

Mental Health Treatment and the Criminal Justice System

By Stephen Allen*

There is a fifty-six percent chance that an inmate in a state prison is suffering from a mental health problem.¹ Of those state prisoners with mental health problems, sixty-one percent committed a violent offense and twenty-five percent have been incarcerated three or more times.² There is also a fifty-eight percent chance a state prisoner with a mental health problem violated facility rules, and a twenty percent chance he was injured as a result of a prison fight.³ Most notably, there is only a thirty-four percent chance a state prisoner with a mental health problem has received any sort of mental health treatment since admission.⁴ Thousands of people in this country, caught in a vicious cycle of repeated incarceration, suffer from mental illness and never receive the specialized treatment they would need to prevent future incarceration.⁵

Prisoners are entitled to proper and adequate mental health treatment under the United States Constitution.⁶ The lack of specialized treatment for mentally ill inmates is

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¹ DORIS JAMES & LAUREN GLAZE, BUREAU OF JUSTICE STATISTICS, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006), available at www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf. In federal penitentiaries, 45% of inmates had mental health problems; in local jails, 64% of inmates had mental health problems. *Id.*

² *Id.* Fifty-six percent of state prison inmates without mental health problems have committed a current or past violent offense and 19% of them have had three or more prior incarcerations. *Id.*

³ *Id.* (comparing prevalence of rules violations and fights between the general populations of inmates versus those with mental health problems).

⁴ *Id.* at 9. Only 43% of state prison inmates without mental health problems had broken facility rules and only 10% had been injured in a prison fight. JAMES & GLAZE, *supra* note 1.

⁵ See Erik Eckholm, *Inmates Report Mental Illness at High Levels*, N.Y. TIMES, Sept. 7, 2006, at A24 (analyzing the Dept. of Justice Special Report on the Mental Health Problems of Prison and Jail Inmates).

⁶ See U.S. CONST. amend. VIII; *Estelle v. Gamble*, 429 U.S. 97, 103 (1976) (recognizing that

the primary cause for higher rates of prison misbehavior, including various disturbances, fights, rule breaking, and suicide.⁷ Additionally, the lack of post-release care leads to an increase in recidivism.⁸ Fortunately, the emergence of preventive outpatient treatment statutes, an expansion of community treatment programs, legislation to improve mental health services for inmates, and the creation of over 100 mental health courts across the country within the last five-to-ten years has brought hope to a desperate situation.⁹ Statistics show that these programs assist mentally ill inmates to successfully re-enter society and reduce rates of recidivism.¹⁰

Part I of this note will briefly examine this country's recent history of treatment for the mentally ill, as well as the relationship between recidivism and mental illness, and

states have an obligation to provide adequate medical treatment and care to those whom they have incarcerated).

⁷ See *Decriminalizing Mental Illness*, N.Y. TIMES, Jul. 16, 2006, at sec. 14; Press Release, Bureau of Justice Statistics, State Prison Homicide Rates Down 93 Percent; Jail Suicide Rates 64 Percent Lower Than in Early 1980s (Aug. 21, 2005), available at <http://www.ojp.usdoj.gov/bjs/pub/press/shspljpr.htm>. The general population rate of suicide is now lower than the rate in state prisons, and much lower than local jails. Suicide has been the leading cause of inmate deaths from 1983 to 2002. *Id.*

⁸ See *Decriminalizing Mental Illness*, *supra* note 7, at sec. 14 (arguing that mentally ill prisoners often end up back in prison due to lack of access to mental health treatment).

⁹ See Rachel A. Scherer, Note, *Toward a Twenty-First Century Civil Commitment Statute: A Legal, Medical, and Policy Analysis of Preventive Outpatient Treatment*, 4 IND. HEALTH L. REV. 361, 362 (2007) (discussing the preventive outpatient statute movement led by New York and California that allows courts to mandate outpatient treatment for mentally ill persons who are, generally speaking, deemed to be a danger to themselves or others); TREATMENT ADVOC. CTR., CRIMINALIZATION OF INDIVIDUALS WITH SEVERE PSYCHIATRIC DISORDERS 2 (Apr. 2007), at <http://www.psychlaws.org/GeneralResources/documents/pdfBPCriminalization.pdf> [hereinafter CRIMINALIZATION OF INDIVIDUALS] (discussing assertive community treatment programs); Press Release, American Psychiatric Association, Legislation Improves Mental Health Services for Mentally Ill Prisoners (Nov. 15, 2007), available at <http://www.psych.org/MainMenu/Newsroom/NewsReleases/2007NewsReleases/LegislationImprovesMentalHealthServicesforMentallyIllPrisoners111607.aspx> (discussing the passage of the "Second Chance Act"); Mary Beth Pfeiffer, *Cruel and Unusual Punishment*, N.Y. TIMES, May 7, 2006, at 17 (advocating that Gov. George Pataki of New York sign legislation that would "prohibit the placement of people with serious mental illnesses in isolated confinement"); *Decriminalizing Mental Illness*, *supra* note 7, at sec. 14 (discussing what the positive effects of proposed legislation would have been prior to veto by Gov. George Pataki); Gerald E. Nora, *Prosecutor as "Nurse Ratched"? Misusing Criminal Justice as Alternative Medicine*, 22 CRIM. JUST. 18, 19 (2007) (discussing the origins of mental health courts); *Mental Health Courts and the Trend Toward a Rehabilitative Justice System*, 121 HARV. L. REV. 1168, 1170 (2008) (stating that, as of 2005, 125 mental health courts had been established in the U.S.).

¹⁰ Eckholm, *supra* note 5, at A24 (discussing the importance of connecting released inmates with mental health treatment within their communities).

will provide a brief discussion of the most prevalent mental illnesses in America's prisons. Part II will examine the "re-entry" movement and consider specific legislation, community treatment programs, and mental health courts. Part III will evaluate the efficacy of the various "re-entry" movement programs and legislation, ultimately concluding that the movement's progress is lacking. This final section will also advocate for a central government agency to oversee and combine all relevant resources in order to expand the scope of intervention so that all mentally ill prisoners receive effective and appropriate treatment.¹¹

PART I

Mentally Ill in America and its Prisons

According to President George W. Bush's New Freedom Commission on Mental Health, the United States' mental health system is in "shambles."¹² This is evidenced by the difficulty in defining the mentally ill population and determining who has received specialized treatment.¹³ It is also exemplified in the lack of effective treatments options, the fragmented and uncoordinated system of resources from state, federal, and private organizations, and the resulting gap in care.¹⁴

The estimated population of mentally ill Americans varies significantly depending on how mental illness is measured and defined.¹⁵ At least fifteen percent, and as many as thirty percent, of Americans suffer from mental illness.¹⁶ Of these

¹¹ See RICHARD G. FRANK & SHERRY A. GLIED, *BETTER BUT NOT WELL*, 147-48 (The Johns Hopkins University Press 2006); Chris L. Jenkins, *N.Y. Law Raises Issues of States' Reach in Patient Care*, WASH. POST, Dec. 30, 2007, at C1 (discussing the key aspects of New York's "Kendra's Law" and their relationship to the law's success rate, but criticizing the narrow scope of the statute's guidelines).

¹² FRANK & GLIED, *supra* note 11, at 2 (discussing the goals of President Bush's 2003 New Freedom Commission on Mental Health).

¹³ *Infra* note 19.

¹⁴ FRANK & GLIED, *supra* note 11, at 5-7 (discussing the problems of mainstreaming the mental health system).

¹⁵ FRANK & GLIED, *supra* note 11, at 10-11. How the mentally ill population is defined often varies. *Id.* Three general constructs are often used: those diagnosed, those treated, and those with a functional impairment. *Id.* Less than 2% of the U.S. population falls into all three groupings. *Id.*

¹⁶ FRANK & GLIED, *supra* note 11, at 24 (noting prevalence of mental illness in the U.S.); *Mental Illness: Facts and Numbers*, Fact Sheet (Nat'l Alliance on Mental Illness) Oct. 2007, at 1, available at http://www.nami.org/Template.cfm?Section=About_Mental_Illness&Template=/ContentManagement/ContentDisplay.cfm&ContentID=53155 (estimating that 25% of the population, or 57.7

individuals, many have an addiction disorder coupled with their mental illnesses.¹⁷ Low socioeconomic status is the characteristic most closely correlated with diagnosable mental illness.¹⁸

While estimates vary, approximately one-third of mentally ill Americans receives some form of mental health treatment.¹⁹ The number of mental health professionals has increased from 7,000 psychiatrists in 1950 to over 200,000 psychiatrists, psychologists, nurses and social workers today.²⁰ The annual indirect economic effect of persons with mental illnesses in the United States is \$79 billion, with about \$63 billion attributable to the loss of productivity associated with persons who suffer from mental illnesses.²¹ As staggering as these numbers are, what is more startling is the lack and

million persons, experienced a mental health disorder in 2004); JAMES & GLAZE, *supra* note 1, at 3 (estimating that one in ten Americans evidenced symptoms of a mental health problem using the same criteria that estimated that 56% of state prisoners had a mental health problem). An estimated 1.7% of the population, at any given time, has a diagnosable severe and persistent mental illness. FRANK & GLIED, *supra* note 11, at 24.

¹⁷ Nat'l Alliance on Mental Illness, *supra* note 16, at 1. Additionally, of persons using homeless services, 31% had a combination of a mental health disorder with an addiction disorder. *Id.*

¹⁸ FRANK & GLIED, *supra* note 11, at 24. This has been the best indicator whether measured by income, education, or occupation. *Id.* The difficulty in assessing the effect of this relationship has been whether mental illness is whether poverty and other social inequities cause mental illness or whether the poverty stricken become poor because of their mental illness. *Id.* at 25.

¹⁹ Compare Nat'l Alliance on Mental Illness, *supra* note 16, at 1 with JAMES & GLAZE, *supra* note 1, at 9 (stating that just over one third of inmates with a mental health problem had received specialized mental health treatment); FRANK & GLIED, *supra* note 11, at 1 (stating that nearly all Americans with a severe mental illness receive treatment). Only one half of children with a diagnosable mental health disorder had received any mental health treatment. Nat'l Alliance on Mental Illness, *supra* note 16, at 1. The availability of treatment for racial and ethnic minorities is even less, and the quality of treatment is often worse. *Id.* See also TREATMENT ADVOC. CTR., WHAT PERCENTAGE OF INDIVIDUALS WITH SEVERE PSYCHIATRIC DISORDERS ARE RECEIVING NO TREATMENT? 1 (Apr. 2007), available at <http://www.psychlaws.org/BriefingPapers/documents/pdfBPWhatpercentageofindividuals.pdf> (estimating that two million persons with schizophrenia and bipolar disorder are not receiving treatment). Only about 50% of persons diagnosed with what would be classified as a severe mental illness had received any form of mental health treatment in the previous twelve months, according to recent U.S. studies. *Id.*

²⁰ FRANK & GLIED, *supra* note 11, at 2-4 (discussing the expansion of spending on mental health care).

²¹ *Treatment Saves Money & Makes Sense*, Fact Sheet, (Nat'l Alliance on Mental Illness, Arlington, VA) Mar. 2007, at 2, available at <http://www.nami.org/Template.cfm?Section=Policy&Template=/ContentManagement/ContentDisplay.cfm&ContentID=44613> (discussing a report compiled by the President's New Freedom Commission on Mental Health) [hereinafter *Treatment Saves Money & Makes Sense*].

misallocation of funding for mental health treatment within the criminal justice system.²²

The deinstitutionalization movement of the 1960s led to an inordinate number of mentally ill persons becoming incarcerated.²³ Following the exposure of atrocious conditions in the nation's public mental hospitals, President John F. Kennedy advocated for better and more humane care for the mentally ill.²⁴ He urged strategies that included outpatient treatment facilities, such as halfway homes, and complement inpatient care.²⁵ Faced with financial constraints, the Johnson administration failed to fully implement President Kennedy's vision for an overhaul of the mental health system.²⁶ What followed was a vast nationwide deinstitutionalization process; many state psychiatric facilities closed without a corresponding increase in outpatient services, causing those who should have been in mental hospitals to instead find themselves in prison or on the

²² See JAMES STEPHAN, BUREAU OF JUSTICE STATISTICS, STATE PRISON EXPENDITURES, 2001 1 (2004), <http://www.ojp.usdoj.gov/bjs/pub/pdf/spe01.pdf> (stating that \$29.5 billion was spent by states on prisons in 2001); *Spending Money in All the Wrong Places: Jails & Prisons*, Fact Sheet (Nat'l Alliance on Mental Illness, Arlington, VA) Apr. 2004, at 1, http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Public_Policy/Policy_Research_Institute/Policy_makers_Toolkit/Spending_Money_in_all_the_Wrong_Places_Jails.pdf (explaining that the U.S. spends an average of \$9 billion per year on prisoners with mental illnesses); JAMES & GLAZE, *supra* note 1, at 1 (explaining that only 34% of state prisoners with mental health problems had received treatment since admission); *Decriminalizing Mental Illness*, *supra* note 7, at sec. 14 (discussing a study from the Correctional Association of New York that stated "the mentally ill prison population had grown at three times the rate of the general prison population.").

²³ *Decriminalizing Mental Illness*, *supra* note 7, at sec. 14 (discussing the movement of the 1960s and 1970s that shut down the facilities that largely cared for the mentally ill). Some call this movement "transhospitalization", because many public mental hospital patients were transferred to general hospitals or nursing homes. FRANK & GLIED, *supra* note 11, at 50-51.

