore unconstitutional). Scholars have suggested that *Robinson* used the Eighth Amendment to decriminalize drug addiction, since the Court felt that addiction should be treated as an illness, not as a crime. *See* J. Michael McWilliams, *"Cruel and Unusual Punishments": Use and Misuse of the Eighth Amendment*, 53 A.B.A. J. 451, 453 (1967). Furthermore, this "disease model of addiction" was a main principle underlying decisions granted by drug courts, which were established in the 1990s. Eric J. Miller, *Embracing Addiction: Drug Courts and the False Promise of Judicial Interventionism*, 65 OHIO ST. L.J. 1479, 1481, 1518 (2004).

[54] *Robinson*, 370 U.S. at 666.

[55] Allison D. Redlich, Henry J. Steadman, John Monahan, Pamela Clark Robbins & John Petrila, *Patterns of Practice in Mental Health Courts: A National Survey*, 30 LAW & HUM. BEHAV. 347, 350 (2006).

Following *Robinson*, two cases considered how an individual's condition could make the violation of certain laws inevitable and should not be considered as a basis for punishment. In concurring with *Powell v. Texas*, Justice White stated that chronic alcoholics may find themselves on the streets:

> [N]ot because their disease compels them to be there, but because, drunk or sober, they have no place else to go and no place else to be when they are drinking. . . . For some of these alcoholics I would think a showing could be made that resisting drunkenness is impossible and that avoiding public places when intoxicated is also impossible.[56]

Thus, while the public drunkenness of the chronic alcoholic defendant in *Powell* was considered inexcusable since he had a home,[57] a chronic alcoholic who is homeless cannot avoid being drunk in public. The plight of such a chronic alcoholic is analogous to the criminalization of a homeless individual with mental illness, as the many mentally ill individuals who are homeless[58] cannot avoid certain public behaviors. Many individuals with mental illness are "incarcerated because they displayed in public the symptoms of untreated mental illness."[59] Their offenses may include hallucinations, suicidal tendencies, or "acting out,"[60] characteristics these individuals may be unable to avoid displaying in public, especially if they lack local resources and familial ties.[61] As such, punishing individuals for unavoidable mental health offenses can be perceived as cruel and unusual.

More recently, in *Jones v. City of Los Angeles*, the Ninth Circuit held

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[56] Powell v. Texas, 392 U.S. 514, 551 (1968) (White, J., concurring).

[57] *Id.* at 553.

[58] *See* EARLEY, *supra* note 17, at 134 (describing a study finding that all of Miami's chronic homeless had mental illness, and that "*[e]very one of them* had been arrested and jailed at some point" (emphasis added)).

[59] James Ridgeway & Jean Casella, *Locking Down the Mentally Ill*, CRIME REPORT (Feb. 17, 2010, 12:06 AM), http://www.thecrimereport.org/viewpoints/locking-down-the-mentally-ill (quoting a report from the Health Services for the Council of State Governments Justice Center's (CSG) Criminal Justice/Mental Health Consensus Project in 2002).

[60] NAT'L ALLIANCE FOR THE MENTALLY ILL & PUB. CITIZEN'S HEALTH RESEARCH GRP., CRIMINALIZING THE SERIOUSLY MENTALLY ILL: THE ABUSE OF JAILS AS MENTAL HOSPITALS 19–20 (E. Fuller Torrey et al. eds., 1992) [hereinafter ABUSE OF JAILS].

[61] *See Helping Mentally Ill People Break the Cycle of Jail and Homelessness: The Thresholds, State, County, Collaborative Jail Linkage Project, Chicago*, 52 PSYCHIATRIC SERVICES 1380, 1381 (2001) [hereinafter *Thresholds*], *available at* http://ajp.psychiatryonline.org/data/Journals/PSS/3578/1380.pdf ("With cuts in health care and public assistance in recent years for people with low incomes, people with mental illnesses are more likely to end up on the streets.").

that a Los Angeles city ordinance prohibiting individuals from sitting, lying, or sleeping on sidewalks and streets could not be enforced against homeless individuals because it was inevitable that violations would occur.[62] The court determined that violations were inevitable because the number of homeless individuals in Los Angeles far exceeded the number of shelter beds available, forcing many individuals to sleep on sidewalks.[63] Further, thirty-three to fifty percent of the city's homeless suffered from mental illness, increasing the likelihood that these individuals would find themselves on the streets involuntarily and in violation of the ordinance.[64] Indeed, individuals with mental illness do not have sufficient community service resources available to them, making it inevitable that some of them will commit certain crimes, such as, at the very least, trespassing or disorderly conduct.[65]

In sum, it can be inferred from the case law protecting homeless individuals, that criminalization of mental illness is symptomatic of a lack of available treatment, just as the "crime" of sleeping in the street is symptomatic of a lack of shelter beds. Many offenders with mental illness are not necessarily at fault for their "criminal" acts or even able to control themselves without proper help. Thus, MHCs, rather than incarceration, are perhaps the best legal construct to address the complexities of these cases.

III. DIVERSION THROUGH MENTAL HEALTH COURTS

The solution to the victimization of individuals with mental illness within the criminal justice system is to divert offenders with mental illness from jails and prisons to community treatment systems. In a jail-diversion system, inmates are diverted into a mental health services system after being identified as a candidate for diversion.[66] Immediate diversion is particularly critical for an individual in the early stages of a severe, but treatable, mental illness, because eighty percent of individuals with mental

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[62] Jones v. City of Los Angeles, 444 F.3d 1118, 1123–25 (9th Cir. 2006), *vacated*, 505 F.3d 1006 (9th Cir. 2007) (citing the Los Angeles Municipal Code section 41.18(d), which read: "No person shall sit, lie, or sleep in or upon any street, sidewalk or other public way.").

[63] *Id.* at 1122–23.

[64] *See id.* at 1123.

[65] BAZELON, *supra* note 47, at 10; ABUSE OF JAILS, *supra* note 60, at 19.

