

## “ARE THERE NO PRISONS?” MENTAL HEALTH AND THE CRIMINAL JUSTICE SYSTEM IN THE UNITED STATES

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I. INTRODUCTION	103
II. A BRIEF HISTORY OF MENTAL HEALTH HOSPITALIZATION IN THE UNITED STATES	107
III. PENROSE’S LAW	110
IV. CURRENT TREATMENT RECOMMENDATIONS	111
<i>A. Symptoms</i>	111
<i>B. Multi-Faceted Treatment Approach</i>	113
V. THE CRIMINAL JUSTICE SYSTEM AND COMPETENCY	115
<i>A. Law Enforcement Interaction with Individuals Having Mental Health Issues</i>	115
<i>B. Duty of Defense Counsel</i>	118
<i>C. Issues Regarding Medication</i>	120
<i>D. Insanity and Diminished Responsibility</i>	121
<i>E. The Criminal Justice System’s Inability to Address Mental Health Issues</i>	123
VI. MENTAL HEALTH COURTS AND DIVERSION PROGRAMS	124
<i>A. Prebooking Diversion</i>	124
<i>B. Mental Health Courts</i>	125
<i>C. Postbooking Diversion</i>	126
VII. CONCLUSION	127

### I. INTRODUCTION

Charles Dickens penned his famous words “are there no prisons?” in 1843’s *A Christmas Carol*, as a part of a dialogue between Ebenezer Scrooge and two gentlemen soliciting donations for the poor.<sup>1</sup> Two years prior to the release of *A Christmas Carol*, Dorothea Dix began a crusade to reform the treatment of mentally ill inmates after

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<sup>1</sup> CHARLES DICKENS, *A CHRISTMAS CAROL* 13 (W. Heinemann ed., Windmill Press 1962) (1843). (“At this festive season of the year, Mr. Scrooge,” said the gentleman, taking up a pen, “it is more than usually desirable that we should make some slight provision for the Poor and Destitute, who suffer greatly at the present time. Many thousands are in want of common necessities; hundreds of thousands are in want of common comforts, sir.” Scrooge asked, “Are there no prisons?” The gentleman replied, “Plenty of prisons.” With relief, Scrooge said, “Oh! I was afraid, from what you said at first, that something had occurred to stop them in their useful course.”)

witnessing firsthand the abhorrent care those individuals received.<sup>2</sup> Dix's efforts resulted in the establishment of new hospitals as well as the reorganization and restructuring of existing hospitals.<sup>3</sup> Dix's observations of "prisoners, chained in dark enclosed spaces, lying in their own filth, without adequate clothing, and abused physically and sexually"<sup>4</sup> motivated her to bring a legal fight.<sup>5</sup> By the end of Dix's efforts in 1880, she had helped establish a total of 32 mental hospitals.<sup>6</sup> Although 170 years have elapsed since Dix began her efforts to reform the treatment of mentally ill inmates, not much has changed—and the public perception of mental illness is still fraught with misunderstanding and fear at best and disbelief and derision at worst.<sup>7</sup>

The inadequate treatment of inmates with mental illness has continued into current times. In 1995, a lawsuit filed on behalf of inmates in the California correction system made its way through the federal court system and to the Supreme Court, which resulted in the 2011 decision *Brown v. Plata*.<sup>8</sup> In *Brown*, the Court found:

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<sup>2</sup> *Dorothea Dix*, DICTIONARY UNITARIAN & UNIVERSALIST BIOGRAPHY (January 3, 2003),

<http://uudb.org/articles/dorotheadix.html> ("In March, 1841, a ministerial student, frustrated with his efforts to teach a Sunday class for women incarcerated in the East Cambridge jail, thought that a woman might better do the task. He approached Dix for advice. She decided to teach the class herself. What she encountered in the jail shocked her and changed her life. The jail was unheated. Those incarcerated were not segregated; hardened criminals, feeble-minded children and the mentally ill all occupied the same quarters. Dix secured a court order to provide heat and to make other improvements.").

<sup>3</sup> Vasantha Reddi, *Dorothea Lynde Dix (1802-1887)*, TRUTH ABOUT NURSING, <http://www.truthaboutnursing.org/press/pioneers/dix.html> (last updated August 26, 2005) ("[B]etween 1843 to 1880—the main years that [Dix] spent advocating for the mentally ill—the number of hospitals for the mentally ill increased almost ten-fold, from 13 to 123. 'Where new institutions were not required, she fostered the reorganization, enlargement, and restaffing—with well-trained, intelligent personnel—of already existing hospitals.' This achievement indicates that her work led to vast improvements in the fledgling profession of nursing. Her efforts eventually resulted in the founding of special facilities for the insane and destitute in the United States, Canada, and at least 13 European countries . . .") (footnotes omitted).

<sup>4</sup> *Id.*

<sup>5</sup> *Id.*

<sup>6</sup> *Id.*

<sup>7</sup> Paul Krassner, *Behind the Infamous Twinkie Defense*, HUFFINGTON POST (Dec. 4, 2008, 02:26 PM), [http://www.huffingtonpost.com/paul-krassner/behind-the-infamous-twink\\_b\\_148474.html](http://www.huffingtonpost.com/paul-krassner/behind-the-infamous-twink_b_148474.html). The "Twinkie Defense" is an expression derived from the 1979 trial of Dan White. On November 27, 1978, White assassinated Mayor George Moscone and Supervisor Harvey Milk. *Id.* At his trial, psychiatrist Martin Blinder testified that White had been depressed at the time of the crime, and he pointed to several behavioral changes indicating White's depression. *Id.* "Dale Metcalf, a former member of Ken Kesey's Merry Pranksters who had become a lawyer, told me how he happened to be playing chess with Steven Scherr, a member of White's legal team. Metcalf had just read *Orthomolecular Nutrition* by Abram Hoffer. He questioned Scherr about White's diet and learned that, while under stress, White would consume candy bars and soft drinks. Metcalf recommended the book to Scherr, suggesting the author as an expert witness. For, in his book, Hoffer revealed a personal vendetta against doughnuts, and White had once eaten five doughnuts in a row. On the witness stand, psychiatrist Martin Blinder stated that, on the night before the murders, while White was 'getting depressed about the fact he would not be reappointed, he just sat there in front of the TV set, binging on Twinkies.'" *Id.* As such, the defense convinced the jury that White's capacity for rational thought had been diminished at the time of the crime. *Id.* The jurors concluded that White was not capable of the premeditation required for murder, and instead, the jury convicted him of voluntary manslaughter. *Id.* Public protests over the verdict led to the White Night Riots. See Paul R. Lynd, *Juror Sexual Orientation: the Fair Cross-Section Requirement, Privacy, Challenges for Cause, and Peremptories*, 46 UCLA L. REV. 231, 233-34 (Oct. 1998); see also JOSHUA DRESSLER, UNDERSTANDING CRIMINAL LAW § 25.04[A] (Frank R. Strong et al. eds., 4th ed. 2006) (stating that the acquittal of John Hinckley caused a national reassessment of the insanity defense, reversing the trend in favor of the American Law Institute's broadened definition of insanity, and prompting a return to the *M'Naghten* test); *id.* § 25.06[B] (noting that after the Hinckley acquittal, some state legislatures and courts eliminated the insanity defense).

<sup>8</sup> 131 S. Ct. 1910, 1922 (2011).

Prisoners in California with serious mental illness do not receive minimal, adequate care. Because of a shortage of treatment beds, suicidal inmates may be held for prolonged periods in telephone-booth sized cages without toilets. A psychiatric expert reported observing an inmate who had been held in such a cage for nearly 24 hours, standing in a pool of his own urine, unresponsive and nearly catatonic. Prison officials explained they had “no place to put him.” Other inmates awaiting care may be held for months in administrative segregation, where they endure harsh and isolated conditions and receive only limited mental health services. Wait times for mental health care range as high as 12 months. In 2006, the suicide rate in California’s prisons was nearly 80% higher than the national average for prison populations; and a court-appointed Special Master found that 72.1% of suicides involved “some measure of inadequate assessment, treatment, or intervention, and were therefore most probably foreseeable and/or preventable.”

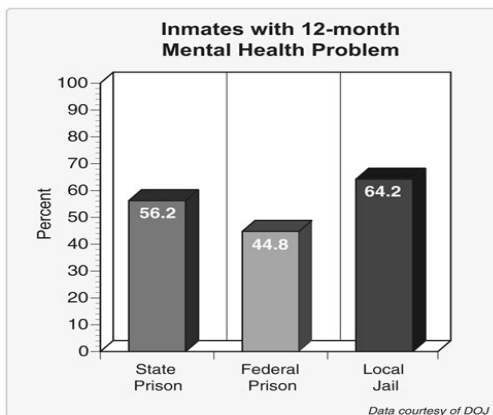
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The report found that the rate of suicides involving inadequate assessment, treatment, or intervention had risen to 82% and concluded that “[t]hese numbers clearly indicate no improvement in this area during the past several years, and possibly signal a trend of ongoing deterioration.”<sup>9</sup>

Mental health issues have an enormous impact on the criminal justice system.<sup>10</sup> Mental difficulties usually become apparent upon initial contact with law enforcement, which may lead to arrest, and tragically at times, death.<sup>11</sup> Individuals with mental health

<sup>9</sup> *Id.* at 1924–25, n.2. (citations omitted).

<sup>10</sup> See *Inmate Mental Health*, NAT’L INST. MENTAL HEALTH, <http://www.nimh.nih.gov/statistics/1DOJ.shtml> (last visited June 27, 2014) [hereinafter *Inmate Mental Health*]. The National Institute of Mental Health (NIMH) is part of the National Institutes of Health (NIH), a component of the U.S. Department of Health and Human Services. This survey indicates “that the rate of mental health problems differ by the type of correctional facility. In this study a mental health problem was defined as receiving a clinical diagnosis or treatment by a mental health professional. Inmates in local jails had the highest prevalence of mental problems, with nearly two thirds of jail inmates (64.2 percent) satisfying the criteria for a mental health problem currently or in the previous year.” *Id.*



<sup>11</sup> Abigail S. Tucker, et al., *Responding to Persons with Mental Illness*, FBI LAW ENFORCEMENT BULLETIN (Oct. 2011), <http://www.fbi.gov/stats-services/publications/law-enforcement-bulletin/october-2011/responding-to-persons-with-mental-illness>.

problems do not respond to the normal criminal justice remedies. Thus, sentencing judges are faced with a no-win scenario: short-term incarceration does little good;<sup>12</sup> probation is often allowed, but usually unsuccessful;<sup>13</sup> and long-term incarceration with the state’s corrections department has equally abysmal results.<sup>14</sup> The prospects for individuals paroled after incarceration are horrendous.<sup>15</sup> The prognosis for effective treatment—as documented by the National Institute for Health and U.S. Department of Justice—is disheartening.<sup>16</sup> Many individuals who are cycled through the criminal justice system have little hope of being successfully treated and maintaining a stable lifestyle for any extended period of time.<sup>17</sup> These results should not surprise those who work in the criminal justice system.

