The Mentally Ill Offender Treatment and Crime Reduction Act and Its Inappropriate Non-Violent Offender Limitation

Liesel J. Danjczek
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INTRODUCTION

Eric Clark was a typical high school student. He performed well in school and sports, and was selected as a member of the homecoming court both his freshman and sophomore years. However, things changed drastically as Clark began to suffer from chronic paranoid schizophrenia. He came to believe that his hometown of Flagstaff, Arizona was populated with aliens, including some in disguise as government officials, and that aliens were out to get him. His parents unsuccessfully tried to get him

* Associate at Rifkin Livingston Levitan & Silver, LLC. B.S., United States Naval Academy, 1999; J.D., The Catholic University of America, Columbus School of Law, 2007; M.A. in Psychology, The Catholic University of America, 2007. The author would like to thank Dr. Alan Abrams for his expert feedback throughout the writing of this paper. The author would also like to thank her parents for their perpetual support and encouragement throughout law school and in all else.


2. See Gibeaut, supra note 1; Lash, supra note 1.

3. See Lash, supra note 1. Clark’s changes occurred in stages. First, Clark became withdrawn from friends and lost interest in sports. His parents then noticed their son having drastic mood swings. Clark’s symptoms quickly escalated as he began having bizarre beliefs, including the belief that his parents were aliens that were going to harm him. Lastly, Clark stopped maintaining his personal hygiene and dropped out of school. Gibeaut, supra note 1; Lash, supra note 1.

4. Clark v. Arizona, 126 S. Ct. 2709, 2717 (2006). Clark believed the only defense against the aliens was to shoot them with bullets. Other bizarre behaviors he exhibited in response to his delusions included “rig[ging] a fishing line with beads and wind chimes at home to alert him to intrusion by invaders” and keeping a bird in his car “to warn of airborne poison.” Id.
psychiatric help, even to the extent of having their son arrested once as a means to have him committed. His parents did not give up in their efforts and his mother actually went to her lawyer's office to try again to get Clark civilly committed on June 20, 2000—just one day before he was arrested for killing a police officer. Around five in the morning on June 21, 2000, Clark was pulled over by Officer Jeff Moritz of the Flagstaff Police for blaring music from his vehicle and Clark fatally shot the officer.

No one disputed the fact that Clark suffered from schizophrenia. In fact, Clark had to be committed to a state hospital for two years before he was finally found competent to stand trial in 2003. The Supreme Court recently affirmed Clark's first-degree murder conviction and he is currently serving twenty-five years to life in prison. Unfortunately, Clark's story is not uncommon. A woman in California, like Clark's parents, "begged and pleaded with prosecutors and psychiatrists to send her son, who suffers from

5. Lash, supra note 1. Although Clark was committed, he was later released against medical advice. Id.

6. Gibeaut, supra note 1, at 38.

7. Clark, 126 S. Ct. at 2716; Lash, supra note 1.

8. Id. The defense argued that Clark thought Officer Moritz was an alien prepared to harm him and, therefore, did not realize the wrongfulness of his act. The prosecution, while agreeing that he was insane, claimed Clark knew the wrongfulness of his actions. As proof, the prosecution looked at Clark's reported statements before the shooting that he wanted to shoot police officers and Clark's action after the shooting of evading the police and hiding the gun. Id. at 2716-18; see also Bureau of Nat'l Affairs, Court Upholds Moral-Incapacity Insanity Test, Limitations on Use of Mental Defect Evidence, 75 U.S.L.W. 7, 7 (July 4, 2006). Schizophrenia is a psychotic disorder that may show itself in some of the following ways: delusions, hallucinations, disorganized speech, or disorganized behavior. Psychotic episodes are as real to a schizophrenic as a person experiencing a dream. James Walker, Getting the Mentally Ill Misdemeanant Out of Jail, 6 SCHOLAR 371, 380-81 (2004). While schizophrenia is incurable, it is treatable. Mark Heyrman, Five Things Every Lawyer Should Know About Mental Health Law, 18 CHI. B. ASS'N REC. 31, 32 (Jan. 2004).

9. Clark, 126 S. Ct. at 2716.

10. Id. at 2737; Gibeaut, supra note 1.
paranoid schizophrenia, to a mental hospital."\(^{11}\) However, like Clark, the son was not sent into the mental health system and later landed in the criminal justice system after he murdered a woman who came to his door asking him to take her cat to a veterinarian.\(^ {12}\) These are just two of many accounts about mentally ill individuals slipping through the cracks in the health care system and ending up in the criminal justice system, a problem termed "the criminalization of the mentally ill."\(^ {13}\)

While the issues the U.S. Supreme Court recently addressed in the case of Clark v. Arizona\(^ {14}\) revolved around the constitutional standards for the insanity defense,\(^ {15}\) this comment is concerned with the need and the

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14. Clark, 126 S. Ct. at 2709, 2716.

15. Id. A divided Supreme Court (a 6-3 decision) ruled that Arizona's insanity test—which focuses solely on whether the defendant knew his actions are right or wrong—is constitutional under the Fourteenth Amendment's Due Process Clause. The Court also ruled that while defendants may have witnesses describe abnormal behavior to contest the requisite mens rea (intent) for a crime, defendants do not have a right to permit expert witnesses to testify as to their mental condition to dispute mens rea. Id.; Lash, supra note 1.
obligation to effectively treat severely mentally ill violent offenders, including violent ones such as Clark, who most likely would never encounter the criminal justice system if proper treatment was received in the community. In addition to the legal and moral reasons to treat these people like every other criminal defendant, there are significant practical concerns regarding this specific class of mentally ill offenders. Simply incarcerating this class has proven to be a disaster that results in the problem of the "revolving door."\footnote{O'Keeffe, supra note 16.} Essentially, these individuals are not given effective treatment in the community or during incarceration so they continually bounce from penal institutions to hospitals due to their illness.\footnote{Id.} This cycle results in people needlessly suffering from mental illnesses, a less safe society, and wasted resources and tax dollars.\footnote{Denckla & Berman, supra note 16.}

This comment specifically focuses on the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA).\footnote{Mentally Ill Offender Treatment and Crime Reduction Act of 2004, Pub. L. No. 108-414, 118 Stat. 2327 (2004).} President Bush signed the act into law in October 2004, and its purpose is "to increase public safety by facilitating collaboration among the criminal justice, juvenile justice, mental health treatment, and substance abuse systems."\footnote{Id. § 3, 118 Stat. at 2328.} Congress, realizing that simply incarcerating all mentally ill offenders is a fruitless solution, created MIOTCRA to encourage the use of new ways to increase awareness of mental health issues and to deal with mentally ill offenders in the criminal justice system, such as diversion programs, enhanced treatment in jails and prisons, and programs to assist mentally ill offenders in their transition back in the community following their incarceration.\footnote{Id. § 2, 118 Stat. at 2327; § 3, 118 Stat. at 2328; § 2991(b)(5)(I), 118 Stat. at 2333-34; see also Denckla & Berman, supra note 16, at 7; Robert Bernstein & Tammy Seltzer, Criminalization of People with Mental Illnesses: The Role of Mental Health Courts in System Reform, 7 D.C. L. Rev. 143, 144-45 (discussing policymakers' concerns regarding the mentally ill in the criminal justice system).}


17. O'KEEFE, supra note 16.

18. Id.


20. Id. § 3, 118 Stat. at 2328.

21. Id. § 2, 118 Stat. at 2327; § 3, 118 Stat. at 2328; § 2991(b)(5)(I), 118 Stat. at 2333-34; see also Denckla & Berman, supra note 16, at 7; Robert Bernstein & Tammy Seltzer, Criminalization of People with Mental Illnesses: The Role of Mental Health Courts in System Reform, 7 D.C. L. Rev. 143, 144-45 (discussing policymakers' concerns regarding the mentally ill in the criminal justice system).
This comment argues that MIOTCRA is flawed in offering grant money for diversion programs, such as mental health courts, that only serve adult and juvenile non-violent mentally ill criminal offenders.\(^{22}\) Diversion programs place appropriate mentally ill offenders in treatment programs rather than incarcerate them.\(^{23}\) These programs have achieved extraordinary success in treating mentally ill offenders and reducing recidivism.\(^{24}\) Under MIOTCRA, only appropriate offenders, those whose crime is deemed to be the product of their mental illness and who are likely to succeed in the treatment program, may be diverted from the criminal justice system.\(^{25}\)

Although MIOTCRA does permit grant money to be used to address treatment for violent mentally ill offenders through in-jail or in-prison programs and re-entry programs,\(^{26}\) jails and prisons were not designed to be psychiatric hospitals. Their environments can actually exacerbate mental

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25. Mentally Ill Offender Treatment and Crime Reduction Act of 2004 § 2991(a)(9), 118 Stat. at 2330. The term “appropriate offender” is used in reference to MIOTCRA’s definition of “preliminary qualified offenders” for diversion programs. *Id.* MIOTCRA uses the term “appropriate” in regards to cases that are eligible for diversion programs. *See id.* § 3(3), 118 Stat. at 2328 & § 2991(a)(4)(A), 118 Stat. at 2329.

illnesses. Treatment programs in penal institutions and re-entry services are often ineffective due to program deficiencies and challenges that arise from the negative effects on offenders' mental illnesses from having been kept in a jail or prison environment. Just as there are appropriate and inappropriate non-violent mentally ill offenders for diversion programs, there are appropriate and inappropriate violent mentally ill offenders for diversion programs. Current diversion programs that accept violent offenders have proven to be successful. Not only is there no need for MIOTCRA's limitation to non-violent offenses for diversion programs, there are theoretical, legal, and public policy arguments for why that limitation should be eliminated.

Allowing violent mentally ill offenders to participate in diversion programs would result in a safer society due to decreased recidivism rates; less suffering for people with serious mental illnesses; financial savings from reduced incarceration and medical fees; and greater benefits from many mentally ill offenders becoming productive members in society. Rather than deny funding to diversion programs that accept violent mentally ill offenders, MIOTCRA should encourage and challenge policy makers to come up with such programs given the success and benefits that can result from them.

27. See Jennifer S. Bard, Re-Arranging Deck Chairs on the Titanic: Why the Incarceration of Individuals with Mental Illness Violates Public Health, Ethical, and Constitutional Principles and Therefore Cannot Be Made Right By Piecemeal Changes to the Insanity Defense, 5 HOUS. J. HEALTH L. & POL'Y 1, 6 (2005). Bard states that, "[p]risons were not designed to house large numbers of the mentally ill, and recent research shows that the cramped, regimented, and punitive atmospheres of prisons exacerbate mental illness and result in inhumane suffering." Id. See also DENCKLA & BERMAN, supra note 16, at 1, 4.