[66] *See* Allison D. Redlich & Karen J. Cusack, *Mental Health Treatment in Criminal Justice Settings*, *in* MENTAL HEALTH SERVICES: A PUBLIC HEALTH PERSPECTIVE 421, 427 (Bruce Lubotsky Levin et al. eds., 3d ed. 2010).

illness can be helped with medication.[67] With sufficient early treatment, success rates are comparable to recovery rates from common surgery.[68] An added benefit of immediate diversion is its cost-effectiveness, since it averts the expenses of imprisonment and trial.[69]

MHCs, as a form of diversion, have successfully reduced re-arrest rates.[70] Like drug courts before them,[71] MHCs are problem-solving courts.[72] However, unlike drug courts, MHCs lack a uniform format,[73] and are thus more difficult to study. MHCs are part of the therapeutic jurisprudence movement,[74] favoring a non-adversarial approach by a judge-led, multidisciplinary team.[75] These courts are founded on the belief that jail should be "the social service system of last resort" for offenders with mental illness.[76] MHCs have grown greatly since their inception; as

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[67] EARLEY, *supra* note 17, at 358.

[68] John E. Cummings, *The Cost of Crazy: How Therapeutic Jurisprudence and Mental Health Courts Lower Incarceration Costs, Reduce Recidivism, and Improve Public Safety*, 56 LOY. L. REV. 279, 287 (2010) (citing Stephen Allen, *Mental Health Treatment and the Criminal Justice System*, 4 J. HEALTH & BIOMEDICAL L. 153, 166 (2008)).

[69] JOHN BRAITHWAITE, RESTORATIVE JUSTICE & RESPONSIVE REGULATION 125 (2002).

[70] Marlee E. Moore & Virginia Aldigé Hiday, *Mental Health Court Outcomes: A Comparison of Re-Arrest and Re-Arrest Severity Between Mental Health Court and Traditional Court Participants*, 30 LAW & HUM. BEHAV. 659, 666–70 (2006) (finding that the re-arrest rate among MHC offenders was about half that of traditional court offenders).

[71] *See generally* Arthur J. Lurigio, Amy Watson, Daniel J. Luchins & Patricia Hanrahan, *Therapeutic Jurisprudence in Action: Specialized Courts for the Mentally Ill*, 84 JUDICATURE 184, 185–86 (2001) (summarizing the history of drug treatment courts).

[72] *See generally* HOPE GLASSBERG & ELIZABETH DODD, COUNCIL ST. GOV'TS JUST. CTR., A GUIDE TO THE ROLE OF CRIME VICTIMS IN MENTAL HEALTH COURTS (2008), *available at* http://csgjusticecenter.org/wp-content/uploads/2012/12/guidetocvinmhc.pdf (describing the collaborative setting of MHCs and arguing for more victims' rights policies in this court system).

[73] Castellano et al., *supra* note 30, at 165.

[74] Merith Cosden, Jeffrey K. Ellens, Jeffrey L. Schnell, Yasmeen Yamini-Diouf & Maren M. Wolfe, *Evaluation of a Mental Health Treatment Court with Assertive Community Treatment*, 21 BEHAV. SCI. & L. 415, 416 (2003).

[75] Lisa Callahan, Henry J. Steadman, Sheila Tillman & Roumen Vesselinov, *A Multi-Site Study of the Use of Sanctions and Incentives in Mental Health Courts*, 37 LAW & HUM. BEHAV. 1, 1 (2013). This team should include mental health professionals who can help the judge make decisions concerning diversion. H. Richard Lamb, Linda E. Weinberger & Cynthia Reston-Parham, *Court Intervention to Address the Mental Health Needs of Mentally Ill Offenders*, 47 PSYCHIATRIC SERVICES 275, 278 (1996).

[76] BUREAU OF JUSTICE ASSISTANCE, U.S. DEP'T OF JUSTICE, EMERGING JUDICIAL STRATEGIES FOR THE MENTALLY ILL IN THE CRIMINAL CASELOAD: MENTAL HEALTH COURTS IN FORT LAUDERDALE, SEATTLE, SAN BERNARDINO, AND ANCHORAGE 2 (Apr. 2000) [hereinafter EMERGING JUDICIAL], *available at* https://www.ncjrs.gov/pdffiles1/bja/182504.pdf.

of 2008, there were around 175 MHCs nationwide,[77] and there are now over 300 worldwide.[78]

Nevertheless, MHCs could use improvement. Since funding is limited,[79] MHCs must restrict their focus. Many MHCs conserve resources by focusing on individuals suffering from serious mental illness, namely severe depression, schizophrenia, and bipolar disorder.[80] For newer MHC programs, "widening the net to those offenders with personality disorders would create a number too large to be handled."[81] MHCs can also be more efficient if law enforcement officials are trained to divert certain offenders before they enter the court system.[82] For instance, minor offenders whose offenses, say trespassing or disorderly conduct, are significantly related to mental illness, can be diverted from the criminal justice system directly into community mental health services.[83] This way, MHC resources can be reserved for offenders who have committed acts or have a history that is less appropriate for direct diversion,[84] and for those who have victimized others.[85]

Additionally, since an offender's entry into an MHC constitutes a waiver of the right to a trial, offenders should be informed of their options and understand the consequences thereof, so their waiver is truly voluntary.[86] Informed consent is critical to preventing coercion,

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[77] Emma Schwartz, *Mental Health Courts: How Special Courts Can Serve Justice and Help Mentally Ill Offenders*, U.S. NEWS & WORLD REPORT (Feb. 7, 2008), http://www.usnews.com/news/national/articles/2008/02/07/mental-health-courts.

[78] Kathi R. Trawver & Stephanie L. Rhoades, *Homesteading a Pioneer Mental Health Court: A Judicial Perspective from the Last Frontier*, 57 AM. BEHAV. SCIENTIST 174, 175 (2013); Angela Pownall, *Test for Mental Health Court*, WEST AUSTRALIAN (Nov. 9, 2012, 6:12 AM), http://au.news.yahoo.com/thewest/a/-/breaking/15337829/test-for-mental-health-court/. MHCs will likely expand in the future: a national survey of MHCs revealed that two-thirds of courts surveyed planned to increase the number of clients served. Redlich et al., *supra* note 55, at 357.

[79] *See, e.g.*, Lurigio et al., *supra* note 71, at 189.

[80] Castellano et al., *supra* note 30; Cummings, *supra* note 68, at 296–97.

[81] Cummings, *supra* note 68, at 307–08.

[82] Perez et al., *supra* note 33, at 67 (noting that there is a need to formally train police officers to recognize and handle individuals with mental illness).

