

DEINSTITUTIONALIZATION, CRIMINALIZATION OF MENTAL ILLNESS, AND THE PRINCIPLE OF THERAPEUTIC JURISPRUDENCE

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I. INTRODUCTION

In 1955, America reached a peak number of patients in state hospitals with approximately 559,000 residents.¹ Between 1965 and 1975, this number plummeted to roughly 200,000.² By 1980, there were fewer than 100,000 state hospital patients in America.³ Today, it is estimated that 35,000 people with mental illness are housed in state hospitals in the America.⁴ This represents a 94% reduction in state hospital patients since the heyday of institutionalization in 1955.

America's declining state hospital population can be attributed to deinstitutionalization. As envisioned, the deinstitutionalization movement sought to establish specialized treatment services for people with mental illness within the community, move persons with mental illnesses out of state hospitals and into community treatment facilities and services, and use such community alternatives to divert those who previously would have been hospitalized from institutionalization.⁵ In theory, deinstitutionalization was a great strategy. Minimizing institutionalization in hospitals would benefit the public, as community mental health treatments would cost less than in a state hospital, and patients would be returned to their communities. Additionally, accountability for treating persons with mental illnesses would be the responsibility of local clinicians instead of the more removed state and federal government authorities.

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1 H. Richard Lamb & Linda E. Weinberger, *The Shift of Psychiatric Inpatient Care from Hospitals to Jails and Prisons*, 33 J. AM. ACAD. PSYCHIATRY LAW, 529, 530 (2005).

2 E. FULLER TORREY, *THE INSANITY OFFENSE: HOW AMERICA'S FAILURE TO TREAT THE SERIOUSLY MENTALLY ILL ENDANGERS ITS CITIZENS*, 3 (1965).

3 PETE EARLEY, *CRAZY: A FATHER'S SEARCH THROUGH AMERICA'S MENTAL HEALTH MADNESS*, 71 (2006).

4 Ana Swanson, *A Shocking Number of Mentally Ill Americans End Up In Prison Instead of Treatment*, WASH. POST, (Apr. 30 2015), <https://www.washingtonpost.com/news/wonk/wp/2015/04/30/a-shocking-number-of-mentally-ill-americans-end-up-in-prisons-instead-of-psychiatric-hospitals/>, (April 30 2015), <https://www.washingtonpost.com/news/wonk/wp/2015/04/30/a-shocking-number-of-mentally-ill-americans-end-up-in-prisons-instead-of-psychiatric-hospitals/>

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

Furthermore, the Community Mental Health Centers Act (CMHC), the last piece of legislation ever signed by President John F. Kennedy, appropriated money for the funding of CMHC; however, the funding was never fully allocated⁶ because within one month of signing CMHC, President Kennedy was assassinated and the funding was needed for the Vietnam War. Without support from the executive branch, a “not in my backyard” (NIMBY) mentality prevailed, where citizens enacted legal barriers and municipal ordinances to halt the establishment of CMHC in their neighborhoods.⁷

Certain goals of the deinstitutionalization movement were realized: the movement of persons with mental illnesses from state hospitals to the community and the diversion of persons with mental illnesses from hospitalization with restrictive civil commitment procedures was put in place. A conjoining of the civil and disability rights movements occurred in which the emphasis for change went beyond racial discrimination to focus on the rights of the disabled. Advocates sought to restrict involuntary hospitalizations unless fully required, and pursued humane conditions in state hospitals via the courts by demanding that patients have a Constitutional right to appropriate treatment.⁸

II. LEGISLATION AND CASES IMPACTING THE DEINSTITUTIONALIZATION MOVEMENT

Legislation and jurisprudence emerged on the periphery of the civil rights era focusing on the civil liberties of persons with mental illnesses due to the lack of proper infrastructure to ensure that people with mental illness are afforded appropriate care when reentering their communities. In 1967, California led the way with the Lanterman-Petris-Short Act, which established precedent for other states to modify their civil commitment statutes, making it more difficult to involuntarily hospitalize persons with mental illnesses.⁹ Over time, abuses and horrid conditions in state hospitals were brought to the attention of policymakers by the media and Dorothea

⁶ John Woolley & Gerhard Peters, *John F. Kennedy XXXV President of the United States: 1961-1963*, 50 – *Special Message to the Congress on Mental Illness and Mental Retardation*, AM.American PRESIDENCY PROJECT (Feb. February 5, 1963), <http://www.presidency.ucsb.edu/ws?pid=9546>; See also Associated Press, *Kennedy's Vision for Mental Health Never Realized*, USA TODAY (Oct. (October 20, 2013, 2:47 PM), www.usatoday.com/story/news/nation/2013/10/20/kennedys-vision-mental-health/3100001/.)

⁷ James Gilligan, *The Last Mental Hospital*, 72*last mental hospital*, PSYCHIATRIC Q., 45–77, 47 (2001). See also Judith G. Rabkin, *Criminal Behavior of Discharged Mental Patients: A Critical Appraisal of the Research*, 86 PSYCHOL. BULL.. *Psychological Bulletin*, 1, 1-2 (1979).

⁸ National Council on Independent Living, *About Independent Living*, NCIL (2016), <http://www.ncil.org/about/aboutil/>.

⁹ *Mental Health: What is the Lanterman-Petris-Short Act?*, ? SUPER.Superior CT. OF CAL., L.A. California, CTY. CT., <http://www.lacourt.org/division/mentalhealth/MH0017.aspx> (last visited Aug. August 11, 2016).

Dix's view of the humane asylum was knocked asunder.¹⁰ Thus, there certainly were legitimate reasons for intervention.