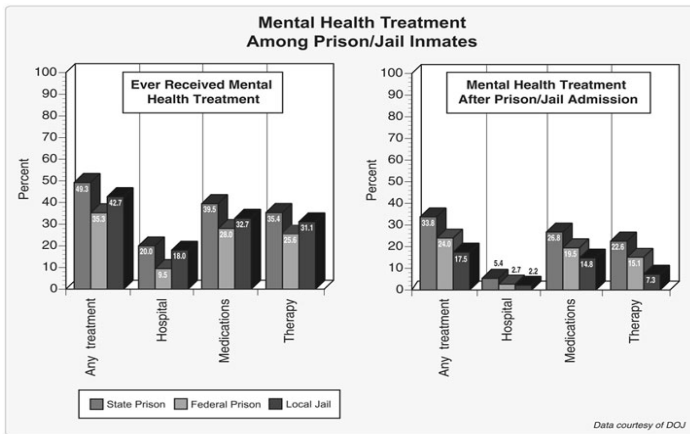
<sup>12</sup> PAULA M. DITTON, BUREAU OF JUSTICE STATISTICS, NCJ 174463, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS (1999), available at <http://www.bjs.gov/content/pub/pdf/mhtip.pdf>; see also AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEPARTMENT HEALTH HUM. SERVS, INTERVENTIONS FOR ADULTS WITH SERIOUS MENTAL ILLNESS WHO ARE INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM (Sep. 13, 2012), [http://effectivehealthcare.ahrq.gov/ehc/products/406/1259/SMI-in-CJ-System\\_ResearchProtocol\\_20120913.pdf](http://effectivehealthcare.ahrq.gov/ehc/products/406/1259/SMI-in-CJ-System_ResearchProtocol_20120913.pdf).

<sup>13</sup> See DITTON, *supra* note 12.

<sup>14</sup> See AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, *supra* note 12.

<sup>15</sup> *Id.*

<sup>16</sup> *Inmate Mental Health*, *supra* note 10. This survey indicates that less than one-half of inmates with a mental health issue have ever received treatment. One-third or fewer received mental health treatment after incarceration. However, these rates differ depending upon the type of correctional facility. *Id.*



<sup>17</sup> See DORIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, NCJ 213600, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES (2006), available at <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>.

**Table 1. Recent history and symptoms of mental health problems among prison and jail inmates**

	Percent of inmates in —	State Prison	Federal Prison	Local Jail
Mental health problem				
<b>Any mental health problem</b>		56.2%	44.8%	64.2%
<b>Recent history of mental health problem</b>		24.3%	13.8%	20.6%
Told had disorder by mental health professional		9.4	5.4	10.9
Had overnight hospital stay		5.4	2.1	4.9
Used prescribed medications		18.0	10.3	14.4
Had professional mental health therapy		15.1	8.3	10.3
<b>Symptoms of mental health disorders</b>		49.2%	39.8%	60.5%
Major depressive disorder		23.5	16.0	29.7
Mania disorder		43.2	35.1	54.5
Psychotic disorder		15.4	10.2	23.9

So, how did the criminal justice system get put in the position of a de facto mental health treatment provider? The answer is found in the history of mental health hospitals, deinstitutionalization, and the application of a 1939 study that coined the term “Penrose’s Law.” As the default mental health provider, the criminal justice system has attempted to deal with mental illness. However, it has been largely ineffective, as evidenced by inmate deterioration and recidivism rates. The inability of the system to appropriately handle mental health issues is a significant concern that needs immediate attention.

## II. A BRIEF HISTORY OF MENTAL HEALTH HOSPITALIZATION IN THE UNITED STATES

State hospitals that treat individuals with mental health disorders have existed since 1773.<sup>18</sup> The call for state hospitals grew out of families’ inability to handle mentally ill individuals and their resulting incarceration in jails or poorhouses.<sup>19</sup> As Virginia’s Royal Governor stated in 1766:

[A] poor unhappy set of People who are deprived of their Senses and wander about the Country, terrifying the Rest of their Fellow Creatures. A legal Confinement, and proper Provision, ought to be appointed for these miserable Objects, who cannot help themselves. Every civilized Country has an [sic] Hospital for these People, where they are confined, maintained and attended by able Physicians, to endeavor to restore them their lost Reason.<sup>20</sup>

These concerns led to the establishment of the Eastern Lunatic Asylum of Virginia in 1773.<sup>21</sup> It was the first hospital to treat mental illnesses in the United States.<sup>22</sup>

The public demand for the creation of state hospitals and asylums grew because the understanding of the causes of mental health disorders shifted from a religious perspective<sup>23</sup> to a more scientific approach.<sup>24</sup> Hospitalization would thus seem to be an enlightened approach to treating mental illnesses. First, it recognizes mental illnesses as a health issue. Second, the approach recognizes that families and communities are ill equipped to care for individuals who are suffering from a serious mental impairment. Yet,

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*Id.* at Table 3. Note: The above table includes “inmates who reported an impairment due to a mental problem.” *Id.* This data is “based on the Survey of Inmates in State and Federal Correctional Facilities, 2004, and the Survey of Inmates in Local Jails, 2002.” *Id.*; see generally *Jails and Prisons: The Nations Largest Psychiatric Facilities*, TREATMENT ADVOCACY CENTER 3-4 (April 2009), [http://www.treatmentadvocacycenter.org/storage/documents/jails\\_and\\_prisons--apr\\_09.pdf](http://www.treatmentadvocacycenter.org/storage/documents/jails_and_prisons--apr_09.pdf).

<sup>18</sup> Lawrence Osborn, *From Beauty to Despair: The Rise and Fall of the American State Mental Hospital*, 80 PSYCHIATRIC Q. 219, 221 (2009), available at <http://www.psychodyssey.net/wp-content/uploads/2011/02/From-Beauty-to-Despair-The-Rise-and-Fall.pdf>.

<sup>19</sup> *Id.* at 220.

<sup>20</sup> *Id.*

<sup>21</sup> *Id.* at 221.

<sup>22</sup> *Id.*

<sup>23</sup> See *id.* at 220 (“American colonists looked to religion as an explanation for madness. Mather, a minister in colonial Massachusetts . . . wrote that Satan himself caused turmoil and melancholy.”) (footnote omitted). Other explanations for mental disorders included an “imbalance of humors, blood phlegm, cholera (yellow bile) and black bile.” *Id.*

<sup>24</sup> See *id.* at 221. Benjamin Rush attributed mental disorders to the vascular system. *Id.* (citing BENJAMIN RUSH, MEDICAL INQUIRIES AND OBSERVATIONS UPON THE DISEASE OF THE MIND (Kimber & Richardson eds., 1812)).

early institutional treatment for the mentally ill resembled a prison more than a hospital.<sup>25</sup> “[P]hysicians placed lunatics in the basement of the hospital in barred cells while violent patients were restrained with straight waistcoats, mad shirts, or iron chains. The hospital did little to actually treat their insanity.”<sup>26</sup>

The “moral treatment” was developed in the United States, as attention focused more on the scientific approach to explain the causes of mental illness.<sup>27</sup> Phillippe Pinel advanced the theory that mental illnesses have a medical origin, and thus focused on treatment that cared for the patient without using restraint, bleeding, or seclusion.<sup>28</sup> The treatment regimen he proposed suggested that the physiological and psychological causes of insanity were curable.<sup>29</sup> Pinel believed that in order to conquer the illness, one must first gain confidence, hope, and the belief that their treatment will work.<sup>30</sup> Under this style of treatment “the physician would hold the dominant role in the asylum and would seek to skillfully break the will of the insane person so he would not object to the treatment the physician prescribed.”<sup>31</sup>

Even though the moral approach to the treatment of mental illnesses gained traction, the need for public institutions increased as populations grew.<sup>32</sup> By the 1850s, the increased population and need for institutions led to the development of a self-sustainability model,<sup>33</sup> known as the Kirkbride Model.<sup>34</sup> Under this model, the “hospital would be linear with symmetrical wings coming off a central administrative building, with a minimum of eight wards per wing.<sup>35</sup> The wings allowed for proper ventilation and light to reach every part of the hospital . . . .”<sup>36</sup> Under the Kirkbride Model, it was important to provide patients with light and visibility to the outside world but also to provide structure and security in the asylum.<sup>37</sup>

This model also sought to separate the violent patients from the non-violent patients, in order to keep peace and reduce agitation of calm patients.<sup>38</sup> Likewise, this model took pride in its appearance; it believed that buildings “should impress favorably not only on the patients,” but also on “others who may visit.”<sup>39</sup> This “therapeutic beauty” included “gardens, fountains, trails, and a grandiose architecture . . . .”<sup>40</sup> The “plan was to make the hospital look as attractive and as impressive as possible to reassure and calm the patients, while bolstering support of family members who committed their loved ones.”<sup>41</sup>

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<sup>25</sup> *Id.* at 222.

<sup>26</sup> *Id.* (footnote omitted).

<sup>27</sup> *Id.* at 221.

<sup>28</sup> *Id.*

<sup>29</sup> *Id.* (citing PHILIPPE PINEL, A TREATISE ON INSANITY (Davis. London & W. Todd trans., 1806)).

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*

<sup>32</sup> *Id.* at 222.

<sup>33</sup> *Id.*

<sup>34</sup> *Id.* (citing THOMAS KIRKBRIDE, ON THE CONSTRUCTION, ORGANIZATION AND GENERAL ARRANGEMENT OF HOSPITALS FOR THE INSANE (1854)).

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*

<sup>38</sup> *Id.*

<sup>39</sup> *Id.*

<sup>40</sup> *Id.*

<sup>41</sup> *Id.*

Funding for institutions also shifted from private donors to public funding,<sup>42</sup> allowing for the expansion of existing institutions as well as the building of new facilities.<sup>43</sup> With the confluence of the medical model for mental health treatment, the creation of institutions dedicated to it (and public funding), treatment in an asylum for the mentally ill was the “consensus among the public and medical community.”<sup>44</sup>

Unfortunately, by the end of the nineteenth century, public institutions found themselves underfunded and grossly overpopulated.<sup>45</sup> One article noted:

As the population increased in America, so did the insane. In 1860 the population of the United States was 31.4 million and the patient population in asylums was roughly 8,500. By 1890 the population in the United States doubled to 63 million and the patient population in asylums increased nine fold to 75,000. Asylums, from their very beginning, faced increased pressure to expand. Growth of population led to larger asylums being constructed which had a toll on the ability to control regimen and moral treatment. Asylums sometimes had a patient census that was triple what the institution was designed for. Without the ability to control regimen and moral treatment slipping, asylum care suffered as well.<sup>46</sup>

The increasing population led to a shift in treatment away from an institutional focus to custodial institutionalization (i.e., warehousing the mentally ill).<sup>47</sup> This change was driven by both the lack of funding of the institutions and the disillusionment with the moral treatment because the mentally ill were not cured.<sup>48</sup> Thus, the treatment model morphed into the custodial model.

In the custodial model, inadequate funding and overcrowding led to an inevitable lack of treatment, or in the worst situations, abuse:

[S]tates had to rely, heavily, on the state hospital; it was difficult to ignore the great amount of distress that was occurring with custodial care. . . . With a doctor ratio sometimes of 1 to 500, and a nurse ratio of 1 to 1,320, there was little treatment that could be properly administered. . . . Whether it was from lack of care, no care, or high use of physical and chemical restraint because of understaffing, abuses occurred.<sup>49</sup>

With the explosion in the number of patients at state hospitals came the development and implementation of new therapies such as “insulin therapy, electroshock therapy (electroconvulsive therapy, ECT), hydrotherapy, psychotherapy and lobotomy.”<sup>50</sup> The

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<sup>42</sup> *Id.* at 223 (footnote omitted).