[83] BAZELON, *supra* note 47, at 10–11.

[84] *Id.* at 11.

[85] Callahan et al., *supra* note 75, at 7 (noting that MHCs will not necessarily incur greater risk or expense by accepting offenders who committed "personal" crimes—those involving a victim—since individuals with mental illness charged with such crimes tend to be more compliant with court conditions).

[86] Tammy Seltzer, *Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illnesses*, 11 PSYCHOL. PUB. POL'Y &

particularly for offenders with mental illness, who may suffer stress from "being arrested and jailed and nonmedicated"[87] and have a lower capacity to make informed decisions.[88] Thus, it may be preferable to have a competency determination precede an individual's consent to treatment in an MHC context.[89]

Some MHCs have adopted traits from the criminal court system that could potentially impede the successful diversion of applicable candidates from the criminal justice system and increase the criminalization of mental illness. These include the use of a post-adjudicative model, the use of jail as a sanction, the improper use of parole officers, and the encouragement of arrests. The following subparts discuss some of the problems associated with adopting such traits and suggest alternative solutions.

A. POST-ADJUDICATIVE MODELS

Diversion to an MHC can occur either pre- or post-adjudication.[90] Pre-adjudication models divert offenders with mental illness from traditional criminal courts entirely and charges against them are either held or dropped.[91] Post-adjudication models require the offender to enter a guilty plea as a condition of admittance to an MHC.[92] In some MHCs, this guilty plea results in a criminal conviction that remains on the offender's record even after he or she completes treatment.[93] To eliminate any stigma resulting from a conviction and to better ensure MHC participants' success in finding housing and employment, convictions should be automatically expunged after an offender successfully completes a treatment period or plan.[94]

L. 570, 575 (2005).

[87] Allison D. Redlich, *Voluntary, But Knowing and Intelligent? Comprehension in Mental Health Courts*, 11 PSYCHOL. PUB. POL'Y & L. 605, 608 (2005); *see also* Seltzer, *supra* note 86.

[88] Kathleen P. Stafford & Dustin B. Wygant, *The Role of Competency to Stand Trial in Mental Health Courts*, 23 BEHAV. SCI. & L. 245, 247 (2005).

[89] *Id.* at 257 (suggesting that competency determinations are important from a constitutional perspective, but also "to ensure that [offenders] who are too disturbed for mental health court are also diverted from the criminal justice system").

[90] Cummings, *supra* note 68, at 297.

[91] *Id.* at 297–98.

[92] *Id.* at 298.

[93] BAZELON, *supra* note 47, at 10.

[94] The Bazelon Center suggests that guilty pleas should not be required at all because the ability to find housing and employment is "crucial to effective mental health treatment, community tenure and management of a long-term psychiatric disability." *Id.* at 11.

B. JAIL AS A SANCTION

Some newly established MHCs have been more willing to use jail to sanction noncompliance.[95] This could be because newer MHCs often accept individuals with felony charges.[96] For example, one survey found a positive correlation between the number of felons in an MHC and that MHC's use of jail as a sanction.[97] Further, offenders facing drug-related charges receive jail as a sanction more often than those who commit serious personal and property offenses.[98] This suggests that jail sanctions are aimed solely at punishing the drug offense, independent of the offender's mental illness. Regardless, jailing can be very disruptive to medication regimens and increase the risk that the offender will commit suicide or be victimized.[99]

In practice, MHCs use jail as a later, not as a last, resort.[100] However, this Note recommends that MHCs either avoid using jail as a sanction altogether[101] or use it as a sanction of last resort, with "specific protocols" limiting its use to instances of "serious noncompliance."[102] These safeguards are necessary since using jail as a sanction limits the effectiveness of diversion and places diverted offenders back into the criminal justice system.

C. COMMUNITY MONITORING BY PAROLE OFFICERS

One study has suggested that ongoing monitoring of offenders with mental illness can help them achieve positive outcomes.[103] Such monitoring can take several forms. Seventy percent of MHCs monitor

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[95] Allison D. Redlich, Henry J. Steadman, John Monahan, John Petrila & Patricia A. Griffin, *The Second Generation of Mental Health Courts*, 11 PSYCHOL. PUB. POL'Y & L. 527, 535 (2005).

[96] *Id.*

[97] Redlich et al., *supra* note 55, at 355–56.

[98] Callahan et al., *supra* note 75, at 6–7.

[99] Trawver et al., *supra* note 78, at 184.

[100] Redlich et al., *supra* note 95.

[101] For instance, as an alternative to jail, the Nathaniel Project in New York uses intensive treatment for probation violations. BAZELON, *supra* note 47, at 12.

[102] MICHAEL THOMPSON, FRED OSHER & DENISE TOMASINI-JOSHI, COUNCIL STATE GOV'TS JUSTICE CTR., IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESSES: THE ESSENTIAL ELEMENTS OF A MENTAL HEALTH COURT 9 (2008), *available at* http://csgjusticecenter.org/wp-content/uploads/2012/12/mhc-essential-elements.pdf (suggesting that sanctions "should be imposed with great care" if needed).

[103] Lamb et al., *supra* note 75.

offenders' treatment upon release into the community using probation officers.[104] However, the use of probation officers is troubling, since many offenders have been sent back to jail for probation violations or for failing to comply with treatment programs.[105] Still, a number of these probation officers predominantly work with offenders with mental illness and receive twenty to forty hours of special training per year, making them more likely to understand how to handle such individuals.[106] Fortunately, an even greater number of MHCs, seventy-nine percent, use mental health professionals, such as case managers, to monitor offenders with mental illness.[107] These numbers—seventy percent parole officers and seventy-nine percent mental health professionals—suggest some overlap in monitoring; in other words, many MHC participants receive the benefit of dual-monitoring by both parole officers and mental health professionals.[108] Ultimately, this means that the vast majority of MHC participants are monitored by individuals with some level of mental health expertise. Such monitoring can enhance the effectiveness of treatment programs by relieving treatment providers of the need to be "the bad guys" and delegating the work to trained professionals.[109]

D. ENCOURAGING ARREST

Police officers may be more inclined to arrest individuals with mental illness if they believe the individuals will get help or be safer if arrested.[110] Ironically, such "mercy arrests"[111] can result if MHC treatment programs

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[104] Redlich et al., *supra* note 55, at 355.