The Lanterman-Short-Petris Act governed the involuntary civil commitment procedure in California and provided an example for the rest of the country by requiring that a person be a danger to him/herself, or others, or be gravely disabled, as a direct result of a mental illness, in order to be civilly committed to a mental hospital.¹¹ The Ninth Circuit case of *Doe v. Gallinot* (1981) called for a showing of dangerousness in such commitments; grave disability, the inability to properly care for one's needs with proper food, shelter, and clothing, can be considered a dangerousness criterion, as there is potential harm to oneself if these essential needs are not met.¹²

Rouse v. Cameron (1966) involved a man intent on being found "not guilty by reason of insanity" (NGRI) of a misdemeanor (carrying a weapon). Had Rouse been pronounced guilty, instead of being acquitted, he could have faced a maximum prison sentence of one year. Instead, Rouse was institutionalized in excess of four years in a state hospital. On appeal, Judge David Bazelon established that patients with a mental illness have a right to treatment when indefinitely psychiatrically committed, even if they are a NGRI acquttee. Judge Bazelon indicated that involuntary hospitalization should be for the purpose of treatment, not punishment, and that without treatment, the hospital becomes a prison. Judge Bazelon also specified that assessments of such patients should take place initially and periodically to ensure the design of treatment regimens geared to a particular individual's needs. While he acknowledged that a cure for each patient might not be guaranteed, he maintained that psychiatrists and other medical personnel should rely on current knowledge to ensure a legitimate effort is made to bring about recovery.¹³

Along with the right to treatment, Judge Bazelon believed that care should be offered in the least restrictive setting possible (e.g., in the community instead of an institution, whenever appropriate and available based on the particulars of a case).¹⁴ Having first conceptualized the "right to treatment" standard in *Rouse v. Cameron* (1966), Judge Bazelon extended the standard in a civil commitment case *Lake v. Cameron* (1966). Ms. Lake was a 60-year-old woman with mental illness who was found wandering the streets and was then hospitalized. She was diagnosed with what we now know as dementia. Judge Bazelon determined that with the availability of

10 David A. Zaheer, *Expanding California's Coerced Treatment For The Mentally Ill: Is The Promise Of Caring Treatment In The Community A Lost Hope?*, 10 S. CAL. INTERDIS. L.J. 385, 386 (2001); See Albert Q. Maisel, *Bedlam 1946: Most U.S. Hospitals Ahospitals re a Shame and a Disgrace*. LIFE MAG, 102 (May 4, 1946), <http://www.pbs.org/wgbh/americanexperience/features/primary-resources/lobotomist-bedlam-1946/>. See also MARY JANE WARD, *THE SNAKE PIT* (1946).

11 Carol A. B. Warren, *Involuntary Commitment for Mental Disorder: The Application of California's Lanterman-Petris-Short Act*, 11 LAW & SOC'Y REV. Society Review, 629-649, 629 (Feb. February 1977).

12 Zaheer, *supra* note 10, at 391.

13 *Rouse v. Cameron*, 373 F.2d 451, 456 (D.C. Cir., 1966).

14 Who We Are, JUDGE DAVID L. BAZELON CTR. FOR MENTAL HEALTH LAW, <http://www.bazelon.org/who-we-are.aspx> (last updated 2014).

family members and/or nursing personnel, Ms. Lake could be cared for in a lesser restrictive environment than a hospital, which brings about the complete deprivation of liberty.¹⁵ The Americans with Disabilities Act later incorporated the “least restrictive environment” standard into federal law for consideration.¹⁶

The next right to treatment case was *Wyatt v. Stickney* (1972), and—as indicated in *Wyatt v. Aderholt* (1974)—emerged as the result of a cigarette tax cut that forced the firing of 99 state hospital employees in Alabama.¹⁷ Cigarettes were being taxed in Alabama, and the taxes were being used to pay for state hospitals. When the tax cut took place, the state hospital employees were fired. Much of the citizenry was displeased with such a tax and the purpose for which it was being used. *Wyatt v. Stickney* (1972) was the first time a federal court held that individuals who had been civilly committed involuntarily had a right to treatment.¹⁸

The class-action lawsuit focused almost exclusively on the employees who had been laid off due to budget cuts incurred after the cigarette tax was nixed and was brought against the state mental health director—Stickney. As a strategic move, the plaintiffs’ attorneys had Ricky Wyatt, a nephew of one of the laid off employees, join the class-action lawsuit. The contention was that with these debilitating layoffs, the system would not be able to provide proper care to Wyatt and others like him. Judge Frank Johnson dismissed the former employees’ suit, maintaining that it was not within his purview to interfere with the right of the Alabama Department of Mental Health to lay off its employees. However, Judge Johnson indicated that he would consider the patients’ complaints.¹⁹

Prior to the cuts, when the agency was more properly staffed, there had been a series of horrific incidents reported there. Examples included one young male patient who had his spleen ruptured by having water propelled via a garden hose into his rectum—resulting in death, while another was secured in a strait jacket for nine years to thwart finger sucking. Fifteen-year-old Ricky Wyatt did not even have a mental illness. He was hospitalized in 1969 to make him behave and, though never administered, he was threatened with shock therapy to keep him in line.²⁰

15 Lake v. Cameron, 364 F.2d 657, 660 (D.C. Cir. 1967).

16 Neil S. Butler, *In The Most Appropriate Setting: The Rights of Mentally Disabled Individuals Under the Americans With Disabilities Act in the Wake of Olmstead*, 49 CATH. U. L. REV. 1021, 1036-37 (2000).

17 Wyatt v. Aderholt, 503 F.2d 1305, 1307 (5th Cir.1974).

18 Wyatt v. Stickney, DISABILITY JUSTICE (2016), <http://disabilityjustice.org/wyatt-v-stickney/> (last updated 2016); The U.S. Supreme Court in *Estelle v. Gamble*, 429 U.S. 97, 104-05 (1976) would ultimately hold that inmates had an 8th Amendment right to treatment; in *Bowring v. Godwin*, 351 F.2d 44, 5 (4th Cir. 1977), the 4th Circuit clarified that the right to treatment includes mental illnesses as well as physical illnesses.

19 Wyatt v. Stickney, TREATMENT ADVOC. CTR., <http://www.treatmentadvocacycenter.org/component/content/article/345> (last updated 2016).

20 Lauren Wilson Carr, *Wyatt v. Stickney: A Landmark Decision*, ALA. ALABAMA DISABILITIES ADVOC. ADVOCACY PROGRAM NEWSL., (July, 2004), <http://adap.ua.edu/ricky-wyatt.html>.