<sup>43</sup> *Id.* (“By 1880, almost 140 asylums were built and by 1890 at least 70 were constructed according to the Kirkbride Model.”).

<sup>44</sup> *Id.* at 224.

<sup>45</sup> *Id.* at 225—26.

<sup>46</sup> *Id.* (footnotes omitted).

<sup>47</sup> *Id.* at 227.

<sup>48</sup> *Id.*

<sup>49</sup> *Id.*

<sup>50</sup> *Id.* at 228.

therapies were employed despite physicians not understanding why or how such therapies worked.<sup>51</sup>

Due to the deplorable conditions,<sup>52</sup> and as result of underfunding, the movement to deinstitutionalization and community-based treatment took hold post-World War II.<sup>53</sup> With the addition of new psychotropic drugs in the 1950s the move toward community-based treatment was further fuelled;<sup>54</sup> along with the legal doctrine of least restrictive alternative for mental health commitments, deinstitutionalization became the new norm.<sup>55</sup> Although deinstitutionalization forged ahead, little attention, and much less funding, was given to state-supported, community-based mental health services.<sup>56</sup> The result was a transformation of patients in state hospitals to mentally ill inmates in jails and prisons. Sadly, this result was predicted over a decade earlier.

### III. PENROSE'S LAW

In 1939, researcher Lionel Penrose published a study from 18 European countries that found an inverse relationship between the number of beds in state mental health facilities and prison populations.<sup>57</sup> Simply put, Penrose's Law states that a reduction of mental health beds increases the number of mentally ill prisoners.<sup>58</sup> Penrose also predicted an increase in crime rates with the reduction of mental health facilities.<sup>59</sup>

The predictive value of Penrose's Law has been fleshed out by several studies.<sup>60</sup> One Canadian study stated:

In 1955, there were 559,000 state hospital beds for a population of 164 million people. By 1994, there were only 72,000 state hospital beds for a population of 250 million people. The beds per 100,000 people had dropped dramatically from 339 to 29. Contemporaneously, the number

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<sup>51</sup> *Id.* "Psychosurgery for example, specifically the lobotomy, was developed by Egas Moniz and widely popularized by Walter Freeman. Freeman spent much time and effort campaigning that his transorbital lobotomy procedure was successful. The outcomes were mixed, with some producing death, but Freeman claimed the success of the procedure until his death." *Id.* (footnotes omitted).

<sup>52</sup> *Id.* at 227 (noting that patients were secluded in straightjackets and finding the conditions comparable to that of a "snake pit").

<sup>53</sup> *Id.* at 228.

<sup>54</sup> *Id.* The first generation of anti-psychotic medications were developed in the mid-1950s, and were thought to support the concept that patients could indeed get better via medicine. *Id.*

<sup>55</sup> *See id.* ("In 1960, the U.S. Supreme Court ruled on a case that became known as the least restrictive alternative. The ruling, once applied, meant that involuntary commitment to a hospital was only possible if there were no other treatments that would give more freedom to the patient. . . . [T]reatment of the mentally ill shifted from the state hospitals to community care. The least restrictive alternative is only one in a series of court rulings that led to and facilitated deinstitutionalization.") (footnote omitted).

<sup>56</sup> *Id.* 228–29. "With the help of anti-psychotic medications and deinstitutionalization, the inpatient population decreased by nearly 80% over the next 30 years. The hope was that community care could provide a smaller, more humane place to treat the mentally ill. In actuality many consider deinstitutionalization and community care a failure on some levels." *Id.* (footnote omitted).

<sup>57</sup> Lionel Penrose, *Mental Disease and Crime: Outline of Comparative Study of European Statistics*, 18 BRIT. J. MED. PSYCHOL. 1, 1–15 (1939).

<sup>58</sup> Pål Hartvig & Ellen Kjelsberg, *Penrose's Law Revisited: The Relationship Between Mental Institution Beds, Prison Population and Crime Rate*, 63 NORDIC J. PSYCHIATRY 51, 51–56 (2009).

<sup>59</sup> *Id.* at 54.

<sup>60</sup> *Id.* at 51 nn. 2–3 (citations omitted).



of people in jails and prisons also rose significantly. The other side of the same phenomenon was the increasing number of prisoners associated with the reduction in psychiatric hospitals. Between 1980 and 1995, the total number of people incarcerated in the United States rose from 501,836 to 1,587,791, a 216 per cent increase—the population at that time increased by only 16 per cent.<sup>61</sup>

As for the United States, a 2009 study reported:

As previously stated, community care is not able to handle serious and chronically mentally ill persons. . . . [B]etween 1955 and 2000 the number of persons being treated in hospitals dropped from 560,000 to around 55,000. Today there is an estimated 300,000 being treated in prisons, with the LA County Jail being the largest public mental health facility in America. In Virginia, the Joint Commission on Health Care reports that regional and local jails house 59% of persons with mental illness versus 23% in state hospitals.<sup>62</sup>

These studies indicate that Penrose’s Law is correct, and the criminal justice system has been forced into its role as the de facto mental health provider. If that is the case, how is the criminal justice system reacting to the influx of mentally ill defendants?

#### IV. CURRENT TREATMENT RECOMMENDATIONS

Dealing with mental health issues has been problematic for the criminal justice system. This is partly because of the system’s lack of understanding with regard to mental health diagnosis, maintenance of mental illness, and the treatment required.

Schizophrenia is one common example of a mental disorder criminals are often diagnosed with.<sup>63</sup> In the normal population, prevalence of schizophrenia ranges from 0.5% to 1.5%. However, it is over twice as common in the prison population, where its prevalence ranges from 2.3% to 3.9%.<sup>64</sup> The onset of the disease usually occurs between the late-teens and the mid-thirties.<sup>65</sup> Interestingly, these ages are also subject to the highest arrest rates.<sup>66</sup>

To understand the appropriate treatment of this mental illness within the criminal justice system, it is necessary to focus on the illness from the perspective of health care professionals. Like many psychological disorders, schizophrenia is complicated in symptomology, diagnosis, and treatment. It is a challenging mental illness and it is incredibly resource-intensive. Such a psychological condition is even more straining on the criminal justice system.

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<sup>61</sup> Gary Chaimowitz, *The Criminalization of People with Mental Illness*, 57 CAN. J. PSYCHIATRY 2, 2 (2012).

<sup>62</sup> Osborn, *supra* note 18, at 229–30.

<sup>63</sup> Richard Redding, *Why It Is Essential to Teach About Mental Health Issues in Criminal Law (and a Primer on How to Do It)*, 14 WASH. U. J.L. & POL’Y 407, 409–10 (2004).

<sup>64</sup> AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, *supra* note 12; AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 308 (4th ed. text rev. 2000) [hereinafter DSM-IV-TR].

<sup>65</sup> DSM-IV-TR, *supra* note 64, at 307.

<sup>66</sup> F.B.I., AGE-SPECIFIC ARREST RATES AND RACE-SPECIFIC ARREST RATES FOR SELECTED OFFENSES 1993-2001, 3 (2003), available at [http://www.fbi.gov/about-us/cjis/ucr/additional-ucr-publications/age\\_race\\_arrest93-01.pdf](http://www.fbi.gov/about-us/cjis/ucr/additional-ucr-publications/age_race_arrest93-01.pdf).

### A. *Symptoms*

The National Institute of Mental Health (NIMH) currently describes the disease as a chronic, severe, and disabling brain disorder:

People with the disorder may hear voices other people don't hear. They may believe other people are reading their minds, controlling their thoughts, or plotting to harm them. This can terrify people with the illness and make them withdrawn or extremely agitated. People with schizophrenia may not make sense when they talk. They may sit for hours without moving or talking. Sometimes people with schizophrenia seem perfectly fine until they talk about what they are really thinking. Families and society are affected by schizophrenia too. Many people with schizophrenia have difficulty holding a job or caring for themselves, so they rely on others for help. Treatment helps relieve many symptoms of schizophrenia, but most people who have the disorder cope with symptoms throughout their lives.<sup>67</sup>

Symptoms of schizophrenia include hallucinations,<sup>68</sup> delusions,<sup>69</sup> thought disorders,<sup>70</sup> movement disorders,<sup>71</sup> negative symptoms,<sup>72</sup> and cognitive symptoms.<sup>73</sup>

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<sup>67</sup> *Schizophrenia*, NAT'L INST. MENTAL HEALTH (Sept. 8, 2009), <http://www.nimh.nih.gov/health/publications/schizophrenia/what-is-schizophrenia.shtml>; see also DSM-IV-TR, *supra* note 64, at 298–302.

<sup>68</sup> *Schizophrenia*, *supra* note 67 (“Hallucinations are things a person sees, hears, smells, or feels that no one else can see, hear, smell, or feel. ‘Voices’ are the most common type of hallucination in schizophrenia. Many people with the disorder hear voices. The voices may talk to the person about his or her behavior, order the person to do things, or warn the person of danger. Sometimes the voices talk to each other. People with schizophrenia may hear voices for a long time before family and friends notice the problem. Other types of hallucinations include seeing people or objects that are not there, smelling odors that no one else detects, and feeling things like invisible fingers touching their bodies when no one is near.”); see also DSM-IV-TR, *supra* note 64, at 299–300.

<sup>69</sup> *Schizophrenia*, *supra* note 67 (“Delusions are false beliefs that are not part of the person’s culture and do not change. The person believes delusions even after other people prove that the beliefs are not true or logical. People with schizophrenia can have delusions that seem bizarre, such as believing that neighbors can control their behavior with magnetic waves. They may also believe that people on television are directing special messages to them, or that radio stations are broadcasting their thoughts aloud to others. Sometimes they believe they are someone else, such as a famous historical figure. They may have paranoid delusions and believe that others are trying to harm them, such as by cheating, harassing, poisoning, spying on, or plotting against them or the people they care about. These beliefs are called ‘delusions of persecution.’”); see also DSM-IV-TR, *supra* note 64, at 299.

<sup>70</sup> *Schizophrenia*, *supra* note 67 (“Thought disorders are unusual or dysfunctional ways of thinking. One form of thought disorder is called ‘disorganized thinking.’ This is when a person has trouble organizing his or her thoughts or connecting them logically. They may talk in a garbled way that is hard to understand. Another form is called ‘thought blocking.’ This is when a person stops speaking abruptly in the middle of a thought. When asked why he or she stopped talking, the person may say that it felt as if the thought had been taken out of his or her head. Finally, a person with a thought disorder might make up meaningless words, or ‘neologisms.’”); DSM-IV-TR, *supra* note 64, at 300.

<sup>71</sup> *Schizophrenia*, *supra* note 67 (“Movement disorders may appear as agitated body movements. A person with a movement disorder may repeat certain motions over and over. In the other extreme, a person may become catatonic. Catatonia is a state in which a person does not move and does not respond to others. Catatonia is rare today, but it was more common when treatment for schizophrenia was not available.”) (footnote omitted); see also DSM-IV-TR, *supra* note 64, at 300–01.