[105] Cosden et al., *supra* note 74, at 425.

[106] SETH J. PRINS & FRED C. OSHER, COUNCIL ST. GOV'TS JUST. CTR., IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESSES: THE ESSENTIAL ELEMENTS OF SPECIALIZED PROBATION INITIATIVES 18–19 (2009), *available at* http://csgjusticecenter.org/wp-content/uploads/2012/12/Improving_Responses_to_People_with_Mental_Illnesses_-_The_Essential_Elements_of_Specialize_Probation_Initiatives.pdf; *see also, e.g.*, SUPERIOR COURT OF CAL., CNTY. OF S.F., BEHAVIORAL HEALTH COURT POLICIES AND PROCEDURES MANUAL 6 (July 2008) [hereinafter S.F. BEHAVIOR HEALTH COURT], *available at* http://www.sfbar.org/forms/lawyerreferrals/ida/BHC_manual.pdf ("A specialized Probation Officer(s) oversees a predominantly or exclusively BHC caseload.").

[107] Redlich et al., *supra* note 55, at 355, 358.

[108] *Id.*

[109] Trawver et al., *supra* note 78, at 182–83.

[110] BAZELON, *supra* note 47, at 15 ("There is an inherent risk that any court-based diversion program, if not accompanied by such reforms and an effective pre-booking diversion program, might lead law enforcement officers to arrest someone with a mental illness with the expectation that this will lead to the provision of services.").

[111] *See, e.g.*, EARLEY, *supra* note 17, at 50.

are more comprehensive than the services these individuals can access in their own communities.[112] Further, "police officers may find it easier to process someone through the criminal justice system than . . . the public mental health system."[113] As a result, many people diverted into MHCs "are people who should not have been arrested in the first place."[114] For example, in one case, when the offender, a woman with schizophrenia, screamed at and shoved a seventy-five year old woman, the victim said she was not hurt and did not want her attacker arrested.[115] However, the victim relented after police officers assured her that her attacker would be sent to a hospital instead of a jail,[116] not realizing her offender would ultimately receive a mandatory sentence because the assault was her third strike.[117] In another example of a mercy arrest gone wrong, a schizophrenic man, initially arrested for trespass, punched an officer who came to release him from jail, resulting in a felony assault charge.[118]

The practice of mercy arrests may explain why individuals "with severe mental illness are jailed more often than hospitalized."[119] To avoid the inefficiencies of using mercy arrests for minor offenses, police officers should be trained to identify mental illness and divert mentally ill offenders directly to community services, particularly if they have committed mere "status crimes."[120] Moreover, such services should be made accessible to all individuals with mental illness, not just to those who come in contact with police officers.[121] If arrestees receive privileged access to desirable resources, such as housing and vocational training,

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[112] *See* BAZELON, *supra* note 47, at 15 (finding that seventy percent of MHCs had access to some services beyond those offered by the mental health system).

[113] *Id.* at 2.

[114] *Id.* at 3.

[115] EARLEY, *supra* note 17, at 176–77.

[116] *Id.*

[117] *Id.* at 177–78, 181–82. For much of her sentence, the woman was shuffled between jail, court, and the hospital to be made "competent" for trial, to no avail.

[118] *Id.* at 49–50.

[119] Joseph Morrissey, Piper Meyer & Gary Cuddeback, *Extending Assertive Community Treatment to Criminal Justice Settings: Origins, Current Evidence, and Future Directions*, 43 COMMUNITY MENTAL HEALTH J. 527, 532 (2007).

[120] BAZELON, *supra* note 47, at 6 ("Effective police diversion programs that prevent arrest for minor offenses and lead instead to services and supports are the first step . . . ."); Petrila, *supra* note 1, at 59 ("Some communities have created the capacity to assess individuals who may have a mental illness *before* they are arrested." (emphasis added)).

[121] BAZELON, *supra* note 47, at 4, 6, 15 (suggesting that services should be accessible to everyone and that doing so will "inevitably reduce the number of incidents between individuals with mental illnesses and law enforcement and justice systems").

more people may feel inclined to seek out arrest in hopes of obtaining such resources.[122] Increasing and publicizing the availability of community treatment resources would decrease the appeal of mercy arrests to both police officers and individuals with mental illness.

IV. USING MENTAL HEALTH COURTS TO RECONNECT OFFENDERS WITH THE COMMUNITY

MHC programs can best reintegrate offenders into the community through community-based services combined with a restorative justice model. Since many MHCs lack sufficient resources,[123] treating individuals with mental illness in community-based settings is much less expensive than housing them and providing mental health services.[124] Similarly, restorative justice processes are more cost-effective than other programs that result in comparable reductions in recidivism.[125]

A. CONNECTING OFFENDERS WITH MENTAL ILLNESS TO COMMUNITY SERVICES

The benefits of connecting mentally ill offenders to community resources may be amplified if they are diverted in the early stages of an illness, when treatment is the most effective.[126] However, since there continues to be a lack of resources for community-based mental health services, MHCs can offer support by forming agreements with community centers to secure treatment services.[127] The following sub-subparts discuss some of the treatment programs that are available to individuals with mental illness.

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[122] E. Lea Johnston, *Theorizing Mental Health Courts*, 89 WASH. U. L. REV. 519, 536 (2012).

[123] Lurigio et al., *supra* note 71, at 189.

[124] DAVID CLOUD & CHELSEA DAVIS, VERA INST. OF JUSTICE, TREATMENT ALTERNATIVES TO INCARCERATION FOR PEOPLE WITH MENTAL HEALTH NEEDS IN THE CRIMINAL JUSTICE SYSTEM: THE COST-SAVINGS IMPLICATIONS 2 (2013), *available at* http://www.vera.org/sites/default/files/resources/downloads/treatment-alternatives-to-incarceration.pdf; *see also* Cummings, *supra* note 68, at 281 (noting that MHC programs can reduce recidivism rates, thereby lowering incarceration rates and saving state and taxpayer dollars).

[125] *See* Paul H. Robinson, *The Virtues of Restorative Processes, the Vices of "Restorative Justice,"* 2003 UTAH L. REV. 375, 376 (2003).