After the cuts, there was only one psychiatrist available for every five thousand state hospital patients in Alabama. Attorneys George Dean and Morton Birnbaum argued that the employee shortages were severely harming the quality of hospital care provided and that this constituted a violation of these patients' right to treatment.²¹ Judge Johnson required the State of Alabama authorities to file a report within six months of his ruling.²² However, he was not satisfied with their response at the end of that time period, and he ruled that those civilly committed had the right to what he termed habilitation within the least restrictive means possible. He even commenced to specify requirements for such things as patient showers, toilet facilities, dining quarters, linen service, and housekeeping.²³

When Judge Johnson intervened in Alabama, the state was 50th in expenditures for persons with mental illnesses and developmentally disabled housed in public institutions.²⁴ While there were indeed horrific conditions in Alabama hospitals, the standards set for hospitals by Johnson were essentially unattainable in the face of a depleted operating budget.²⁵ In fact, in Alabama from 1970 to 1975, facing a 377% increase in costs to operate facilities, the state hospital population decreased by almost two-thirds.²⁶ Other states followed suit by decreasing state hospital censuses.²⁷ As such, Wyatt has been criticized for leading the way to massive deinstitutionalization resulting in a lack of treatment for a significant portion of persons with mental illnesses.²⁸

In *O'Connor v. Donaldson* (1975), the U.S. Supreme Court considered for the first time due process requirements with relation to the state's power of "parens patriae" to civilly commit an individual, which was the doctrine that governed involuntary hospitalizations up to that time.²⁹ Parens patriae literally translated means "parent of the country," and refers to the state's responsibility to intervene and protect those who cannot protect themselves—such as children and persons with mental illnesses in crises.³⁰

At the age of forty-eight, Donaldson went from Philadelphia to Florida to visit his parents. While there, he informed his father that he believed that one of his neighbors in Philadelphia was trying to poison him. Donaldson's father sensed that his son was delusional and petitioned the court to consider civil commitment proceedings. Donaldson was not represented by counsel and ended up being committed for over fourteen years to the Florida State

21 TREATMENT ADVOC. ADVOCACY CTR., *supra* note 19.

22 See Wyatt v. Stickney 325 F. Supp 781, 785 (M.D. Ala. 1971).

23 Wyatt v. Stickney, 344 F. Supp. 387, 390, 396-97, 403-05 (M.D. Ala. 1972).

24 Carol A. B. Warren, *supra* note 11.

25 TREATMENT ADVOC. ADVOCACY CTR., *supra* note 19.

26 *Id.*

27 *Id.*

28 *Id.*

29 Paul F. Stavis, Civil Commitment: Past, Present, and Future, Address at the Annual Conference of the National Alliance for the Mentally Ill (July 21, 1995), *reprinted in* TREATMENT ADVOC. CTR.)

30 Suzanne M. Boyce et al., *Developments in Policy: Welfare Reform*, 16 YALE L. & POL'Y REV. 221, 244, 249 (1997).

mental health system. His “treatment” ward held one thousand patients that were only monitored by one doctor, an obstetrician, and a nurse in the infirmary. Several more suitable alternatives for housing/treatment were offered for Donaldson over the years, but the Florida authorities ignored them. Ironically, as Donaldson’s case made its way to the U.S. Supreme Court, he was released and became successfully employed as a hotel clerk.³¹ Upon deciding *O’Connor v. Donaldson*, the U.S. Supreme Court ruled that “[a] State cannot constitutionally confine, without more, a non- dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.”³²

Police detained Alberta Lessard after a reported suicide attempt, and a judge subsequently civilly committed her for treatment, as she was diagnosed with paranoid schizophrenia.³³ Upon initially considering the standard for dangerousness, the court in *Lessard v. Schmidt* held that “the state must bear the burden of proving that there is an extreme likelihood that if the person is not confined he will do immediate harm to himself or others.”³⁴ Also, as noted in *Lessard*, it was determined that “Wisconsin civil commitment procedures did not provide adequate due process rights to those who were committed and ordered... safeguards be instituted, including adequate notice, the right to counsel, availability of the privilege against self-incrimination, and a speedy hearing.”³⁵

Thus, the final decision in *Lessard v. Schmidt* (1976) would further narrow civil commitment standards, changing the view that such decisions should be centered within the medical arena to now being resolved within the police power of the state and quasi-criminal court processes as clients would have procedural protections extended to them.³⁶ While there was slight variation among the states, with the *parens patriae* doctrine restricted, most jurisdictions focused their commitment guidelines on dangerousness to others or to self, often with a grave disability requirement attached.³⁷

III. THE CRIMINALIZATION OF MENTAL ILLNESS

The previously discussed Lanterman-Petris-Short Act was signed into law in 1967 by Governor Ronald Reagan and came into full effect in 1972.³⁸ This legislation was highly popular and actually passed both the House and Senate in California without a dissenting vote. This act preceded several of

31 *O’Connor v. Donaldson – Significance*, LAW.JRANK.ORG, <http://law.jrank.org/pages/24781/O-Connor-v-Donaldson-Significance.html> (last visited Aug. 3, 2016).

32 *O’Connor v. Donaldson*, 422 U.S. 563, 576 (1975).

33 *Lessard v. Schmidt: Eliminating Barriers to the Treatment of Mental Illness*, TREATMENT ADVOC. ADVOCACY CTR., <http://www.treatmentadvocacycenter.org/component/content/article/344> (last visited Aug. 3, 2016).

34 *Lessard v. Schmidt*, 349 F. Supp. 1078, 1093 (E.D. Wis. 1972).

35 *Lessard v. Schmidt*, 413 F. Supp. 1318, 1319 (E.D. Wis. 1976).

36 TREATMENT ADVOCACY CENTER, *supra* note 33.

37 Stavits, *supra* note 29; Meridith Lenell, *The Lanterman-Petris-Short Act: A Review After Ten Years*, 7 GOLDEN GATE U. L. REV., 733, 734 (1977).