²⁴ Nora, *supra* note 9, at 18. Prior to 1950, persons with serious mental illnesses were secluded from the general public in mental hospitals where they often received painful and ineffective treatment. FRANK & GLIED, *supra* note 11, at 1. Public mental hospitals at this time have been described as "buildings swarming with naked humans herded like cattle ... pervaded by a fetid odor so heavy, so nauseating, that the stench seemed to have almost a physical existence of its own" *Id.* at 1 (quoting Albert Deutsch's 1948 book, "The Shame of States"). Electroconvulsive therapy (ECT) was introduced in 1934 and hailed for its effectiveness in treating depression and schizophrenia. *Id.* at 36. The use of ECT as a form of treatment declined as "reports emerged of patients breaking limbs and fracturing vertebrate as their bodies gyrated on the operating table." *Id.* Prior to the 1950s, treatment for persons with schizophrenia often included hydrotherapy, insulin shock therapy, and psychosurgery. *Id.* at 32.

²⁵ Nora, *supra* note 9, at 18. In 1963, Kennedy formed the Community Mental Health Centers program with the goal of offering and encouraging access to mental health care by reducing the price of community based mental health services. FRANK & GLIED, *supra* note 11, at 59.

²⁶ See Nora, *supra* note 9, at 18 (discussing Kennedy's vision for the mentally ill).

streets without access to effective treatment.²⁷ Prison officials witnessed a rise in both their general and mentally ill inmate populations, while mental health professionals witnessed the migration of their patient populations from mental health facilities to prison.²⁸ Consequently, the “criminalization” of the mentally ill in America began.²⁹ Today, mentally ill persons who commit crimes or create public disturbances often directly go to jail or prison, making America’s prisons the “de facto custodians of people with mental illness.”³⁰

According to a Department of Justice study, over half of the U.S. inmate population in 2005 had mental health problems.³¹ The prevalence of mental health problems was higher among female inmates and inmates aged twenty-four and under.³²

²⁷ Nora, *supra* note 9, at 18. President Kennedy’s vision was also arguably retarded by legislation brought forth by civil libertarians that largely restricted the capability to involuntarily commit mentally ill persons. *Id.* Contrary to popular belief, the number of persons incarcerated in prisons or confined to mental hospitals actually dropped from 1960 to 1990. *Id.* at 23. The numbers of incarcerated or confined persons fell from 685,000 persons in the mid 1950s, to 533,000 persons in 1970, and to 436,000 persons in 1980. *Id.* This number increased to 863,000 persons in 1990; some attribute this rise to the advent of the American ‘War on Drugs’ in the 1980s. *Id.*

²⁸ Nora, *supra* note 9, at 23 (discussing the transition from mental hospitals serving as primary caretaker for mentally ill Americans to the prison system fulfilling this role).

²⁹ See *Decriminalizing Mental Illness*, *supra* note 7, at sec. 14 (positing that persons who would have typically gone to state psychiatric facilities are now placed in jail or prison “where they receive little treatment and where their symptoms usually get worse” as a result of the deinstitutionalization movement).

³⁰ Pfeiffer, *supra* note 9, at 17 (discussing the role of prisons in caring for the mentally ill).

³¹ JAMES & GLAZE, *supra* note 1, at 1. This equates to 705,600 prisoners in state prisons, 78,800 prisoners in federal prisons, and 479,900 prisoners in local jails. *Id.* It has been estimated that 200,000 of these prisoners have a serious mental illness. FRANK & GLIED, *supra* note 11, at 16. Data for the Dept. of Justice study was compiled through personal interviews with prisoners at state and federal prisons, and local jails. JAMES & GLAZE, *supra* note 1, at 1. A recent history of a mental health problem or symptoms of a mental health disorder, as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), were used as the criteria to determine if a prisoner suffered from a mental health problem. *Id.* These figures are higher than past studies because “inmates describing any symptoms of problems like major depression or mania were counted along with those with diagnosed psychiatric disorders.” Eckholm, *supra* note 5, at A24. 49% of all inmates in U.S. prisons and jails met criteria for a diagnosable mental health disorder, versus just 11% of the general population. JAMES & GLAZE, *supra* note 1, at 3.

³² JAMES & GLAZE, *supra* note 1, at 4. Of the general population, 12% of females and 9% of males aged eighteen or older met the criteria for symptoms of a mental health disorder. *Id.* An astounding percentage of women incarcerated exhibited mental health problems: 73.1% in state prison; 61.2% in federal prison; and 75.4% in local jail. *Id.* Of persons aged twenty-four or younger, 62.6% exhibited mental health problems in state prison; 57.8% in federal prison; and 70.3% in local jails. *Id.* Compare *Mentally Ill Offender Treatment and Crime Reduction*

Approximately twenty-four percent of state prison inmates exhibited evidence of a mental health disorder.³³ In addition to low socioeconomic status, strong indicators of mental illness include criminal record, substance dependence or abuse, homelessness, sexual abuse, and parental abuse of alcohol and drugs.³⁴ Available figures make it clear that an extraordinary number of persons with mental health problems end up in state or federal prisons and in local jails.³⁵

The Most Prevalent Disorders Among Mentally Ill Prisoners

According to the 2004 Department of Justice Study, depression was the most

Reauthorization and Improvement Act of 2008, H.R. 3992, 110th Cong. §2(3) (2008) (noting that “rates of mental illness among women in jail are almost twice that of men”) with FRANK & GLIED, *supra* note 11, at 13 (stating that age and gender have no effect on the probability of having a mental illness).

³³ JAMES & GLAZE, *supra* note 1, at 2. Mental health disorders were measured through diagnosis, overnight stay in a hospital, prescribed medication or professional therapy. *Id.* Twenty-one percent of local jail inmates and 14% of federal inmates exhibited a past history of a mental health disorder. *Id.*

³⁴ JAMES & GLAZE, *supra* note 1, at 1. Sixty-one percent of prisoners with mental health problems in state prison have a current or past violent offense, while just 56% of the general inmate population does. *Id.* Twenty-five percent of prisoners with mental health problems in state prison have three or more prior incarcerations versus just 19% of the general inmate population. *Id.* Seventy-four percent of prisoners with a mental health problem in state prison have substance dependence or abuse problems, while just 56% of the general population does. *Id.* Thirteen percent of prisoners with mental health problems were homeless in the year before their arrest versus just 6% of those without mental health problems. *Id.* Twenty-seven percent of prisoners with mental health problems in state prison experienced past physical or sexual abuse, while just 10% of the general prison population had. *Id.* Thirty-nine percent of prisoners with mental health problems in state prison had parents that abused alcohol or drugs versus 25% of those without mental health problems. JAMES & GLAZE, *supra* note 1, at 1. Once in prison, mentally ill persons are also more likely to be charged with violating facility rules and twice as likely to be injured in a fight. *Id.* Fifty-eight percent of prisoners with a mental health problem in state prison were charged with violating facility rules versus 43% of those without mental health problems. *Id.* Twenty-four percent of prisoners with a mental health problem in state prison were charged with a physical or verbal assault in prison versus 14% of the general inmate population. *Id.* Twenty percent of prisoners with a mental health problem in state prison were injured in a fight since admission versus just 10% of the general inmate population. *Id.*

³⁵ Eckholm, *supra* note 5, at A24. In local jails, where 64% of inmates report a mental health problem, many mentally ill persons are being held without charges and are typically awaiting transfer to a hospital, or psychiatric ward, or psychiatric evaluation. JAMES & GLAZE, *supra* note 1, at 1; CRIMINALIZATION OF INDIVIDUALS, *supra* note 9, at 1. These figures may actually be low estimates since many jails and prisons do not have the requisite expertise or appropriate facilities to properly diagnose mental illness, and because many jails and prisons limit treatment and diagnosis to the most severely ill or dysfunctional. Nora, *supra* note 9, at 18.

prevalent mental health problem reported within the inmate population.³⁶ Around forty percent of state prisoners reported at least one symptom of major depression.³⁷ As a diagnosis, major depression is characterized by occurrence of one or more major depressive episode.³⁸ A major depressive episode is marked by “at least two weeks of depressed mood or loss of interest accompanied by at least four additional symptoms of depression.”³⁹ Such symptoms include changes in appetite, weight, sleep habits, or psychomotor activity; diminished energy; expressing guilt or worthlessness; trouble concentrating, thinking, and making decisions; or recurring thoughts of death and committing suicide.⁴⁰ Additionally the individual must present social, occupational, or functional impairment in a clinically significant way.⁴¹ Degree of impairment varies from person to person, but in extreme cases, “the person may be unable to perform minimal self-care or to maintain minimal personal hygiene.”⁴²

The onset of symptoms for a major depressive episode develops over days and weeks.⁴³ Symptoms of anxiety and general depression may be apparent and last for weeks or months before a full major depressive episode ensues.⁴⁴ Major depression, if left untreated, can last in excess of four months.⁴⁵ Fortunately, in most cases, individuals with major depression eventually return to normal functional level and experience a complete remission of symptoms.⁴⁶

The most common forms of treatment for major depression are medication and

³⁶ JAMES & GLAZE, *supra* note 1, at 3 (discussing the prevalence certain mental health symptoms and disorders among the inmate population).

³⁷ JAMES & GLAZE, *supra* note 1, at 3 (discussing prevalence of symptoms of major depression among prison and jail populations). Forty-nine percent of jail inmates reported major depression symptoms of insomnia or hypersomnia, the highest percentage of a specific symptom in any one group. *Id.*

³⁸ AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 345 (4th ed., text revision 2000) [hereinafter *DSM-IV-TR*].

³⁹ *Id.* at 349 (discussing the “essential feature” of a major depressive episode).

⁴⁰ *Id.* These symptoms must be worse than the person’s pre-major depressive episode status or newly present in order to be indicative of a major depressive episode. *Id.*

⁴¹ *Id.* (discussing diagnosis criteria).

⁴² *Id.* at 351 (comparing degrees of impairment).

⁴³ *DSM-IV-TR*, *supra* note 38, at 354 (stating that the duration of major depressive episodes vary).

⁴⁴ *DSM-IV-TR*, *supra* note 38, at 349-54 (delineating associated symptoms and disorders)

⁴⁵ *DSM-IV-TR*, *supra* note 38, at 354 (noting possible duration of untreated major depressive episode).

⁴⁶ *DSM-IV-TR*, *supra* note 38, at 354 (noting that complete remission occurs in majority of cases). In some chronic cases, however, major depression can last for two years or more. *Id.*

psychotherapy.⁴⁷ Antidepressant medications, such as Prozac and Zoloft, are prescribed by medical professionals to normalize the reuptake of certain neurotransmitters that regulate mood.⁴⁸ Antidepressants typically take at least three to four weeks to provide full therapeutic relief, although medication is often prescribed for a longer period of time with the goal of avoiding relapse.⁴⁹ Many persons, especially those with chronic or recurrent depression, are required to stay on antidepressants for an indefinite period of time.⁵⁰

Psychotherapy, also known as “talk therapy,” is another generally accepted form of treatment for major depression.⁵¹ Psychotherapy has been shown to be the most effective form of treatment for those with mild to moderate depression.⁵² Cognitive Behavioral Therapy (CBT) and Interpersonal Therapy (IPT) have emerged as the most successful forms of psychotherapy for treating major depression.⁵³ CBT assists persons in changing the negative thoughts and behaviors that contribute to their depression.⁵⁴ IPT has proven effective in helping persons identify, understand, and try to correct personal relationships that contribute to their depression.⁵⁵ However, studies have shown that psychotherapy alone is often not enough to alleviate symptoms, and that a combination of medication and psychotherapy is often the most effective way to combat major depression.⁵⁶

Psychotic disorders, such as bipolar disorder and schizophrenia, are also prevalent among inmate populations.⁵⁷ Bipolar disorder and schizophrenia are the

⁴⁷ NAT'L INST. OF MENTAL HEALTH, DEPRESSION 4 (2007), *available at* <http://www.nimh.nih.gov/health/publications/depression/nimhdepression.pdf> [hereinafter DEPRESSION].

⁴⁸ *Id.* at 13. Side effects of antidepressants include headaches, nausea, insomnia and nervousness, agitation, sexual dysfunction, dry mouth, constipation, bladder problems, blurred vision, and drowsiness. *Id.* at 15.

⁴⁹ *Id.* at 13.

⁵⁰ *Id.* at 13. Because of this trend, treatment for depression has gradually shifted to primary care physicians. FRANK & GLIED, *supra* note 11, at 35.

⁵¹ DEPRESSION, *supra* note 47, at 18.

⁵² DEPRESSION, *supra* note 47, at 18.

⁵³ DEPRESSION, *supra* note 47, at 18. CBT and IPT are the two forms of psychotherapy currently recommended by the American Psychiatric Association. FRANK & GLIED, *supra* note 11, at 36.

⁵⁴ DEPRESSION, *supra* note 47, at 18.

⁵⁵ DEPRESSION, *supra* note 47, at 18.

⁵⁶ DEPRESSION, *supra* note 47, at 18.

⁵⁷ JAMES & GLAZE, *supra* note 1, at 2 (indicating that 10% of Federal inmates, 15 percent of State inmates, and 24% of jail inmates reported at least one symptom of psychotic disorder). Compare these statistics with the 3.1% of the general population with symptoms of a psychotic disorder.

mental illnesses most commonly correlated with violence among mentally ill prisoners.⁵⁸ Persons with schizophrenia and bipolar disorder are four times as likely as the general population to be arrested for violent crimes.⁵⁹ Studies by the Bureau of Justice Statistics and the National Institute of Justice have shown that eighty percent of the violent crimes committed by persons with these mental health disorders are done while they are symptomatic and un-medicated.⁶⁰ Conversely, when their illnesses are in remission, usually as a result of specialized treatment, their arrest rates are comparable to those of the general population.⁶¹

Bipolar disorder is characterized by the occurrence of one or more manic episodes and one or more major depressive episodes, usually occurring in close succession.⁶² In other words, the person experiences dramatic mood swings from “an abnormally and persistently elevated, expansive, or irritable mood” to a sad and hopeless mood.⁶³ As previously noted, major depressive episodes are classified by “at least two weeks of depressed mood or loss of interest accompanied by at least four additional symptoms of depression.”⁶⁴ Manic episodes must last for at least a week and consist of an abnormal mood that can be elevated or irritable.⁶⁵ This kind of episode must be accompanied by at least three symptoms “from a list that includes inflated self-esteem or grandiosity, decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased involvement in goal-directed activities or psychomotor agitation, and excessive involvement in pleasurable activities with high potential for painful consequences.”⁶⁶

The negative social impact incurred by individuals suffering from bipolar disorder is generally significant.⁶⁷ For example, ten-to-fifteen percent of persons with bipolar disorder commits suicide.⁶⁸ Attempted suicide and suicidal thoughts occur more often when the afflicted individual is in a depressive state.⁶⁹ Also, while one is in a

Id.