[126] Cummings, *supra* note 68 (citing Allen, *supra* note 68).

[127] Trawver et al., *supra* note 78, at 179.

1. Assertive Community Treatment Programs

MHCs sometimes incorporate Assertive Community Treatment (ACT) programs into their treatment of offenders with mental illness.[128] ACT programs are "evidence-based" programs that originated in response to deinstitutionalization.[129] They typically operate using a "team approach with a small client to case manager ratio; treatment provided where the client lives, with a focus on helping the client obtain their basic needs; and assertive, persistent engagement of weakly motivated clients."[130] One particular ACT/MHC model includes a fifteen-to-one client to case manager ratio, Section 8 housing, vocational training, transportation to meetings, and group substance abuse and community reentry training.[131] Participants in this model are less likely to be convicted of a new crime, but, interestingly, are more likely to be arrested.[132] Fortunately, most of these arrests result from probation violations, not new criminal allegations, and do not result in conviction.[133] The use of jail time as a sanction and the greater scrutiny of participants as opposed to non-participants likely explains why probation violation arrests were so frequent in this model.[134]

Still, ACT programs have "produce[d] specific results consistently and . . . have demonstrated efficacy and cost-effectiveness in securing positive outcomes."[135] Additionally, ACT programs qualify for Medicaid reimbursement and utilize other federal funds like SSI and housing vouchers.[136] Such funding is critical, since many states do not fund MHCs.[137] However, because ACTs rely on a low client to case manager ratio to maximize success, implementing such programs on a broad scale may be challenging. For instance, the Bonneville County MHC in Idaho is particularly limited, in part because it enrolls all of its clients in an ACT program.[138] While few treatment alternatives are as studied as ACT programs,[139] any successful alternative to an ACT program should at least

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[128] JOHNSON, *supra* note 22, at 1–3.

[129] *Id.*

[130] Cosden et al., *supra* note 74.

[131] *Id.* at 420.

[132] *Id.* at 424–35.

[133] *Id.*

[134] *Id.* at 425.

[135] JOHNSON, *supra* note 22, at 2.

[136] *Id.* at 3; Morrissey et al., *supra* note 119, at 529.

[137] Callahan et al., *supra* note 75.

[138] Redlich et al., *supra* note 95, at 531.

[139] *See* JOHNSON, *supra* note 22, at 4 ("ACT represents the most empirically studied

offer "coordinated treatment for both mental illnesses and substance abuse problems."[140]

2. Independent Community Support Systems

Community support systems for offenders with mental illness are fragmented, partly due to "not in my backyard" (NIMBY) sentiments, but also due to a federal restriction called the "sixteen-bed rule," which only allows halfway houses and treatment centers to house up to sixteen patients.[141] Still, successful community support programs do exist. For example, Passageway, a halfway house established in Miami-Dade County, Florida accepts "deeply troubled" offenders responsible for "horrible crimes."[142] Despite opposition to the program's presence in the community, no Passageway client has committed a serious crime against anyone in the area surrounding the facilities.[143] As another example, a Chicago community support program, Thresholds, has bypassed the sixteen-bed rule by securing single room occupancy housing for its participants.[144] Both Passageway and Thresholds only accept residents who voluntarily take medication and stress the importance of social relations for the participants' ultimate success.[145] For instance, Thresholds participants form close relationships with program counselors,[146] and Passageway's founder, Tom Mullen, has said that Passageway is successful because "[w]e *care* about one another. We are a community."[147]

B. MHC-SUPERVISED VICTIM-CENTERED RESTORATIVE JUSTICE AS A SUPPLEMENT TO COMMUNITY SERVICES

Restorative justice focuses on restoring social ties among the victim,

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community mental health approach available.").

[140] THOMPSON ET AL., *supra* note 102, at 6 (noting that the most effective programs provide such treatments).

[141] EARLEY, *supra* note 17, at 320–22; *see also* 42 C.F.R. § 435.1010 (2012) (stating the "sixteen-bed rule," which limits halfway houses and treatment centers to housing up to sixteen patients).

[142] EARLEY, *supra* note 17, at 317, 322.

[143] *Id.* at 323.

[144] *Thresholds*, *supra* note 61.

[145] *Id.*; EARLEY, *supra* note 17, at 323.

[146] *Thresholds*, *supra* note 61.

[147] EARLEY, *supra* note 17, at 318, 341.

the offender, and the community.[148] The centerpiece of restorative justice is a meeting that brings these parties together.[149] Each party is encouraged to invite loved ones, whose opinions, if valued by the offender, can be critical to the success of the meeting.[150] Restorative justice emphasizes "community involvement and citizen engagement,"[151] and supplements community services by contributing to reintegration.[152]

Although restorative justice has not been studied extensively in an MHC context, restorative justice has been successful in the criminal justice context and appears particularly suited to MHCs.[153] Since restorative justice encourages collaboration and problem-solving,[154] and MHCs are problem-solving courts, a seamless integration of the two models seems intuitive. One early study indicated that MHCs "attempt to present a supportive environment in which participants have confidence that they can speak and have their problems addressed."[155] This is just the sort of environment that offenders and victims need to address their concerns and understand each other's victimhood. In contrast, the criminal justice system "in culture and ethos is diametrically opposed to restorative justice."[156] Likewise, MHCs are also incompatible with the criminal justice system, since they divert offenders away from the criminal justice system and are non-adversarial.

1. Modeling Restorative Justice on Two Conceptions of Victimhood

a. Traditional Victims

Many people perceive a victim's desire for vengeance as an

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[148] Gabriel Hallevy, *Therapeutic Victim-Offender Mediation Within the Criminal Justice Process—Sharpening the Evaluation of Personal Potential for Rehabilitation While Righting Wrongs Under the ADR Philosophy*, 16 HARV. NEGOT. L. REV. 65, 73–74 (2011).

[149] DECLAN ROCHE, ACCOUNTABILITY IN RESTORATIVE JUSTICE 2 (2003).

[150] *Id.* at 9–10; *see also* BRAITHWAITE, *supra* note 69, at 26.

[151] CAROLINE G. NICHOLL, U.S. DEP'T OF JUSTICE, TOOLBOX FOR IMPLEMENTING RESTORATIVE JUSTICE AND ADVANCING COMMUNITY POLICING 3 (1999), *available at* http://www.cops.usdoj.gov/pdf/publications/e09990003_web.pdf.