38 *Mental Health: What is the Lanterman-Petris-Short Act?, ss? upra* note 9.

the cases discussed above and has even been referred to as the Magna Carta of the mentally ill due to placing restrictive legal limits on the ability to involuntarily hospitalize persons with mental illnesses.³⁹ For example, a study in San Mateo County, California, compared arrest rates from three-and-a-half-years before to four-and-a-half-years after enactment of the Act. The study revealed that arrests of persons with mental illnesses during this time period increased by four-and-one-half-times.⁴⁰ Considering such occurrences associated with implementation of an Act aimed at restricting civil commitment in the name of preserving civil liberties, Abramson was prompted to remark, “It would indeed be ironic if the Magna Carta of the mentally ill ... led to their criminal stigmatization and incarceration in jails and prisons, where little or no mental health treatment is provided.”⁴¹

Without adequate community treatment in place, thousands of persons with severe mental illness, many of whom did not have the ability or resources after years of hospitalization to care for themselves or to seek and obtain treatment, were released into society. State hospitals downsized or closed, resulting in more persons with mental illnesses gravitating to the streets and encountering a society and criminal justice system not equipped to deal with their needs.⁴² Many entered into homelessness, became arrest and incarceration statistics, and some died.⁴³ These mass encounters of persons with mental illnesses leading to arrest (often for minor offenses) and/or imprisonment are referred to as the “criminalization of mentally disordered behavior” and have come to be known as the criminalization of mental illness.⁴⁴ While not everyone is in agreement that deinstitutionalization *caused* the criminalization of mental illness,⁴⁵ evidence indicates that deinstitutionalization was an instrumental factor in bringing about the criminalization of persons with mental illnesses.⁴⁶

Studies show that arrest rates for persons with mental illnesses examined before and after deinstitutionalization are more likely to be arrested after

39 Marc F. Abramson, *The Criminalization of Mentally Disordered Behavior: Possible Side Effect of A New Mental Health Law*, 23. *Hosp. & Community Psychiatry*, 101, 101 (1972).

40 See Larry Sosowsky, *Explaining The Increased Arrest Rate Among Mental Patients: A Cautionary Note*, 137. *AM. J. PSYCHIATRY* 1602 (1980).

41 Abramson *supra* note 39, at 105.

42 Fox Butterfield, *Prisons Replace Hospitals for the Nation's Mentally Ill*, N.Y. TIMES, March 5, 1998, http://www.nytimes.com/1998/03/05/us/asylums-behind-bars-special-report-prisons-replace-hospitals-for-nation-s.html?_f=0; Ken Kerle, *American Jails: Looking to the Future*, (1998).

43 Gilligan, *supra* note 7, at 47.

44 Abramson, *supra* note 39, at 103-104; H. Richard Lamb & Linda E. Weinberger, *Persons with Severe Mental Illness in Jails and Prisons: A Review*, 49 *PSYCHIATRIC SERVICES*, 483, 484 (1998).

45 See WILLIAM H. FISHER, *COMMUNITY BASED INTERVENTIONS FOR CRIMINAL OFFENDERS WITH SEVERE MENTAL ILLNESS* (2003); Michael F. *Impact of Mentally Ill Offenders on the Criminal Justice System: Hearing Before the Subcomm. on Crime of the H. Comm. on the Judiciary*, 106th Cong. (2000) (statement of Michael F. Hogan, Director, Ohio Department of Mental Health) Michael F. Hogan,.

46 See H. Richard Lamb, Linda E. Weinberger & Bruce H. Gross, *Mentally Ill Persons in the Criminal Justice System: Some Perspectives*, 75. *PSYCHIATRIC Q.* 107, 109 (2004); H. Richard Lamb & Linda E. Weinberger, *Persons with Severe Mental Illness in Jails and Prisons: A Review*, 49. *PSYCHIATRIC SERVS.* 483, 483, 487 (1998).

deinstitutionalization than before.⁴⁷ One California study on deinstitutionalization spanning from 1972 to 1975 found that patients with mental illness and no previous arrests were three times more likely than members of the general public to be arrested when released into the community.⁴⁸ Arrests of persons with mental illnesses often tend to be for minor crimes.⁴⁹ In fact, research reveals that persons with mental illness do not commit most acts of violence, and the vast majority of these individuals will never perpetrate a violent act.⁵⁰ Nuisance crimes, such as loitering or trespassing, or subsistence crimes motivated by hunger or hygiene often constitute the reasons persons with mental illnesses come into contact with the police.⁵¹ With no perceived appropriate treatment alternatives in place, the police sometimes resort to what have been termed “mercy bookings.”⁵² The basic motivation for such arrests from the police perspective is at least the person with mental illness will be provided shelter, a bed, a place to shower, and acquire sustenance. Unfortunately, there is no mercy for many persons with mental illnesses locked up in the criminal justice system. Persons with mental illness in custody have been found to be twice as likely as inmates who are not mentally ill to be physically victimized by those in custody and three times as prone to being sexually violated.⁵³ Even their victimization by staff has been found to be higher, both physically and sexually, than that of those in custody without mental illness.⁵⁴

Police may also find it more expedient to use the criminal justice process over that of civil commitment. Police know that medical providers may

47 See Glenn W. Swank & Darryl Winer, *Occurrence of Psychiatric Disorder in a County Jail Population*, 133 AM. J. PSYCHIATRY 1331 (1976); Gary E. Whitmer, *From Hospitals to Jails: The Fate of California's Deinstitutionalized Mentally Ill*, 50 AM. J. ORTHOPSYCHIAT, 65, 65-67 (1980); Edward Guy, Jerome J. Platt, Israel Zwerling & Samuel Bullock, *Mental Health Status of Prisoners in an Urban Jail, Criminal Justice and Behavior*, 12 CRIM. JUST. AND BEHAV. 29 (1985); Linda A. Teplin, *The Prevalence of Severe Mental Disorder Among Male Urban Jail Detainees: Comparison with Epidemiologic Catchment Area Program.*, 80 AM. J. PUB. HEALTH 663, 665-66 (1990).