28. Id.


While many jurisdictional diversion programs ban violent mentally ill offenders, such as California's Mentally Ill Offender Criminal Reduction Act (MIOCR),\(^{32}\) the trend has been for more and more programs to permit at least some violent offenders.\(^{33}\) This comment focuses on federal funding under MIOTCRA because

\[\text{[t]hough the Supreme Court has chosen to leave this complex issue [the challenges posed by mentally ill offenders] to the states, the states look to the federal authorities for guidance. Mental illness and its effects, both inside and outside of the criminal justice system, is a national issue calling for a unified, organized, and coordinated approach.}^{34}\]

As mentioned in the President's New Freedom Commission on Mental Health 2003 report, "as has long been the case in America, local innovations under the mantle of national leadership can lead the way for successful transformation throughout the country."\(^{35}\)

Part I of this comment discusses the reason MIOTCRA was created and its contents. Part II discusses which violent mentally ill offenders should be allowed to participate in diversion programs funded by MIOTCRA and also the theoretical, legal, and public policy arguments for why they should be allowed in MIOTCRA-funded diversion programs. Part III highlights some types of diversion programs and also discusses some that currently accept violent mentally ill offenders.


PART I: THE MENTALLY ILL OFFENDER TREATMENT AND CRIME REDUCTION ACT

SECTION A: The Reason for MIOTCRA—The Criminalization of the Mentally Ill

MIOTCRA is a response to "the criminalization of the mentally ill." People with mental illnesses are not receiving needed treatment through the mental health system and, as a result of their mental health, are ending up in the criminal justice system. The number of the mentally ill incarcerated continues to increase and current statistics indicate that the rates of serious mental illness are three to four times greater in jails than in the general population. The U.S. institution holding the most people with mental illness is not a mental health institution, but rather the Los Angeles County Jail. As the numbers of mentally ill in jails and prisons have increased over the years, the number hospitalized for mental illness has sharply decreased. In 1955, 560,000 people were hospitalized with mental illness in the U.S. compared to 80,000 in 1999.

Some findings stated in MIOTCRA include: over 16% of adults incarcerated in U.S. jails and prisons have a mental illness; 20% of juveniles

36. See Press Release, Campaign for Mental Health Reform, Mental Illness Over-Represented in Jail & Prisons (Sept. 6, 2006), available at http://www.mhreform.org/9-7-06-mental-illness-over-represented-in-jails-and-prisons.html; Tosmasini & Imas, supra note 13, at 52; Stoil, supra note 13, at 8. The term criminalization of the mentally ill refers to the improper diversion of many mentally ill people to the criminal justice system. See Gondles, supra note 13, at 6.

37. See DENCKLA & BERMAN, supra note 16, at 1. The use of the term 'criminal justice system' in this comment refers to the criminal justice system and also the juvenile justice system.


39. Id. at xiii.

40. DENCKLA & BERMAN, supra note 16, at 3 ("While the number of people with mental illness in state psychiatric hospitals has decreased precipitously over the last thirty years, the number of mentally-ill people in jails and prisons has steadily increased.").

41. Id.
involved in the juvenile justice system have a serious mental illness; up to 40% of adults suffering from a serious mental illness will come in contact with the criminal justice system at some point; the majority of those suffering from a mental illness or emotional disorder in the criminal and juvenile systems respond to proper treatment; and collaborative programs between the mental health, substance abuse, and criminal or juvenile systems can lower the amount of incarcerated mentally ill people while improving public safety.\footnote{42} The factors that lead to the criminalization of the mentally ill are beyond the scope of this comment.\footnote{43} However, some contributing factors include deinstitutionalization,\footnote{44} stricter standards for civil commitment,\footnote{45} the lack of community mental health resources,\footnote{46} funding shortages,\footnote{47} and public policy changes such as "the get tough on crime" and anti-drug movements.\footnote{48} Regardless of the causes, the problem of criminalizing mental


\footnote{43} The cause of the criminalization of the mentally ill is complex and not simply the result of one or two factors. See CSG, supra note 38, at xiii; Honberg & Gruttadoro, supra note 24, at 22. For a discussion on the causes see Lamb, Weinberger & Gross, supra note 24, at 109-11.

\footnote{44} "‘Deinstitutionalization’ is a term that describes the systematic shift in resources for treating people with mental illness- from large, residential, state-run psychiatric hospitals to community-based treatment.” DENCKLA & BERMAN, supra note 16, at 2. The deinstitutionalization movement started in the 1960’s and lead to the mass closing of state mental institutions. Community health service programs were supposed to take the place of the state mental institutions in treating the mentally ill. The problem is that the network was never effectively established, leaving many mentally ill people to be diverted into the criminal justice system. See Dean H. Aufderheide & Patrick H. Brown, Crisis in Corrections: The Mentally Ill in America's Prisons, CORRECTIONS TODAY, Feb. 2005, at 30, 31, 32.

\footnote{45} See Lamb, Weinberger & Gross, supra note 24, at 110.

\footnote{46} Id.

\footnote{47} Thomas W. White & Elizabeth Gillespie, Mental Health Problems: Addressing the Unfunded Mandate, CORRECTIONS TODAY, Oct. 2005, at 108.
illness must be addressed and corrected. While efforts need to be made to treat this population in the community before they become involved the criminal justice system, for those who have already slipped through the cracks, treatment must be given so the revolving door comes to halt. MIOTCRA is commendable as an attempt on the federal level to address this problem. However, as will be discussed, it falls short in forcing the diversion programs it funds to limit their participants to only non-violent offenders.

48. See Lamb, Weinberger & Gross, supra note 24, at 109; Maureen Buell, Facilitating Collaboration Between Correctional and Mental Health Systems, CORRECTIONS TODAY, Oct. 2003, at 141, 141. For a discussion of the public policy influence on the criminalization of the mentally see Alfred Blumstein, Douglas W. Cassel, Bernadine Dohrn, Mark J. Heyrman, Randolph N. Stone & Franklin E. Zimring, Mass Incarceration: Perspectives on U.S. Imprisonment, 7 U. CHI. L. SCH. ROUNDTABLE 91, 91-121 (2000). Public policy changes, such as the harsher repercussions for drug offenders and parole violators, are problematic in regards to people with mental illness because they often abuse drugs to cope with their symptoms and lack the ability to flawlessly conform to their parole requirements. See DENCKLA & Berman, supra note 16, at 4-6.

49. See generally DENCKLA & Berman, supra note 16, at 1 (discussing how in failing to treat this class of mentally ill offenders, everyone loses because “[d]efendants with mental illness fail to receive the help they need. The justice system fails to deploy resources either efficiently or effectively. And the community at large fails to address a serious public safety problem.”). There are some people with mental illness who deserve to be incarcerated. There are varying degrees of mental illness and people suffering from a mental illness have different abilities to control their actions and abide by the law. This comment is concerned with people with a serious mental illness and whose crimes are considered solely the result of their mental illness and are deemed to be good candidates for treatment programs.

50. See DENCKLA & Berman, supra note 16, at 4; see also Long Island Legal Briefs, LONG ISLAND BUS. NEWS, Feb. 3, 2006 [hereinafter LIBN ] (explaining that the revolving door consists of these individuals continually cycling through the criminal justice system because they never receive the appropriate treatment to prevent them from committing crimes that are solely a product of their illness).

SECTION B: The Contents of the MIOTCRA

MIOTCRA is a five-year grant program that authorizes up to $50 million annually in funding for community and state programs that involve collaboration between the mental health system and the criminal justice systems.\textsuperscript{52} MIOTCRA grant money can be used to create or expand mental health courts or similar courts; for specialized training for mental health and/or criminal justice employees regarding mentally ill offenders; for programs that support collaborative efforts between the mental health and criminal justice systems; and for programs that support collaboration between State and local governments regarding mentally ill offenders.\textsuperscript{53}

MIOTCRA encourages that funds be used for diversion programs and alternative prosecution and sentencing programs such as crisis intervention teams.\textsuperscript{54} It also promotes using funds for in-jail or in-prison treatment and for transitional re-entry services for when mentally ill offenders are released from jail or prison.\textsuperscript{55} MIOTCRA stresses the importance of having adequate support services (such as mental health, substance abuse, housing, education, and job placement services) available when a mentally ill offender rejoins society.\textsuperscript{56}

MIOTCRA states in its purpose that collaboration is needed to increase sentencing alternatives for "appropriate nonviolent offenders with mental illness;" and promote communication among various criminal justice personnel, mental health personnel, support services personnel, and "nonviolent offenders with mental illness or co-occurring mental illness and substance abuse disorders."\textsuperscript{57} A "preliminary qualified offender" under MIOTCRA must have been diagnosed at some point with a mental illness;

\textsuperscript{52} Mentally Ill Offender Treatment and Crime Reduction Act of 2004, Pub. L. No. 108-414, § 2991(h), 118 Stat. 2327, 2335 (2004). While this amount of money is far from sufficient to cover the cost of reform that needs to be accomplished to tackle the problem of the criminalization of the mentally ill, and the financial shortcomings are crucial, the budget is beyond the scope of this article, which is concerned with the substantive shortcomings. See Stoil, supra note 13, at 8, 10-11.

\textsuperscript{53} Mentally Ill Offender Treatment and Crime Reduction Act of 2004 § 2991(b)(2).

\textsuperscript{54} Id. § 2991(b)(5)(I)(i).

\textsuperscript{55} Id. § 2991(b)(5)(I)(iv).

\textsuperscript{56} Id. § 2991(b)(5)(C)(ii)(VI).

\textsuperscript{57} Id. § 3(3), (6).
have committed an offense in which its commission is deemed to be the product of mental illness; and have committed a non-violent offense. The definition of “non-violent offense” used in MIOTCRA is an offense that does not have as an element the use, attempted use, or threatened use of physical force against the person or property of another or is not a felony that by its nature involves a substantial risk that physical force against the person or property of another may be used in the course of committing the offense.

This limit constrains all programs funded under MIOTCRA from diverting violent mentally ill offenders. By denying violent offenders to be considered for diversion programs, MIOTCRA is in contradiction to its own purpose and goals. MIOTCRA is meant to assist those that, had the health system not failed to treat them, would never have landed in the criminal justice system in the first place. Key components of MIOTCRA include collaboration by a federal task force on ways to reduce recidivism with mentally ill offenders, and a list of “best practices” used in the criminal justice system with mentally ill offenders that must be created by the Attorney General and the Secretary of Health and Human Services. The goals of MIOTCRA are to promote health and public safety, in addition to saving government money. Also, assuming the reasoning behind treating mentally ill offenders differently under MIOTCRA funded diversion programs is because they lack


59. Id. § 2991(a)(8).


62. See id.; Mentally Ill Offender Treatment and Crime Reduction Act of 2004 § 3, 118 Stat. at 2328; Leahy, supra note 60.
the standard criminal culpability, the type of crime committed should be irrelevant. The distinction between offense types for diversion program eligibility under MIOTCRA should be eliminated.