[152] Garner et al., *supra* note 3, at 8.

[153] *Id.* at 7–8, 14.

[154] Ted Watchel & Paul McCold, *Restorative Justice in Everyday Life*, *in* RESTORATIVE JUSTICE AND CIVIL SOCIETY 114, 121 (Heather Strang & John Braithwaite eds., 2001).

[155] EMERGING JUDICIAL, *supra* note 76, at 67.

[156] Charles Pollard, *"If Your Only Tool is a Hammer, All Your Problems Will Look Like Nails,"* *in* RESTORATIVE JUSTICE AND CIVIL SOCIETY 165, 172 (Heather Strang & John Braithwaite eds., 2001).

unbending desire.[157] The victims' rights movement, which resulted in "fixed sentences and the abolition of parole boards in some parts of the [United States],"[158] may have contributed to this perception. But victims do not necessarily desire that their offenders be harshly punished. In restorative justice contexts, some victims "just want the offender to help himself."[159] It is likely that victims will exhibit even greater sympathies when their offenders have mental illness. Take, for example, the case discussed in Part III.D, where the elderly victim only agreed to sign a complaint against her schizophrenic assailant after the police told her that her attacker would be sent to a hospital if arrested.[160] Counseling victims prior to restorative justice meetings and addressing the extent to which the offender's mental illness may have caused the crime can cultivate such sympathies.[161] This will help the victim see the offender as a de facto victim in a restorative justice context, rather than as a criminal.[162]

The impact of restorative justice on the victims of crime has been studied extensively. Restorative justice processes can render victims more levelheaded by lessening post-traumatic stress symptoms and the desire for revenge.[163] Thus, reintegrating victims reintegration into the community may be just as important an objective of restorative justice as the reintegration of offenders reintegration, since restorative justice enables victims to "feel secure again in the community."[164] When victims participate in a restorative justice process, they tend to return to work and resume their lives sooner,[165] which can be beneficial to the economy.

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[157] Austin Sarat, *Vengeance, Victims and the Identities of Law*, 6 SOC. & LEGAL STUD. 163, 164 (1997) (describing the victims' rights movement as a "clamor for the return of revenge").

[158] Heather Strang, *The Crime Victim Movement as a Force in Civil Society*, *in* RESTORATIVE JUSTICE AND CIVIL SOCIETY 69, 74 (Heather Strang & John Braithwaite eds., 2001) (citation omitted).

[159] Lawrence W. Sherman & Heather Strang, *Restorative Justice: The Evidence*, RESTORATIVE JUST. ONLINE 39 (2007), http://www.restorativejustice.org/10fulltext/restorative-justice-the-evidence.

[160] *See also* EARLEY, *supra* note 17, at 176–77.

[161] Thomas L. Hafemeister, Sharon G. Garner & Veronica E. Bath, *Forging Links and Renewing Ties: Applying the Principles of Restorative and Procedural Justice to Better Respond to Criminal Offenders with a Mental Disorder*, 60 BUFF. L. REV. 147, 211–12 (2012).

[162] *See id.*

[163] Sherman et al., *supra* note 159, at 12–13.

[164] Hafemeister et al., *supra* note 161, at 204; *see also* Barton Poulson, *A Third Voice: A Review of Empirical Research on the Psychological Outcomes of Restorative Justice*, 2003 UTAH L. REV. 167, 196–97 (2003) (finding that victims who underwent a restorative justice process, as opposed to a criminal justice process, were one-third less likely to fear re-victimization).

[165] Sherman et al., *supra* note 159, at 13.

Furthermore, many victims report being highly satisfied with experiences in restorative justice conferences as compared with experiences in the courtroom during the prosecutions of their offenders.[166] By way of such conferences, victims avoid the "verbal mauling" that they might otherwise have to endure during cross-examination.[167] The only time victims appear less satisfied with restorative justice is when a conference fails to happen and a case is forced to go to court.[168]

Finally, the restorative justice process provides a forum for offenders to offer apologies, which can be critical to victim satisfaction. For instance, one study reported that ninety percent of victims felt they deserved an apology.[169] Whereas offenders have little opportunity to apologize or make amends in the criminal justice system,[170] eighty-six percent of victims who underwent a restorative justice conference said they received an apology.[171] Offenders are nearly seven times more likely to apologize in a restorative justice context than in court.[172] Apologies also seem to reduce recidivism.[173] In the four years after apologizing to their victims, offenders proved three times less likely to be convicted of another crime than offenders who did not apologize.[174]

Nonetheless, a restorative justice process may be more effective if it reaches beyond what the criminal justice system traditionally considers victims, and involves affected family members and friends along with people like judges, police, teachers, and social workers.[175] The presence of any family members who will care for the offender upon release can be particularly important, since family ties can rehabilitate offenders better than institutions.[176] Studies suggest that community placement is successful only if the perspectives of the mentally ill offender, their family members, and the involved clinical staff members are "fully articulated

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[166] *Id.* at 63 (noting that seventy percent of those who experienced a restorative justice conference were satisfied, compared with forty-two percent of those whose cases went to court).

[167] Pollard, *supra* note 156, at 174.

[168] BRAITHWAITE, *supra* note 69, at 46–47 (summarizing the findings from another scholar's review of empirical literature).

[169] Sherman et al., *supra* note 159, at 63.

[170] Pollard, *supra* note 156, at 173.

[171] Sherman et al., *supra* note 159, at 63.

[172] Poulson, *supra* note 164, at 189.

[173] *See* Hafemeister et al., *supra* note 161, at 199.

[174] *Id.*

[175] *See* ROCHE, *supra* note 149.

[176] BRAITHWAITE, *supra* note 69, at 95, 99.

and understood."[177] Restorative justice sessions can provide a forum for such communications to take place and can therefore serve as a basis for successful reintegration.