48 Sosowsky, *supra* note 40.

49 See Robin E. Clark, Susan K. Ricketts & Gregory J. McHugo, *Legal System Involvement and Costs for Persons in Treatment for Severe Mental Illness and Substance Use Disorders*, 50. PSYCHIATRIC SERVS. 641 (1999); Alison Evans Cuellar, Lonnie M. Snowden, & Toby Ewing, *Criminal Records of Persons Served in the Public Mental Health System*, 58. PSYCHIATRIC SERVICES, 114, 114, 117-18 (2007); E. FULLER TORREY, *OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS* (1997).

50 RISDON N. SLATE, JACQUELINE BUFFINGTON-VOLLUM & WESLEY JOHNSON, *THE CRIMINALIZATION OF MENTAL ILLNESS: CRISIS AND OPPORTUNITY FOR THE JUSTICE SYSTEM* 75 (2nd ed. 2013); Alyssa Dale O'Donnell, *Monsters, Myths, and Mental Illness: A Two-Step Approach to Reducing Gun Violence in the United States*, 25 S. CAL. INTERDISC. L.J. 475, 476 (2016); Theresa Flerx, *When Human Development Goes Awry*, PERSPECTIVE PONDERINGS 1 (January 3, 2013), http://www.tflerxanecdotalist.com/blog---perceptive-ponderings/when-human-development-goes-awry_.

51 Clark, *supra* note 49.

52 H. Richard Lamb, Linda E. Weinberger & Walter J. DeCuir, Jr., *The Police and Mental Health*, 53 PSYCHIATRIC SERVS. 1266, 1268 (2002).

53 Cynthia Blitz, Nancy Wolff & Jing Shi, *Physical Victimization in Prison: The Role of Mental Illness*, 31. JOURNAL INT'L J. JOURNAL L. & PSYCHIATRY 385, 391 (2008); Nancy Wolff, Cynthia Blitz, & Jing Shi, *Rates of Sexual Victimization in Prison for Inmates With and Without Mental Disorders*, 58. PSYCHIATRIC SERVS. 1087, 1092 (2007).

54 *Id.*

refuse to civilly commit a subject or release the individual back onto the streets after a short observation period whereby the police may have to be called again for intervention. Whereas, if the police take the person to jail, even on a minor charge, it sets in motion a system that can't say no – the criminal justice system.⁵⁵

The community mental health system has been criticized, at times, for being content to have criminal justice professionals assume the responsibility for handling persons with mental illnesses in the criminal justice system.⁵⁶ Treatment providers have been known to sometimes skirt their duties by turning away subjects for recurrent hospitalizations, past violence, substance abuse, and/or inability to financially cover services – prompting one researcher to lament that “jails have become the poor person’s mental hospitals.”⁵⁷ Deinstitutionalization, coupled with the lack of proper community treatment infrastructure, has been blamed for contributing to the incarceration of persons with mental illnesses. In fact, the three largest inpatient psychiatric facilities in the United States are jails (Los Angeles County Jail, Rikers Island, New York City, and Cook County Jail, Chicago), with larger populations of persons with mental illnesses locked up than can be found in any psychiatric hospital in the country.⁵⁸ It is likely, no matter which state you live in, that a jail or prison in that state holds more persons with mental illnesses than any psychiatric facility in the same state. In fact, with the exceptions of Washington, DC, Kansas, New Jersey, the Dakotas, Washington, and Wyoming, the remaining 44 states have at least one jail or prison that houses more persons with severe mental illnesses than any state operated psychiatric hospital within their respective borders.⁵⁹

Some argue that the disproportionate representation of persons with mental illnesses in the criminal justice system is mainly the result of strict drug laws and iron-fisted crime control policies and is not primarily the fault of deinstitutionalization.⁶⁰ However, others maintain that with the advent of deinstitutionalization, treatment for persons with mental illnesses was never deinstitutionalized and was merely transferred from state hospitals to jails and prisons, resulting in what has been referred to as *trans-institutionalization* – a movement of persons with mental illnesses from one type of institution (e.g. a hospital) to another (e.g. a jail or prison).⁶¹

55 Lamb, Weinberger & Gross, *supra* note 46, at 112.

56 See Mary T. Zdanowicz, *A Sheriff's Role in Arresting the Mental Illness Crisis*, 53. SHERIFF 38 (2001).

57 Linda A. Teplin, *Keeping the Peace: Police Discretion and Mentally Ill Persons.*, NAT'L INST.. National Institute Justice JUST. J. Justice Journal, 8, 9 (2000); Fox Butterfield, *Prisons Brim with mentally Mentally Ill, Study Finds*, N.Y. mentally ill, study finds. NEW YORK TIMES (July 12, 1999), <http://www.nytimes.com/1999/07/12/us/prisons-brim-with-mentally-ill-study-finds.html>.

58 Ted Gest, *A Summit on the Mentally Ill in U.S. Jails*, CSG JUST. Justice CTR. (April 19, 2016), <http://csgjusticecenter.org/mental-health/media-clips/a-summit-on-the-mentally-ill-in-u-s-jails/>.

59 Swanson, *supra* note 4.

60 Arthur J. Lurigio, *People With Serious Mental Illness in the Criminal Justice System: Causes, Consequences, and Correctives*, 91 PRISON Journal J. Journal 66, 66 (2011).