PART II: VIOLENT MENTALLY ILL OFFENDERS

While MIOTCRA is a step in the right direction and better than nothing, it is shortsighted in offering funding to diversion programs that only accept non-violent offenders. Considering the costs to public safety and financial resources, this country cannot afford to ignore the treatment needs of violent mentally ill offenders. Judge Greg Mathis noted that “untreated, mood disorders, such as bipolar disorder, can lead to violent, and sometimes criminal, behavior.” He goes on to say that these people can be rehabilitated with proper treatment. MIOTCRA should be amended to delete the non-violent offender requirement for diversion programs to conform with legal standards, moral standards, and the purpose and goals stated in MIOTCRA itself.

SECTION A: Which Violent Mentally Ill Offenders Should Be Allowed in Diversion Programs Funded Under MIOTCRA

MIOTCRA, using the exact definition used by the Human Rights Watch in “Ill Equipped” to define “serious mental illness,” defines “mental illness” as

a diagnosable mental, behavioral, or emotional disorder (A) of sufficient duration to meet Diagnostic and Statistical Manual of

63. This assumption comes from the requirement in MIOTCRA that to be a “preliminary qualified offender” eligible for diversion programs, the commission of the offense must be deemed to be “the product of the person’s mental illness.” Mentally Ill Offender Treatment and Crime Reduction Act of 2004 § 2991(a)(9)(B).


67. Id.
Mental Disorders published by the American Psychiatric Association and (B)(i) that, in the case of an adult, has resulted in functional impairment that substantially interferes with or limits 1 or more major life activities; or (ii) that, in the case of a juvenile, has resulted in functional impairment that substantially interferes with or limits the juvenile’s role of functioning in family, school, or community activities.68

The Act goes on to define a “preliminary qualified offender” as a non-violent offender who has been diagnosed with a mental illness or who displays obvious symptoms of mental illness, whose offense is considered the product of his or her mental illness, and who is deemed appropriate for diversion by a pretrial screening process or by a judge or magistrate.69 This definition of mental illness allows great flexibility for which mental disorders can be targeted under MIOTCRA.70

Mental illness, under the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), includes both Axis I disorders, which are clinical syndromes such as schizophrenia, bipolar disorder, and major depression, and Axis II disorders, which are personality disorders.71 Many diversion programs involving mentally ill offenders exclude people with Axis II disorders because personality disorders are often considered harder to treat or untreatable.72 MIOTCRA commendably does not force programs to cut out this population of mentally ill.73


69. Id. § 2991(a)(9).

70. MIOTCRA allows great flexibility by broadly defining “mental illness” in that it does not limit the definition to any specific mental disorders or type of mental disorders.


73. As discussed, the definition of mental illness in MIOTCRA is broad and does not expressly exclude any mental illnesses or class of mental illnesses. See Mentally Ill Offender Treatment and Crime Reduction Act of 2004 § 2991(a)(7).
Allowing states and communities to decide if they want their programs to include offenders with Axis II disorders is laudable in allowing grant applicants to decide where they want to target their effort since there has been no definitive proof that personality disorders are untreatable.\(^7^4\) Also, the reason many programs eliminate Axis II disorders in part is due to limited mental health personnel so additional funding from MIOTCRA may allow these programs to expand to take into account approaches to dealing with Axis II offenders.\(^7^5\) Allowing people with Axis II disorders into diversion programs is also important because comorbidity (a condition including disorders from both Axis I and Axis II) is common.\(^7^6\)

However, while MIOTCRA confers this great discretion to communities and states in deciding which type of mental illnesses they want to target with diversion programs, it allows no discretion to decide to divert violent mentally ill offenders under its funding restrictions.\(^7^7\) The MIOTCRA definition for "preliminary qualified offender" introduces the limit of non-violent offenders for diversion programs in order to be eligible for funding.\(^7^8\) It should make no difference if an offense was violent or not if a crime is determined to be the product of a mental illness, in addition to concluding that the mental illness can most likely be managed with treatment and/or medication because in either case the requisite mens rea is lacking and treatment is an effective solution.\(^7^9\)

MIOTCRA funds should be permitted to divert a qualified offender, regardless of offense type, who is believed to have an acceptably low risk of recidivism upon treatment. The fact that the majority of the seriously

\(^7^4\) Blackburn, supra note 71, at 304

\(^7^5\) HUMAN RIGHTS WATCH, supra note 72, at 304.

\(^7^6\) Blackburn, supra note 71, at 298.

\(^7^7\) Mentally Ill Offender Treatment and Crime Reduction Act of 2004 § 2991(a)(4)(A).

\(^7^8\) Id. § 2991(a)(9).

\(^7^9\) See Grachek, supra note 64, at 1500-01. Criminal culpability is lacking if the commission of the crime is deemed to be the result of a mental illness, as is required by MIOTCRA. Mentally Ill Offender Treatment and Crime Reduction Act of 2004 § 2991 (a)(9)(B). Likewise, treatment must be considered an effective solution in order to be eligible for a diversion program under MIOTCRA. Id.
mentally ill are incarcerated for minor misdemeanors\textsuperscript{80} does not mean that those who commit violent offenses should be ignored. As has been pointed out, "[a]lthough it is important to remember that violent crimes make up only a small percentage of insanity pleas and that many people with mental illness are in prison for non-violent offenses, a system that does not address the needs of violent offenders can only be a partial solution."\textsuperscript{81}

The answer, therefore, to which violent mentally ill offenders should be permitted in diversion programs funded under MIOTCRA, is those deemed appropriate under the same decision-making processes employed to determine appropriate non-violent mentally ill offenders for diversion. Since MIOTCRA-funded diversion programs must consider how one's mental illness affects his or her level of responsibility in addition to his or her potential for rehabilitation,\textsuperscript{82} there is no need to enforce a limitation based on the type of crime committed. The discretion afforded under the current procedures used in diversion programs is appropriate to determine which violent offenders should be included in diversion programs.

\textit{SECTION B: Why Violent Mentally Ill Offenders Should Be Allowed in Diversion Programs Funded Under MIOTCRA}

Although MIOTCRA permits grant money to be used to treat violent mentally ill offenders while they are incarcerated or through re-entry programs,\textsuperscript{83} those programs are often ineffective and inappropriate for a violent offender who otherwise meets the MIOTCRA requirements for a preliminary qualified offender.\textsuperscript{84} Since the crime must be the product of mental illness,\textsuperscript{85} these violent offenders, like non-violent offenders eligible for diversion under MIOTCRA, lack the level of responsibility that justifies punishment. For both theoretical and legal reasons, these violent mentally ill offenders should not serve any time in penal institutions. Additionally, the purpose and goals stated in MIOTCRA, along with public policy

\begin{itemize}
\item \textsuperscript{80} Bard, \textit{supra} note 27, at 42.
\item \textsuperscript{81} \textit{Id}.
\item \textsuperscript{82} Mentally Ill Offender Treatment and Crime Reduction Act of 2004 § 2991(a)(9).
\item \textsuperscript{83} \textit{Id.} § 2991(b)(5)(I)(iv).
\item \textsuperscript{84} See Bard, \textit{supra} note 27, at 6; Denckla & Berman, supra note 16, at 1, 4.
\item \textsuperscript{85} Mentally Ill Offender Treatment and Crime Reduction Act of 2004 § 2991(a)(9)(B).
\end{itemize}
considerations, support allowing appropriate violent mentally ill offenders to participate in diversion programs because it would result in a healthier society, a safer society, and conservation of government resources and taxpayer dollars.

1. The Problem with Incarceration and Re-entry Treatment Programs as Justifications to Exclude Violent Mentally Ill Offenders from Diversion Programs Under MIOTCRA

While there are other options for treating violent mentally ill offenders, such as in jail or when they transition back into the community, there are "significant therapeutic implications" from incarcerating mentally ill offenders.\textsuperscript{86} Mentally ill offenders are often stigmatized and picked on while incarcerated because they are seen as easy targets.\textsuperscript{87} Mental illnesses can be exacerbated from the stressful, violent, crowded and noisy conditions in penal institutions and from the offender being isolated from friends and family.\textsuperscript{88}

Furthermore, offenders with mental illnesses commonly have trouble conforming their conduct to the rules and regulations in penal institutions.\textsuperscript{89} As a result, mentally ill offenders are often punished by means including isolation and denial from participation in various jail/prison programs while incarcerated.\textsuperscript{90} Making matters worse, the effects from isolation and other punishments can aggravate mentally ill offenders' "already fragile


\textsuperscript{88} \textit{Id.} at 37; Fellner, supra note 86, at 391.

\textsuperscript{89} Fellner, supra note 86, at 395; Stone, supra note 86, at 299. For further discussion on why complying with prison rules is difficult for mentally ill offenders, see Fellner, supra note 86, at 395. Washington State found that while seriously mentally ill offenders accounted for only 18.7% of inmates, they accounted for 41% of prison infractions. \textit{Id.} at 396.

\textsuperscript{90} Fellner, supra note 86, at 395-401. These punishments, which are supposed to help maintain control in penal facilities, serve no deterrent purpose for mentally ill inmates who are unable to meaningfully control their conduct. \textit{Id.} at 401.
personalities."91 and "adverse[ly] effect . . . [their] adaptive and coping abilities."92 These disciplinary infractions also result in mentally ill offenders serving longer sentences than those without mental disorders due to the loss of accumulated "good time" and/or parole denial.93 Statistics show that "jail inmates with mental illness stay in jail an average three to four times longer than other inmates."94 Thus, while a jail or prison environment is challenging for any offender, it poses appreciably greater risks for mentally ill offenders.95 Essentially, as argued by Human Rights Watch, the penal system is "not only serving as a warehouse for the mentally ill, but it is also acting as an incubator for worse illness and psychiatric breakdowns."96

While it is important to note that incarceration may have some benefits, it cannot be said that the benefits outweigh the costs for seriously mentally ill violent offenders otherwise appropriate for diversion.97 Benefits can come from the structure provided by penal institutions, the provision of essentials such as shelter and food, and treatment for substance abuse and mental health problems, if provided.98 However, while in-jail or in-prison treatment is better than none, penal treatment programs face significant challenges. Because mentally ill offenders often deteriorate from incarceration, they can become even harder to treat and need even more intense treatment or hospitalization.99 Unlike hospitals or other environments that are conducive to reducing stress to effectively treat mental

91. Norton, supra note 87, at 37.

92. Stone, supra note 86, at 302.

93. Id. at 299; Fellner, supra note 86, at 401.


95. See Fellner, supra note 86, at 391-95; Seltzer, supra note 33, at 572-74; Stone, supra note 86, at 285-86, 299-304.

96. Locked Up, ECONOMIST, Nov. 15, 2003, at 32.


98. Id.

illnesses, jails and prisons are likely to increase stress and make effective treatment difficult, if not impossible.\(^\text{100}\)