⁵⁸ Nora, *supra* note 9, at 18.

⁵⁹ Nora, *supra* note 9, at 18.

⁶⁰ Nora, *supra* note 9, at 18.

⁶¹ Nora, *supra* note 9, at 18.

⁶² DSM-IV-TR, *supra* note 38, at 382 (discussing the essential feature of bipolar disorder).

⁶³ DSM-IV-TR, *supra* note 38, at 349, 357, 382 (detailing the specific symptoms of manic and major depressive episodes).

⁶⁴ DSM-IV-TR, *supra* note 38, at 349.

⁶⁵ DSM-IV-TR, *supra* note 38, at 357 (stating the features of a manic episode).

⁶⁶ DSM-IV-TR, *supra* note 38, at 357.

⁶⁷ DSM-IV-TR, *supra* note 38, at 384 (discussing effects of bipolar disorder).

⁶⁸ DSM-IV-TR, *supra* note 38, at 384.

⁶⁹ DSM-IV-TR, *supra* note 38, at 384.

severe manic episode, child abuse, spousal abuse, and other violent acts may occur.⁷⁰ Many persons with bipolar disorder also have an alcohol or substance abuse disorder.⁷¹ School failure, job failure, antisocial behavior, and divorce are also associated with bipolar disorder.⁷²

Bipolar disorder is treatable, especially through a long term preventive treatment program consisting of medication and psychosocial treatment.⁷³ Medications known as “mood stabilizers” are often prescribed by doctors for extended periods of time to treat bipolar disorder.⁷⁴ When manic or depressive episodes re-emerge, doctors often prescribe short term medication to help patients cope and break through the specific episodes.⁷⁵

When combined with medication, psychosocial treatments, such as psychotherapy, “are helpful in providing support, education, and guidance to people with bipolar disorder and their families.”⁷⁶ Psychosocial treatment can lead to improved overall functioning, decreased hospitalizations, and improved mood stability.⁷⁷ Psychosocial treatment is typically provided by a social worker, counselor, or psychologist and is most effective when done in conjunction with prescribed medication from a psychiatrist.⁷⁸

Schizophrenia also has a substantial impact on the inmate population, and is characterized by a combination of positive and negative symptoms “that have been

⁷⁰ DSM-IV-TR, *supra* note 38, at 384.

⁷¹ DSM-IV-TR, *supra* note 38, at 384 (stating that persons with bipolar disorder are also more likely to have a history of alcohol or substance abuse).

⁷² DSM-IV-TR, *supra* note 38, at 384 (declaring also that anorexia, bulimia, panic disorder, and social phobias are also associated with bipolar disorder).

⁷³ NAT'L INST. OF MENTAL HEALTH, BIPOLAR DISORDER 12 (2007), *available at* <http://www.nimh.nih.gov/health/publications/bipolar-disorder/nimhbipolar.pdf> [hereinafter BIPOLAR DISORDER]. Bipolar disorder is better controlled with continuous treatment. *Id.* Maintaining a journal or chart of treatment, sleep patterns, mood patterns, and life events is important in understanding and treatment of the illness and can allow the treating doctor to make effective and necessary adjustments to the treatment program when necessary. *Id.* at 12-13.

⁷⁴ *Id.* at 13.

⁷⁵ *Id.* at 13. Side effects of these types of medication include nausea, tremors, weight gain, and a decline in sexual drive, dry mouth, hair loss, and anxiety. *Id.* at 16.

⁷⁶ *Id.* at 17.

⁷⁷ BIPOLAR DISORDER, *supra* note 73, at 17. Family therapy, cognitive behavioral therapy (CBT), psycho-education and interpersonal and social rhythm therapy are common forms of psychosocial treatment. *Id.*

⁷⁸ BIPOLAR DISORDER, *supra* note 73, at 17.

present for a significant portion of time during a one-month period with some signs of the disorder persisting for at least six months.”⁷⁹ Social and occupational dysfunction is associated with this disorder.⁸⁰ A diagnosis requires two out of the five positive or negative symptoms to be present, unless “the delusions are bizarre or hallucinations involve ‘voices commenting’ or ‘voices conversing,’ then the presence of only one item is required.”⁸¹ Delusional symptoms affect 11.8 percent of the state prison population while 7.9 percent of the state prison population is affected by hallucinations.⁸² A schizophrenia diagnosis also requires the presence of other, less severe symptoms, such as disorganized thinking or speech.⁸³

Studies have shown that only a subset of individuals with schizophrenia is more likely than the general population to engage in violent behavior.⁸⁴ Schizophrenia is often associated with “substance-related disorders.”⁸⁵ Other mental disorders such as anxiety, obsessive-compulsive disorder, and panic disorder are more prevalent in persons with schizophrenia than in the general population.⁸⁶

Treatment of schizophrenia is focused on alleviating its symptoms because its

⁷⁹ DSM-IV-TR, *supra* note 38, at 298. Positive symptoms include hallucinations, delusions, abnormal thoughts and perceptions, and disorders of movement. NAT'L INST. OF MENTAL HEALTH, SCHIZOPHRENIA 5 (2006) [hereinafter SCHIZOPHRENIA], *available at* <http://www.nimh.nih.gov/health/publications/schizophrenia/schizophrenia-booket---2006.pdf>. Negative symptoms are more difficult to recognize, but “represent a loss or decrease in the ability to initiate plans, speak, express emotion, or find pleasure in everyday life.” *Id.*

⁸⁰ DSM-IV-TR, *supra* note 38, at 304-05 (discussing features and behavior associated with schizophrenia).

⁸¹ DSM-IV-TR, *supra* note 38, at 301-02.

⁸² JAMES & GLAZE, *supra* note 1, at 2. Symptoms of delusions are reported to be present in 7.8% of the federal prison population and 17.5% of the local jail population. *Id.* Symptoms of hallucinations are reported to be present in 4.8% of the federal prison population and 13.7% of the local jail population. *Id.*

⁸³ DSM-IV-TR, *supra* note 38, at 300-02.

⁸⁴ DSM-IV-TR, *supra* note 38, at 300-02. “The major predictors of violence behavior are male gender, younger age, past history of violence, noncompliance with antipsychotic medication, and excessive substance abuse.” *Id.* Convicted Texas killer Scott Louis Panetti, whose execution was recently stopped by the Supreme Court, was hospitalized fourteen times prior to his incarceration for schizophrenia, manic depression, hallucinations, and delusions of persecution. Ralph Blumenthal, *Justices Block Execution of Delusional Texas Killer*, N.Y. TIMES, June 29, 2007, at A25.

⁸⁵ DSM-IV-TR, *supra* note 38, at 304 (noting high rate of substance-related disorders among persons with schizophrenia). Approximately 80% to 90% of individuals with schizophrenia regularly smoke cigarettes. *Id.* (noting also that schizophrenics tend to smoke cigarettes with high nicotine content).

⁸⁶ DSM-IV-TR, *supra* note 38, at 304.

cause is still unknown.⁸⁷ Antipsychotic medications that operate by eliminating the positive symptoms of schizophrenia have been available for close to sixty years.⁸⁸ These medications often cause severe side effects such as tremors, restlessness, rigidity, and persistent muscles spasms.⁸⁹ More recently, a new class of treatments known as atypical antipsychotics was developed, and these promise significantly fewer adverse side effects.⁹⁰ Additionally, this new generation of antipsychotics has been shown to treat effectively even individuals who had limited success with prior antipsychotic medications; many persons show a significant reduction in hallucinations and delusions within just six weeks.⁹¹ Regardless of the medication used, the disease requires constant and continuous treatment to avoid relapse.⁹²

Psychosocial treatment has been shown effective for persons whose schizophrenia has been stabilized through medication.⁹³ In particular, this form of treatment is effective in improving the ability to establish relationships, motivation, self-care, communication, and employment.⁹⁴ Schizophrenics who have been stabilized and partake in psychosocial treatment often have fewer relapses and are able to attend school, work, and social events.⁹⁵

⁸⁷ SCHIZOPHRENIA, *supra* note 79, at 9.

⁸⁸ SCHIZOPHRENIA, *supra* note 79, at 9. Chlorpromazine was the first antipsychotic drug introduced in the U.S. FRANK & GLIED, *supra* note 11, at 29. Chlorpromazine alleviates delusions and hallucinations and was introduced to the U.S. in 1954. *Id.*

⁸⁹ SCHIZOPHRENIA, *supra* note 79, at 9. According to 1961 research, 40% of schizophrenics experienced a side effect exhibited by tremors, rigidity and motor inertia, known as extrapyramidal syndrome. FRANK & GLIED, *supra* note 11, at 30.

⁹⁰ SCHIZOPHRENIA, *supra* note 79, at 9. In the 1980s, atypical antipsychotics such as clozapine, olanzapine, quetiapine, and risperidone were introduced. FRANK & GLIED, *supra* note 11, at 30. These drugs were similar to antipsychotics in effectiveness, but offered relief from extrapyramidal syndrome, which translates into a greater likelihood of compliance with a prescribed medication regimen. *Id.* at 30-31.

⁹¹ SCHIZOPHRENIA, *supra* note 79, at 9.

⁹² SCHIZOPHRENIA, *supra* note 79, at 11.

⁹³ SCHIZOPHRENIA, *supra* note 79, at 12. The combination of the two forms of treatment, medication and psychotherapy, also reduces the likelihood of relapse. FRANK & GLIED, *supra* note 11, at 32.

⁹⁴ SCHIZOPHRENIA, *supra* note 79, at 12. Other forms of treatment for schizophrenia include illness management, rehabilitation, family education, and cognitive behavioral therapy. *Id.* at 13.

⁹⁵ SCHIZOPHRENIA, *supra* note 79, at 12. Since 1950, treatment for schizophrenia has gradually shifted from controlled institutional settings, such as public mental hospitals, to community based treatment. FRANK & GLIED, *supra* note 11, at 35.

Treatment of Mental Illness

When mental illnesses are diagnosed early, the success rate of treatment is comparable to that of common surgical treatments.⁹⁶ Early detection and early intervention often results in less disabling and shorter bouts of illness.⁹⁷ However, many persons with mental illnesses do not seek medical treatment until a decade after symptoms first appear, and when they do seek care it is often in the wrong place.⁹⁸ Without access to effective treatment, the inmate population more often experiences severe mental illness, frequently manifested by negative social behavior that results in repeat charges for transgressing criminal law.⁹⁹

In general, the well being of most Americans with mental illnesses has vastly improved since 1950.¹⁰⁰ This is largely due to financing and delivery improvements for mental health care.¹⁰¹ Mental health care has been funneled into traditional health care due to the transformation of the delivery system from a centralized, bureaucratic system, to a more market-oriented system.¹⁰² While this transformation has created a vast number of resources and choices for many Americans with mental illnesses, this

⁹⁶ *Treatment Saves Money & Makes Sense*, *supra* note 21, at 2 (comparing rates of success of mental health treatment to treatment for other common disorders).

⁹⁷ *Treatment Saves Money & Makes Sense*, *supra* note 21, at 2 (arguing that investing in effective forms of mental health treatment saves lives and money).

⁹⁸ *Treatment Saves Money & Makes Sense*, *supra* note 21, at 2 (stating that less than one third of persons with a diagnosable mental health disorder receive mental health services in a given year); JAMES & GLAZE, *supra* note 1, at 1 (stating approximately one third of prisoners with a mental health problem had received treatment since admission). Between 2000 and 2003, emergency department visits at U.S. hospitals with mental illness as the primary diagnosis increased at four times the rate of other emergency department visits. *Treatment Saves Money & Makes Sense*, *supra* note 21, at 2.

⁹⁹ JAMES & GLAZE, *supra* note 1, at 1; *supra* text accompanying note 30.

¹⁰⁰ FRANK & GLIED, *supra* note 11, at 26. In the early 1960s, persons with mental illnesses had very few treatment choices, whereas today, they have become market consumers, choosing from a vast array of choices such as psychiatric hospitals, general hospitals, private hospitals, clinical or private outpatient care, etc. *Id.* at 48. In 1956, state spending accounted for close to 60% of overall spending. *Id.* at 49. This changed dramatically with the advent of Medicaid and Medicare in 1965 as well as expanded private insurance coverage. *Id.* By 1971, state spending decreased to 23% of total mental health care spending. *Id.* This percentage has since stable. *Id.*

¹⁰¹ FRANK & GLIED, *supra* note 11, at 48. Spending on mental health care has increased from \$1.14 billion in 1956 to \$85.4 billion in 2001, with the greatest increase in spending occurring between 1956 and 1971. *Id.* at 49.