61 Heather Barr, *Transinstitutionalization in the Courts: Brad H. v. City of New York, and the Fight for Discharge Planning for People with Psychiatric Disabilities Leaving Rikers Island*, 49. CRIME & Delinquency DELINQ. Delinquency 97, 99 (2003); *People with Mental Illnesses Involved in the*

Whatever the causes, we do know that across countries and time periods, there has consistently been an inverse relationship between correctional and psychiatric hospital populations; in other words, as correctional populations increase, psychiatric hospital populations decrease, and vice versa.⁶²

Current estimates show that persons with serious mental illness comprise 20 percent of inmates in jails and 15 percent of prisoners in state prisons.⁶³ Considering the total number of persons incarcerated, this translates to roughly 356,000 inmates with serious mental illnesses in jails and state prisons, meaning that there are 10 times more persons with serious mental illness incarcerated than the approximately 35,000 remaining patients in state hospitals.⁶⁴

IV. IMPEDIMENTS TO TREATMENT

A potential contributing factor to the criminalization of mental illness is privatization of the mental health system. For example, Fred Markowitz found a predominance of private psychiatric hospital beds in cities to be significantly related to increases in both arrest and crime rates.⁶⁵ Some contend that a causal relationship exists between the manifestation of serious mental illness and constraining insurance regulations.⁶⁶ Also, preferred drug lists and restricted formularies have been used by state legislatures with persons with mental illnesses with projected savings into the millions of dollars. Try first, and even further, policies have been implemented whereby a person on Medicaid or in custody will be offered a cheaper generic drug instead of what has been known to work in the past. Or, a brand name drug will be purchased by a state or jail, for example, in bulk at a reduced price and used in place of previous more expensive medication that has been known to work for a person with mental illness. Of course, the problem with psychotropic medications is that they are not as successful when substituted for other medications, and the failures can be horrific.⁶⁷

Criminal Justice System: Hearing before the H. Subcomm. on Oversight and Investigations of the Energy and Commerce Committee (2014) (statement of Steve Leifman, J., Chair, Supreme Court of Florida Task Force on Substance Abuse and Mental Health Issues in the Courts); Zaheer, *supra* note 10, at 392.

⁶² Lamb & Weinberger, *supra* note 44, at 484, 486; Steven Raphael, *The Deinstitutionalization of The Mentally Ill and Growth in the U.S. Prison Populations 1971 to 1996* (Sept. 2000), <http://ist-socrates.berkeley.edu/~raphael/raphael2000.pdf>.

⁶³ E. Fuller Torrey, Mary T. Zdanowicz, A D Kennard et al., *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey*, TREATMENT Advocacy ADVOC. Advocacy CTR. (Apr. (April 8, 2014)

<http://www.treatmentadvocacycenter.org/storage/documents/backgrounders/how%20many%20individuals%20with%20serious%20mental%20illness%20are%20in%20jails%20and%20prisons%20final.pdf>.

⁶⁴ *Id.*

⁶⁵ See Fred E. Markowitz, *Psychiatric hospital Hospital Capacity, Hospital capacity, homelessness, and Crime and arrest Arrest Rates*, 44 *arrest rates*. CRIMINOLOGY 45. (2006).

⁶⁶ T. Howard Stone, *Therapeutic Implications of Incarceration for Persons with Severe Mental Disorders: Searching for Rational Health Policy*, 24. AM. J. CRIM. L. 283, 296, 298, 342-46, 348-358 (1997).

⁶⁷ Elizabeth Gudrais, *New Medicaid Law on Generic Drugs Draws Criticism*, generic drugs draws criticism. Providence J., (July 27, 2006); See also; Susan Levine, *Stability of Mentally Ill*

An example of Florida's restricted formulary for Medicaid gone awry can be seen with Keith Howard.⁶⁸ He had been dealing with schizophrenia for twenty years and reportedly had never been violent toward anyone but himself.⁶⁹ However, once subjected to Florida's cost-cutting measure for Medicaid, his brand name drug, not on the preferred drug list, was discontinued, substitutes did not work, and he decompensated.⁷⁰ Within two months of having his medication that had successfully kept his hallucinations in check taken away, he spiraled out of control, and on November 8, 2005, Howard killed his mother, believing that she had associated with serial killer Danny Rolling and had assisted Lee Harvey Oswald in the assassination of President Kennedy. Howard remains institutionalized, having later been determined to be not guilty by reason of insanity⁷¹—an insanity contributed to by the State of Florida.

Managed care dominates the dispensing of health care in America, including mental health care, and is seen with people who have health insurance in the private system of health care and increasingly in the public system as well. To minimize expenditures, managed care organizations strictly scrutinize services, many of which must be approved prior to being performed.⁷² The goal of managed care companies is not necessarily to deliver quality services; it is to bring about profits.⁷³ Commissions of \$880 per denial have reportedly been paid by managed care companies to psychiatrists/treatment providers to deny psychiatric hospital admissions and needed care to persons with mental illnesses,⁷⁴ purportedly to cut expenditures and maximize profits.

Managed care and health maintenance organizations (HMOs) have been criticized for offering false promises similar to that of deinstitutionalization:

Shaken by Medicare Drug Plan Problems; Some Prescription Danieal Have Heightened Stress, WASH., Washington POST (Feb.(February 6, 2006); William J. Rich, *The Path of mentallyMentally Ill Offenders*, 36mentally ill offenders. FORDHAM UrbanURB. L. J.Urban Law Journal 89, 101-02, 106-07 (2009); Slate, R. N. (2005, April 12). Medicaid reform, preferred drug lists, and allowing open access to psychotropic medications. Testimony before the Florida Senate Committee on Health Care, Tallahassee, FL in Slate, *supra* note 50 at 496.

⁶⁸ See Stephen Hudak, *Orlando-Area Man Who Killed Mom in '05 had Lost Access to Antipsychotic Meds*, ORLANDO SENTINEL (Nov. (November 13, 2007),) http://articles.orlandosentinel.com/2007-11-13/news/howard13_1_mascotte-keith-howard-mental-health.

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² Carol T. Mowbray, Kyle L. Grazier & Mark Holter, *Managed Behavioral Health Care in the Public Sector: Will It Become the Third Shame of the States?*, 53? PSYCHIATRIC SERVICES 157, 160-64 (2002).

⁷³ Susan Brink, *I'll Say I'm Suicidal: The Mentally Ill Struggle Through the Maze of Managed Care*, U.S. NEWS ONLINE (Jan. 19, 1998), <http://www.redandgreen.org/Medical/Suicidal/19mana.htm>.