<sup>72</sup> *Schizophrenia*, *supra* note 67 (“Negative symptoms are associated with disruptions to normal emotions and behaviors. These symptoms are harder to recognize as part of the disorder and can be mistaken for depression or other conditions. These symptoms include the following: ‘[f]lat affect’ (a person’s face does not move or he or she talks in a dull or monotonous voice), [l]ack of pleasure in everyday life, [l]ack of ability to begin and sustain planned activities, [s]peaking little, even when forced to interact. People with negative symptoms need help with everyday tasks. They often neglect basic personal hygiene. This may make them seem lazy or unwilling to help themselves, but the problems are symptoms caused by the schizophrenia.”); see also DSM-IV-TR, *supra* note 64, at 301.

In addition to these incredibly difficult symptoms, the issue of dual diagnosis can further complicate diagnosis and treatment:

Dual diagnosis [occurs when someone] has both a mental disorder and an alcohol or drug problem. These conditions occur together frequently. In particular, alcohol and drug problems tend to occur with [d]epression, [a]nxiety disorders, [s]chizophrenia, [and] [p]ersonality disorders. Sometimes the mental problem occurs first. This can lead people to use alcohol or drugs that make them feel better temporarily. Sometimes the substance abuse occurs first. Over time, that can lead to emotional and mental problems.<sup>74</sup>

As a feature of the disease, substance abuse complicates treatment.<sup>75</sup> Regardless of the combination of symptoms, once the diagnosis has been made, then the question of treatment comes into play. The NIMH advocates a multi-faceted approach to treating the disease.<sup>76</sup>

#### B. *Multi-Faceted Treatment Approach*

There is no cure for schizophrenia.<sup>77</sup> Depending on the severity of the disease and responsiveness to treatment, some individuals learn to function very well, while others continue with life-long impairments.<sup>78</sup> Once diagnosed, treatment for schizophrenia can include anti-psychotic drugs, psychosocial therapy, and rehabilitative strategies. If the individual has a dual diagnosis, the NIMH recommends that substance abuse treatment can be used concurrently with other treatment regimens for schizophrenia.<sup>79</sup>

The treatment for schizophrenia entails the administration of antipsychotic drugs.<sup>80</sup> Antipsychotic drugs can have severe side-effects including drowsiness, dizziness, blurred vision, rapid heartbeat, sun sensitivity, skin rashes, and, in women, menstrual problems.<sup>81</sup> There are also physical manifestations such as rigidity, muscle spasms, tremors, and restlessness.<sup>82</sup> A severe physical side effect of long-term use of antipsychotic

<sup>73</sup> *Schizophrenia*, *supra* note 67 (“Cognitive symptoms are subtle. Like negative symptoms, cognitive symptoms may be difficult to recognize as part of the disorder. Often, they are detected only when other tests are performed. Cognitive symptoms include the following: [p]oor ‘executive functioning’ (the ability to understand information and use it to make decisions), [t]rouble focusing or paying attention, [p]roblems with ‘working memory’ (the ability to use information immediately after learning it). Cognitive symptoms often make it hard to lead a normal life and earn a living. They can cause great emotional distress.”); DSM-IV-TR, *supra* note 64, at 305 (describing the symptoms with associated laboratory findings).

<sup>74</sup> Nat’l Inst. of Health, *Dual Diagnosis*, MEDICINE PLUS, <http://www.nlm.nih.gov/medlineplus/dualdiagnosis.html> (last updated Jan. 20, 2014); *see also* DSM-IV-TR, *supra* note 64, at 304, 309–10 (describing comorbidity and differential diagnosis based on etiology).

<sup>75</sup> *Dual Diagnosis*, *supra* note 74.

<sup>76</sup> *Schizophrenia*, *supra* note 67.

<sup>77</sup> *Schizophrenia*, AM. PSYCHIATRIC ASS’N, <http://www.psychiatry.org/schizophrenia> (last visited June 29, 2014).

<sup>78</sup> *Id.*

<sup>79</sup> *Schizophrenia*, *supra* note 67.

<sup>80</sup> *Id.* (“Antipsychotic medications have been available since the mid-1950’s. The older types are called conventional or ‘typical’ antipsychotics. . . . In the 1990’s, new antipsychotic medications were developed. These new medications are called second generation, or ‘atypical’ antipsychotics. One of these medications, clozapine (Clozaril) is an effective medication that treats psychotic symptoms, hallucinations, and breaks with reality.”); *see also* *Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE)*, NAT’L INST. FOR MENTAL HEALTH, [www.nimh.nih.gov/funding/clinical-trials-for-researchers/practical/catie/index.shtml](http://www.nimh.nih.gov/funding/clinical-trials-for-researchers/practical/catie/index.shtml) (last visited February 22, 2014) (providing additional information regarding antipsychotic medications and their effectiveness and side effects).

<sup>81</sup> *Schizophrenia*, *supra* note 67.

<sup>82</sup> *Id.*

medication is tardive dyskinesia,<sup>83</sup> a condition causing uncontrollable muscle movement that may not be curable.<sup>84</sup>

If the medications relieve some of the symptoms, there are additional therapies administered to help the individual function effectively.<sup>85</sup> One such therapy is psychosocial treatment.<sup>86</sup> The purpose of psychosocial therapy is to help individuals deal with everyday challenges including “difficulty with communication, self-care, work,<sup>87</sup> and forming and keeping relationships.”<sup>88</sup> In some cases, where symptoms persist in an individual despite treatment with medication, cognitive behavioral therapy is used.<sup>89</sup> The purpose of the therapy is to enable individuals to “test the reality of their thoughts and perceptions, how to ‘not listen’ to their voices, and how to manage their symptoms overall.”<sup>90</sup>

The NIMH also recommends a rehabilitative strategy be developed to assist the individual to function with day-to-day stressors that include “job counseling and training, money management counseling, help in learning to use public transportation, and opportunities to practice communication skills.”<sup>91</sup> Family members can assist individuals in maintaining medication compliance and developing coping skills to deal with the disease.<sup>92</sup> NIMH also recommends self-help groups as a way to assist individuals with schizophrenia cope with the disease.<sup>93</sup>

These are the current treatment recommendations by NIMH. The question is whether or not the criminal justice system can provide this type of treatment to individuals who come into contact with it. Mental health issues must be dealt with from the time of arrest and through the pretrial detention, pretrial proceedings, trial, and post-trial proceedings—which include sentencing. In the event of a guilty verdict, treatment of

<sup>83</sup> *Id.* (“Long-term use of typical antipsychotic medications may lead to a condition called tardive dyskinesia (TD). TD causes muscle movements a person can’t control. The movements commonly happen around the mouth.”).

<sup>84</sup> *Id.* (“TD can range from mild to severe, and in some people the problem cannot be cured. Sometimes people with TD recover partially or fully after they stop taking the medication.”).

<sup>85</sup> *Id.* (“Antipsychotics are usually in pill or liquid form. Some anti-psychotics are shots that are given once or twice a month. Symptoms of schizophrenia, such as feeling agitated and having hallucinations, usually go away within days. Symptoms like delusions usually go away within a few weeks. After about six weeks, many people will see a lot of improvement. However, people respond in different ways to antipsychotic medications, and no one can tell beforehand how a person will respond.”).

<sup>86</sup> *Id.*

<sup>87</sup> *Id.* (“Rehabilitation programs can include job counseling and training, money management counseling, help in learning to use public transportation, and opportunities to practice communication skills. Rehabilitation programs work well when they include both job training and specific therapy designed to improve cognitive or thinking skills. Programs like this help patients hold jobs, remember important details, and improve their functioning.”).

<sup>88</sup> *Id.*

<sup>89</sup> *Id.*

<sup>90</sup> *Id.*

<sup>91</sup> *Id.* (“Rehabilitation emphasizes social and vocational training to help people with schizophrenia function better in their communities. Because schizophrenia usually develops in people during the critical career-forming years of life (ages 18 to 35), and because the disease makes normal thinking and functioning difficult, most patients do not receive training in the skills needed for a job.”).

<sup>92</sup> *Id.* (“People with schizophrenia are often discharged from the hospital into the care of their families. So it is important that family members know as much as possible about the disease. With the help of a therapist, family members can learn coping strategies and problem-solving skills.”).

<sup>93</sup> *Id.* (“Self-help groups for people with schizophrenia and their families are becoming more common. Professional therapists usually are not involved, but group members support and comfort each other. People in self-help groups know that others are facing the same problems, which can help everyone feel less isolated. . . . Once patients learn basic facts about schizophrenia and its treatment, they can make informed decisions about their care.”).

mentally ill inmates must continue until the individual completes their sentence. Throughout this process, which may last decades, the individual's competency and treatment are constantly revisited by a system that was never designed or intended to cope with mental health diagnosis or treatment.

## V. THE CRIMINAL JUSTICE SYSTEM AND COMPETENCY

### A. Law Enforcement Interaction with Individuals Having Mental Health Issues

Community law enforcement agencies are often the de facto diagnosticians when encountering individuals with mental health problems.<sup>94</sup> Although not all law enforcement encounters involve individuals with disorders as severe as schizophrenia, run-ins are common with people who have less severe mental illnesses.<sup>95</sup> In professor Linda Teplin's 2000 article, *Keeping the Peace: Police Discretion and Mentally Ill Persons*, she describes three options available to police when confronted on the street with individuals who have mental health issues.<sup>96</sup> These options include: (1) informal disposition, (2) arrest, or (3) hospitalization.<sup>97</sup>

Informal disposition is overwhelmingly preferred by officers, with 72% of encounters handled accordingly.<sup>98</sup> These individuals are typically described as the neighborhood characters,<sup>99</sup> troublemakers,<sup>100</sup> or quiet, unobtrusive "mentals."<sup>101</sup> Informal dispositions by officers are a reflection of a long-term trend toward deinstitutionalization.<sup>102</sup>

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<sup>94</sup> H. Richard Lamb, Linda E. Weinberger, & Walter J. DeCuir, Jr., *The Police and Mental Health*, PSYCHIATRIC SERVS. (Oct. 1, 2002), <http://ps.psychiatryonline.org/article.aspx?articleID=87145> (pointing out that police have inadequate training in handling encounters with this segment of the community); Tucker et al., *supra* note 11.

<sup>95</sup> Gary Cordner, *People with Mental Illness*, CENTER FOR PROBLEM-ORIENTED POLICING (2006), [http://www.popcenter.org/problems/mental\\_illness](http://www.popcenter.org/problems/mental_illness).

<sup>96</sup> Linda A. Teplin, *Keeping the Peace: Police Discretion and Mentally Ill Persons*, NAT'L INST. JUST. J. 9, 9–10 (July 2000), available at <https://www.ncjrs.gov/pdffiles1/jr000244c.pdf>.

<sup>97</sup> *Id.*

<sup>98</sup> *Id.* at 9 (noting that police resolve situations informally 72% of the time.).