¹⁰² FRANK & GLIED, *supra* note 11, at 68-69. Today, approximately 86% of Americans, and 80% of mentally ill Americans, have insurance, public or private, to help offset the high expense of mental health care. *Id.* at 49.

decentralized system also “allows some people with significant impairment to fall through the cracks.”¹⁰³

Under the Eighth Amendment of the United States Constitution, states have an obligation to provide adequate medical treatment for those who are incarcerated.¹⁰⁴ To prove a constitutional violation, a prisoner must satisfy a two-part test.¹⁰⁵ From an objective standpoint, an inmate must prove that he has been deprived of the “minimal civilized measure of life’s necessities.”¹⁰⁶ Subjectively, an inmate must show that prison or medical personnel acted with deliberate indifference to his medical needs.¹⁰⁷ The deliberate indifference standard is a challenging one for a prisoner to satisfy.¹⁰⁸

In order for failure to provide appropriate treatment to constitute cruel and unusual punishment there must be deliberate indifference to the prisoner’s medical needs.¹⁰⁹ Arguably, the fact that guards in the prison system frequently prevent or delay inmates’ access to proper medical services shows indifference.¹¹⁰ To prove deliberate indifference, however, an inmate must show that the prison guard, doctor, or other personnel, had a culpable mind in intentionally depriving him of appropriate medical care.¹¹¹ A failure to provide appropriate medical care without the requisite intent does not constitute a wanton infliction of pain, and would not be considered cruel and unusual punishment.¹¹²

Generally, prisoners are entitled to appropriate treatment for their mental health problems and states have a genuine interest in providing this treatment.¹¹³ According to

¹⁰³ FRANK & GLIED, *supra* note 11, at 69.

¹⁰⁴ U.S. CONST. amend. VIII; *Estelle v. Gamble*, 429 U.S. 97, 104 (1976).

¹⁰⁵ *Wilson v. Seiter*, 501 U.S. 294, 299 (1991).

¹⁰⁶ *Id.* at 304.

¹⁰⁷ *Estelle v. Gamble*, 429 U.S. 97, 104 (1976).

¹⁰⁸ *Hallett v. Morgan*, 296 F.3d 732, 744 (9th Cir. 2002).

¹⁰⁹ *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (delineating “deliberate indifference” standard); *Erickson v. Pardus*, 127 S. Ct. 2197, 2198 (2007) (stating that deliberate indifference to an inmate’s medical needs constitutes a wanton infliction of pain which violates the Eighth Amendment’s cruel and unusual punishment clause).

¹¹⁰ *Erickson v. Pardus*, 127 S. Ct. 2197, 2198 (2007) (discussing prisoners’ medically necessary Hepatitis C program being intentionally terminated because prisoner violated prison code of conduct).

¹¹¹ *Wilson v. Seiter*, 501 U.S. 294, 297 (1991).

¹¹² *Id.* Low numbers of mental health professionals in a given correctional facility has not been shown to violate the Eighth Amendment. *Hallett v. Morgan*, 296 F.3d 732, 748 (9th Cir. 2002).

¹¹³ *See* 72 C.J.S. *Prisons* § 86 (2007); *see also* *State v. Owens*, 557 P.2d 562, 564 (Ariz. Ct. App. 1976) (stating that the Arizona Department of Corrections must ensure the well-being and safety

a Department of Justice study, nearly all of this country's state prison facilities reported providing mental health services to their inmates in the year 2000.¹¹⁴ However, in most states an individual must be both mentally ill and a significant danger to himself or others in order for the system to compel treatment.¹¹⁵ The excessive number of people suffering from mental illness in jails and prisons and the high rates of recidivism within this segment of the population, strongly suggest that the criminal justice system is not providing effective treatments.¹¹⁶

Prisoners with mental health problems are often the individuals who "slip through the cracks" of the U.S.'s mental health system.¹¹⁷ According to a 2004 Department of Justice Study, fewer than half of state prison inmates with a mental health problem had ever received any mental health treatment, and even fewer had used prescribed medications or undergone professional mental health therapy.¹¹⁸ In the year prior to their arrests, prisoners were even less likely to have received mental health

of mentally ill inmates through appropriate measures such as involuntary hospitalization to a State hospital). Prisoners are just as entitled to medical care for mental health illnesses as they are for other physical illnesses, and prisons are under a duty to provide this. 72 C.J.S. *Prisons* § 86 (2007); *see also* *Bowring v. Godwin*, 551 F.2d 44, 48 (4th Cir. 1977) (arguing that prisoners who exhibit symptoms of serious mental illness are entitled to mental health treatment if such treatment may cure or alleviate prisoners' symptoms). Unfortunately, correctional facilities' primary duty is not to provide mental health treatment, so they often lack the requisite numbers of mental health professionals. *See* Rachel A. Scherer, Note, *Toward a Twenty-First Century Civil Commitment Statute: A Legal, Medical, and Policy Analysis of Preventive Outpatient Treatment*, 4 IND. HEALTH L. REV. 361, 414 (2007).

¹¹⁴ *See* JAMES STEPHAN, BUREAU OF JUSTICE STATISTICS, STATE PRISON EXPENDITURES, 2001 1 (2004), <http://www.ojp.usdoj.gov/bjs/pub/pdf/spe01.pdf> (stating that \$29.5 billion was spent by states on prisons in 2001 and reporting 1,394 of 1,558 state adult correctional facilities provided health services to their incarcerated).

¹¹⁵ *Washington v. Harper*, 494 U.S. 210, 211 (1990) (interpreting a Washington State statute); *see also* *Bowring v. Godwin*, 551 F.2d 44, 48 (4th Cir. 1977) (stating that whether or not a prisoner is eligible for mental health treatment is to be determined by medical necessity).

¹¹⁶ JAMES & GLAZE, *supra* note 1, at 1-2; *supra* text accompanying note 31.

¹¹⁷ *See generally*, FRANK & GLIED, *supra* note 11, at 5-7.

¹¹⁸ JAMES & GLAZE, *supra* note 1, at 9. Of inmates with mental health problems, 49.3% of state prisoners, 35.3% of federal prisoners, and 42.7% of local jail inmates had ever received mental health treatment. *Id.* Of state prisoners with mental health problems, 39.5% had used prescribed medication, 35.4% had received professional mental health therapy, and 20% had ever had an overnight hospital stay. *Id.* Of federal prisoners with mental health problems, 28% had used prescribed medication, 25.6% had received professional mental health therapy, and just 9.5% had ever had an overnight hospital stay. *Id.* Of local jail inmates with mental health problems, 32.7% had used prescribed medication, 31.1% had received professional mental health therapy, and 18% had ever had an overnight stay in a hospital. *Id.*

treatment.¹¹⁹

For many mentally ill persons, being sent to prison represents a great opportunity for care, given the possibility of their being placed in a government-sponsored treatment program.¹²⁰ Yet, in 2004, roughly one-third of state prisoners reporting a mental health problem had received mental health treatment since admission.¹²¹ Fewer than twenty-seven percent of state prisoners with a mental health problem had used prescription medication since incarceration.¹²² Just twenty-three percent of state prisoners with a mental health problem had undergone professional mental health therapy while incarcerated.¹²³ A mere 5.4% of state prisoners with mental health problems are hospitalized while incarcerated.¹²⁴

State prisoners with mental health problems spend an average of five months longer in prison than those without a mental health problem.¹²⁵ Prisoners with mental health problems are also more easily provoked by other inmates and therefore more likely to violate prison rules than inmates without mental illness.¹²⁶ Additionally, a study

¹¹⁹ JAMES & GLAZE, *supra* note 1, at 9. In the year prior to arrest, 22.3% of state prisoners, 14.9% of federal prisoners, and 22.6% of local jail inmates with mental health problems received treatment. *Id.* Of state prisoners with mental health problems, 15.8% had used prescribed medication, 11.3% were on prescribed medication when arrested, 11.5% had undergone professional mental health therapy, and 5.8% had an overnight stay in a hospital in the year prior to arrest. *Id.* Of federal prisoners with mental health problems, 10.1% had used prescribed medication, 7.3% were on prescribed medication when arrested, 8% had undergone professional mental health therapy, and 3.2% had stayed overnight in a hospital during the year prior to arrest. *Id.* Of local jail inmates with mental health problems, 16.9% had used prescribed medication, 12.3% were on prescribed medication when arrested, 12.3% had undergone professional mental health therapy, and 6.6% had stayed overnight in a hospital during the year prior to arrest. *Id.*

¹²⁰ Nora, *supra* note 9, at 18 (arguing that society is rewarding criminal conduct as the best means for finding a government treatment program by providing mentally ill offenders with mental health and drug treatment in jail). *Id.* Los Angeles County Jail, Riker's Island Prison in New York, and Cook County Jail in Illinois are the three largest psychiatric facilities in the U.S. *Id.*

¹²¹ JAMES & GLAZE, *supra* note 1, at 9. This number has increased approximately 5% since 1997. *Id.* Since admission, just 24% of federal inmates, and 17.5% of local jail inmates with a mental health problem had received treatment. *Id.*

¹²² JAMES & GLAZE, *supra* note 1, at 9. Since incarceration, 19.5% of federal prisoners and 14.8% of local jail inmates with mental health problems had used prescription medication. *Id.*

¹²³ JAMES & GLAZE, *supra* note 1, at 9. Since incarceration, 15.5% of federal prisoners and 7.3% of local jail inmates with mental health problems had undergone professional mental health therapy. *Id.*

¹²⁴ JAMES & GLAZE, *supra* note 1, at 9. 2.7% of federal prisoners and 2.2% of local jail inmates with mental health problems had been hospitalized since incarceration. *Id.*

¹²⁵ JAMES & GLAZE, *supra* note 1, at 8.

¹²⁶ JAMES & GLAZE, *supra* note 1, at 1.

from the Correctional Association of New York found that prison officials habitually place mentally ill prisoners in solitary confinement.¹²⁷ The conditions in solitary confinement are severe and often exacerbate the condition of mentally ill inmates.¹²⁸ Prisoners are frequently kept in solitary confinement for up to twenty-three hours per day, for up to thirty days.¹²⁹ They are fed inadequate meals three times per day.¹³⁰ Many persons are suicidal after solitary confinement; some have been observed “weeping in their cells,” or having “mutilated their own flesh,” or having “smeared feces on themselves.”¹³¹

As discussed earlier, substance abuse or dependence disorders are often associated with mental illness, especially among the prison population.¹³² Often mentally ill prisoners are placed in substance abuse treatment programs in prison or as part of their parole.¹³³ Once released from prison, however, mentally ill persons are put back into society with no regard for their continued access to medication or

¹²⁷ Pfeiffer, *supra* note 9, at 17. (discussing statement by psychiatrist Terry Kupers that 64% of inmates in maximum security “special housing units”, i.e. solitary confinement, are mentally ill). “One report found that inmates who suffered from serious mental illnesses spent six and a half times longer in disciplinary units than other inmates generally.” *Id.* Even when mental health professionals are involved in the decision-making process, mentally ill inmates often end up in solitary confinement because there is nowhere else to put them. Beth Healy and Michael Rezendes, *Better Prison Mental Health Care Sought*, BOSTON GLOBE, May 2, 2007, available at http://www.boston.com/yourlife/health/mental/articles/2007/05/02/better_prison_mental_health_care_sought/.

¹²⁸ Pfeiffer, *supra* note 9, at 17. Many persons in solitary confinement are in jail as a result of nonviolent, drug related crimes. Sol Wachtler, *A Cell of One's Own*, N.Y. TIMES, Sept. 24, 2006, at 14. A former New York judge, Sol Wachtler, was placed in a solitary confinement unit while in a federal prison and suffering from bipolar disorder; he described it as follows:

The special housing unit is a seemingly endless row of claustrophobic cells – mine was about seven feet by eight feet – each with its own steel sink and toilet. Against one wall there is a metal rack covered by a thin oil cloth covered pad. This is the bed. The door is solid steel with a vertical slot that allows for a guard to peer in. A small, knee-high horizontal slot is used to deliver and return food trays. The walls are made of concrete cement blocks. Light comes in from a very small barred window and a large fluorescent light that is on all day and part of the night. *Id.*

¹²⁹ Sarah Kershaw, *More Scrutiny for Mentally Ill in State Prisons*, N.Y. TIMES, Apr. 25, 2007, at B1.

¹³⁰ *Id.* (describing meals consisting of cabbage and pasty flour).

¹³¹ *Id.* (discussing documentation from the Correctional Association of New York). Fifty-two inmates successfully committed suicide in New York state penitentiaries between 1998 and 2004. Wachtler, *supra* note 128, at 14.

¹³² Nora, *supra* note 9, at 18. An estimated 25 to 50% of persons addicted to drugs have a mental illness. *Id.* at 19. Over 90% of inmates with a substance abuse problem also have an anti-social personality disorder, schizophrenia, or bipolar disorder. *Id.*

¹³³ Nora, *supra* note 9, at 18.

treatment.¹³⁴ Unfortunately, without supplemental mental health services, the substance abuse programs provided to prisoners are essentially “exercises in futility,” and many will resume habits that brought them within the ambit of criminal law in the first place.¹³⁵ Studies indicate that, upon release, mentally ill former inmates tend to create more disturbances, commit more crimes, and eventually cycle back into the criminal justice system.¹³⁶

PART II

Developments

Within the last ten years there have been many developments that give hope for the de-criminalization of mental illness. These advances include assertive community treatment (ACT) programs, development of alternative forms of housing for mentally ill inmates, proposed and passed legislation, preventive outpatient treatment statutes, and mental health courts.¹³⁷ Both studies conducted by the Department of Justice and input from mental health professionals have shown that it is essential for mentally ill prisoners to receive mental health treatment in their communities.¹³⁸ Data indicates that this “re-entry” movement assists in preventing mentally ill inmates from returning to prison.¹³⁹

ACT programs cost less than half of the cost of incarcerating persons with severe psychiatric disorders.¹⁴⁰ ACT provides the mentally ill with individualized service twenty-four hours per day, similar to that of a psychiatric ward in a hospital.¹⁴¹ The

¹³⁴ See Nora, *supra* note 9, at 19.

¹³⁵ Nora, *supra* note 9, at 19 (noting implication of co-morbidity of drug addiction and mental illness).

¹³⁶ See Nora, *supra* note 9, at 19. Ninety-five percent of all incarcerated will be released into society at some point. NANCY G. LAVIGNE, ET. AL., DEPT. OF JUSTICE, PRISONER REENTRY AND COMMUNITY POLICING: STRATEGIES FOR ENHANCING PUBLIC SAFETY 3 (Dept. of Justice) (2006), available at <http://www.cops.usdoj.gov/mime/open.pdf?Item=1701>.