Compounding matters is the fact that many penal institutions lack adequate personnel and services to effectively treat mentally ill offenders.\(^\text{101}\) Penal institutions were designed for the purpose of security and custody, not to provide mental health services.\(^\text{102}\) Funding is strained in trying to provide both services in the criminal justice system.\(^\text{103}\) However, even with proper funding, providing effective treatment to mentally ill offenders while incarcerated is problematic because they need an institution based on entirely different goals, philosophies, policies, and interventions than that for other offenders.\(^\text{104}\) Treatment given in jails and prisons is often for the primary purpose of maintaining order and safety in the jail or prison itself rather than for the long-term recovery of mentally ill inmates.\(^\text{105}\) Trying to incorporate services for offenders with services for mental health is "just another of man's attempt to square the circle."\(^\text{106}\) Judge William Wayne Justice adequately stated the problem in the Texas case *Ruiz v. Johnson*:\(^\text{107}\)

It is deplorable and outrageous that this state's prisons appear to have become a repository for a great number of its mentally ill citizens. Persons, who, with psychiatry care, could fit well into society, are instead locked away, to become wards of the state's penal system. Then, in a tragic ironic

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103. White & Gillespie, *supra* note 47, at 109. White and Gillespie label the problem of the financial strain on the criminal justice system as the "unfunded mandate." *Id.*


twist, they may be confined in conditions that nurture, rather than abate, their psychoses.\footnote{108}

Hans Toch and Kenneth Adams, in their book "The Disturbed Violent Offender," state that two major problems with using prisons with mentally ill offenders are that prison routines and close cohabitation pose problems with mentally ill behaviors.\footnote{109} Toch and Adams argue that disturbed violent offenders must be segregated from the general prison population to be properly treated.\footnote{110} They advocate for a separate facility so deviance from prison rules and routines due to mental illness can be tolerated.\footnote{111} It is important to note that Toch and Adams do not support all mentally ill offenders to be admitted to such programs; they state it must be presumed that the inmate can graduate from the program or be transferred to another program when they transition back into society.\footnote{112} Using diversion to get mentally ill offenders out of jails and prisons benefits those institutions as much as the mentally ill because, as a result, jails and prisons are easier to run in addition to being safer for staff and sane inmates.\footnote{113}

While treatment programs in penal institutions may be acceptable for some mentally ill offenders,\footnote{114} MIOTCRA should not ignore that they are improper for violent, seriously mentally ill offenders who are appropriate for diversion. Likewise, while re-entry programs have been found to be successful in reducing recidivism and should be advocated for mentally ill offenders that are incarcerated, they do not justify the total exclusion of

\begin{footnotes}
\footnote{108}{Aufderheide & Brown, supra note 44, at 33.}
\footnote{109}{TOCH & ADAMS, supra note 13, at 183.}
\footnote{110}{Id. at 187.}
\footnote{111}{Id.}
\footnote{112}{Id. at 188.}
\footnote{113}{Id. at 223; Editorial, Decriminalizing Mental Illness, N.Y. TIMES, July 16, 2006, § A14, at 13. Jails and prisons are not safer because the mentally ill are dangerous per se, rather, untreated mentally ill people may pose a significant risk of danger. Mentally ill individuals appropriate for treatment are not more dangerous than the general population, with proper treatment. See Shannon, supra note 102, at 332; Fisler, supra note 30, at 588.}
\footnote{114}{For example, treatment programs in penal institutions would be acceptable for offenders who belong there because they possessed the requisite mens rea; in other words, their crime was not the result solely of their mental illness.}
\end{footnotes}
violent mentally ill offenders from diversion programs under MIOTCRA. As discussed, being incarcerated can drastically affect a mentally ill offender's ability to be effectively treated. While re-entry programs are better than nothing, violent mentally ill offenders who are appropriate for diversion should be diverted rather than waiting until they are released, at which point their condition may have greatly deteriorated, to attempt to effectively treat them. Just like their non-violent counterparts, if these violent mentally ill offenders are deemed to be in the criminal justice system as a result of their mental illness and are considered likely to succeed in a diversion program and not recidivate, then nothing should prevent or delay their effective treatment.

2. Theoretical Arguments for Diversion

There are two rationales for a therapeutic approach in dealing with appropriate mentally ill offenders, regardless of what type of crime they commit. The first is that society must be protected by tending to the mental illness that leads to the criminal act, regardless of their crime level. Reducing crime protects society, and to reduce recidivism with this population of mentally ill offenders, their mental illnesses must be effectively treated. The second underlying rationale is "to recognize that criminal sanctions, whether intended as punishments or deterrents, are neither effective nor morally appropriate when mental illness is a significant cause of the criminal act." Based on these two underlying principles,

115. See Vanessa St. Gerard, State News, CORRECTIONS TODAY, Oct. 2004, at 14, 14. A re-entry program for mentally ill offenders in Pittsburgh, Pennsylvania has reduced recidivism to 9.9% and costs only $3000 a person compared to the national average of $25,000 annually for a prison inmate. A Utah re-entry program reduced recidivism rates by 9% in an eighteen-month period, saving taxpayers approximately five million dollars.

116. Id.

117. See Bernstein & Seltzer, supra note 21, at 148.

118. Id.

119. See Bard, supra note 27, at 13, 21. To support her argument that mental illness must be treated to reduce crime, Bard uses a graph prepared by NAMI, which shows an inverse relationship between the amount of people committed to mental institutions in the early 1960's and the amount of people with mental illness in prison currently.

120. See Bernstein & Seltzer, supra note 21, at 148.
MIOTCRA should permit the diversion programs it funds to include violent mentally ill offenders.

The four traditional justifications for punishment are deterrence, retribution, rehabilitation, and confinement. Under these justifications, there is no reason to exclude offenders from diversion programs based on whether a crime was violent or non-violent. The purpose of deterrence, whether general or specific, is not being served in excluding all violent mentally ill offenders from diversion programs since the mental illness, and not free choice, must be the underlying cause of a crime to be eligible for any diversion program funded under MIOTCRA. Someone with schizophrenia, like Clark, who suffers from delusions that they must protect themselves from imminent lethal attack due to their mental illness, will not be deterred from the consequences of breaking the law no matter how severe.

Likewise, it cannot be said that retribution is being served by punishing someone for a crime attributable to a medical problem and not free choice. Seriously mentally ill offenders, including violent ones, do not possess the same level of culpability as average criminals due to their "reduced capacity to process information and adapt their conduct to social expectations and norms." If a treatable, violent mentally ill offender was not aware of his or her act so as to be truly responsible for his or her actions, retribution is not being properly served by incarcerating them. If an offense is considered a product of mental illness, the mentally ill offender can be viewed as a victim of his or her disease in the commission of the offense. Also, since diversion programs established under MIOTCRA are

121. Bard, supra note 27, at 61-62.

122. See id. at 62, 66.

123. See Byers, supra note 34, at 467 (discussing how Daniel M'Naghten fell under this category of psychotic delusions and killed another claiming self-defense because he thought that government officials were conspiring against him due to his delusions).

124. Id. at 502.

125. Bard, supra note 27, at 68-69.

126. See Acquaviva, supra note 24, at 985-86 (quoting Associate Judge Lawrence P. Fox, of Cook County, Illinois, Mental Health Court, when describing the Mental Health Court model, "It's innovative and appropriate for criminal justice to recognize we have a lot of people in jail more because of their mental illness than their criminality . . . . They need treatment more than they need to be in jail, more than they need to be punished.")
designed to address the cracks in the health system, appropriate offenders, whether non-violent or violent, can also be seen as victims of the mental health system that failed to treat them before they fell into the criminal justice system.127

By locking up violent mentally ill offenders without ensuring they receive effective health treatment, rehabilitation is not being furthered. More commonly, rather than receiving rehabilitative treatment, these individuals are abused by others while incarcerated.128 Even if some treatment is provided while incarcerated, mentally ill offenders may be even worse off than prior to their incarceration due to their condition deteriorating in a prison or jail environment.129 As stated by Jamie Fellner, the director of the U.S. Program of Human Rights Watch: "Placing the mentally ill in a brutal environment that they are not equipped to navigate without the aid of robust mental health services promotes neither rehabilitation nor prison security. It smacks more of cruelty than justice."130

Lastly, excluding the violent mentally ill from diversion programs funded under MIOTCRA does not further the goal of confinement. The reason behind confinement is safety, not punishment.131 If a mentally ill offender can be effectively diverted, there is no need for confinement. As discussed, even if treatment is given in jail and prison, it is often ineffective due to deficiencies in the program and/or the destructive jail or prison environment. Removing a treatable violent mentally ill offender from society without ensuring adequate treatment cannot be said to truly preserve safety in proper balance with individuals' right to liberty for the purpose of confinement.132


128. Gracheck, supra note 64, at 1489.

129. See Bard, supra note 27, at 6; Denckla & Berman, supra note 16, at 1, 4.

130. Fellner, supra note 86, at 412.

131. Bard, supra note 27, at 68.

132. See id. at 67-68 (because of strong liberty interests, Bard discusses how overuse of institutionalization in the context of civil commitment led to a deinstitutionalization movement in the context of civil commitment. In footnote 347, Bard refers to the fact that merely placing criminals in jails does not always lead to a safer society because "imprisonment, with its resulting concentration of law breakers and its permanent stigma,
3. Legal Arguments for Diversion

Our justice system recognizes varying levels of responsibility based on mental capacity, regardless of whether a crime was violent or non-violent. Children are considered to lack the mental facilities to be fully responsible for their actions. Likewise, the Supreme Court held in *Atkins v. Virginia* that it is unconstitutional to execute mentally retarded offenders due to the lack of proportionality between their culpability and the punishment. The insanity defense, guilty but mentally ill verdict, mens rea standards, and similar legal devices all take into account mental capacity regardless of offense level. Based on this principle of responsibility and culpability, MIOTCRA should not ban violent mentally ill offenders from diversion programs. By only addressing non-violent offenders in regards to diversion programs, MIOTCRA unfortunately "leaves the foundation issue of culpability unacknowledged and unaddressed." 

increases rather than decreases crime." (citing GERRY JOHNSTONE, RESTORATIVE JUSTICE: IDEAS, VALUES, DEBATES 90-91 (2002)). Bard says "other elements of punishment" must be considered in addition to the "remov[al] of criminals from society." Extending her analysis to the criminalization of the mentally ill, merely locking this class up without proper treatment will not lead to a safer society. When these individuals are eventually released, their illness will likely be worse from being incarcerated and they will likely recidivate and continue the cycle of the revolving door. *See* Stone, *supra* 86, at 356-57. It is important to note that in stating that none of the traditional reasons for punishment justifies MIOTCRA's exclusion of all violent mentally ill offenders from diversion programs, it does not refer to all mentally ill offenders but only those that qualify otherwise as preliminary offenders under MIOTCRA. As mentioned, for a mentally ill offender to be eligible for anything funded by MIOTCRA, the crime must be deemed solely the result of a mental illness and the offender must be considered an appropriate candidate for treatment. Those mentally ill offenders that do not meet that requirement may deserve to be excluded due to one or more of the traditional reasons for punishment.