⁷⁴ Edward R. Edward R. Edward R. Sodaro & Jennifer Ball, *Neglected Adolescent Mental Illness: Managed Care at Its Worst*, NAT'L COALITION OF MENTAL HEALTH PROF. & CONSUMERS (Jan. 1999), http://archive-org-2012.com/org/t/2012-12-21_1031686_10/A-PARENT-S-SEARCH-FOR-MENTAL-HEALTH-CARE/; Also, seeSee also Slate, *supra* note 50, at 64.

an effective system of prevention services coupled with early intervention.⁷⁵ Managed care, with its pre-certifications and strict review of services, resembles the constraints set on civil commitment criteria in the 1970s—namely prohibitive admission procedures and limited involuntary civil commitment stays—with similar outcomes. Results like those of deinstitutionalization in the 1960s might reasonably be expected. Police, with more limited and restrictive possibilities for care, will increasingly resort to handling even minor offenses carried out by persons with mental illnesses by incarcerating them and removing them from society.⁷⁶ Thus, the supposed cost-saving restrictions of managed care can merely result in cost-shifting to the government in the form of housing persons with mental illnesses in jails and prisons.⁷⁷

Furthermore, mentally ill offenders typically lose their eligibility for medical benefits while incarcerated, and reinstatement without proper discharge planning can take up to three months, provided that someone has the wherewithal to pursue reinstatement.⁷⁸ Therefore, the Council of State Governments has recommended that Medicaid benefits be temporarily suspended instead of being terminated.⁷⁹ Other needs of those being released from custody back into the community include housing, transportation, food, and clothing.⁸⁰

Other impediments to treatment for persons with mental illnesses include stigma and anosognosia. Anosognosia, sometimes seen in stroke victims, refers to a lack of insight into one's illness; this is often seen in persons with mental illnesses, as they do not realize that they are ill and in need of treatment.⁸¹ As indicated by a former U.S. Surgeon General, stigma within our society creates the greatest obstacle to persons with mental illnesses seeking treatment, as they fear being labeled and shamed for their illness.⁸²

75 Kane, C. Kane, C. Catherine F. Kane, *Deinstitutionalization and Managed Care: Déjà Vu?*, 46 *PSYCHIATRIC SERVS.* 883, 833 (1995).

76 Jennifer C. Bonovitz & Jay S. Bonovitz, *Diversion of the Mentally Ill into the Criminal Justice System: The Police Intervention Perspective*, 138 *AM. J. OF PSYCHIATRY* 973, 973 (1981); Bonita M. Veysey, *The Intersection of Public Health and Public Safety in U.S. Jails: Implications and Opportunities of Federal Health Care Reform*, in *EXPLORING HEALTH REFORM AND CRIMINAL JUSTICE: RETHINKING THE CONNECTION BETWEEN JAILS AND COMMUNITY HEALTH* 1 (2011).

77 Veysey, *supra* note 77, at 8.

78 HUMAN RIGHTS WATCH, *Failure to Provide Discharge Services*, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 192 (2003), <http://www.hrw.org/reports/2003/usa1003/24.htm>.

79 COUNCIL STATE GOV'TS, *CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT*, CHAPTER III: PRETRIAL ISSUES, ADJUDICATION, AND SENTENCING (2002) <https://www.ncjrs.gov/pdffiles1/nij/grants/197103.pdf>.

80 *Id.* at 110.

81 Amador, X. Amador, X. XAVIER AMADOR, *I AM NOT SICK I DON'T NEED HELP: HOW TO HELP SOMEONE WITH MENTAL ILLNESS ACCEPT TREATMENT* (Vida Press 2006).

82 U.S. DEP'T OF HEALTH AND HUMAN SERVS., *MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL* (1999).

III. A DIFFERENT TACT FOR CRIMINAL JUSTICE AUTHORITIES: THERAPEUTIC JURISPRUDENCE

The application of the law may have therapeutic or anti-therapeutic effects.⁸³ The traditional criminal justice process tends to look backward, finding fault, making accusations, and inflicting punishment. However, decisions rendered within the spirit of therapeutic jurisprudence reflect concern for the future consequences on individuals, relationships, and the community long after a person's contact with the justice system is over.⁸⁴ Thus, proper intervention and linkage to treatment now may prevent constant recycling through the criminal justice system of persons with mental illnesses and be of benefit to all over time.

Due to the inadequacies previously discussed, more and more persons with mental illnesses are being absorbed into the criminal justice system. It has been recommended that criminal justice leaders who carry a lot of clout—such as sheriffs, judges, police chiefs, and wardens—should take the lead in lobbying for additional funds for mental health services and professionals.⁸⁵ Criminal justice and mental health professionals are more frequently entering into partnerships with clearly delineated responsibilities specified in memorandums of understanding. These interagency agreements, entered into by agency heads, can serve to facilitate interactions between agencies to ensure that there are no-decline agreements in place between law enforcement and treatment providers so that providers cannot refuse to treat persons brought to their doors by police.⁸⁶

The crucial role that criminal justice practitioners play in the interface of the mental health and criminal justice systems is reflected in the sequential intercept model designed by Mark Munetz and Patti Griffin.⁸⁷ The model represents points for intervention for persons with mental illnesses who come into contact with the criminal justice/mental health system. These points reflect places where these individuals can leave the criminal justice system, reenter society, and be linked to treatment. The locations for intercession include emergency and police services, initial detention and hearings, “[j]ail, courts, forensic evaluations, and forensic commitments, [r]entry from jails, state prisons, and forensic hospitalizations, [and c]ommunity corrections and community support services.”⁸⁸

83 Michael L. Perlin, *Teaching Civil Rights: “They Keep it All Hid”: The Ghettoization of Mental Disability Law and Its Implications for Legal Education*, 54 ST. LOUIS L.J. 857, 875 (2010).

84 Risdon N. Risdon N. Risdon N. Slate, *From the Jailhouse to Capitol Hill: Impacting Mental Health Court Legislation and Defining What Constitutes a Mental Health Court*, 49 CRIME & DELINQ. 6, 15 (2003).

85 See, e.g., statement of Steve Leifman, *supra* note 61; See, John Petrila et al., *Debating Outpatient Commitment: Controversy, Trends, and Empirical Data*, 49 CRIME & DELINQ. 157 (2003).