¹³⁷ CRIMINALIZATION OF INDIVIDUALS, *supra* note 9, at 3-4; Nora, *supra* note 9, at 22; Reentry Policy Council, 1/22/2008: Recap of the Second Chance Act of 2007, available at http://reentrypolicy.org/announcements/recap_of_sca (last visited Feb. 22, 2008); see generally, Rachel A. Scherer, Note, *Toward a Twenty-First Century Civil Commitment Statute: A Legal, Medical, and Policy Analysis of Preventive Outpatient Treatment*, 4 IND. HEALTH L. REV. 361 (2007).

¹³⁸ Eckholm, *supra* note 5, at A24 (discussing goals of the re-entry movement).

¹³⁹ See Eckholm, *supra* note 5, at A24 (stating that prisons need to connect released mentally ill prisoners with mental health treatment in their communities).

¹⁴⁰ CRIMINALIZATION OF INDIVIDUALS, *supra* note 9, at 2-3 (stating that ACT costs around \$60/day per person, where as it costs jails and prisons \$137/day per person).

¹⁴¹ CRIMINALIZATION OF INDIVIDUALS, *supra* note 9, at 2-3.

main difference between a psychiatric ward and ACT is that with the latter, the mentally ill patient does not have to be admitted to a hospital since ACT professionals are available to meet participants in their chosen environment.¹⁴² This option can make mentally ill persons feel more comfortable with their treatment and can remove the stigma of psychiatric wards.¹⁴³ ACT programs have proven to be most effective when they are implemented via some sort of court or community treatment order to ensure the person receives the medication and specialized treatment essential for recovery.¹⁴⁴

As the country's psychiatric hospitals continue to close, prisons need to adapt to be able to serve their mentally ill populations.¹⁴⁵ It has been suggested that prisons "must develop alternative forms of housing for disturbed inmates and must staff them with people who are trained to understand the difference between insubordination and insanity."¹⁴⁶ The New York State Legislature passed a bill that would ban the use of solitary confinement for mentally ill prisoners, but Governor George Pataki vetoed the law.¹⁴⁷ The bill also sought to expand "residential mental health treatment programs, provide better training for corrections staff, and . . . give mental health professionals a greater role in deciding treatment options."¹⁴⁸

After this bill was vetoed, an agreement was reached and Governor Eliot Spitzer signed into law a measure to limit the use of solitary confinement for mentally ill inmates.¹⁴⁹ The bill does not completely bar solitary confinement for mentally ill inmates, but it offers more services and assessment for mentally ill inmates in solitary confinement.¹⁵⁰ Nine million dollars were added to the state budget, most of which is to create alternative residential units to house as many as 300 mentally ill inmates.¹⁵¹ Under the new law, an extensive review must precede the individual's placement in solitary confinement, and mentally ill inmates will be permitted to leave their cells for up

¹⁴² CRIMINALIZATION OF INDIVIDUALS, *supra* note 9, at 2-3.

¹⁴³ CRIMINALIZATION OF INDIVIDUALS, *supra* note 9, at 2-3.

¹⁴⁴ CRIMINALIZATION OF INDIVIDUALS, *supra* note 9, at 2-3.

¹⁴⁵ See Pfeiffer, *supra* note 9, at 17; *Decriminalizing Mental Illness*, *supra* note 7, at sec. 14.

¹⁴⁶ Pfeiffer, *supra* note 9, at 17.

¹⁴⁷ Wachtler, *supra* note 128, at 14. Many other states, such as California, Connecticut, Florida, New Jersey, and Texas, have passed similar legislation. *Id.*

¹⁴⁸ Pfeiffer, *supra* note 9, at 17 (arguing that the bill "would have paid for itself" by reducing time incarcerated for mentally ill persons and reducing recidivism).

¹⁴⁹ Joel Stashenko, *Spitzer, Lawmakers Agree to Limit Solitary Confinement for Mentally Ill Inmates*, N.Y. L. J. 1, Jul. 19, 2007. The bill is based on a settlement arising from federal litigation. *Id.*

¹⁵⁰ Kershaw, *supra* note 129, at B1. The bill also does away with the pasty flour and cabbage diet. Stashenko, *supra* note 151.

¹⁵¹ Stashenko, *supra* note 151.

to four hours per day for therapy and treatment.¹⁵² The New York bill is expected to pressure other states to review their solitary confinement policies.¹⁵³

On November 13, 2007, the U.S. House of Representatives passed the Second Chance Act with an overwhelming majority voting in favor of the bill.¹⁵⁴ Although attempts to pass the bill in the Senate failed in 2007, it elicited broad bi-partisan support and is expected to pass in 2008.¹⁵⁵ The Act is similar to President's Bush's Prisoner Reentry Initiative, which was announced during his 2004 State of the Union Address.¹⁵⁶ The goal of President Bush's initiative was to provide mentoring and transitional services for prisoners re-entering local communities through faith-based and community organizations.¹⁵⁷ Like President Bush's initiative, the Second Chance Act is intended to provide "critical resources designed to reduce recidivism and increase public safety."¹⁵⁸

The Second Chance Act is designed to assist released inmates in finding mental health and substance abuse treatment, offer more opportunities for job placement and

¹⁵² Kershaw, *supra* note 129, at B1.

¹⁵³ Kershaw, *supra* note 129, at B1. The bill also calls for initial mental health screenings for all prisoners entering the system. *Id.* Similar developments are underway in Massachusetts, including more involvement from mental health professionals in deciding whether or not mentally ill inmates can handle solitary confinement, increased training for corrections officers, and, possibly, the establishment of alternative housing for mentally ill inmates. Beth Healy and Michael Rezendes, *Better Prison Mental Health Care Sought*, BOSTON GLOBE, May 2, 2007, available at http://www.boston.com/yourlife/health/mental/articles/2007/05/02/better_prison_mental_health_care_sought/.

¹⁵⁴ Second Chance Act, H.R. 1593, 110th Cong. (2007); News Release, American Psychiatric Association, *Legislation Improves Mental Health Services for Mentally Ill Prisoners*, Nov. 15, 2007, available at <http://www.psych.org/MainMenu/Newsroom/NewsReleases/2007NewsReleases/LegislationImprovesMentalHealthServicesforMentallyIllPrisoners111607.aspx>. The legislation was sponsored by Congressman Danny Davis of Illinois and passed by a vote of 347-62. *Id.*

¹⁵⁵ Reentry Policy Council, 1/22/2008: Recap of the Second Chance Act of 2007, available at http://reentrypolicy.org/announcements/recap_of_sca (last visited Feb. 22, 2008). The bill was stalled by Alabama Senator Jeff Sessions, who requested more time to review certain revisions. *Id.* For the text of the Senate bill, see Second Chance Act, S.1060, 110th Cong. (2007). In the Senate, sponsors included Senators Joseph Biden of Delaware, Arlen Specter of Pennsylvania, Sam Brownback of Kansas, and Patrick Leahy of Vermont. REENTRY POLICY COUNCIL, ONE-PAGE FACT SHEET ON THE SECOND CHANCE ACT OF 2007, available at http://www.reentrypolicy.org/publications/sca_2007_onepager;file (last visited Feb. 22, 2008).

¹⁵⁶ REENTRY POLICY COUNCIL, 1/22/2008: RECAP OF THE SECOND CHANCE ACT OF 2007, available at http://reentrypolicy.org/announcements/recap_of_sca (last visited Feb. 22, 2008).

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

training, aid in housing transition, and offer case management services.¹⁵⁹ The Second Chance Act's estimated annual authorization would be \$165 million.¹⁶⁰ The bill includes several key provisions focused on providing grants to state and local governments and non-profit groups to assist prisoner reentry, and to provide guidance and support for best practices and training procedures.¹⁶¹

In 2004, the Justice and Mental Health Collaboration Program (JMHCPC) grant program was established with the unanimous passage in both the House and Senate of The Mentally Ill Offender Treatment and Crime Reduction Act.¹⁶² The program, which is administered by the U.S. Department of Justice, was given appropriations of \$5 million in 2006 and 2007.¹⁶³ It is expected to facilitate collaboration between the criminal justice, mental health, and substance abuse systems, to increase public safety, and to give the mentally ill in the criminal justice system better access to effective treatment.¹⁶⁴ The grant program requires a joint application from both a mental health agency and criminal justice (and/or juvenile justice) entity of government, which is meant to ensure that the mental health and criminal justice systems receiving funds work

¹⁵⁹ *Id.*

¹⁶⁰ REENTRY POLICY COUNCIL, ONE-PAGE FACT SHEET ON THE SECOND CHANCE ACT OF 2007, *available at* http://www.reentrypolicy.org/publications/sca_2007_onepager;file (last visited Feb. 22, 2008).

¹⁶¹ *Id.* Key provisions include: demonstration grants to state and local governments to promote safe and successful reentry of former inmates through "employment services, substance abuse treatment, housing, family programming, mentoring, victims services, and methods to improve release and revocation using risk-assessment tools;" mentoring grants to non profit organizations to mentor and provide reintegration services to adult inmates reentering the community; offender reentry substance abuse treatment that will create "grants to improve the availability of drug treatment to offenders in prisons, jails, and juvenile facilities;" grants to create family drug treatment programs for families of incarcerated minors; federal reentry initiative to guide the Bureau of Prison Services on enhanced reentry planning procedures; authorization for the U.S. Dept. of Justice to conduct reentry related research; and a National Adult and Juvenile Offender Reentry Resource Center to establish "a national resource center to collect and disseminate best practices and to provide training on and support for reentry efforts." *Id.*

¹⁶² 42 U.S.C. § 3797 (2004); CONSENSUS PROJECT, THE MENTALLY ILL OFFENDER TREATMENT AND CRIME REDUCTION ACT, *available at* http://consensusproject.org/downloads/miotcra_background.pdf (last visited Feb. 23, 2008) [hereinafter CONSENSUS PROJECT, TREATMENT AND CRIME REDUCTION].

¹⁶³ CONSENSUS PROJECT, TREATMENT AND CRIME REDUCTION, *supra* note 162. The Bureau of Justice Assistance, a division of the Office of Justice Programs in the Dept. of Justice, runs the program. *Id.*

¹⁶⁴ CONSENSUS PROJECT, TREATMENT AND CRIME REDUCTION, *supra* note 162. The JMHCPC awards three types of grants: up to \$50,000 for twelve months for planning grants; up to \$250,000 for thirty months for planning and implementation grants; and up to \$200,000 for twenty-four months for implementation and expansion grants. *Id.*

in concert to improve outcomes for inmates and former inmates with mental illnesses.¹⁶⁵

On January 25, 2008, the House passed the Mentally Ill Offender Treatment and Crime Reduction Reauthorization and Improvement Act of 2008.¹⁶⁶ The bill will boost JMHCP grant funding in order to improve services for mentally ill inmates, and to provide training for inmates and the law enforcement officers responsible for them.¹⁶⁷ Specifically, the bill will increase funding from \$50 million to \$75 million annually to provide for specialized training for law enforcement officers, more focused mental health services for female inmates, added and expanded mental health courts, more treatment and resource centers in local communities, and resources for research studies.¹⁶⁸

Over 100 mental health courts have been established in the U.S. within the last decade.¹⁶⁹ These courts combine the criminal justice system with mental health treatment and have been shown to be especially effective with mentally ill persons who

¹⁶⁵ CONSENSUS PROJECT, TREATMENT AND CRIME REDUCTION, *supra* note 162. In 2006, twenty-seven grants were awarded in nineteen states and the District of Columbia. *Id.* Two of the grants were used to develop crisis intervention training programs, while ten were used in conjunction with mental health courts. *Id.* In 2007, twenty-six grants were awarded in sixteen grants. *Id.* Most of these grants are going to be used to target adults, although most have not determined what type of program they will implement. *Id.*

¹⁶⁶ H.R. 3992, 110th Cong. (2008). The bill was introduced to the Senate on Nov. 5, 2007. S. 2304, 110th Congress (2007). The House bill is sponsored by Representative Robert Scott of Virginia and the Senate Bill is sponsored by Senators Ted Kennedy of Massachusetts and Pete Domenici of New Mexico. Second Chance Act, H.R. 1593, 110th Cong. (2007); News Release, *American Psychiatric Association, Legislation Improves Mental Health Services for Mentally Ill Prisoners* (Nov. 15, 2007), available at <http://www.psych.org/MainMenu/Newsroom/NewsReleases/2007NewsReleases/LegislationImprovesMentalHealthServicesforMentallyIllPrisoners111607.aspx>.

¹⁶⁷ Second Chance Act, H.R. 1593, 110th Cong. (2007); News Release, *American Psychiatric Association, Legislation Improves Mental Health Services for Mentally Ill Prisoners*, Nov. 15, 2007, available at <http://www.psych.org/MainMenu/Newsroom/NewsReleases/2007NewsReleases/LegislationImprovesMentalHealthServicesforMentallyIllPrisoners111607.aspx>.

¹⁶⁸ CONSENSUS PROJECT, FACTSHEET, THE MENTALLY ILL OFFENDER TREATMENT AND CRIME REDUCTION REAUTHORIZATION AND IMPROVEMENT ACT OF 2007 H.R. 3992, available at http://consensusproject.org/downloads/miotcra_reauth_factsheet.pdf (last visited Feb. 23, 2008) [hereinafter CONSENSUS PROJECT, FACTSHEET, REAUTHORIZATION AND IMPROVEMENT ACT].