<sup>99</sup> *Id.* at 11 ("Neighborhood characters were persons whose idiosyncrasies were well known to police in their precinct. Virtually any officer could talk about 'Crazy Harry,' 'Batman,' or 'Mailbox Molly.' These were neighborhood characters who were defined by police as 'mentals' but who were never hospitalized because they were known quantities. Police had certain expectations regarding the parameters of their behavior. As a consequence, the police tolerated a greater degree of deviance from them. More important, officers' familiarity with each citizen's particular symptoms enabled them to 'cool them out,' making an informal disposition that much easier. The following is a rather common encounter of this type: There's a lady in the area who claims she has neighbors who are beaming rays up into her apartment. The officer said he usually handles the situation by telling her, 'We'll go downstairs and tell the people to stop beaming the rays,' and she's happy. The officer seemed quite happy about this method of handling the problem. He could do something for the lady, and even though it's not the same kind of assistance he might give another type of situation, he could allay the lady's fears by just talking to her.").

<sup>100</sup> *Id.* ("If an emotionally disturbed citizen has been labeled a 'troublemaker,' hospitalization or arrest is very unlikely. Intervention in such cases is considered not worth the trouble. An example was a woman rejected by the mental hospital, who, 'whenever she came into the station, caused an absolute disruption. She would take off her clothes, run around the station nude, and urinate on the sergeant's desk. Officers felt it was such a hassle to have her in the station and in lockup that they simply stopped arresting her.'").

<sup>101</sup> *Id.* ("Persons whose symptoms of mental disorder are relatively unobtrusive are likely to be handled informally. They offend neither the populace nor the police with obvious manifestations of their illness, and their symptoms are not considered serious enough to warrant hospitalization. Moreover, quiet 'mentals' are considered more disordered than disorderly and so are unlikely to provoke arrest. Through officers' experiences with neighborhood characters, they know just how to soothe the emotionally disturbed person, to act as a 'street-corner psychiatrist.' In this way, they help to maintain many mentally ill people within the community and make deinstitutionalization a more viable public policy.").

<sup>102</sup> *Id.* at 9; Tucker et al., *supra* note 11 ("The trend toward deinstitutionalization between the 1960s and 1980s contributed to the increased contact between police and individuals with mental illness.").

If the officer makes the decision to arrest, it triggers the involvement of the criminal justice system that is woefully unprepared to handle mental health treatment. The defendant’s competency is usually the first post-arrest inquiry.<sup>103</sup> The question of competency is one that has befuddled courts for hundreds of years. Even now, for every-day functioning purposes, the level of competency acceptable for legal purposes is much lower than that of what a physician treating a patient with a mental illness would deem proficient.<sup>104</sup> As the Supreme Court observed in evaluating the burden of proof in a competency proceeding:

The prohibition against trying the incompetent defendant was well established by the time Hale and Blackstone wrote their famous commentaries. (“[I]f a man in his sound memory commits a capital offence ... [a]nd if, after he has pleaded, the prisoner becomes mad, he shall not be tried: for how can he make his defence?”). The English cases which predate our Constitution provide no guidance, however, concerning the applicable standard of proof in competency determinations.

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Beginning in the late 18th century, cases appear which provide an inkling of the proper standard. In *King v. Frith*, for example, the court instructed the jury to “diligently inquire ... whether John Frith, the now prisoner at the bar ... be of sound mind and understanding or not....” Some 50 years later the jurors received a nearly identical admonition in *Queen v. Goode*: “You shall diligently inquire, and true presentment make ... whether John Goode ... be insane or not....” Similarly, in *King v. Pritchard*, the court empaneled a jury to consider “whether the prisoner is mute of malice or not; secondly, whether he can plead to the indictment or not; thirdly, whether he is of sufficient intellect to comprehend the course of proceedings on the trial....”<sup>105</sup>

The fundamental importance of a defendant’s competency to stand trial was articulated in *Riggins v. Nevada*:

Competence to stand trial is rudimentary, for upon it depends the main part of those rights deemed essential to a fair trial, including the right to effective assistance of counsel, the rights to summon, to confront, and to cross-examine witnesses, and the right to testify on one’s own behalf or to remain silent without penalty for doing so.<sup>106</sup>

In 1960, the U.S. Supreme Court decided *Dusky v. United States*,<sup>107</sup> and set a parameter to measure a defendant’s competency to stand trial. The Court stated:

<sup>103</sup> *Criminal Justice Section Standards: Mental Health*, A.B.A., [http://www.americanbar.org/publications/criminal\\_justice\\_section\\_archive/crimjust\\_standards\\_mentalhealth\\_toc.html](http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_mentalhealth_toc.html) (last visited June 29 2014).

<sup>104</sup> See generally Kirk Heilbrun, et al., *Standards of Practice and Care in Forensic Mental Health Assessment: Legal, Professional, and Principles-Based Considerations*, 14 PSYCHOL. PUB. POL’Y & L. 1, 3–4 (2008), available at <http://www.mentalcompetency.org/resources/guides-standards/files/Heilbrun,%20et%20al.%20--%20Standards%20of%20Practice%20and%20Care-pdf>.

<sup>105</sup> *Cooper v. Oklahoma*, 517 U.S. 348, 356–57 (1996) (citations omitted).

<sup>106</sup> 504 U.S. 127, 139–40 (1992).

<sup>107</sup> 362 U.S. 402, 402 (1960).

[I]t is not enough for the district judge to find that ‘the defendant (is) oriented to time and place and (has) some recollection of events,’ but that the ‘test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding-and whether he has a rational as well as factual understanding of the proceedings against him.’<sup>108</sup>

In just three paragraphs, the Supreme Court introduced the concept of a criminal defendant needing to have a “rational understanding” of how to assist counsel, appreciate the charges against them, and understand the proceedings.<sup>109</sup>

In 1966, the Court in *Pate v. Robinson*<sup>110</sup> held a murder conviction should be set aside because the lower court did not grant a hearing on the issue of the defendant’s competency.<sup>111</sup> Then, in *Drope v. Missouri*,<sup>112</sup> the Court announced the current three part test for competency: “It has long been accepted that a person whose mental condition is such that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defense may not be subjected to a trial.”<sup>113</sup>

The Supreme Court has held that the constitution presumes a defendant is competent. To prove otherwise, the burden is on the defendant to establish his incompetency.<sup>114</sup> Furthermore, the Court found that the constitution requires the defendant to prove his incompetency by a preponderance of the evidence, while also finding that the heightened standard of clear and convincing evidence violates due process.<sup>115</sup>

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<sup>108</sup> *Id.* The Court’s decision was premised on the sufficiency of the record found in *Dusky v. U.S.*, 271 F.2d 385, 387–89 (8th Cir. 1959). The lower court reviewed the evidence produced at hearing, where experts opined: “He is oriented as to time, place, and person. He denies complete memory of the events of the day of the alleged offense. . . . It is the opinion of the staff, following interview of the patient, that he had improved in recent weeks but his condition is still such that he is unable to understand the nature of the proceedings with reference to the charges against him and is unable to properly assist counsel in his defense. The patient is receiving tranquilizing medications and would probably deteriorate quickly if treatment was stopped at this time. . . . Doctor Sturgell also expressed the opinion that the defendant understood what he was charged with, knew that if there was a trial it would be before a judge and jury, knew that if found guilty he could be punished, and knew who his attorney was and that it was his duty to protect the defendant’s rights.” *Id.*

<sup>109</sup> *Dusky*, 362 U.S. at 402–03.

<sup>110</sup> 383 U.S. 375 (1966).

<sup>111</sup> *Id.* at 385.

<sup>112</sup> 420 U.S. 162 (1975).

<sup>113</sup> *Id.* at 171.

<sup>114</sup> *Medina v. California*, 505 U.S. 437, 446 (1992) (“Based on our review of the historical treatment of the burden of proof in competency proceedings, the operation of the challenged rule, and our precedents, we cannot say that the allocation of the burden of proof to a criminal defendant to prove incompetence ‘offends some principle of justice so rooted in the traditions and conscience of our people as to be ranked as fundamental.’”) (quoting *Patterson v. New York*, 432 U.S. 197, 202 (1977)). The Court further found there is “no historical basis for concluding that the allocation of the burden of proving incompetence to the defendant violates due process . . . .” *Medina*, 505 U.S. at 448.

<sup>115</sup> *Cooper v. Oklahoma*, 517 U.S. 348, 368–69 (1996) (“The prohibition against requiring the criminal defendant to demonstrate incompetence by clear and convincing evidence safeguards the fundamental right not to stand trial while incompetent. Because Oklahoma’s procedural rule allows the State to put to trial a defendant who is more likely than not incompetent, the rule is incompatible with the dictates of due process.”).



### B. *Duty of Defense Counsel*

On a daily basis, criminal defense attorneys confront clients who are mentally impaired—some with disorders as severe as schizophrenia.<sup>116</sup> The choices that attorneys are left with while representing these individuals are bleak. On one hand, counsel is to represent a client “zealously” within the limits of the law.<sup>117</sup> On the other hand, lawyers are sworn to uphold the Constitution.<sup>118</sup> Since it is a violation of due process to allow an incompetent individual to proceed in the criminal justice system,<sup>119</sup> is the defense counsel obliged to investigate the client’s competency to stand trial even when the client resists?

The American Bar Association (ABA) Model Code of Professional Responsibility (MCPR) attempts to address that issue.<sup>120</sup> The rules dictate “the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.”<sup>121</sup> Of course, however, for the practitioner sitting in an interview room with a client suffering from a serious mental disorder,<sup>122</sup> such a rule provides little or no guidance. The commentary to the rule is a bit more helpful:

In determining the extent of the client’s diminished capacity, the lawyer should consider and balance such factors as: the client’s ability to articulate reasoning leading to a decision, variability of state of mind, and ability to appreciate consequences of a decision; the substantive fairness of a decision; and the consistency of a decision with the known long-term commitments and values of the client. In appropriate circumstances, the lawyer may seek guidance from an appropriate diagnostician.<sup>123</sup>

Again, the reality of practice overshadows the rule and its commentary. The attorney is confronted with confidential information that leads them to believe the client is mentally impaired. At this point in the criminal justice process, the lawyer is asked to assume the role of both psychiatrist and advocate. The ABA Criminal Justice Standards state:

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<sup>116</sup> See *supra* text accompanying notes 63–64.

<sup>117</sup> See MODEL RULES OF PROF’L CONDUCT PREAMBLE cmt. 2 (2013).

<sup>118</sup> See Carol Rice Andrews, *The Lawyer’s Oath: Both Ancient and Modern*, 22 GEO. J. LEGAL ETHICS 3, 48 (2009) (“Twenty-one states and most federal courts use a simple oath in which the lawyer swears to support the relevant laws and constitution and also promises good conduct.”).

<sup>119</sup> See *Pate v. Robinson*, 383 U.S. 375, 378 (1966) (“The State concedes ‘the conviction of an accused person while he is legally incompetent violates due process.’”).

<sup>120</sup> See, e.g., MODEL RULES OF PROF’L CONDUCT R. 1.14 (“(a) When a client’s capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client. (b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client’s own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian. (c) Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client’s interests.”).

<sup>121</sup> *Id.* at R. 1.14(a).

<sup>122</sup> See generally DSM-IV-TR, *supra* note 64, at 273–315 (discussing the symptoms and features of schizophrenia and other psychotic disorders).

<sup>123</sup> MODEL RULES OF PROF’L CONDUCT R. 1.14 cmt. 6.