136. See Bard, *supra* note 27, at 28-42 (discussing the various types of insanity defenses along with mental health courts). Bard notes that the problem of mental health courts, unlike the types of insanity defenses, is that is does not address violent offenders. *Id.* at 42.

Although the law’s treatment of mental illness is complicated due to the lack of a universal consensus on how much brain impairment from mental illness is enough to excuse serious criminal behavior,\textsuperscript{138} that reason does not justify automatically treating all mentally ill violent offenders like a standard criminal defendant. While the insanity defense and similar legal channels were designed to take mental illness into account, they often fail to adequately protect many mentally ill offenders, such as Clark.\textsuperscript{139} With no other options such as diversion available, these mentally ill offenders, whose crime was the sole result of a treatable mental illness that the health system failed to adequately address, are unfairly treated as having the same responsibility level as a nonmentally ill offender.

While the Supreme Court should employ the \textit{Atkins} culpability principle as the basis for its decisions regarding the medical treatment of mentally ill offenders, it has instead used the Eighth Amendment’s prohibition against “cruel and unusual punishment.”\textsuperscript{140} However, even under the Eighth Amendment’s framework, the automatic exclusion of violent mentally ill offenders from the diversion programs under MIOTCRA should be eliminated. Penal regulations and prison officials’ conduct violate the Eighth Amendment if it causes “the unnecessary and wanton infliction of pain”\textsuperscript{141} or if it is incompatible with “the evolving standards of decency that mark the progress of a maturing society.”\textsuperscript{142} By automatically denying all violent mentally ill offenders access to diversion programs, MIOTCRA is violating the Eighth Amendment in both regards.

The U.S. Supreme Court held in the 1976 case of \textit{Estelle v. Gamble}\textsuperscript{143} that the Eighth Amendment prohibition against cruel and unusual punishment forbids jails and prisons from being deliberately indifferent “to

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139. \textit{Id.} at 5, 43, 72.
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140. Byers, \textit{supra} note 34, at 506-07. Byers states that while the Supreme Court has not based its decision regarding the treatment of mentally ill offenders on the proportionality principle, the lower courts may do so based on \textit{Atkins v. Virginia}. \textit{Id.} at 525. “Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishment inflicted.” \textsc{U.S. Const.} amend. VIII.
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142. Stone \textit{supra} note 86, at 322-23; \textit{see Estelle}, 429 U.S. at 102-04.
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143. \textit{Estelle}, 429 U.S. at 104-05.
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serious needs of inmates of prisoners with severe mental disorders," regardless of whether they committed a violent or non-violent offense. If incarceration prevents effective treatment from being given to violent mentally ill offenders where diversion programs are used for similarly situated non-violent offenders, incarceration in those cases would be the "unnecessary and wanton infliction of pain." It is important to note that Estelle v. Gamble involved a prisoner's physical back problem and the Supreme Court has never expressly extended the right to treatment under Estelle to mental health care, although some argue that the decision directly incorporates the right to such treatment. Various jurisdictions have interpreted the ruling in Estelle to include the right to treatment for mental illnesses, such as in the Fourth Circuit Court of

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144. Stone, supra note 86, at 357.

145. The Court stated that under the Eighth Amendment,

> [t]hese elementary principles establish government's obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such failure may actually produce physical "torture or a lingering death" . . . . In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose.

Estelle, 429 U.S. at 103 (citation omitted). This sets the high standard of deliberate indifference for entitlement to medical treatment. Mere negligence, substandard care or malpractice is not enough to satisfy the requirement of deliberate indifference to a prisoner's medical need. See Fellner, supra note 86, at 405. However, mentally ill inmates, such as the one in an Illinois prison who hears voices of dead people, attempts to eat his own flesh and cuts his legs and arms in order to relax, or the prisoner in an Indiana prison who constantly picks into his ears in an attempt to get the radio he believes is located in his nerves, have strong arguments that there was deliberate indifference to their medical needs in not providing them with proper treatment. See Locked Up, supra note 96, at 32.


147. Thomas Hafemeister & John Petrila, Treating The Mentally Disordered Offender: Society's Uncertain, Conflicted, And Changing Views, 21 FLA. ST. U. L. REV. 731, 769 (1994); see also Aufderheide & Brown, supra note 44, at 32 (stating that Estelle v. Gamble "clearly determined that the Eight Amendment requires that prison officials provide a system of ready access to adequate medical care, including mental health care.").
Appeals' opinion in Bowring v. Godwin and the Ninth Circuit Court of Appeals' opinion in Doty v. County of Lassen. Considering these holdings, in addition to the medical and psychological advances made since Estelle was decided in 1976 and that the Eighth Amendment must be considered in light of "the evolving standards of decency that mark the progress of a maturing society," it should be inferred that the Eighth Amendment right to treatment includes the right to mental health treatment.

Bowring v. Godwin specifically held that mental health care falls under the Eighth Amendment's right to medical treatment for prisoners. The Bowring court stated that there is "no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart." It established a three-part test to determine when a prisoner has an Eighth Amendment right to psychological or psychiatric care: "(1) that the prisoner's symptoms evidence serious disease or injury; (2) that the disease or injury is curable or may be substantially alleviated; and (3) that the potential for harm to the prisoner by reason of delay or the denial of care would be substantial." The opinion in Bowring also stated that such deprivation of treatment would also be a Fourteenth Amendment Due Process Clause violation since it could result in deprivation of life.

Doty v. County of Lassen, also holding that inmates have a right to mental health treatment, said that an inmate "must show deliberate indifference to a 'serious' medical condition." It said a serious medical condition is more than just the general discomforts that come from being

149. Doty v. County of Lassen, 37 F.3d 540, 547 (9th Cir. 1994); see Bard, supra note 27, at 20; Stone, supra note 86, at 324.
150. Estelle, 429 U.S. at 102 (quoting Trop v. Dulles, 356 U.S. 86, 100-01 (1958)).
151. Bowing, 551 F.2d at 47-48.
152. Id. at 47; see Bard, supra note 27, at 20 n.67.
153. Bowing, 551 F.2d at 47.
154. Id.
155. Doty, 37 F.3d at 546 (quoting McGuckin v. Smith, 947 F.2d 1050, 1059 (9th Cir. 1992)); see Stone, supra note 86, at 325.
incarcerated. A serious medical need was defined as when an offender had "an injury that a reasonable doctor would find important and worthy of comment and treatment, . . . the presence of a medical condition that significantly affects an individual's daily activities, and . . . the existence of chronic or substantial pain."\textsuperscript{157}

The more recent case of \textit{Madrid v. Gomez}\textsuperscript{158} held that the conditions at Pelican Bay Prison in California were in violation of the Eighth Amendment because they were "grossly deficient"\textsuperscript{159} for lack of adequate mental health facilities and staffing.\textsuperscript{160} Thus, an Eighth Amendment violation occurs if prison conditions exacerbate serious mental illness and prison officials know the conditions will result in a deterioration of mental illness.\textsuperscript{161} As discussed, even when treatment is offered in jail or prison, it is often ineffective and unable to prevent mental illnesses from worsening, particularly when compared to diversion programs if they are available. Therefore, in order to provide effective treatment and avoid potential Eighth Amendment challenges, MIOTCRA should not automatically exclude all violent mentally ill offenders from being eligible for diversion programs.

While it is understandable that "releasing low-level offenders to treatment is easier to build consensus around, politically safer, and less likely to lead to outraged headlines if a program participant re-offends,"\textsuperscript{162} that does not excuse Congress from ignoring violent mentally ill offenders' constitutional rights. If Congress will not act, then the courts should step in because although

\begin{quote}
[mental illness and crime are political issues, with potential political solutions . . . if the popular will is too weak for the job, then it falls to the judicial branch to rescue the seriously ill offender and his fate
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\textsuperscript{156} \textit{Doty}, 37 F.3d at 546; see \textit{Stone}, supra note 86, at 326.

\textsuperscript{157} \textit{Doty}, 37 F.3d at 546 n.3 (citing \textit{McGuckin}, 974 F.2d at 1059-60); see \textit{Stone}, supra note 86, at 326.


\textsuperscript{159} \textit{Id.} at 1222.

\textsuperscript{160} \textit{Id.}; see \textit{Stone}, supra note 86, at 327.

\textsuperscript{161} \textit{Stone}, supra note 86, at 327.

\textsuperscript{162} \textit{NATHANIEL PROJECT}, supra note 24, at 1.
from “the vicissitudes of political controversy” and to establish basic
tenets of decency “as legal principles to be applied by the courts.”163

In addition to the Eighth Amendment jurisprudence, MIOTCRA
should not limit diversion programs to only serving non-violent mentally ill
offenders under international human rights law, which requires treatable
mentally ill offenders receive effective treatment.164 The United States is a
party to the International Covenant on Civil and Political Rights.165
Pertinent provisions of the treaty include that the goal of the penal system is
for inmates’ “reformation and social rehabilitation,”166 and that inmates have
a right to be free from torture and from cruel, inhumane or degrading
treatment.167 Since “imprisonment by its very nature has an adverse effect
on mental health,” as pointed out by the World Health Organization,
diversion should be advocated for all appropriate mentally ill offenders,
regardless of whether an offense is violent.168

4. Policy Arguments for Diversion

While Congress should eliminate the MIOTCRA violent offender
limit under the legal principles of criminal responsibility and the protection
from cruel and unusual punishment, there are additionally public policy
rationales for which it should do so.169 Suitably stated, “[t]he most
important point we must make here is that constitutional minima in this (or
any other) area must not be confused with desirable governmental policy,

U.S. 624, 638 (1943)).

164. Fellner, supra note 86, at 391, 405, 412 (“The failure of U.S. prisons to address
adequately the special needs of prisoners with serious mental illness . . . flies in the face
of international human rights standards.”). Whereas diversion programs are designed to
ensure severely mentally ill offenders receive proper treatment, Fellner points out, “U.S.
prisons are not designed or equipped for mentally ill offenders.” Id. at 391.

165. International Covenant on Civil and Political Rights art. 10, Mar. 23, 1976, 999
U.N.T.S. 171; see Fellner, supra note 86, at 407.

166. International Covenant on Civil and Political Rights, supra note 165, at art. 10.

167. Id. at art. 7; see Fellner, supra note 86, at 407.

168. Fellner, supra note 86, at 411 (referring to WORLD HEALTH ORG., INFORMATION
Document/MNH/WHO_ICRC_InfoShl_MNH_Prisons.pdf.).

desirable professional practices or standards, or desirable penal practices or standards." Policy-based reasons why Congress should eliminate the violent offender diversion restriction in MIOTCRA include that mental health will be improved, society will be better protected, and governmental resources and taxpayer dollars will be conserved.