¹⁶⁹ Nora, *supra* note 9, at 22; see *Mental Health Courts and the Trend Toward a Rehabilitative Justice*, 121 HARV. L. REV. 1168, 1169 (Feb. 2008). The first mental health court was established in 1997 in Broward County, Florida. *Id.*

have committed drug and nuisance misdemeanor crimes.¹⁷⁰ Most mental health courts are voluntary and only accept persons who have committed misdemeanors or minor felonies.¹⁷¹ Mental health courts strive to provide mentally ill persons with the type of services they would have received in mental hospitals in the past.¹⁷² They are found to be most successful when the collaboration results in detailed and individual treatment plans with meticulous oversight and treatment.¹⁷³

For example, the mental health court in Cook County, Illinois has been especially effective and successful in reducing recidivism.¹⁷⁴ The Cook County mental health court initially served twenty-five defendants per year, but with a new \$1.2 million federal grant to cover three years of treatment, they expect to increase service to seventy-five defendants per year.¹⁷⁵ In the year before admission into the mental health court program, participants had averaged four arrests and two convictions and spent 130 days in jail.¹⁷⁶ After admission, “76 percent of participants have no arrests, and 89 percent no convictions, and 97 percent no felony convictions.”¹⁷⁷ Participants will average twenty-one days in jail in the year after admission, and those days usually will result from not complying with their program.¹⁷⁸ The program consists of four phases, gradually ceding involvement and control to the individual.¹⁷⁹ Individuals “graduate” after meeting certain objectives including stabilized income and housing, as well as no further arrests or criminal complaints.¹⁸⁰

¹⁷⁰ Nora, *supra* note 9, at 22. The mental health courts usually include a judge, prosecutor, public defender and mental health professionals whose primary responsibility is the docket of the mental health court and who are usually well trained in mental health and its treatment. *Mental Health Courts and the Trend Toward a Rehabilitative Justice*, 121 HARV. L. REV. 1168, 1169 (2008) (arguing that, because of the dedicated and specialized personnel, “the courts take on a unique character as a place where therapy can actually begin, not merely be prescribed.”).

¹⁷¹ Nora, *supra* note 9, at 22; *Mental Health Courts and the Trend Toward a Rehabilitative Justice*, 121 HARV. L. REV. 1168, 1169 (Feb. 2008) (stating that early mental health courts dealt primarily with inmates guilty of repeated misdemeanors). These included persons guilty of public nuisance crimes ranging from public urination to general harassment cases. Nora, *supra* note 9, at 22.

¹⁷² Nora, *supra* note 9, at 22.

¹⁷³ Nora, *supra* note 9, at 23.

¹⁷⁴ Nora, *supra* note 9, at 22. The court was formed in 2004. *Id.*

¹⁷⁵ Nora, *supra* note 9, at 21.

¹⁷⁶ Nora, *supra* note 9, at 22.

¹⁷⁷ Nora, *supra* note 9, at 22.

¹⁷⁸ Nora, *supra* note 9, at 22.

¹⁷⁹ Nora, *supra* note 9, at 23.

¹⁸⁰ Nora, *supra* note 9, at 23. The initial phase consists of: weekly personal and or phone reports with a probation officer; cooperation with a mental health professional as part of an ACT program or psychosocial rehabilitation program; medication and mental health assessment monitoring, sometimes daily; attendance at substance abuse counseling meetings up to seven days

The preventive outpatient treatment (POT) movement began with New York and California.¹⁸¹ The New York statute, known as “Kendra’s Law,” is named after a woman who was pushed in front of a subway car by a mentally ill person who was not in treatment.¹⁸² California’s statute was modeled after the New York law, and is known as “Laura’s Law” for a young woman who was killed in a random shooting by a person diagnosed with schizophrenia.¹⁸³ Forty-two states, including a Michigan, which has a statute known as “Kevin’s Law,” have developed their own versions of preventive outpatient statutes.¹⁸⁴ This movement has been precipitated by the shutdown of forty-four state psychiatric hospitals during the 1990s, which released many mentally ill patients into society without adequate treatment.¹⁸⁵ The movement has also been advanced by the “publicity surrounding several high-profile crimes that have involved people with psychiatric problems.”¹⁸⁶ What distinguishes POT statutes from past statutes is that under a POT statute a judge can force treatment on mentally ill persons living in the community who are not complying with a treatment regimen, whereas, in the past, this could only be done to institutionalized persons.¹⁸⁷

Past statutes, commonly known as danger-or-grave-disability statutes, required a

per week; random drug tests; monthly status reports with the mental health court judge; weekly meetings with a drug treatment case manager; and, in some cases, completion of a residential substance abuse program. *Id.* The subsequent phases are less restrictive and include: monthly reports to a probation officer; attendance at treatment sessions as prescribed; random drug tests; status hearings every three months with the mental health court; substance abuse counseling up to twice per week; education or job training participation as individually prescribed by the treatment program; and twice per week reports to a drug case manager. *Id.* In order to successfully complete the program, individuals must meet a series of objectives: six months without prescription drug, illicit drug, or alcohol abuse; six months of daily productive activity; completion of all court ordered treatment; substance abuse counseling meetings as needed or directed; completion of job skills training or GED, if required; and continuous compliance with all treatment regimens. *Id.*

¹⁸¹ See N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2005); see also CAL. WELF. & INST. CODE §§ 5345-5349.5 (West 2008).

¹⁸² Tresa Baldas, *States Allow Courts to Force Treatment*, 27 NAT’L L. J. 4 (2005).

¹⁸³ Scherer, *supra* note 9, at 385.

¹⁸⁴ Baldas, *supra* note 184, at 4. “Kevin’s Law” was named after a Michigan college student who was killed at a bus station by a schizophrenic with a history of avoiding treatment. *Id.*

¹⁸⁵ Baldas, *supra* note 184, at 4.

¹⁸⁶ Baldas, *supra* note 184, at 4. Along with this publicity and attention, POTs have received several endorsements from prominent mental health associations and agencies, including The Treatment Advocacy Center, The American Association of Psychiatrists, and the National Institute for Mental Health. Scherer, *supra* note 9, at 363.

¹⁸⁷ Baldas, *supra* note 184, at 4.

demanding standard for judges to force treatment on individuals.¹⁸⁸ In order to mandate any kind of treatment under a danger-or-grave disability statute, it must be proven that a person is a serious danger to himself or to others.¹⁸⁹ This standard is very hard to satisfy, especially in court, and laws using this standard fail to protect a large number of mentally ill individuals in dire need of treatment but who may not pose an obviously grave danger to themselves or others.¹⁹⁰ POT statutes seek to fill this void by providing a longer forced outpatient treatment program, with eligibility based on a more “medically-based evidentiary approach” that assesses mental illness “severity and history . . . in conjunction with stricter legal criteria, such as the traditional ‘dangerousness’ standard.”¹⁹¹

Given that most POT statutes are modeled after the New York statute, this section will closely examine “Kendra’s Law.”¹⁹² Under the statute, court-ordered outpatient treatment is based on seven required criteria.¹⁹³ First, only persons aged eighteen or older are eligible.¹⁹⁴ Second, a person must be suffering from mental illness.¹⁹⁵ Third, the person must be “unlikely to survive safely in the community

¹⁸⁸ Scherer, *supra* note 9, at 366-67. The standard of “clear and convincing evidence” of an imminent or considerable risk of injury to themselves or others or of grave disability is required under danger-or-grave disability statutes. *Id.* at 366. This demanding standard has been shown to be troublesome in its executing in protecting the mentally ill individual and the public safety at large. *Id.* at 366-67. These statutes often take effect too late to effectively rehabilitate the mentally ill individual. *Id.* at 367. Involuntary treatment is not permitted until the mentally ill individual is in a period of extreme deterioration, rather than taking effect in the moments leading up to extreme deterioration which would provide a greater chance of effective rehabilitation. *Id.* at 367.

¹⁸⁹ Scherer, *supra* note 9, at 366-67 (discussing how the standard must be proven by “clear and convincing evidence”). This demanding standard is often difficult to prove in court and often fails to protect a considerable portion of the severely mentally ill population. *Id.*

¹⁹⁰ Scherer, *supra* note 9, at 367. The Virginia Tech massacre is an example of this failure to protect. *Id.* The assailant showed multiple signs of a deteriorating mental illness that was reported to authorities by professors and roommates, but he did not receive any meaningful treatment because he could not meet the high requirement of being shown to be a grave danger to himself or others. *Id.*

¹⁹¹ Scherer, *supra* note 9, at 368. Most POT statutes require a minimum six months of outpatient treatment, where as past danger-or-grave-disability statutes just required a minimum of seventy hours of forced treatment with a show of improvement in symptoms. *Id.* 370, 385-86.

¹⁹² See Scherer, *supra* note 9, at 363.

¹⁹³ N.Y. MENTAL HYG. LAW § 9.60(c) (McKinney 2005).

¹⁹⁴ N.Y. MENTAL HYG. LAW § 9.60(c)(1) (McKinney 2005).

¹⁹⁵ N.Y. MENTAL HYG. LAW § 9.60(c)(2) (McKinney 2005). Although severity of a mental illness is not a criterion, a person must be clinically diagnosed by a mental health provider. Scherer, *supra* note 9, at 386-87.

without supervision, based on a clinical determination.”¹⁹⁶ Fourth, the person must illustrate a history of failed compliance with mental health treatment that has necessitated hospitalization at least twice within the last six months; resulting in at least one act constituting “serious physical harm to self or others within the last forty-eight months.”¹⁹⁷ Fifth, it must be demonstrated that, “as a result of his or her mental illness, [the individual is] unlikely to voluntarily participate in outpatient treatment that would enable him or her to live safely in the community.”¹⁹⁸ Sixth, the person must need assisted outpatient treatment “in order to prevent a relapse or deterioration which would be likely to result in serious harm to the person or others.”¹⁹⁹ Last, the person must be likely to benefit from the forced outpatient treatment.²⁰⁰

Under Kendra’s Law, more persons may petition a court to determine eligibility.²⁰¹ There are eight classes of persons who are eligible to bring such a petition, including parents and siblings of mentally ill persons.²⁰² The petition must state the facts supporting the petition and “shall be accompanied by an affirmation or affidavit of a physician” in support of POT intervention.²⁰³

Since its inception, statistics have shown that “Kendra’s Law” is a widespread

¹⁹⁶ N.Y. MENTAL HYG. LAW § 9.60(c)(3) (McKinney 2005). This criterion does bring severity into the equation as it puts power in the hands of the medical professional determine whether or not this person can survive safely on their own. *See id.*; Scherer, *supra* note 9, at 387.

¹⁹⁷ N.Y. MENTAL HYG. LAW § 9.60(c)(4) (McKinney 2005). Alternately an individual may satisfy this criterion by threatening or attempting serious physical harm. *Id.*

¹⁹⁸ N.Y. MENTAL HYG. LAW § 9.60(c)(5) (McKinney 2005). This criterion is important because it considers whether or not the person has the insight to realize they have an illness and voluntarily get treatment for it. Scherer, *supra* note 9, at 388.

¹⁹⁹ N.Y. MENTAL HYG. LAW § 9.60(c)(6) (McKinney 2005).

²⁰⁰ N.Y. MENTAL HYG. LAW § 9.60(c)(7) (McKinney 2005).

²⁰¹ Scherer, *supra* note 9, at 391-92.

²⁰² Scherer, *supra* note 9, at 391-93. Those who may bring a petition include: (1) an adult over eighteen years of age living with the subject; (2) A parent, child, sibling, or spouse of the mentally ill individual over eighteen years old; (3) if the person is hospitalized, the Director of the hospital; (4) A director of any type of mental health agency or organization that provides mental health services to the mentally ill individual; (5) A qualified psychiatrist who is treating the person or supervising the mental health treatment of the mentally ill person; (6) a licensed psychologist or social worker providing mental health treatment to the individual; (7) social services director or official of the county where the mentally ill individual is, or is expected, to be; and (8) the mentally ill individuals parole or probation officer. N.Y. MENTAL HYG. LAW § 9.60(e) (McKinney 2005).

²⁰³ N.Y. MENTAL HYG. LAW § 9.60(e)(2). Persons who file false petitions are subject to criminal prosecution. Scherer, *supra* note 9, at 393.

success.²⁰⁴ The statute has been praised for its detail in outlining the responsibilities for all parties involved, its clear monitoring requirements and provisions, and its incorporation of those provisions to order non-compliant mentally ill persons into hospitals.²⁰⁵ For mentally ill persons who received treatment by virtue of the statute, rates of homelessness, arrests, hospitalizations and incarcerations fell dramatically.²⁰⁶ Unfortunately, although the program received \$32 million dollars in funding, due to the narrow statutory criteria, only 3,766 mentally ill persons received treatment court orders in the first five years following enactment.²⁰⁷ As a further illustration, in 2006, of more than 400,000 mentally ill adults living in New York, only 1,800 fell within the statute's criteria at any given time.²⁰⁸

PART III – Analysis

Developments in Correctional Facilities

Thousands of mentally ill persons across the country are being punished— not for being criminals, but for being sick.²⁰⁹ Often, being sent to prison, though tragic, is their best opportunity to receive treatment.²¹⁰ Once in prison, mentally ill inmates are more likely to be punished for minor violations, and more likely to be involved in disturbances, resulting in punishments that may exacerbate their mental illnesses.²¹¹ Mentally ill inmates often re-enter society with more pronounced symptoms than they had before incarceration and it is often only a matter of time before they cycle back into the prison system.²¹²

Prisoners are entitled to appropriate mental health treatment under the Eight Amendment of the U.S. Constitution.²¹³ Although nearly all correctional facilities claim

²⁰⁴ Scherer, *supra* note 9, at 408.

²⁰⁵ Jenkins, *supra* note 11, at C1 (comparing Kendra's Law with outpatient treatment of mentally ill persons in other states).

²⁰⁶ N.Y. STATE OFFICE OF MENTAL HEALTH, KENDRA'S LAW: FINAL REPORT ON THE STATUS OF ASSISTED OUTPATIENT TREATMENT 17 (2005), available at http://www.omh.state.ny.us/omhweb/kendra_web/finalreport/. Homelessness fell 74%; Psychiatric hospitalization fell 77%; Arrests fell 83%; and incarcerations fell 87%. *Id.*

²⁰⁷ *Id.* at 2, 7 (indicating less than 40% of persons referred to Assisted Outpatient Treatment coordinators were found eligible).