Defense counsel should move for evaluation of the defendant's competence to stand trial whenever the defense counsel has a good faith doubt as to the defendant's competence. If the client objects to such a motion being made, counsel may move for evaluation over the client's objection. In any event, counsel should make known to the court and to the prosecutor those facts known to counsel which raise the good faith doubt of competence.<sup>124</sup>

While seemingly answering the question about defense counsel's obligation to raise the issue, the standards then require counsel to file a motion and "set forth the specific facts that have formed the basis for the motion,"<sup>125</sup> while at the same time admonishing defense counsel that they "should not divulge confidential communications or communications protected by the attorney-client privilege."<sup>126</sup> Since confidential information is often revealed by the client, these internally contradictory standards put defense counsel in a difficult, if not impossible, situation. Defense counsel can develop other sources of information: prior hospitalization or treatment (if the defendant discloses and signs waivers); prior prosecutions where mental health issues were raised (the applications and orders would be public record but the substance of evaluations and attorney interviews would require waivers from the client); and family, friends, or acquaintances (this again requires the client to cooperate and give the information to the attorney if it exists).<sup>127</sup>

Even if counsel files an application for a competency hearing and the defendant is found incompetent, the case is not over. The criminal case is stayed until the defendant's competency is restored.<sup>128</sup> The goal of mental health treatment is to restore competency so that the criminal case proceeds, not to treat the defendant or to manage the underlying mental illness on a long-term basis. Consequently, in cases where a defendant may have a stark diagnosis, the goal is only to bring the defendant to a level where they can function for their criminal case, not to manage their symptoms. At that point, the case is revived and the mental health inquiries focus on potential defenses to the crime charged with the competency question lingering in the background.

Competency is often only met for a limited period of time and then the client lapses, dropping their mental capacity below the required baseline.<sup>129</sup> This oscillation undercuts the premise that an individual meets the standards for competency. Mental capacity varies from day-to-day in each individual. A static ruling by the court on a given day does not assure the defendant will remain competent for any particular length of time.

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<sup>124</sup> ABA CRIMINAL JUSTICE STANDARDS § 7-4.2(c) (2013).

<sup>125</sup> *Id.* at R. 7-4.2(d).

<sup>126</sup> *Id.* at R. 7-4.2(f).

<sup>127</sup> See *Mental Illness, Your Client, and Criminal Law*, CONN. APPLESEED NETWORK 1, 25–26 (May 2007), <http://ctappleseed.org/pdfs/707/mi-criminallawhandbook.pdf>.

<sup>128</sup> See *Wright v. Sec'y for Dep't of Corr.*, 278 F.3d 1245, 1251 (11th Cir. 2002) (explaining that because the defendant was found to have competence restored, the criminal proceeding continued); See also *Restoration of Competency to Stand Trial*, HOGG FOUND. FOR MENTAL HEALTH (March 2013), <http://www.hogg.utexas.edu/uploads/documents/Competency%20Restoration%20Brief.pdf>.

<sup>129</sup> John D. King, *Candor, Zeal, and the Substitution of Judgment: Ethics and the Mentally Ill Criminal Defendant*, 58 AM. U. L. REV. 207, 231–32 (2008).

### C. *Issues Regarding Medication*

Another problem in addressing competency is the use of psychotropic medication. Those with a mental illness are not always compliant in treatment due to a lack of insight into their diagnosis or a lack of interest in getting better.<sup>130</sup> In the 1992 decision *Riggins v. Nevada*, the Supreme Court attempted to address the problem of forcibly medicating an individual in order to maintain competency and the defendant’s right to effectively present a defense.<sup>131</sup> On one hand, it is a violation of due process to try an individual who isn’t competent.<sup>132</sup> On the other hand, the defendant is entitled to present a defense in a fashion that the jury understands.<sup>133</sup> In its analysis, the Court drew a distinction between *Riggins* (a pretrial detainee) and individuals who had been convicted and who were being forcibly medicated while incarcerated.<sup>134</sup> The Court had previously noted the effects of antipsychotic medications in *Washington v. Harper*:

The purpose of the drugs is to alter the chemical balance in a patient’s brain, leading to changes, intended to be beneficial, in his or her cognitive processes. While the therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects. One such side effect identified by the trial court is acute dystonia, a severe involuntary spasm of the upper body, tongue, throat, or eyes. The trial court found that it may be treated and reversed within a few minutes through use of the medication Cogentin. Other side effects include akathisia (motor restlessness, often characterized by an inability to sit still); neuroleptic malignant syndrome (a relatively rare condition which can lead to death from cardiac dysfunction); and tardive dyskinesia, perhaps the most discussed side effect of antipsychotic drugs. Tardive dyskinesia is a neurological disorder, irreversible in some cases, that is characterized by involuntary, uncontrollable movements of various muscles, especially around the face.... [T]he proportion of patients treated with antipsychotic drugs who exhibit the symptoms of tardive dyskinesia ranges from 10% to 25%. According to the American Psychiatric Association, studies of the condition indicate that 60% of tardive dyskinesia is mild or minimal in effect, and about 10% may be characterized as severe.<sup>135</sup>

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<sup>130</sup> Tania M. Lincoln et al., *Correlates and Long-Term Consequences of Poor Insight in Patients with Schizophrenia: A Systematic Review*, 33(6) SCHIZOPHRENIA BULL. 1324, 1324–42 (Nov. 2007), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2779879/>.

<sup>131</sup> 504 U.S. 127, 132–33 (1992).

<sup>132</sup> See *Drope v. Missouri*, 420 U.S. 162, 171–72 (1975).

<sup>133</sup> *Riggins*, 504 U.S. at 133 (“The record in this case narrowly defines the issues before us. The parties have indicated that once the District Court denied [the defendant’s] motion to terminate use of [the antipsychotic drug], subsequent administration of the drug was involuntary.”).

<sup>134</sup> *Id.* at 133–34 (“In *Harper*, a prison inmate alleged that the State of Washington and various individuals violated his right to due process by giving him Mellaril and other antipsychotic drugs against his will. Although the inmate did not prevail, we agreed that his interest in avoiding involuntary administration of antipsychotic drugs was protected under the Fourteenth Amendment’s Due Process Clause. ‘The forcible injection of medication into a non-consenting person’s body,’ we said, ‘represents a substantial interference with that person’s liberty.’” (quoting *Washington v. Harper*, 494 U.S. 210, 229 (1990)) (footnotes omitted).

<sup>135</sup> 494 U.S. at 229–30 (citations omitted).

The Court concluded that the record lacked enough detailed findings as to warrant the forced administration of antipsychotic medication to Riggins.<sup>136</sup> In *Harper*, the Court previously held that the involuntary administration of antipsychotic drugs would be constitutionally permissible:

First, there must be a “valid, rational connection” between the prison regulation and the legitimate governmental interest put forward to justify it. Second, a court must consider “the impact accommodation of the asserted constitutional right will have on guards and other inmates, and on the allocation of prison resources generally.” Third, “the absence of ready alternatives is evidence of the reasonableness of a prison regulation,” but this does not mean that prison officials “have to set up and then shoot down every conceivable alternative method of accommodating the claimant’s constitutional complaint.”<sup>137</sup>

The Court concluded:

We hold that, given the requirements of the prison environment, the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate’s medical interest.<sup>138</sup>

The questions remain regarding a defendant’s competency to stand trial, ability to present a defense, and the right to a full and fair trial. The complications of understanding a psychiatric diagnosis and discerning the effects of psychotropic medications force the criminal justice system to enter a quagmire from which it cannot extricate itself. The list of drugs used to treat individuals with mental illnesses presents a maze which is difficult for psychiatrists and psychologists to navigate. NIMH lists more than 100 different medications to treat disorders ranging from psychosis to ADHD.<sup>139</sup>

For the attorneys and judges handling cases involving mental health issues, the complexity and nuances of understanding the disease process and medications used in treating the disease are so overwhelming. Often, they simply give up and rely on reluctant experts who do not understand the criminal justice system to guide them in their decision making process. The premise that a medicated client is a competent client is simply not true.

#### D. *Insanity and Diminished Responsibility*

Most jurisdictions still employ the 1843 M’Naghten standard to gauge a defendant’s sanity.<sup>140</sup> The M’Naghten rule examines whether, at the time of the

<sup>136</sup> *Riggins*, 504 U.S. at 138 (“Because the record contains no finding that might support a conclusion that administration of antipsychotic medication was necessary to accomplish an essential state policy, however, we have no basis for saying that the substantial probability of trial prejudice in this case was justified.”).

<sup>137</sup> 494 U.S. at 224–25 (citations omitted).

<sup>138</sup> *Id.* at 227 (footnote omitted).

<sup>139</sup> NAT’L INST. OF MENTAL HEALTH, MENTAL HEALTH MEDICATIONS 17–24 (2012), available at <http://www.nimh.nih.gov/health/publications/mental-health-medications/index.shtml>.

<sup>140</sup> *The Insanity Defense Among the States*, FINDLAW, <http://criminal.findlaw.com/criminal-procedure/the-insanity-defense-among-the-states.html> (last visited June 30, 2014) (indicating that the states currently using the M’Naghten rule are: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Georgia, Iowa,

commission of the offense, the defendant knew the difference from right and wrong or understood the nature and quality of his acts.<sup>141</sup> The second test regarding insanity is the Model Penal Code rule.<sup>142</sup> The third test is the Durham rule, which was articulated in the 1954 decision by the Court of Appeals for the District of Columbia.<sup>143</sup> The test is a condemnation of the M’Naghten rule:

The science of psychiatry now recognizes that a man is an integrated personality and that reason, which is only one element in that personality, is not the sole determinant of his conduct. The right-wrong test, which considers knowledge or reason alone, is therefore an inadequate guide to mental responsibility for criminal behavior. As Professor Sheldon Glueck of the Harvard Law School points out in discussing the right-wrong tests, which he calls the knowledge tests:

‘It is evident that the knowledge tests unscientifically abstract out of the mental make-up but one phase or element of mental life, the cognitive, which, in this era of dynamic psychology, is beginning to be regarded as not the most important factor in conduct and its disorders. In brief, these tests proceed upon the following questionable assumptions of an outworn era in psychiatry: (1) that lack of knowledge of the ‘nature or quality’ of an act (assuming the meaning of such terms to be clear), or incapacity to know right from wrong, is the sole or even the most important symptom of mental disorder; (2) that such knowledge is the sole instigator and guide of conduct, or at least the most important element therein, and consequently should be the sole criterion of responsibility when insanity is involved; and (3) that the capacity of knowing right from wrong can be completely intact and functioning perfectly even though a defendant is otherwise demonstrably of disordered mind.’<sup>144</sup>

Meanwhile, some jurisdictions have eliminated insanity as a defense to a crime.<sup>145</sup>

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Louisiana, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Virginia, and Washington).

<sup>141</sup> R v. M’Naghten, (1843) 8 Eng. Rep. 718 (H.L.) (“Notwithstanding a party accused did an act, which was in itself criminal, under the influence of insane delusion, with a view of redressing or revenging some supposed grievance or injury, or of producing some public benefit, he is nevertheless punishable if he knew at the time that he was acting contrary to law. That if the accused was conscious that the act was one which he ought not to do; and if the act was at the same time contrary to law, he is punishable. In all cases of this kind the jurors ought to be told that every man is presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction: and that to establish a defence on the ground of insanity, it must be clearly proved that *at the time of committing the act the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or as not to know that what he was doing was wrong.*”) (emphasis added).