Without the benefit of the diversion programs, mentally ill offenders are often left with the insanity defense as their only way to get the treatment they truly need. When the insanity defense is either nonexistent or fails in a case of a mentally ill offender, the potential options of a mens rea standard of guilt or a guilty but mentally ill verdict do not ensure a mentally ill offender will receive proper treatment. For example, Steve DeRoss, the Sacramento County assistant chief probation officer, stated that without proper treatment and medication, the mentally ill are "in and out of the system, in and out of where they're living and jail, (which) generally exacerbates the problem."

As discussed, while efforts have been made to try and treat these individuals while they are incarcerated, programs are often deficient and all too often the inmates' mental health deteriorates, rather than improves. Mental health courts and other diversion programs should therefore be encouraged under MIOTCRA for appropriate violent mentally ill offenders, who may be the most in need of treatment and the ones who society will benefit the most by treating. It has been noted that "the most appropriate target of treatment among mentally disordered offenders is the mental disorder, and that by treating the mental disorder, the likelihood of criminal recidivism will thereby be reduced." Compared to 28% of federal


171. Pustilnik, supra note 65, at 218.

172. As discussed throughout this article, treatment in jails and prisons are often ineffective. See Bard, supra note 27. Thus, the only way to receive proper treatment is in a mental health facility, not a penal institution. Without eligibility for diversion programs, the only hope for being sent to a treatment facility rather than a penal institution is through the insanity defense.


174. Cooper, supra note 24, at 3.
prisoners without mental illnesses, 49% of federal prisoners with mental illnesses have three or more prior probations, incarcerations, or arrests. MIOTCRA goes against its own goals of improving mental health care and promoting a safer society by excluding appropriate violent mentally ill offenders from diversion programs, where they would likely receive the necessary treatment to successfully manage their illness and stay out of the criminal justice system. The purpose of MIOTCRA is for states and communities to experiment and collaborate to find the best solutions to deal with mentally ill offenders. It is important to note that while there is an association between violence with mental illnesses, people with mental illnesses are estimated to be responsible for no more than 10% of serious violent episodes in the U.S. and “strangers constitute only a small minority of the victims of violence committed by those with psychosis.” A National Alliance for the Mentally Ill and Public Citizen’s Health Research Group survey suggests that for those rare cases when mentally ill individuals commit serious crimes, frequently the offenders’ mental illness(es) were not treated. When appropriate mentally ill offenders are given effective treatment, they are no more dangerous than the general population; it is simply lack of treatment that makes them dangerous. Thus, there is no basis to the belief that people with mental illnesses are inherently dangerous. Rather, there is plenty of support for the position that appropriate violent mentally ill offenders, like their non-violent counterparts, can succeed in diversion programs to manage their illness and conform to the law.

175. Marie E. Rice, Grant T. Harris & Vernon L. Quinsey, Treatment for Forensic Patients, MENTAL HEALTH AND LAW 141, 142 (Bruce D. Sales & Saleem A. Shah eds., 1996).


178. Rice, Harris & Quinsey, supra note 175, at 142; Elizabeth Walsh & Thomas Fahy, Violence in Society: Contribution of Mental Illness is Low, 325 BMJ 507, 508 (2002).

179. Shannon, supra note 102, at 332.

180. Id.; Seltzer, supra note 33, at 584.

181. Rice, Harris & Quinsey, supra note 175, at 142.
Although there is a need for more research showing that treatment results in reduced recidivism, both in regards to violent and non-violent mentally ill offenders, "there are data that indicate promise for training in moral reasoning, academic programs, and provision of prosocial models who model anticriminal values and attitudes."182 Studies conducted with violent mentally ill offenders support the conclusion that while severe mental illnesses such as schizophrenia are associated with violence, medication compliance and awareness of one's mental illness are key predictors to violence for this population.183 One study found that enhanced treatment compliance for psychotic disorders such as schizophrenia was the most significant factor in achieving positive clinical and social outcomes, which included reduced violence.184 A 1998 MacArthur Foundation study found a 50% reduction in rate of violence for people treated for their serious brain disorders.185 A briefing paper by the Treatment Advocacy Center (TAC) states that when severely mentally ill people take their medications, they are no more dangerous than the general population; whereas, when they are not taking their medication, they are more dangerous than the general population.186

The TAC briefing paper cited one study that found an inverse correlation between schizophrenics' propensity to violence and their blood level of antipsychotic medication, while another study cited found a correlation between severely mentally ill patients' failure to take medication and their history of violent acts in the community.187 The briefing paper also

182. Id. at 165.

183. TREATMENT ADVOCACY CENTER, VIOLENT BEHAVIOR: ONE OF THE CONSEQUENCES OF FAILING TO TREAT INDIVIDUALS WITH SEVERE PSYCHIATRIC DISORDERS (2003), available at http://www.psychlaws.org/BriefingPapers/BP8.htm [hereinafter VIOLENT BEHAVIOR]. It is also important to note that the risk for violence is greatly increased when mentally illness coexists with a substance abuse problem, which is common because people suffering from mental illnesses often use drugs and/or alcohol to soothe their symptoms. Id.

184. Blackburn, supra note 71, at 300-01.


186. VIOLENT BEHAVIOR, supra note 183.

187. Id. at 2.
discussed a study finding that rather than schizophrenia itself, inadequately treated symptoms of delusions and hallucinations predicted violent behavior.\(^{188}\) That study found that 71% of violent schizophrenics had medication compliance problems compared to only 17% of those without hostile behaviors.\(^{189}\) An additional study mentioned found more than 75% of schizophrenics offended due to delusions and concluded that treating this population is just as important for public safety as it is for personal health reasons.\(^{190}\)

Like non-violent seriously mentally ill offenders, the crimes of violent mentally ill offenders are often the product of a treatable illness rather than criminality.\(^{191}\) When that is the case and effective treatment is provided, violent offenders do not pose any greater risk of danger than non-violent offenders.\(^{192}\) Therefore, a violent mentally ill offender, whose crime is considered solely the result of a manageable mental illness such as schizophrenia, should not be automatically denied opportunities for effective treatment in diversion programs funded by MIOTCRA. Lastly, government resources and tax dollars can be more efficiently utilized by allowing appropriate violent mentally ill offenders to be diverted. Mentally ill offenders spend more time incarcerated and use a significant amount of crisis intervention resources.\(^{193}\) Often, this class of offenders has to be transferred to higher security prisons due to their irrational behavior, which ends up costing more than providing mental health care.\(^{194}\)

\(^{188}\) Id. at 3.

\(^{189}\) Id.

\(^{190}\) Id. at 4.

\(^{191}\) There is evidence supporting the belief that violent acts committed by psychotic offenders are directly attributable to the psychotic disorder. Id. See also B. G. Link, H. Andrews & F. T. Cullen, \textit{Reconsidering the Violent and Illegal Behavior of Mental Patients}, 57 \textit{Am. Soc. Rev.} 275 (1992). Research conducted by Link et al. found that people in the general population who report feeling psychotic symptoms are more likely to report they recently engaged in violent behavior.

\(^{192}\) Shannon, \textit{supra} note 102, at 332.

\(^{193}\) Stratton, \textit{supra} note 94, at 902-03.

\(^{194}\) \textit{Greg Jones & Michael Connelly}, \textit{State Comm'N on Criminal Sentencing Pol'y, Mentally Ill Offenders and Mental Health Care Issues} (Feb. 2002), \textit{available at} \url{http://www.msccsp.org/publications/mental.html}. 
Additional indirect costs include the “lost productivity from untreated or undertreated mental illness and from incarceration.”

Justice Evelyn Lundberg Stratton, a justice for the Supreme Court of Ohio and the chair of the Supreme Court of Ohio Advisory Committee on Mentally Ill in the Courts, states additional costs associated with the problem of the revolving door are “paying for police officers to repeatedly arrest, transport, and process mentally ill defendants, as well as for jail costs associated with treatment and crisis intervention, salaries for judges and court staff, prosecutors and defense attorneys, and many more hidden costs.”

While the extra costs would be justified if they produced a benefit in deterrence or public safety, that is not the case.

In addition to costing more, by incarcerating violent mentally ill offenders appropriate for diversion, penal officials are being distracted from their primary mission of providing security. Prisons are being forced to be de facto mental hospitals and deal with problems that should be handled and addressed in the mental health system. These offenders take up needed space in jails and prisons while straining the limited mental health resources available in the penal system. Thus, it is important for diversion programs to reach out to any appropriate mentally ill offenders, regardless of what type of crime they committed since “[r]esponding to problems of mental illness principally through the criminal justice system imposes billions of dollars annually on the public, above any offsetting benefit in public safety and deterrence, and imposes terrible human costs on people who suffer from these illnesses.”

The reasons why violent mentally offenders should be permitted in diversion programs under MIOTCRA go right to the heart of why MIOTCRA was created. MIOTCRA was developed to address the mentally

195. Pustilnik, supra note 65, at 219. Pustilnik also notes that there is an indirect cost due to “the lost productivity of the family members or other intimates who provide unpaid care for a person with a mental illness.” Id.

196. Stratton, supra note 94, at 902-03.

197. Pustilnik, supra note 65, at 219.

198. Bernstein & Seltzer, supra note 21, at 161.

199. Stone, supra note 86, at 357.

200. Pustilnik, supra note 65, at 218. Pustilnik cites a list of federal and state task forces and committees that have noted these costs. Id.
ill population who slipped through the cracks of the health care system. MIOTCRA was idealized as a way to provide care for mentally ill offenders who have treatable mental disorders and would not have landed in the criminal justice system but for their disorder. MIOTCRA was developed to stop the “revolving door” and ensure that this population was getting the necessary treatment to stay out of the criminal justice system, resulting in a safer society and appropriate resource allocation. For those very reasons, MIOTCRA should not force the diversion programs it funds to exclude violent mentally ill offenders from consideration for care.

PART III: WAYS MIOTCRA FUNDS CAN, AND SHOULD, BE USED TO DIVERT VIOLENT MENTALLY ILL OFFENDERS

While the Supreme Court lets state courts struggle to balance humane treatment of mentally ill offenders with public safety, some argue that there should be a unified and standardized approach to handling mental illness in the criminal justice system. While treatment of mentally ill offenders is so diverse and much more empirical research is still needed, states should be allowed to experiment and focus on various solutions to handle mentally ill offenders. Effort must be made to see that mentally ill violent offenders, like non-violent ones, receive the mental health treatment they need to stop cycling into the criminal justice system.