In spite of all the benefits victims may receive from the restorative justice process, they may still be reluctant to participate. Though some scholars believe it is crucial for victims to participate in the restorative justice process "to confront [an offender] with an authentic account" of the wrongs committed, they also acknowledge that victims should not be coerced into participation and should be free to decline to participate.[178] Coupled with the offender's voluntary consent to the MHC program, as set forth in Part III, this would create a fully voluntary meeting.

b. Offenders with Mental Illness as De Facto Victims

As discussed in Part II, offenders with mental illness who encounter the criminal justice system are frequently victims of their personal histories and of societal history. This model of victimhood would seem to contradict the restorative justice philosophy of holding offenders responsible for their actions.[179] Still, restorative justice seems capable of recognizing the victimhood of such offenders, since restorative justice "condemn[s] the behavior, not the offender."[180] For instance, victim-offender meetings push offenders to change their behavior by exposing them to the harm caused by their acts and inciting feelings of remorse.[181] Since some crimes committed by offenders with mental illness are better explained by a lack of proper treatment than a lack of morals,[182] the remorse that these offenders may experience during the restorative justice process may prompt them to control their illness by cooperating with medication and treatment plans.

Offenders who participate in victim-offender meetings are also "more likely to find jobs, pursue educational goals, and partner with community

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[177] Heather L. Holley, Phyllis Hodges & Betty Jeffers, *Moving Psychiatric Patients from Hospital to Community: Views of Patients, Providers, and Families*, 49 PSYCHIATRIC SERVICES 513, 514 (1998).

[178] R.A. Duff & S.E. Marshall, *Communicative Punishment and the Role of the Victim*, 23 CRIM. JUST. ETHICS 39, 47–48 (2004).

[179] *See* Robert F. Schopp, *Integrating Restorative Justice and Therapeutic Jurisprudence*, 67 REV. JUR. U.P.R. 665, 668 (1998).

[180] NICHOLL, *supra* note 151, at 10; *see also* Watchel et al., *supra* note 154 ("Restorative justice approaches . . . acknowledg[e] the intrinsic worth of the wrongdoer.").

[181] NICHOLL, *supra* note 151, at 13–14.

[182] *See supra* Parts II.A–B.

members."[183] Thus, restorative justice can help offenders with mental illness become productive members of their communities. Additionally, offenders respond more positively to processes they perceive as fair, and they generally perceive victim-offender meetings as fair, especially when compared to court proceedings.[184] A fair process can create a ripple effect whereby "procedural fairness by authorities quite strongly increases trust in authorities, and trust in authorities in turn has considerable effects in increasing identification with one's community and society and ultimately participation in the community."[185] Offenders with mental illness, in particular, may be more responsive to such fairness.[186]

It may be more difficult to conceive of mentally ill offenders as victims if their crimes are very serious or are driven by factors other than their illness. Still, restorative justice programs led by MHCs may be well suited to handle complex cases like that of a felony offender whose crime resulted from a combination of criminal motives, drug abuse, and mental illness.[187] Indeed, some MHCs already aim to address both drug abuse and mental illness.[188] Scholars have also suggested that restorative justice may have a greater impact in reducing recidivism when used to address serious crimes.[189] Ultimately, however, the goal of MHCs is community reentry. Thus, MHCs should consider excluding those charged with murder or serious sex offenses,[190] since such offenders are less likely to be accepted into the community, regardless of the extent to which their illness contributed to their acts.

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[183] Hafemeister et al., *supra* note 161, at 199.

[184] BRAITHWAITE, *supra* note 69, at 54; *see also* Poulson, *supra* note 164, at 178–79 (stating that offenders who participated in restorative justice programs were twice as likely to perceive the criminal justice system as fair, compared to those involved in court proceedings).

[185] BRAITHWAITE, *supra* note 69, at 67.

[186] Sarah Kopelovich, Philip Yanos, Christina Pratt & Joshua Koerner, *Procedural Justice in Mental Health Courts: Judicial Practices, Participant Perceptions, and Outcomes Related to Mental Health Recovery*, 36 INT'L J.L. & PSYCHIATRY 113, 113 (2013).

[187] Castellano et al., *supra* note 30, at 165 (noting that there are some MHCs that address both drug abuse and mental illness); Trawver et al., *supra* note 78, at 180–81.

[188] *See* Castellano et al., *supra* note 30, at 165.

[189] Sherman et al., *supra* note 159, at 68; *see also* Johnston, *supra* note 122, at 566 (explaining that treating offenders' mental illness could help to reduce recidivism, even among those who have committed violent crimes).

[190] The San Francisco County MHC, for instance, bars those charged with murder or sex offenses from its program. S.F. BEHAVIOR HEALTH COURT, *supra* note 106, at 3.

2. Integrating Restorative Justice into the MHC Process

Having a team of people dedicated solely to restorative justice can help bring victims and offenders together more effectively than existing agencies that are already stretched thin.[191] These teams can include legal and mental health professionals as well as administrative support staff to help expedite and provide support at various stages of the restorative justice process. For instance, to ensure earlier screening and diversion, many propose that intake staff at local jails be trained to identify the signs of various mental illnesses.[192] Others propose that police be trained to facilitate pre-booking diversion.[193] Streamlining the process is important, since delaying the restorative justice session may make the offending act so "distant in time as to make recovery relatively unlikely, as well as diminish the ability of the parties to sufficiently recall the relevant underlying events and circumstances to engage in the needed exchange of information."[194]

Nevertheless, there are a number of reasons why a victim-offender meeting cannot occur right after the offending act. The United Nations and other authorities suggest that the parties should agree to meet voluntarily.[195] Parts III and IV.B.1.a. above explain some of the justifications for voluntariness. Both parties must also be mentally prepared to meet, since the victim may be emotional, and the offender may need additional treatment.[196] If the offender's mental illness symptoms are not under control by the time of the restorative justice meeting, it could cause the meeting to fail[197] and "compound the victim's suffering."[198]

The offender's competence may be another hurdle MHCs must overcome before commencing a victim-offender meeting. A defendant's

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[191] Sherman et al., *supra* note 159, at 36.

[192] Teplin & Swartz, *supra* note 35, at 2–3, 15.

[193] Redlich et al., *supra* note 55.

[194] Hafemeister et al., *supra* note 161, at 211. Diversion candidates tend to be identified by legal and mental health professionals. Stafford et al., *supra* note 88, at 246.

[195] E.S.C. Res. 2000/14, U.N. Doc. E/2000/INF/2/Add.2 at 35 (2000); ROCHE, *supra* note 149, at 121 (discussing the importance of ensuring that victim-offender meetings are voluntary); NICHOLL, *supra* note 151, at 9.