<sup>142</sup> See MODEL PENAL CODE § 4.01 (2013) (“(1) A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law. (2) As used in this Article, the terms ‘mental disease or defect’ do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct.”).

<sup>143</sup> Durham v. United States, 214 F.2d 862, 874–75 (D.C. Cir. 1954) (stating that “an accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect.”) (footnote omitted), *abrogated by* United States v. Brawner, 471 F.2d 969, 981–83 (D.C. Cir. 1972).

<sup>144</sup> *Id.* at 871–72 (discussing the history of the M’Naghten test and objections to its continued use).

<sup>145</sup> *The Insanity Defense Among the States*, *supra* note 140 (stating that Kansas, Montana, Idaho, and Utah do not allow the insanity defense).

Again, the problem with formulating legal tests to establish criminal culpability is that antiquated concepts of mental health still exist—as well as a disregard for developments in science. The notion that we would treat mental illnesses with the same therapies in existence in 1843 (when M’Naghten’s case articulated the prevailing test for insanity) would result in gasps of disbelief from medical practitioners. Legal tests should be developed in deference to and in incorporation with current medical diagnoses and treatment.

#### E. *The Criminal Justice System’s Inability to Address Mental Health Issues*

For the mentally ill, the criminal justice system typically reacts by medicating them to control their illness.<sup>146</sup> The notion that medication is the panacea to treat mental health issues is prevalent among the bench and bar.<sup>147</sup> As previously noted in this article, administering antipsychotic medication is one part of the treatment of schizophrenia.<sup>148</sup> However, in a recent clinical study regarding the effectiveness of antipsychotic medication in treating schizophrenia, one finding indicated antipsychotic medication does not significantly improve cognition.<sup>149</sup> In other words, medication alone does not assist an individual to produce and understand language, engage in problem solving, and make decisions.<sup>150</sup> This cognitive process is essential for an individual to have “sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding,” and to have a “rational as well as factual understanding of the proceedings against him.”<sup>151</sup> The fundamental legal question of competency is undercut by current science and its evaluation of medications used to treat schizophrenia.

<sup>146</sup> Lael Montgomery, *When Worlds Collide: Mentally Ill Criminal Defendants—Part II*, 29(7) COLO. LAW. 101, 101–05 (July 2000).

<sup>147</sup> *Id.*

<sup>148</sup> *Schizophrenia*, *supra* note 67.

<sup>149</sup> Hori H. et al., *Antipsychotic Medication and Cognitive Function in Schizophrenia*, 86 SCHIZOPHRENIA RES. 138, 138–146 (Sept. 2006), available at <http://www.ncbi.nlm.nih.gov/pubmed/-16793238>.

<sup>150</sup> *See id.*

<sup>151</sup> *Dusky v. United States*, 362 U.S. 402, 402 (1960). The Supreme Court’s decision was premised on the sufficiency of the record from the lower court: “At a hearing held pursuant to 18 U.S.C.A. § 42.4, on January 21, 1959, to determine whether the defendant was competent to stand trial, the court had before [it] a detailed report of a Neuropsychiatric Examination of the defendant. This report was dated October 30, 1958, and was signed by Doctor L. Moreau, Staff Psychiatrist at Medical Center. On the last page of the report appears the following: ‘He is oriented as to time, place, and person. He denies complete memory of the events of the day of the alleged offense. . . . This patient, charged with kidnapping, has no previous criminal record. In November, 1949, he was investigated for robbery and was released the same day. He was reared in an atmosphere of severely traumatic circumstances because of the discord between his parents and has always suffered from feelings of inadequacy. He has been grossly maladjusted since childhood. He was discharged charged [sic] from the Navy because of a psychoneurosis and has been a patient in Veterans Administration hospitals on two occasions since 1956. He has also received psychiatric care through the psychiatric receiving center in Kansas City, Missouri. Since admission to the Medical Center he has shown marked emotional turmoil, insomnia, tension, feelings of self-devaluation, ambivalent feelings, and impaired judgment and insight. He complains [sic] of having feelings of being followed and visual hallucinations. Almost since admission he has required the use of tranquilizing medications. . . .’ Attached to this report was a report of the Psychiatric Staff of the Medical Center, dated October 30, 1958, signed by Doctor Joseph C. Sturgell, Chief of the Neuropsychiatric Service, reading as follows: ‘The findings of psychiatric examination were presented by Dr. Louis Moreau. Other records were reviewed and the patient was interviewed by the members of the Psychiatric Staff. It is the opinion of the staff, following interview of the patient, that he had improved in recent weeks but his condition is still such that he is unable to understand the nature of the proceedings with reference to the charges against him and is unable to properly assist counsel in his defense. The patient is receiving tranquilizing medications and would probably deteriorate quickly if treatment was stopped at this time. . . .’ The court also had before it a report of the Neuropsychiatric Staff of the Medical Center, dated January 20, 1959, as to an examination of the defendant on January 8, 1959, signed by Doctor Sturgell for the Psychiatric Staff. It reads as follows: . . . ‘When examined by the staff, the patient again presented evidence of symptoms mentioned above. The staff is of the opinion that this man is mentally ill with a

## VI. MENTAL HEALTH COURTS AND DIVERSION PROGRAMS

The criminal justice system has been forced to react because of the influx of the mentally ill. In an effort to adjust to additional problems posed by this influx, courts have created its own ad hoc mental health treatment delivery systems. There are two systems of diversion programs: prebooking and postbooking.<sup>152</sup>

### A. *Prebooking Diversion*

Prebooking diversion of an individual with a mental illness comes in several variants. Prebooking diversion programs consist of law enforcement authorities determining whether to place an individual in a mental health setting rather than arrest.<sup>153</sup> These programs often employ specialized police units or Crisis Intervention Teams.<sup>154</sup> This model includes a variant in which officers are specially trained to act as “liaisons to [the] mental health system.”<sup>155</sup> Another model involves departments hiring mental health professionals who can provide real-time consultation with field officers.<sup>156</sup> The third model includes employing mobile mental health crisis teams who are part of the local mental health system.<sup>157</sup> There are also additional responses employed by law enforcement to deal with individuals with mental illnesses.<sup>158</sup> If the case is not diverted and an arrest

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diagnosis of schizophrenia. Because of this illness, he is unable to properly understand the proceedings against him and unable to adequately assist counsel in his defense.’ The only witness testifying at the hearing was Doctor Sturgell, whose testimony was in substantial conformity with the reports in evidence. He explained the statement in Doctor Moreau’s report that the defendant was oriented as to time, place and person, as follows: ‘This means that he is able to know the day of the week, the hour, the place in which he finds himself geographically, and the circumstances of his present situation. He knows he is in a court room; he knows the day of the week and the day of the year, and he knows that you are his attorney and Judge Smith is the judge. This is the orientation to person. He knows it all.’ Doctor Sturgell also expressed the opinion that the defendant understood what he was charged with, knew that if there was a trial it would be before a judge and jury, knew that if found guilty he could be punished, and knew who his attorney was and that it was his duty to protect the defendant’s rights.” *Dusky v. United States*, 271 F.2d 385, 387–90 (8th Cir. 1959) *rev’d*, 362 U.S. 402 (1960).

<sup>152</sup> See Frank Sirotych, *The Criminal Justice Outcomes of Jail Diversion Programs for Persons with Mental Illness: A Review of the Evidence*, 37 J. AM. ACAD. PSYCHIATRY L. 461, 462–63 (2009).

<sup>153</sup> *Id.* at 462.

<sup>154</sup> *Id.*

<sup>155</sup> *Id.*

<sup>156</sup> *Id.*

<sup>157</sup> *Id.*

<sup>158</sup> See *id.* at 462–63 (“In addition to these models . . . [there are] three additional precharge diversion models: joint police/mental health teams, specialized reception centers, and joint protocol initiatives. Joint police/mental health teams are composed of a mental health crisis worker and a plain-clothes police officer. The crisis worker undertakes mental health assessments, while the police officer can effect an apprehension pursuant to civil mental health legislation and transport individuals in psychiatric crisis to a hospital when civil commitment is required. When civil commitment criteria are not met, the team attempts to steer the subject of the police call to community care services in lieu of criminal arrest for behavior that could constitute low-level criminal offenses. Reception center models involve specialized crisis response sites where police officers can take an individual in psychiatric crisis requiring psychiatric assessment and immediately return to their regular patrol duties. These reception centers are secure facilities that have the legal authority to take custody of persons in crisis and can provide assessment, mental health treatment, and referral to outpatient community mental health and addiction services. Detoxification services are frequently located on site. Operating 24 hours a day, these one-stop service centers are thought to promote diversion by providing an expeditious alternative to transporting individuals in crisis to an emergency department where officers may have to wait long periods to have an individual assessed and may face refusals to admit individuals because of unmet criteria for civil commitment. Finally, joint protocol initiatives represent a generic category of prebooking diversion initiatives for models in which mental health service providers and the police mutually develop common operating procedures that enable police officers to connect an individual with a mental health agency, in lieu of laying a charge.”).

occurs, the defendant will be booked, and the criminal justice system will come into play with the possibility of postbooking diversion.<sup>159</sup>

### B. *Mental Health Courts*

Mental health courts are a “dedicated docket for persons” with a mental illness.<sup>160</sup> The court and other actors in mental health courts have training to deal with individuals who are mentally ill.<sup>161</sup> The first problem with mental health courts is that the underlying premise behind the concept is to only accept individuals who are rational enough to obey treatment recommendations under the threat of sanctions—or self-selectivity.<sup>162</sup> The criteria for acceptance is restricted by the nature of the mental illness the defendant has,<sup>163</sup> the type of crime the defendant is charged with,<sup>164</sup> and whether or not the defendant has a concurrent substance abuse problem.<sup>165</sup> The referrers—as one would expect—include judges, attorneys, jailors, and mental health professionals, while non-traditional referrers include “families, service providers, law enforcement personnel, community agencies, and parole officers.”<sup>166</sup> With success rates or graduation<sup>167</sup> rates driving the discussion of mental health courts, proponents can devise a system where the courts are handling low risk offenders with minimal mental health disorders to demonstrate a greater success rate.

<sup>159</sup> *Id.*

<sup>160</sup> *Id.* at 463.

<sup>161</sup> *Id.* (“[M]ental health courts are diversion initiatives in which the diversion process occurs in one specialized court. The judge, prosecutor, defense lawyer, and other court staff may have specialized training in working with persons with serious mental illness and will often work collaboratively, in conjunction with mental health court liaison staff, to link the accused to treatment and supports. These courts mandate community-based mental health treatment and monitor participants’ treatment adherence, using both praise and sanctions to encourage treatment compliance. Moreover, the promise of dismissed charges or the avoidance of incarceration is used as an incentive to participate in treatment.”).