Diversion programs, such as mental health courts (“MHCs”) and outpatient treatment programs, have proven to be highly successful in cost-effectively treating mentally ill offenders, reducing recidivism, and reducing violence. As such, federal funding under MIOTCRA should not prevent states and communities from allowing violent mentally ill offenders to participate in diversion programs. Just as Dr. Sally Satel criticized President Bush’s New Freedom Commission on Mental Health for failing to address the “hard-to-treat” group of mentally ill offenders and remarked that “severe

201. DeWine, supra note 61.

202. Id.; Stratton Testimony, supra note 60.

203. DeWine, supra note 61; Leahy, supra note 60.

204. See Hafemeister & Petrila, supra note 147, at 869; Byers, supra note 34, at 514.


206. AOT, supra note 30.
and persistent illness is a factor in 10-15[\%] of violent crimes,” MIOTCRA deserves to be criticized for not allowing the hard-to-treat group of violent mentally ill offenders to be permitted in diversion programs.\(^\text{207}\)

**SECTION A: Mental Health Courts**

MIOTCRA encourages that funding be used to establish more MHCs.\(^\text{208}\) Prior to MIOTCRA, the America’s Law Enforcement and Mental Health Project Act, which was signed into law on November 13, 2000 by President Bill Clinton, granted federal funds for the development or expansion of MHCs.\(^\text{209}\) MHCs are a method to divert mentally ill offenders from jail or prison to get them the necessary treatment so they can conform to the laws.\(^\text{210}\) Most judges are unfamiliar with the mental health system and lack the ability to adequately access mentally ill offenders or know what options are available to effectively assist them.\(^\text{211}\) Specialized mental health courts address this problem and involve personnel with the knowledge and training to appropriately sentence suitable defendants to treatment rather than incarceration.\(^\text{212}\) The goal is to reduce recidivism by addressing the

\(^{207}\) Byers, *supra* note 34, at 516-17.


\(^{209}\) America’s Law Enforcement and Mental Health Project Act § 3(a), 42 U.S.C. § 3796ii (2000); Acquaviva, *supra* note 24, at 988-89.

\(^{210}\) Advocates, *supra* note 127. MHCs were developed based on the success of drug courts. There are now several types of specialized “problem-solving courts” in addition to drug courts and mental health courts, which include community courts, domestic violence courts, and re-entry courts. Rather than focus on punishment for the crime committed, these courts focus on the root problem that lead to the criminal act, in order to reduce the likelihood of future criminal acts. *Denckla & Berman, supra* note 16, at 7. A definition given for mental health courts is that they “1) are criminal courts, 2) have separate dockets exclusive to persons with mental illness, 3) divert defendants from jail and/or prison into community-based mental health treatment, and 4) judicially monitor mental health treatment and potentially impose sanctions for non-compliance.” *O’Keefe, supra* note 16, at 2 (citing Henry J. Steadman et al., *Mental Health Courts: Their Promise and Unanswered Questions, 52 Psychiatric Services 457, 457-58 (2001)).

\(^{211}\) See *Denckla & Berman, supra* note 16, at 1.

\(^{212}\) *Id.* at 7.
root of the problem—the mental illness—for which these people wind up in court.\textsuperscript{213}

The first MHC was opened in 1997 in Broward County, Florida and since mid-2006 over 100 have opened in the United States.\textsuperscript{214} Depending on the jurisdiction, the point at which defendants are identified as suitable candidates for MHC varies.\textsuperscript{215} Most MHCs use a deferred prosecution or deferred sentencing model.\textsuperscript{216} Participation in an MHC is voluntary and the length of judicial supervision and treatment varies depending on each defendant’s individual needs.\textsuperscript{217} However, most MHCs have a one-year minimum treatment period to ensure defendants receive adequate treatment so as to prevent recidivism.\textsuperscript{218} Treatment can involve any combination of services such as outpatient treatment, case management, or highly structured 24-hour care.\textsuperscript{219} Judicial monitoring is employed to ensure compliance with the program and to access the progress of the treatment.\textsuperscript{220}

Most MHCs currently allow only offenders with non-violent, misdemeanor charges diagnosed with Axis I disorders.\textsuperscript{221} However, since 2001, some have started to allow violent felony offenders, such as the

\begin{itemize}
  \item \textsuperscript{213} Id.
  \item \textsuperscript{215} DENCKLA & BERMAN, supra note 16, at 9.
  \item \textsuperscript{216} Honberg & Gruttadaro, supra note 24, at 24.
  \item \textsuperscript{217} DENCKLA & BERMAN, supra note 16, at 8, 10.
  \item \textsuperscript{218} Id. at 10.
  \item \textsuperscript{219} Lamb et al., supra note 24, at 122.
  \item \textsuperscript{220} DENCKLA & BERMAN, supra note 16, at 10. An important feature of MHCs is that they maintain jurisdiction over the mentally ill offender while in treatment. Therefore, compliance with the program is ensured but, if the person fails to comply, the participant can face consequences including revocation of the grant to participate in the treatment program followed by standard criminal sentencing. See Bernstein & Seltzer, supra note 21, at 156-58.
  \item \textsuperscript{221} DENCKLA & BERMAN, supra note 16, at 9.
\end{itemize}
Brooklyn MHC. Unlike drug courts, which rush to place offenders in treatment programs, MHCs are precautionary and have a lengthy assessment and intake process to ensure only appropriate participants are accepted and that a suitable individualized treatment plan is developed prior to release from custody. Just as MIOTCRA permits the diversion programs funded under it to include mentally ill offenders with Axis II disorders, even though the majority of MHCs accept participants with only Axis I disorders, it should permit those programs the option to divert violent mentally ill offenders.

Studies have found MHCs to be highly effective and cheaper than other options in dealing with mentally ill offenders. In particular, MHCs have been found to be effective in reducing recidivism, including violent offenses. A Broward County, Florida study found that from October 2001 to September 2002 only 27% of MHC participants were rearrested and that none of the first 675 participants have since committed a violent offense. While the participants in the Broward County MHC were all non-violent misdemeanor offenders, a King County, Washington study involved

222. Mental Health Courts, supra note 33, at 5; Bernstein & Seltzer, supra note 21, at 149; Seltzer, supra note 33, at 578. Of the 20 oldest MHCs studied by the Judge David L. Bazelon Center for Mental Health Law, only half accepted participants with misdemeanor charges and half accepted some participants with felony charges under certain circumstances. A more recent survey showed that 56.5% of sixty-nine MHCs accepted participants charged with felonies. Seltzer, supra note 33, at 577.

223. Fisler, supra note 30, at 592.

224. Shapiro, supra note 214; Henry J. Steadman & Michelle Naples, supra note 23; Editorial, Divert Mentally Ill Offenders, CINCINNATI ENQUIRER, Oct. 10, 2006, at 6B [hereinafter ENQUIRER]; Cooper, supra note 24. For studies listing successful statistics of MHC programs, see Acquaviva, supra note 24, at 990-93.

225. Acquaviva, supra note 24, at 990 (discussing studies conducted on both violent and non-violent recidivism in the "Mental Health Court Effectiveness" section); Lamb et al., supra note 24, at 113; Cooper, supra note 24, at 2; NATHANIEL PROJECT, supra note 24, at 4.

226. Acquaviva, supra note 24, at 990-91 (citing Jenni Bergal, Justice That Works: Mentally Ill Defendants Avoid the Revolving Door of Jail, Get Their Lives Back on Track Through Mental Health Court's Assistance, SUN SENTINEL (Ft. Lauderdale, Fla.), Nov. 24, 2002, at 1A; LeRoy L. Kondo, Advocacy of the Establishment of Mental Health Specialty Courts in the Provision of Therapeutic Justice for Mentally Ill Offenders, 28 AM. J. CRIM. L. 255, 257 (2001)).
offenders with violent criminal activity and found that for MHC participants, violent criminal activity was reduced by 88%. In addition, that study found that 75% of the participants did not commit any offenses one year after their graduation from the MHC program. A Hamilton County, Ohio MHC has also successfully reduced recidivism in cutting re-offender rates to less than 10%.

MHCs have also been a financial success. The daily cost of the mental health court in Ohio is only $30; the daily cost in prison is $60, the daily cost in a mental hospital is $451, and the daily cost in a general hospital is $1500. In addition to costing less to administer, money is saved by the decreased arrest rates and hospital time associated with offenders processed through MHCs. The Santa Clara MHC saves approximately $600,000 yearly in jail space. Its first 900 or so graduates


228. Id.

229. ENQUIRER, supra note 224, at 6B.

230. See Mental Health Courts, supra note 33; Shapiro, supra note 214; LIBN, supra note 50; ENQUIRER, supra note 224, at 6B.

231. Shapiro, supra note 214.

232. See Mental Health Courts, supra note 33. The Harvard Mental Health Letter discusses the findings of a survey of several MHC programs that after one year of being processed through MHCs, the individuals had fewer arrests, greater life satisfaction, better mental health, and less need for residential drug treatment. An Alaska study found that before participating in a MHC, the average days in a mental hospital was 18 and the average days in jail was 85, while after participating in a MHC program, the average days in a mental hospital was 3 and the average days in jail was 16. A Florida study found that individuals processed through MHCs spent 75% less days in jail than individuals processed normally in the criminal system. Id. The authors of the Harvard Mental Health Letter note that all of the above studies were random assignment rather than controlled. They do cite one Santa Barbara, California study that was controlled and found equal re-arrest rates and time spent in jail. However, it is important to note that the study also found that MHC participants were more likely to be rearrested for parole violations rather than new crimes.

233. See Cooper, supra note 24.
saved more than $10 million of county funds and $13 million of state funds by reduced jail and prison costs.\(^{234}\) Connecticut found that the average cost per person for hospitalization plus incarceration in the first 90 days following arraignment was only $1322 for offenders in a jail diversion program compared to $3819 for those not diverted.\(^{235}\)

Tammy Seltzer, writing for the Judge David L. Bazelon Center for Mental Health Law, argues that MHCs, if used at all, should only be used for more serious offenses.\(^{236}\) She states that mentally ill offenders with minor charges should be diverted either at prebooking or at arraignment and that MHCs are appropriate only for those who cannot be diverted at those early stages, essentially those with more serious offenses.\(^{237}\) Seltzer argues that by relying too heavily on MHCs as a solution for treating mental illness, not enough attention is being given to correct the deficiencies in the health system, which should reach the mentally ill before they ever offend.\(^{238}\) Under her logic, MIOTCRA should not only permit MHCs to include violent offenders, but should also exclude non-violent minor misdemeanor offenders from participating in MHCs. Non-violent minor misdemeanor offenders should be handled in the health system without any processing in the criminal justice system.

*An Example: Brooklyn Mental Health Court*

An example of a MHC that chooses to focus on seriously mentally ill offenders who are chronic misdemeanor offenders or felony offenders, rather than minor misdemeanor offenders, is the Brooklyn MHC (BMHC).\(^{239}\) Due to its belief, like many other MHCs, that treatment should not last longer than what the typical sentence would be for an underlying offense in a standard court proceeding, BMHC stakeholders chose to accept felons because they felt for treatment to be truly effective it had to be for a

\(^{234}\) See id.


\(^{236}\) Seltzer, supra note 33, at 577.

\(^{237}\) Id. at 577-78.

\(^{238}\) Id. at 581-83. Seltzer points out that the "criminal and juvenile justice systems are not the appropriate front door to access mental health care." Id. at 583.