²⁰⁸ Jenkins, *supra* note 11, at C1 (critiquing the narrow scope of Kendra's Law).

²⁰⁹ See JAMES & GLAZE, *supra* note 1, at 1; see *supra* text accompanying note 27.

²¹⁰ Nora, *supra* note 9, at 18-19; *supra* text accompanying note 120.

²¹¹ JAMES & GLAZE, *supra* note 1, at 10; see also *supra* text accompanying note 30.

²¹² See generally, JAMES & GLAZE, *supra* note 1, at 9; see *supra* text accompanying note 30.

²¹³ U.S. CONST. amend. VIII; *Estelle v. Gamble*, 429 U.S. 97, 104-05 (1976).

to offer mental health treatment, just 34 percent of state prisoners reporting a mental health problem actually receive treatment.²¹⁴ Of those who receive mental health treatment, an even smaller percentage receives clinically appropriate treatment.²¹⁵ For depression, schizophrenia, and bipolar disorder, the most prevalent mental health disorders in prison, a combination of psychotherapy and medication is the most effective treatment.²¹⁶ A recent survey found that just 26.8 percent of state inmates with mental health problems were receiving prescribed medication, and just 22.6 percent were receiving mental health therapy.²¹⁷

Correctional facilities were not built, and are not equipped, to be mental health facilities, and they face numerous problems when attempting to deal with mentally ill inmates.²¹⁸ First, most correctional facility employees lack appropriate mental health training.²¹⁹ Second, correctional facilities lack sufficient mental health professionals and mental health facilities.²²⁰ Third, even if they have access to mental health professionals or facilities, they cannot force treatment onto an inmate unless that inmate is deemed to (1) have a mental illness, and (2) be a grave danger to himself or to others.²²¹ This high standard forces prison officials to use alternate disciplinary measures, oftentimes solitary confinement.²²² Fourth, mental illness is often associated with substance abuse, and although prison often offers substance abuse treatment programs, without simultaneous mental health services, these programs are short-term fixes at best.²²³ Inmates frequently return to self-medicating with alcohol or drugs and end up back in prison on the corresponding criminal charges.²²⁴ Last, correctional facilities do not require

²¹⁴ JAMES & GLAZE, *supra* note 1, at 9. Just 24% of federal prisoners and 17% of local jail inmates with mental health problems reported receiving mental health treatment since admission. *Id.* All federal prisons, and most state prisons, are mandated to provide mental health services to inmates. *Id.* These services include initial mental health screenings, therapy and counseling through mental health professionals, and distribution of psychotropic medication. *Id.*

²¹⁵ See JAMES & GLAZE, *supra* note 1, at 2-3, 9-10; see also *supra* notes 119-121.

²¹⁶ See DEPRESSION, *supra* note 47, at 8, 16; SCHIZOPHRENIA, *supra* note 80, at 12; BIPOLAR DISORDER, *supra* note 73, at 17.

²¹⁷ JAMES & GLAZE, *supra* note 1, at 9.

²¹⁸ Scherer, *supra* note 9, at 414; see *supra* text accompanying note 113.

²¹⁹ See Second Chance Act of 2007, H.R. 1593, 110th Cong. (2007); see also Pfeiffer, *supra* note 9, at 17.

²²⁰ See Second Chance Act of 2007, H.R. 1593, 110th Cong. (2007); see also Pfeiffer, *supra* note 9, at 17.

²²¹ See Scherer, *supra* note 9, at 366 (discussing the New York standard for mandatory outpatient treatment).

²²² See Pfeiffer, *supra* note 9, at 17 (discussing how prisons treat mentally ill prisoners).

²²³ See Nora, *supra* note 9, at 19 (declaring these programs to often be futile).

²²⁴ See Nora, *supra* note 9, at 19 (reinforcing the relationship between mentally ill inmates and

mentally ill inmates to show an improvement in their condition before release, and often release is not conditional upon medication or treatment.²²⁵

Recent developments, such as increased training for correctional officers and limitations on solitary confinement, though noble efforts, are unlikely to have a substantial effect on rates of recidivism for mentally ill inmates.²²⁶ New York has set important standards; hopefully other states will follow suit and demand a limit to solitary confinement for mentally ill inmates.²²⁷ The state has increased its budget in order to create more alternative residential housing units for mentally ill inmates, to provide better training to corrections officers, to offer better access to treatment and services for mentally ill inmates while in solitary confinement, and to limit the severity of solitary confinement for those with mental illness.²²⁸

Although limiting exposure to the brutal conditions of solitary confinement and increasing opportunity for treatment may help to mollify the effect the prison system has on the individual's condition, none of these efforts fully removes the threat of harm to at-risk inmates from prison culture.²²⁹ These mentally ill individuals will still be incarcerated, and they are still more likely to break facility rules, get in fights, and be placed in solitary confinement.²³⁰ These developments do not lower the standard for forced treatment nor do they mandate outpatient treatment as a condition of every mentally ill inmate's release.²³¹

Federal Legislation

The Second Chance Act of 2007 authorizes grants for states to develop programs to assist prisoners in successfully reentering society.²³² The bill has a number of positive aspects.²³³ First, it is very broad and is not limited to one group or segment

substance abuse).

²²⁵ See Nora, *supra* note 9, at 20-21 (comparing prison reentry efforts with those of mental health courts).

²²⁶ See CONSENSUS PROJECT, FACTSHEET, REAUTHORIZATION AND IMPROVEMENT ACT, *supra* note 168.

²²⁷ Stashenko, *supra* note 151.

²²⁸ Stashenko, *supra* note 151.

²²⁹ Stashenko, *supra* note 151.

²³⁰ See Nora, *supra* note 9, at 19.

²³¹ See generally, Scherer, *supra* note 9, at 368.

²³² Second Chance Act, H.R. 1593, 110th Cong. (2007).

²³³ See REENTRY POLICY COUNCIL, 1/22/2008: RECAP OF THE SECOND CHANCE ACT OF 2007, at http://reentrypolicy.org/announcements/recap_of_sca (last visited Feb. 22, 2008) [hereinafter

of the prison population.²³⁴ Second, and most importantly, its stated goal is to reduce recidivism rates; thus, it enacts a number of conditions and requirements for research.²³⁵ Third, the bill authorizes grants for in-prison programs such as educational, employment, and literacy training, as well as re-entry programs such as transitional services and mentoring.²³⁶ Fourth, the bill authorizes grants for programs focused on women and juveniles.²³⁷

While the Second Chance Act may be successful in creating more programs to assist in the re-entry movement, it also has some shortcomings.²³⁸ First, the Act does not divert inmates from prison and includes little in the way of prevention programs.²³⁹ There is minimal funding for diversionary programs, such as mental health courts or residential psychiatric facilities.²⁴⁰ Although some funding is offered for in-prison educational programs, the majority of the funds are focused on successfully reintegrating prisoners into society, rather than on mental health treatment.²⁴¹ Second, it does not authorize funding to be used to educate the public about mental health issues and thus does nothing to reduce the stigma of being mentally ill.²⁴² Third, the bill lacks teeth.²⁴³ It has no supervision mechanism to assure that mentally ill inmates are following prescribed programs, and mandates a maximum participation of one year in any given program, despite the fact that most mental illnesses, especially the severe illnesses experienced by many mentally ill offenders, require continuous treatment.²⁴⁴

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²³⁴ Second Chance Act, H.R. 1593, 110th Cong. (2007); *see* REENTRY POLICY COUNCIL, ONE-PAGE FACT SHEET ON THE SECOND CHANCE ACT OF 2007, *at* http://www.reentrypolicy.org/publications/sca_2007_onepager;file (last visited Feb. 22, 2008) [hereinafter REENTRY POLICY COUNCIL, FACTSHEET].

²³⁵ Second Chance Act, H.R. 1593, 110th Cong. (2007).

²³⁶ Second Chance Act, H.R. 1593, 110th Cong. (2007); *see supra* text accompanying note 162.

²³⁷ Second Chance Act, H.R. 1593, 110th Cong. (2007); *see* REENTRY POLICY COUNCIL, FACTSHEET, *supra* note 234; *see supra* text accompanying note 162.

²³⁸ *See generally*, Second Chance Act, H.R. 1593, 110th Cong. (2007).

²³⁹ *See generally*, Second Chance Act, H.R. 1593, 110th Cong. (2007); REENTRY POLICY COUNCIL, FACTSHEET, *supra* note 234.

²⁴⁰ *See generally*, Second Chance Act, H.R. 1593, 110th Cong. (2007); REENTRY POLICY COUNCIL, FACTSHEET, *supra* note 234.

²⁴¹ *See* REENTRY POLICY COUNCIL, RECAP, *supra* note 233.

²⁴² *See* Second Chance Act, H.R. 1593, 110th Cong. (2007); *see* REENTRY POLICY COUNCIL, FACTSHEET, *supra* note 234.

²⁴³ *See generally*, REENTRY POLICY COUNCIL, FACTSHEET, *supra* note 234.

²⁴⁴ *See* REENTRY POLICY COUNCIL, FACTSHEET, *supra* note 234; *see generally*, REENTRY POLICY COUNCIL, RECAP, *supra* note 233.

The Mentally Ill Offender Treatment and Crime Reduction Reauthorization and Improvement Act of 2008 may be the most expansive legislation offered yet.²⁴⁵ The Act seeks to ensure the collaboration between the criminal justice system, mental health agencies, and substance abuse programs.²⁴⁶ If the 2008 Mentally Ill Offender Treatment and Crime Reduction Reauthorization and Improvement Act passes in Congress, it will bring with it a \$25 million annual increase in funding to cover specialized training for law enforcement officers.²⁴⁷ The bill will also provide funding focused on mental health services for mentally ill female inmates, who, as previously noted, constitute an astounding percentage of the total female inmate population.²⁴⁸ The bill would also add and expand mental health courts and fund more local community treatment centers.²⁴⁹

While the 2004 Act and the 2008 bill have a lot to offer, their scope and overall effect are minimal.²⁵⁰ There are over 1,500 correctional facilities in the country, yet only twenty-seven grants were issued in 2006, and only twenty-seven more in 2007.²⁵¹ Likewise, projects supported by this grant money, including mental health courts and crisis intervention centers, are narrow in scope, benefit just a very small percentage of the mentally ill offender population, and are unlikely to have a significant effect on current rates of recidivism.²⁵²

Mental Health Courts

Mental health courts have shown remarkable results in reducing recidivism among mentally ill offenders.²⁵³ Mental health courts have successfully brought the criminal justice system, mental health agencies and corporations, and substance abuse

²⁴⁵ See generally, H.R. 3992, 110th Cong. (2008); S. 2304, 110th Congress (2007); see *supra* notes 165-66.

²⁴⁶ CONSENSUS PROJECT, FACTSHEET, REAUTHORIZATION AND IMPROVEMENT ACT, *supra* note 168.

²⁴⁷ CONSENSUS PROJECT, FACTSHEET, REAUTHORIZATION AND IMPROVEMENT ACT, *supra* note 168.

²⁴⁸ See H.R. 3992, 110th Cong. (2008); see S. 2304, 110th Congress (2007); see also CONSENSUS PROJECT, FACTSHEET, REAUTHORIZATION AND IMPROVEMENT ACT, *supra* note 168.

²⁴⁹ See CONSENSUS PROJECT, FACTSHEET, REAUTHORIZATION AND IMPROVEMENT ACT, *supra* note 168.

²⁵⁰ See generally, CONSENSUS PROJECT, TREATMENT AND CRIME REDUCTION, *supra* note 162; see *supra* text accompanying note 166.

²⁵¹ See generally, CONSENSUS PROJECT, TREATMENT AND CRIME REDUCTION, *supra* note 162; see *supra* text accompanying note 166.

²⁵² See CONSENSUS PROJECT, TREATMENT AND CRIME REDUCTION, *supra* note 162.

²⁵³ Nora, *supra* note 9, at 21-23.

programs together.²⁵⁴ Most importantly, they are diversionary programs, meaning that persons voluntarily enter the mental health court and submit to a prescribed treatment program rather than enter the criminal justice system.²⁵⁵ While mentally ill offenders cannot be forced into the mental health court, it can be an appealing alternative to confinement in a correctional facility.²⁵⁶

Mental health courts implement programs that are individually tailored and usually involve a progression through multiple phases.²⁵⁷ The initial phase of the treatment program and its supervision are intensive.²⁵⁸ As the individual becomes immersed in the program, the program and its supervision become less stringent provided the mentally ill offender shows progress.²⁵⁹ One key distinction between mental health courts and traditional prison programs is that in order to successfully complete the mental health court program, the individual is required to demonstrate significant improvement in dealing with their illness by meeting a series of targeted objectives.²⁶⁰ Supervision by the criminal justice system, mental health agencies, and substance abuse programs is key aspect of mental health courts and should be part of all treatment programs, in or out of jail.²⁶¹

Despite their great potential value, mental health courts are unlikely to make a major impact on overall rates of recidivism unless they are expanded in scope and prevalence.²⁶² Mental health courts are still somewhat rare, with only about a hundred currently operating.²⁶³ The number of courts will grow with increased funding, but the scope of these courts also must be expanded.²⁶⁴ Most mental health courts deal primarily with mentally ill offenders guilty of misdemeanors and minor felonies.²⁶⁵ Mentally ill violent offenders, often those with untreated schizophrenia and bipolar disorders, are often excluded from these programs because of the type of crimes they

²⁵⁴ Nora, *supra* note 9, at 22; *see supra* text accompanying note 171.

²⁵⁵ Nora, *supra* note 9, at 22; *supra* text accompanying note 172.

²⁵⁶ *Cf.* Nora, *supra* note 9, at 22.

²⁵⁷ Nora, *supra* note 9, at 23; *supra* text accompanying note 181.

²⁵⁸ Nora, *supra* note 9, at 23; *supra* text accompanying note 181.

²⁵⁹ Nora, *supra* note 9, at 23; *supra* text accompanying note 181.