[196] Hafemeister et al., *supra* note 161, at 209–10 (noting that there are some offenders who may not be able to participate because treatment is ineffective).

[197] *Id.*

[198] NICHOLL, *supra* note 151, at 22; *see also* Garner et al., *supra* note 3, at 11 (explaining that an offender's mental illness may cause him or her to exhibit symptoms that could make victims feel frustrated, frightened, and vulnerable).

competence in his or her own criminal trial is "fundamental to an adversary system of justice."[199] Like traditional courts, MHCs hold a "thorough hearing . . . to determine whether a defendant is competent to participate in proceedings."[200] While a traditional courtroom trial of a defendant with a mental illness will not proceed unless an evaluation shows the defendant is competent to stand trial,[201] the MHC/restorative justice competency standard should be higher and should incorporate a determination of whether an offender understands the gravity and the consequences of the act committed.[202] This understanding, or lack thereof, can serve to gauge the offender's rehabilitative potential.[203] An offender who meets this higher standard will likely further the aims of a restorative justice conference.

It may take a while for an offender to achieve this standard, but fortunately, MHCs "have a lengthy assessment and intake process," during which case managers can designate an offender as competent for MHC and restorative justice proceedings.[204] In general, they will look to an offender's admission of his or her own guilt as an early indicator of "competency" for a restorative justice conference,[205] and as mentioned in Part III.A, many MHCs will not admit offenders into their programs without a guilty plea.[206] Nonetheless, this requirement should not deter offenders from choosing restorative justice if they are informed of its benefits, since several studies have shown that offenders without mental illness "readily took responsibility for serious crimes" when presented with restorative justice as an alternative to traditional criminal justice.[207] Still, safeguards should be established to ensure that offenders are fully informed of the consequences of admitting guilt and how that impacts consent to an MHC program.

Once the meeting occurs, however, multiple parties' involvement in forming a plan is critical. MHC judges can facilitate restorative justice sessions, or at least ensure that any agreements reached are fair and

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[199] Drope v. Missouri, 420 U.S. 162, 172 (1975).

[200] Garner et al., *supra* note 3, at 5.

[201] ERICKSON ET AL., *supra* note 10, at 55.

[202] Hallevy, *supra* note 148, at 78.

[203] *Id.* at 90.

[204] *See* Danjczek, *supra* note 44, at 106.

[205] Hallevy, *supra* note 148, at 78.

[206] BAZELON, *supra* note 47, at 10.

[207] Sherman et al., *supra* note 159, at 13.

reasonable.[208] This latter role is particularly important, since victims are typically allowed to interject and have their responses incorporated into a plan of action that is developed during the session.[209] Since victims may either want harsher sanctions or feel pressured to agree to lesser sanctions than would ordinarily apply,[210] a judge's discretion is important. Reaching a plan prior to sentencing could also ensure that the conditions imposed on the offender reflect the victim's and the community's responses to the offense.[211] Finally, the offender's input is just as important, since offenders who voluntarily agree to the terms of the agreement may be more likely to commit to an MHC decision.[212]

Ultimately, restorative justice is about encouraging a dialogue to facilitate the healing of victims, offenders, and communities. Establishing a dialogue between the parties fosters the recognition by each of the others' right "to dignity and appreciation."[213] Restorative justice "breaks down stereotypes about victims, images of monster offenders, and assumptions about apathetic and uncaring communities. People are encouraged to see that others too have strengths and weaknesses—and are human."[214] It is an important process in the MHC context, giving victims the opportunity to begin to understand, and perhaps forgive the offender's action, insofar as it was an involuntary manifestation of the offender's mental illness. For offenders, a focus on "the behavior, not the offender" may also help them rehabilitate themselves.[215]

V. CONCLUSION

Restorative justice is a unique process that initiates a healing process between victims and offenders with mental illness, reconnects these individuals with their communities, and counteracts the stigma and

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[208] *Id.* at 39–42.

[209] BRAITHWAITE, *supra* note 69, at 26.

[210] Hafemeister et al., *supra* note 161, at 217.

[211] Hallevy, *supra* note 148, at 75; *see also* Duff et al., *supra* note 178, at 43 (suggesting that the victim's interpretation of the crime should be evaluated in the context of what is best for the community). These responses may best be determined by a mental health professional or an MHC judge who can objectively comprehend the offender's illness in relation to the crime that was committed.

[212] Redlich, *supra* note 87, at 610, 615; Heathcote W. Wales, Virginia Aldigé Hiday & Bradley Ray, *Procedural Justice and the Mental Health Court Judge's Role in Reducing Recidivism*, 33 INT'L J.L. & PSYCHIATRY 265, 266 (2010).

[213] Hallevy, *supra* note 148, at 87.

[214] NICHOLL, *supra* note 151, at 8.

[215] *See* Hafemeister et al., *supra* note 161, at 204–05.

isolation offenders often face. Its impact on stigma is critical for offenders with mental illness, since stigma can inhibit recovery and negatively affect mental health.[216] Restorative justice sessions can provide a forum for offenders to explain their own victimization and to recognize that their acts stem from their illness, which perpetuated the cycle of victimization. In a restorative justice session, both parties can agree to put an end to this cycle, allowing themselves to move on with a renewed ability to make productive contributions to society.

Although restorative justice must be further studied in an MHC context, it can likely enhance the impact that MHCs have on the communities they serve, making them an influential fixture in society. MHCs can increase understanding and trust among victims, offenders, and community members and reduce recidivism, all of which can begin to undo some of the damage caused by decades of criminalizing mental illness. Thus, combining MHC restorative justice programs with increased funding for community resources and mental health training for police officers can forge a community network similar to that which President Kennedy envisioned in 1963. This network would be based on a solid foundation of caring, relationships, and true understanding within communities. Then, perhaps, individuals with mental illness can transcend their histories of victimization and fully partake in these more enlightened communities, and eventually, in society as a whole.

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[216] Marie Ilic et al., *Belittled, Avoided, Ignored, Denied: Assessing Forms and Consequences of Stigma Experiences of People with Mental Illness*, 35 BASIC & APPLIED SOC. PSYCHOL. 31, 32, 38 (2013).