<sup>162</sup> See Julie B. Raines & Glenn T. Laws, *Mental Health Court Survey*, 45 CRIM. L. BULL. 4, 5 (Summer 2009) (“An area of concern for any public agency is having positive outcomes—no matter what the program. One common problem among the mentally ill is compliance to authority. In order to investigate compliance amongst participants in mental health court systems, the following issues were examined: how the court manages participant compliance; how many participants on average drop out of the program; and the recidivism rate of graduates. The respondents were asked what they did to manage participant compliance and they were given the following response categories: (1) use rewards to encourage participation such as fewer therapy sessions and/or court sessions; (2) apply sanctions for non-compliance such as more therapy sessions, more court sessions, and/or jail time; (3) no sanctions; and (4) problems with compliance so there is no need to manage compliance. The respondents were instructed to choose all that applied. Overwhelmingly 100% of respondents used sanctions while 93% used rewards to encourage compliance. A miniscule 3% recorded having no problems with compliance. The largest number of respondents, 31%, reported a drop out rate of less than 5% of participants and only 10% reported a drop out rate of 30% or more.”); see also Sirotych, *supra* note 152, at 463 (“[E]nrollment in the mental health court is voluntary.”).

<sup>163</sup> See Sirotych, *supra* note 152, at 463 (“Although they share several common features, mental health courts vary considerably in their operation. They differ on the type of charges that they accept (misdemeanor versus felony versus a combination), on the type of community supervision that they employ (community treatment providers monitoring treatment adherence and reporting back to the court versus probation officers or court personnel monitoring compliance), and on the type of dispositions that they entertain (dismissal of charges, guilty plea but deferred sentence, or conviction with probation in lieu of a jail sentence). The courts also vary in the duration of court supervision of treatment and in the frequency of status review hearings of treatment progress. Finally, they vary in the use of sanctions for noncompliance with treatment conditions. Sanctions may include returning the person to court for hearings, admonishments, imposition of stricter treatment conditions, and reincarceration.”); see also Raines & Laws, *supra* note 162, at Figure 1-1 (illustrating that the categories include: depression, bipolar, mania, psychosis, personality disorder, and other.).

<sup>164</sup> Raines & Laws, *supra* note 162, at Figure 1-2.

<sup>165</sup> *Id.* at Figure 1-5.

<sup>166</sup> *Id.* at Figure 1-4.

<sup>167</sup> *Id.* at Figure 2-1 (questioning the use of the term “graduation” when dealing with individuals suffering from mental health issues).



The secondary problem with mental health courts is the relatively low number of individuals involved in the system.<sup>168</sup> As for a reduction in recidivism for participants in mental health courts, one survey seems to be hopeful;<sup>169</sup> however, a more comprehensive review of other studies reveals a mixed bag of results, with two studies finding “no difference between participants and nonparticipants in the prevalence rates of recidivism.”<sup>170</sup> Given that the goal of any criminal justice system is to reduce recidivism, these results undercut the value of mental health courts per se.

### C. *Postbooking Diversion*

The second model of diversion is postbooking.<sup>171</sup> There is jail-based diversion, where pretrial services screen and assign individuals to community based mental health services,<sup>172</sup> and court-based diversion, where mental health professionals working in the court system screen and assign individuals to community-based mental health services.<sup>173</sup> This system operates in multiple courts.<sup>174</sup> One study comparing prebooking diversion programs with postbooking programs notes that individuals in postbooking programs were more “functionally impaired” than individuals involved in prebooking programs.<sup>175</sup> It also notes that postbooking programs were coercive in their nature, as a “part of a continuum of social control.”<sup>176</sup>

The goal of these programs is to eliminate or reduce the need for the criminal justice system’s interaction with mentally ill individuals. An evaluation of the programs would necessarily focus on the amount of time in incarceration and rates of recidivism. A

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<sup>168</sup> *See id.* (“Some courts, 10%, have fewer than 15 participants at any given time. However the largest number of respondents, about one-third, see between 16–30 participants at any point in time. There are numerous factors that play into these figures; such as the size of the jurisdiction, the size of the budget, the amount of manpower, and the amount of local services available. Likewise, when survey respondents were asked how many participants were seen in a year’s time, the numbers varied greatly. The highest percentage of respondents, 24%, provided this program to over 150 participants during the course of a year. How long is the typical participant involved in a diversion program prior to graduation? The majority of courts, 71%, stated that their participants were in the program for over a year. From the eleven to twelve month time frame, 18% of courts graduated participants and the last 11% of the courts surveyed graduated participants within anywhere from five to ten months.”) (citation omitted).

<sup>169</sup> *Id.* (“Figure 3-1 shows that the majority of mental health court participants are staying in their treatment programs. Likewise, the recidivism rate, according to respondents, seems equally encouraging: 42% of respondents recorded a recidivism rate of 5% or less (see Figure 3-1). Although the recidivism rate appears low, 25% of the respondents unfortunately did not track recidivism, skewing the results.”).

<sup>170</sup> Sirocich, *supra* note 152, at 468.

<sup>171</sup> *Id.* at 462.

<sup>172</sup> *Id.* at 463 (“Jail-based postbooking diversion programs are typically operated by pretrial service personnel or specialized jail personnel who identify, assess, and divert mentally ill detainees from custody to community-based mental health treatment with the consent of the prosecutor, judge, and defense lawyer. Jail liaisons undertake mental health assessments of detainees and develop a treatment plan for individuals in cooperation with jail mental health staff and community-based mental health service providers.”).

<sup>173</sup> *Id.* (“[C]ourt-based postbooking diversion programs employ mental health clinicians who work within the courthouse. They screen the arraignment lists for known clients and receive additional referrals from court staff. They conduct assessments and, in negotiations with the prosecutor, defense, and judge, develop a treatment plan to secure a bail release of the mentally ill accused person. Typically cases are continued for a brief period to ensure that the patient is linked and adhering to the necessary treatment services before charges are withdrawn. Alternatively, an accused person may be convicted and receive probation with special treatment conditions rather than a custodial sentence. Diversion occurs in multiple courts before multiple judges.”).

<sup>174</sup> *Id.*

<sup>175</sup> Pamela K. Lattimore et al., *A Comparison of Prebooking and Postbooking Diversion Programs for Mentally Ill Substance-Using Individuals with Justice Involvement*, 19 J. CONTEMP. CRIM. JUST. 30, 58 (Feb. 2003).

<sup>176</sup> *Id.*

review of current studies indicates that diversion programs do not reduce recidivism.<sup>177</sup> Mental health courts,<sup>178</sup> court based diversion,<sup>179</sup> jail based diversion,<sup>180</sup> and prebooking diversion<sup>181</sup> all seem to have a minimal effect on recidivism. However, these programs do significantly reduce the amount of time the mentally ill are incarcerated.<sup>182</sup> These studies need to continue.

## VII. CONCLUSION

Unfortunately, the discussion of mental health and the criminal justice system in the 21st century is hauntingly familiar. The problem with the treatment of the mentally ill is that it has not changed since 1766, when the medical model of treatment gained support. It came with the recognition that individual families and communities were not able to handle the problem. As a result, jails, prisons, and workhouses were filled with the mentally ill. Public mental health hospitals were created to alleviate the problem. Yet, chronic overcrowding and underfunding of the state hospitals created warehousing of the mentally ill and led to neglect and abuse of patients in state hospitals. This mistreatment of patients within the state hospital system led to deinstitutionalization. Community-based treatment was believed to provide a better delivery system for mental health services. Unfortunately, community-based treatment was never developed or implemented. The mentally ill were turned out of hospitals onto the streets—homeless with no treatment or support system—which, in many cases, led to a repeated cycle of arrest and prosecution.

The role of treating individuals with a mental illness was deposited in the criminal justice system as a result of deinstitutionalization. Currently, the role of psychiatrist is passed among the participants in the criminal justice system. From the officer on the street, to defense counsel, to the courts, and ultimately to the jails and prisons, individuals with little or no mental health training are making treatment decisions.

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<sup>177</sup> Sirotych, *supra* note 152, at 469 (“[E]vidence suggests that diversion programs in general do not reduce recidivism among persons with mental illness. In addition . . . evidence suggests that the diversion initiatives, as a broad category of interventions targeting persons with serious mental illness, reduce time spent in custody by adults with serious mental illness. Tentative evidence suggests that court-based diversion programs that mandate treatment adherence serve to reduce the amount of jail time that the mentally ill accused serve relative to treatment as usual or to jail-based diversion programs that do not mandate and monitor treatment compliance. Further study is needed to verify this finding.”).

<sup>178</sup> *Id.* at 468 (“Six studies were located in which the criminal justice outcomes of mental health courts was evaluated. Of the six, four reported on the prevalence rates of recidivism. One study, with a retrospective observational design and propensity-weighted regression analyses used to attenuate the biasing effects of nonrandom assignment, found a 26 percent reduction in the probability of a new charge among mental health court participants relative to nonparticipants. Another study, with a prospective quasi-experimental design that compared subjects who opted into a mental health court with those who opted out, found an increase in the prevalence of recidivism among the opt-in group. The remaining two studies, a retrospective cohort study and a pre-post with comparison group study, found no difference between participants and nonparticipants in the prevalence rates of recidivism.”).

<sup>179</sup> *See id.* (“[E]vidence supports the use of court-based diversion to reduce the length and prevalence of incarceration among persons with serious mental illness; however, there is as yet no evidence to suggest that this diversion model serves to reduce the incidence or prevalence of recidivism in this group.”).

<sup>180</sup> *Id.* at 467 (“[E]vidence indicated no overall reduction in the subsequent criminal activity of individuals receiving jail-based diversion relative to their nondiverted counterparts, but very tentative evidence of an interaction effect showing that jail-based diversion may reduce the incidence of arrest among low-level misdemeanants.”).

<sup>181</sup> *See id.* (“[E]vidence supports the use of prebooking programs to reduce the amount of time that mentally ill persons spend in custody with greatest support for a police-based specialized police response model; however, the existing evidence does not support the use of prebooking programs to prevent recidivism in this population.”).

<sup>182</sup> *Id.* at 466, Table 2.

Legislatures have attempted to solve a medical problem with a legal solution—a solution that has failed miserably.

Legal tests formulated for competency, insanity, and diminished responsibility are flawed in that they treat mental health issues like an on-off switch—the individual is competent or not competent; the individual is sane or insane; the individual can form the culpable mental state (*mens rea*) or the individual cannot. This approach in formulating legal tests does nothing to address the medical issues arising on a routine basis in the criminal justice system.

This fundamental misunderstanding of mental illnesses results in mistreatment and death for those involved in the system. Although diversion programs are reducing the number of days incarcerated, there is no evidence they reduce recidivism. It should be remembered that diversion programs are really a reaction to deinstitutionalization and constitute a mental health treatment delivery system. They are, simply put, the newest variant in a series of failed programs.

The result of the application of Penrose’s Law is increased crime rates and incarceration of the mentally ill. We have come full circle. *Brown v. Plata*<sup>183</sup> appears to have been predictable and inevitable based on studies that have been completed by the psychiatric community. Until policy makers are willing to establish and maintain sustained funding for a mental health treatment system run by medical personnel, changes in existing delivery systems are the equivalent of rearranging deck chairs on the Titanic.

We end where we began, with Scrooge asking: “Are there no prisons?”<sup>184</sup> Unfortunately, the answer today is the same as it was then: Yes, “Plenty of prisons.”<sup>185</sup>

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<sup>183</sup> 131 S. Ct. 1910, 1923 (2011).

<sup>184</sup> DICKENS, *supra* note 1.

<sup>185</sup> *Id.*