²⁶⁰ Nora, *supra* note 9, at 23; *supra* text accompanying note 181.

²⁶¹ Nora, *supra* note 9, at 22; *supra* text accompanying note 171.

²⁶² *See generally*, CONSENSUS PROJECT, TREATMENT AND CRIME REDUCTION, *supra* note 162.

²⁶³ CONSENSUS PROJECT, FACTSHEET, REAUTHORIZATION AND IMPROVEMENT ACT, *supra* note 168.

²⁶⁴ Nora, *supra* note 9, at 21.

²⁶⁵ Nora, *supra* note 9, at 22.

have committed.²⁶⁶ It is imperative that mental health courts expand their scope to accept mentally ill persons who have committed violent crimes.²⁶⁷ Most of these persons will eventually be released from prison and re-enter society; if they continue to be excluded from treatment programs they will continue to be dangerous, and will likely be arrested again.²⁶⁸

Mental health courts were largely established by judges and their leadership has been crucial to the development up of the courts.²⁶⁹ One unfortunate implication of this is that mental health courts may not survive in the absence of a founding judge's guidance.²⁷⁰ This problem could be alleviated through the expansion of mental health courts, by educating members of the criminal justice system on mental health, and with the continued positive results from collaboration between the criminal justice and mental health systems.²⁷¹

Preventive Outpatient Statutes

POT statutes, especially New York's "Kendra's Law" have also been show to be very successful for a limited group of mentally ill individuals.²⁷² The efficacy of POT statutes is attributable to the clear descriptions they provide regarding each role involved in the process.²⁷³ They lay out eligibility criteria and monitor requirements and provisions.²⁷⁴ Prior to enactment of POT statutes, judges could only force treatment on institutionalized persons.²⁷⁵ POT statutes now permit forced treatment of mentally ill individuals living in the community and forced hospitalization for individuals who fail to comply with their POT-mandated treatment order.²⁷⁶ Additionally, under prior statutes, a very limited number of people had the authority to file a petition for forced treatment.²⁷⁷ Under current POT statutes, more persons—including parents, children,

²⁶⁶ See Nora, *supra* note 9, at 22.

²⁶⁷ See *generally*, Nora, note 9, at 22; see *supra* text accompanying note 172.

²⁶⁸ See Nora, *supra* note 9, at 19; see also Pfeiffer, *supra* note 9, at 17.

²⁶⁹ See Nora, *supra* note 9, at 22.

²⁷⁰ See Nora, *supra* note 9, at 22.

²⁷¹ Nora, *supra* note 9, at 23; CONSENSUS PROJECT, FACTSHEET, REAUTHORIZATION AND IMPROVEMENT ACT, *supra* note 168.

²⁷² Scherer, *supra* note 9, at 409.

²⁷³ See *generally*, N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2005).

²⁷⁴ *Id.*

²⁷⁵ See Scherer, *supra* note 9, at 366.

²⁷⁶ See Scherer, *supra* note 9, at 368; see also Baldas, *supra* note 184, at 4

²⁷⁷ See Scherer, *supra* note 9, at 366.

siblings, roommates and treating mental health professionals—can file such petitions.²⁷⁸

While this enforcement power, coupled with the increased number of persons able to file petitions, has allowed POT statutes to reach further than ever before, greater expansion is needed.²⁷⁹ Despite the success during their brief history, POT statutes are still too limited in scope.²⁸⁰ For example, in New York less than one-half of one percent of mentally ill adults in 2006 fell under the POT statute's eligibility criteria at any given time.²⁸¹ In its first five years, only 3,766 court orders were issued under "Kendra's Law."²⁸² For POT statutes to have a significant impact on rates of recidivism among the mentally ill offender population, the eligibility criterion needs to be expanded so that the law applies to more than one half of one percent of the mentally ill population.²⁸³ POT statutes also need to be linked with the criminal justice system and implemented as conditions of release and part of parole programs.²⁸⁴

In its first few years, the New York POT statute has shown remarkable success.²⁸⁵ Rates of homelessness, arrests, hospitalizations and incarcerations fell drastically since the inception of the statute.²⁸⁶ If the statute can be expanded to include a greater number of mentally ill offenders and if it is more closely linked with the criminal justice system—possibly as a diversionary program—the program established by New York's POT statute might truly help mentally ill offenders to overcome their illnesses while helping to remove the threat that those with untreated mental illness pose to innocent people.²⁸⁷

²⁷⁸ Scherer, *supra* note 9, at 391-92.

²⁷⁹ *See generally*, Jenkins, *supra* note 11, at C1.

²⁸⁰ *See* N.Y. STATE OFFICE OF MENTAL HEALTH, *supra* note 208, at 7 (finding that in approximately five years just 10,078 persons were referred to determine eligibility). Just 40 percent of these referrals resulted in a filing of a petition for a court order. *Id.* 93 percent of these petitions were granted resulting in court orders. *Id.* *See generally*, Jenkins, *supra* note 11, at C1.

²⁸¹ Jenkins, *supra* note 11, at C1.

²⁸² N.Y. STATE OFFICE OF MENTAL HEALTH, *supra* note 208, at 7.

²⁸³ *See generally*, Jenkins, *supra* note 11, at C1.

²⁸⁴ *See generally*, N.Y. STATE OFFICE OF MENTAL HEALTH, *supra* note 208, at 3-7; Jenkins, *supra* note 11, at C1.

²⁸⁵ Scherer, *supra* note 9, at 409.

²⁸⁶ N.Y. STATE OFFICE OF MENTAL HEALTH, *supra* note 208, at 17; *supra* text accompanying note 208.

²⁸⁷ *See generally*, N.Y. STATE OFFICE OF MENTAL HEALTH, *supra* note 208, at 3-7; Jenkins, *supra* note 11, at C1.

Assertive Community Treatment Programs (ACT)

ACT programs are appealing because the cost per-person-per-day is less than half of what it costs to house a mentally ill inmate, yet the services provided are similar to those of a psychiatric hospital.²⁸⁸ ACT also provides mentally ill offenders with the services of mental health professionals, without the stigma of a psychiatric ward.²⁸⁹ However, ACT is primarily an auxiliary program, more effective when part of a greater network of multiple treatment components.²⁹⁰

Recommendations

The resources to appropriately treat all mentally ill Americans are available, but must be expanded.²⁹¹ Lack of treatment is the primary reason mental health problems are so prevalent in the prison system.²⁹² The lack of appropriate treatment is partly attributable to a lack of coordination or unification amongst all mental health resources and to the narrow scope of existing remedial programs.²⁹³

The scope of POT statutes should be expanded to ensure that more at risk mentally ill persons are brought into outpatient treatment programs before they end up in jail; funding for mental health courts needs to be increased to expand their prevalence; and ACT programs need to increase in number and scope to further ensure that these individuals receive the specialized treatment they need.²⁹⁴

To complement any expansion of mental health programs, there must be a centralized body responsible for coordinating all efforts to address mental health in U.S. prisons.²⁹⁵ A new government agency, or new branch of an existing agency, could

²⁸⁸ CRIMINALIZATION OF INDIVIDUALS, *supra* note 9, at 2 (discussing cost and treatment benefits of ACT programs).

²⁸⁹ CRIMINALIZATION OF INDIVIDUALS, *supra* note 9, at 2-3 (analogizing ACT programs to "hospitals without walls").

²⁹⁰ CRIMINALIZATION OF INDIVIDUALS, *supra* note 9, at 2-3 (declaring that ACT programs need an enforcement mechanism in order to ensure appropriate medications and other treatment is complied with).

²⁹¹ FRANK & GLIED, *supra* note 11, at 26; text accompanying notes 100-02 (discussing improvements in the delivery of mental health care).

²⁹² See generally, FRANK & GLIED, *supra* note 11, at 5-7.

²⁹³ See generally, FRANK & GLIED, *supra* note 11, at 147-48.

²⁹⁴ Jenkins, *supra* note 11, at C1; CONSENSUS PROJECT, FACTSHEET, REAUTHORIZATION AND IMPROVEMENT ACT, *supra* note 168; see CRIMINALIZATION OF INDIVIDUALS, *supra* note 9, at 3-4.

²⁹⁵ FRANK & GLIED, *supra* note 11, at 147-48.

accomplish this goal.²⁹⁶ In any case, to expand existing programs and ensure that resources are used effectively, there must be a central agency to administer these programs.²⁹⁷

As many of the diversionary programs will not be applicable to all of the mentally ill inmate population, treatment within prisons needs to improve as well.²⁹⁸ The statistics are clear that less than one-third of inmates receives either medication or psychotherapy, even though a combination of the two is the most effective strategy for fighting most mental illnesses.²⁹⁹ To combat the high rate of substance abuse associated with mental illness, many individuals are placed in substance abuse programs, yet these are rarely effective when they are not combined with medication and psychotherapy.³⁰⁰ Mentally ill individuals are also more likely to be placed in solitary confinement, which often exacerbates symptoms of mental illness.³⁰¹

For those who are not violent offenders and are guilty of nuisance-type misdemeanors, diversionary programs such as mental health courts coupled with assertive community treatment programs are the best method for treatment and rehabilitation.³⁰² Treatment in the community is sometimes highly effective for these persons while, prison systems tend to aggravate their conditions.³⁰³ In lieu of state psychiatric hospitals providing around the clock, supervised, mental health treatment, mental health courts have shown noteworthy success in treating many mentally ill offenders, especially when coupled with ACT programs.³⁰⁴

²⁹⁶ FRANK & GLIED, *supra* note 11, at 147-48.

²⁹⁷ See generally, FRANK & GLIED, *supra* note 11, at 147-48.

²⁹⁸ See Nora, *supra* note 9, at 22 (showing that most mental health courts do not accept violent offenders into their programs); JAMES & GLAZE, *supra* note 1, at 9 (finding that most mentally ill prisoners do not receive appropriate mental health treatment).

²⁹⁹ JAMES & GLAZE, *supra* note 1, at 9; text accompanying notes 118-20.

³⁰⁰ See Nora, *supra* note 9, at 19; *supra* text accompanying note 132.

³⁰¹ Pfeiffer, *supra* note 9, at 17. Being placed in prison, and especially solitary confinement, is not conducive to the improvement of mental illnesses. *Id.* A move into solitary confinement is often a result of a rules violation or a fight coupled with the fact that most prison personnel are not trained to deal with mentally ill inmates. See JAMES & GLAZE, *supra* note 1, at 1.

³⁰² See Nora, *supra* note 9, at 22 (discussing the successes of early mental health courts that targeted non violent misdemeanants).

³⁰³ See CRIMINALIZATION OF INDIVIDUALS, *supra* note 9, at 3-4; JAMES & GLAZE, *supra* note 1, at 1-3.

³⁰⁴ Nora, *supra* note 9, at 22-23 (discussing the successes of the Cook County Mental Health Court). See also Eckholm, *supra* note 5, at A24 (discussing the need to connect mentally ill prisoners with community treatment programs once released from prison).

When symptomatic and untreated, persons with schizophrenia and bipolar disorder are four times more likely to commit a violent crime than the general population.³⁰⁵ But when asymptomatic and under treatment, there is no difference between the general and mentally ill populations regarding their likelihood to commit a violent crime.³⁰⁶ These violent mentally ill offenders are essentially being ignored by the criminal justice system.³⁰⁷ They do not fall under the eligibility criteria for most POT statutes, mental health courts, and ACT programs because they have committed violent crimes.³⁰⁸ Even though violent offenders seem to fit the standard for mandated treatment of danger to themselves or others more so than other mentally ill offenders, they often do not receive the treatment they need in or out of prison.³⁰⁹ Prisons need to offer specialized treatment to these violent, mentally ill offenders, and when they are released into their communities (as ninety-five percent of inmates are), they should be required to complete outpatient ACT-type programs as a condition of their release or parole.³¹⁰

Conclusion

Mental health care for the American mentally ill population has greatly improved over the last half century. Treatment access and options have vastly increased for most Americans. But with this great expansion in mental health care, many of the most vulnerable Americans have “slipped through the cracks” of the system and unfairly suffer, despite the availability of existing resources.

The deinstitutionalization movement caused the criminalization of the mentally ill and forced our nation’s prisons to become the largest psychiatric facilities.³¹¹ With this shift came the overcrowding of correctional facilities and higher rates of recidivism. Statistics show that mentally ill inmates are more likely to be repeat offenders, and that inmates with certain illnesses are more likely to commit violent crimes. Prisons were

³⁰⁵ Nora, *supra* note 9, at 19.

³⁰⁶ Nora, *supra* note 9, at 19.

³⁰⁷ See generally, Nora, *supra*, note 9, at 22; Jenkins, *supra* note 11, at C1; CRIMINALIZATION OF INDIVIDUALS, *supra* note 9, at 3-4.

³⁰⁸ See Nora, *supra* note 9, at 22 (discussing the limitations of mental health courts); Jenkins, *supra* note 11, at C1 (describing the narrow scope of the New York POT statute); CRIMINALIZATION OF INDIVIDUALS, *supra* note 9, at 3-4; *supra* text accompanying note 171.

³⁰⁹ See generally, Scherer, *supra* note 9, at 366-67, 410.

³¹⁰ See DEPT. OF JUSTICE, OFFICE OF COMMUNITY ORIENTED POLICING SERVICES, PRISONER REENTRY AND COMMUNITY POLICING 6 (2006), available at <http://www.cops.usdoj.gov/mime/open.pdf?Item=1701>.

³¹¹ See *Decriminalizing Mental Illness*, *supra* note 7.

never designed to handle the mentally ill population, and data shows that they are not well equipped to do so. That said, the movement to de-criminalize mental illness is under way, and many of the resulting developments show great promise. In order to sustain and expand this success, these programs need to be centralized and coordinated under the umbrella of a unified government agency. They also need to be expanded in number and scope to alleviate the burden on correctional facilities and society and so that specialized treatment can be offered to those who desperately need it.