86 Courtenay L. Sellers et al., *Responding to Persons with Mental Illnesses: Police Perspectives on Specialized and Traditional Practices*, 23 BEHAV. SCI. LAW 647, 650 (2005); Teplin, *supra* note 57.

87 Mark R. Munetz & Patricia A. Griffin, *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, 57 PSYCHIATRIC SERVS. 544 (2006).

88 *Id.* at 545.

Ideally, if appropriate and sufficient treatment were available in the community, there would be no need to have protocols in place to divert persons with mental illnesses from the criminal justice system. In the absence of adequate treatment available, innovative strategies have been developed and implemented in the criminal justice system. Examples of pre-booking approaches used to divert persons with mental illnesses to treatment include mobile crisis teams, community service officers, and use of police crisis intervention teams [CIT]⁸⁹ (with over 2,620 CIT programs in place across the country).⁹⁰ Pre-trial diversion programs have been used in a number of jurisdictions, and model jail diversion programs for persons with mental illnesses are in existence.⁹¹ Linkage to treatment is guided by more than 300 mental health courts around the country today.⁹² CIT training has also been developed for detention and correctional officers to help de-escalate incidents in custodial situations.⁹³ Discharge planning is considered an essential element for potentially successful return to the community from incarceration for persons with mental illnesses; however, it has been found to be the least offered mental health service to those in jails prior to release.⁹⁴ There have also been training protocols put in place for probation officers supervising persons with mental illnesses in the community and recommendations made regarding proper numbers for specialized caseloads.⁹⁵ Forensic assertive community treatment (FACT) teams are found around the country with probation officer members.⁹⁶ Probation officers, armed with court orders, as members of FACT teams have what has been referred to as therapeutic leverage to get participants to comply with treatment protocols or face consequences.⁹⁷ This is also true of mental health courts mentioned above; however, judges also have the ability to hold managed care authorities in contempt of court if they fail to comply with treatment orders directed by the court.⁹⁸

Successful examples of the criminal justice system tapping into the Affordable Care Act for discharge planning and/or linkage to community treatment can be seen with the Minnesota Department of Corrections, the Ohio Department of Rehabilitation and Correction, the San Francisco County Sheriff's Department, the Cook County Jail and probation officers in Chicago.⁹⁹ Those states that adopted Obamacare were able to provide care to

89 Slate, *supra* note 50, at 43.

90 THE UNIVERSITY OF MEMPHIS CIT CENTER, <http://www.cit.memphis.edu/> (last visited Oct. 9, 2016).

91 Slate, *supra* note 50, at 461-62.

92 COUNCIL STATE GOV'TS, *Mental Health Courts* (2016), <http://csgjusticecenter.org/mental-health-court-project/>.

93 Slate, *supra* note 50, at 434.

94 Steadman, H. Steadman, H. Henry J. Steadman & Bonita M. Veysey, *Providing Services for Jail Inmates with Mental Disorders*, NAT'L INST. JUSTICE (1997).

95 Slate, *supra* note 50, at 473.

96 *Id.* at 467, 469-71.

97 *Id.* at 468.

98 *Id.* at 388.

99 Risdon N. Risdon N. Risdon N. Slate & Laura Usher, *Health Coverage for People in the Justice System: The Potential Impact of Obamacare*, 78 FED. PROB. 19 (2014).

over 350,000 individuals with mental illness in 2014. However, over 568,000 uninsured low-income persons with mental illness in America were denied such treatment, primarily in the central and southern United States, as their states opted out of Medicaid expansion. Such blocked avenues to mental health treatment are associated with increased criminal justice system contact for persons with mental illnesses, homelessness, suicides, and costly hospitalizations and utilization of emergency room services.¹⁰⁰ While not without concerns regarding, for example, coercion, outpatient commitment¹⁰¹ legislation has been touted as a means for reducing the criminalization of mental illness.¹⁰² However, it, like every intercept point on the sequential intercept model, is not worth the paper it is printed on if adequate mental health services, including long-term care,¹⁰³ are not in place in a community.¹⁰⁴ Likewise, if practitioners at each intercept point are not properly trained to recognize the signs and symptoms of mental illness and how to link persons to treatment services, the model is without utility.

VI. CONCLUSION

“There is no shame in having a mental illness The shame is in not receiving adequate treatment, and any entity that obfuscates that treatment should be considered criminal. A person should not have to commit a crime to have a chance at some semblance of treatment in America.”¹⁰⁵ This is true even if criminal justice authorities have to take the lead in linking persons with mental illnesses to treatment.

“‘The character Holden Caulfield [in the book *The Catcher in the Rye*] envisioned himself standing in a field of rye on the edge of a cliff with the mission of catching all those in danger of falling and saving them from going over the edge of the cliff In a civilized society, we are morally responsible for catching those persons with mental illness that we can and saving them from going over the edge of the cliff into the abyss of the criminal justice system.’ Criminal justice practitioners are logically positioned, whether they want to be or not, as the gatekeepers for salvaging persons with mental illnesses[;]”¹⁰⁶ with the help of mental health professionals may they continue to do so.

100 Ana Swanson, *These States Leave the Most Mentally Ill Adults Untreated. Guess what Else They Have in Common.*, WASH. POST: WONKBLOG (Apr. 14, 2015), <https://www.washingtonpost.com/news/wonk/wp/2015/04/14/these-states-leave-the-most-mentally-ill-adults-untreated-guess-what-else-they-have-in-common/>.

101 Elyn R. Saks, *Special Theme: Preventive Outpatient Commitment for Persons with Serious Mental Illness: Involuntary Outpatient Commitment*, 9 PSYCH. PUB. POL. AND L. 94 (2003).

102 See Slate, *supra* note 50, at 161-62.

103 *Id.* at 164-65; Zaheer, *supra* note 10, at 402.

104 Lamb & Weinberger, *supra* note 1, at 533.

105 Slate, *supra* note 50, at 506.

106 *Id.* at 505.