\(^{239}\) The Brooklyn MHC was opened in 2002. Pyne, supra note 205.
period longer than a simple misdemeanor sentence would permit. Research has shown that outpatient commitment orders of six months or longer "have fewer hospitalizations, shorter hospital stays, greater adherence to community treatment, fewer acts of violence, and fewer instances of victimization than patients receiving similar services under outpatient commitment orders for shorter periods." While the BMHC originally did not accept violent felons, it changed its policy "as it became clear that mental illness was sometimes an underlying factor leading to violent crimes." As of June 2006, violent offenders accounted for 42% of the 562 total referrals and 43% of the 262 participants.

The mission of BMHC is to treat its participants effectively and increase public safety by reducing recidivism and stopping the "revolving door." The fact that these participants were slipping through the cracks in the health care system is apparent in the finding that while 70% of the 106 participants enrolled in the program as of June 30, 2004 had been hospitalized for psychiatric reasons at least once, only 30% were in treatment at the time of the arrest. To be eligible for BMHC, a defendant must plead guilty and "must have a 'serious and persistent mental illness' for which there is a known treatment." A psychiatric assessment is required prior to program acceptance to determine clinical eligibility and also to devise an individualized treatment plan in order to properly account for public safety and manage risk. If an offender is considered to possess too high of a risk for violence or possesses too low of a likelihood of successful treatment completion, they are screened out of BMHC. Referrals can

241. Fisler, supra note 30, at 591.
243. Id. at 26.
244. Id. at iii, 1.
245. Id. at vi, 47.
246. Id. at iii, 8; Fisler, supra note 30, at 593.
248. Fisler, supra note 30, at 593.
come from competency proceedings, judges, defense attorneys, prosecutors, and other specialized problem-solving courts. The judge and the prosecutor can unilaterally deny a defendant participation in BMHC.

The treatment program under BMHC consists of four phases: "(1) adjustment in treatment; (2) engagement in treatment; (3) progress in treatment; and (4) continued progress and preparing to graduate." The length of each period depends on the length "of the mandate, with the exception of the first phase, which lasts three months from the plea date." A wide range of mental health services may be employed, including day treatment programs, individual therapy, intensive psychiatric rehabilitation treatment programs, psychosocial clubs, and assertive community treatment (ACT) teams. The MHC can also order "supported housing, which includes both community residences with 24-hour on-site staff and supported apartment programs with less intensive clinical support." In addition to mental health services, treatment plans can include substance abuse treatment, case management, education, and employment services. Following successful completion, all charges are dismissed or reduced.

The Center for Court Innovation conducted a process evaluation and preliminary outcome evaluation of BMHC. Of importance to this comment, 37% of the offenders in the period covered by the study had

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249. O'KEEFE, supra note 16, at 15. "[P]roblem-solving courts include specialized drug courts, domestic violence courts, community courts, and family treatment courts." Id. at 1. These specialized courts "seek to improve the outcomes for victims, communities, and defendants." Id.

250. Fisler, supra note 30, at 597.


252. Id. at 29.

253. Fisler, supra note 30, at 595.

254. Id. at 596.

255. Id. at 595.

256. Id. at 593.

257. Id. at 601.
violent felony charges. Overall BMHC had positive effects on recidivism, hospitalizations, homelessness, substance use, and psychosocial functioning. While 78% had at least one arrest prior to program participation and 27% had been arrested in the year prior to program participation, only 16% were arrested in the first year after enrollment. As for hospitalizations, while 50% of the participants had been hospitalized for psychiatric reasons the year prior to their involvement with BMHC, only 19% had hospitalizations the year after their enrollment. Using the Health of the Nation Outcome Scale (HoNOS) at intake and at the twelve-month follow-up to measure psychosocial functioning, “participants showed statistically significant improvements on the scales measuring problems with cognition, depressed moods, living conditions, and occupations and activities.” Along with these praiseworthy results, the “unusually high one-year program retention rate of 83% suggests that the Brooklyn Mental Health Court has a meaningful positive effect on its participants.”

Ann Swern of the Brooklyn District Attorney’s Office, in speaking about BMHC, said, “We are making an investment in treatment in order to prevent the reoccurrence of crime—particularly violent crime—by offenders with mental illness.” For that same reason, MIOTCRA should encourage MHCs to accept violent offenders, rather than exclude them. BMHC has demonstrated that these courts can successfully “identify, assess, and monitor offenders with mental illness; and . . . link offenders with mental.


259. Id. at 58.

260. Id. at vii, 53.

261. Id. at vii, 52-53.

262. Id. at 53-54. The HoNOS (The Royal College of Psychiatrists’ Research Unit, 2002) was designed by The Royal College of Psychiatrists and has proven to be reliable and valid. It “is comprised of 12 scales . . . [which are] scored from 0 (no problem) to 4 (severe to very severe problem).” Id. at viii. The scales “measure a wide range of health and social domains.” Id. at 53.

263. Id. at 58.

264. Fisler, supra note 30, at 593.
illness to appropriate mental health treatment services" to address both mental health treatment needs and public safety concerns.

SECTION B: Assertive Community Treatment/Assisted Outpatient Treatment

Some jurisdictions, including those that have MHCs, may use assertive community treatment (ACT) or assisted outpatient treatment (AOT) programs as diversion programs for mentally ill offenders. Depending on the program, mentally ill offenders can be diverted at various points, whether by a police officer arriving on scene, mental health professionals in mobile crisis teams, or through the courts. The rationale under these programs, like for MHCs, is that the offender would never have ended up in the criminal justice system if he or she would have received the necessary treatment in the community. Thus, ACTs and AOTs provide an outpatient model of care to ensure these individuals are receiving all of the treatment and assistance they need in the community to effectively manage their illness and abide by the laws. The services they provide include "medications and medication management, case management services, housing assistance, substance abuse treatment, vocational supports and mobile crisis management." A treatment team is available 24 hours a day, 365 days a year for participants.

The goal of ACTs and AOTs "is not to make presently dangerous individuals nondangerous." Rather, the mentally ill participants are presumed to not be dangerous while under the care and supervision of the


266. Id. at 1.

267. See Honberg & Gruttadaro, supra note 24, at 24; Heyrman, supra note 8, at 393-97.

268. Lamb, Weinberger & Gross, supra note 24, at 121.

269. Heyrman, supra note 8, at 394.

270. Id. at 394.


272. Heyrman, supra note 8, at 395-96.

273. Lamb, Weinberger & Gross, supra note 24, at 114.
Therefore, while ACTs and AOTs may not be appropriate for cases such as murder, it may be appropriate for a mentally ill offender with a less severe violent charge. It is important to remember that under MIOTCRA, a mentally ill offender is defined as being "violent" if he or she just threatened violence or committed a felony that involved a mere risk of violence to either a person or property.

When outpatient treatment is court-ordered, the participants remain under the jurisdiction of the criminal justice system and their outpatient status can be revoked, or other consequences given, if they do not comply with the program. Outpatient treatment is a proficient way to "balance the patient’s liberty interests with the State's interest in protecting the mentally ill individual and the community." As for the effectiveness of ACTs and AOTs, "there is a large body of literature documenting the success of these programs in reducing hospitalizations, homelessness, arrests and other consequences of untreated mental illnesses" such as violence and victimization. They have been found to improve treatment compliance and substance abuse treatment.

274. *Id.*

275. This comment uses the word "may not be appropriate" in regards to a murder charge because there are times arguably that ACT or AOT may be appropriate a mentally ill offender that commits murder. An example may be in a case involving post-partum depression.


278. Winchell, *supra* note 11, at 229.


281. *Id.*
An Example: The Nathaniel Project

An example of an ACT program that accepts violent mentally ill offenders is the Nathaniel Project in New York City. The Nathaniel Project, which started in 2000, is run by the Center for Alternative Sentencing and Employment Services (CASES) and is an alternative only for those offenders diagnosed with an Axis I disorder and who are prison-bound for felonies, including violent offenses. Many participants are homeless and have co-occurring substance abuse problems. Approximately 50% of participants are charged with violent crimes and 75% of participants have a history of violence. Rather than incarceration, participants receive two years of intensive case management and community supervision under the program.

Anyone can refer criminal defendants to the Nathaniel Project, although most referrals come from court personnel. The program conducts its own multi-step screening and risk-assessment to decide which offenders are appropriate participants. Once the Nathaniel Project decides to accept a defendant, staff members go to the court to advocate for the offender to be released into the program. Prior to entry, the participants plead guilty and then sign a contract to participate in the program that is


284. Seltzer, supra note 33, at 585.


286. Seltzer, supra note 33, at 585.

287. CASES, supra note 282.

288. Id.

289. NATHANIEL PROJECT, supra note 24, at 2.
entered into the court record, at which point the sentencing is adjourned. Participants live in supervised housing or receive residential treatment.

The case workers must see their clients at least three times a week during the first two months, then at least twice a week for the next two months, followed by at least once a week for the last eight months of their first year in the program. During the second year, the case management changes to a monthly supervision model. At all times during the program, someone is available on call twenty-four hours a day. In addition to mental health care, the program ensures that participants are taught living skills such as money management, and have the financial resources, including access to public benefits, for medications and any other essentials they need such as food and clothing. The participants attend periodic court progress dates and, following successful completion of the program, their criminal charges are reduced or dismissed.

The Nathaniel Project has produced positive results in working with mentally ill offenders who commit serious crimes. The program retains 80% of its clients for the full two years and 79% had permanent housing after one year in the program. The number of arrests for participants dropped from 101 in the year prior to entry to just 7 in the year following entry. The Nathaniel Project is a cost-effective solution when its $14,578

290. ALAMEDA, supra note 285, at 3.

291. Id. at 5.

292. CASES, supra note 282.

293. Id. By the second year, “[p]articipants are expected to have a stable living situation, to be engaged in treatment, and to have developed a community-based support network.” Id.

294. ALAMEDA, supra note 285, at 5.

295. Awards, supra note 283, at 1314; CASES, supra note 282.

296. ALAMEDA, supra note 285, at 4.

297. Id. at 6; Awards, supra note 283, at 1315.

298. ALAMEDA, supra note 285, at 6; Awards, supra note 283, at 1315.

299. ALAMEDA, supra note 285, at 6.
annual cost for a participant is compared to the $29,678 annual cost to provide services in a state prison or the $53,224 annual cost to provide services in a city jail.\(^{300}\)

The Nathaniel Project demonstrates that appropriate violent mentally ill offenders can be successfully treated in the community.\(^{301}\) The program has never turned a mentally ill offender away due to the severity of the crime committed or the offender’s past history of violence.\(^{302}\) Rather than look at crime level, it looks at actual risk to the public.\(^{303}\) MIOTCRA similarly should not look at crime level in determining which mentally ill offenders are appropriate for diversion programs.

**CONCLUSION**

While the problem of criminalizing the mentally ill is commendably being targeted on the federal level by MIOTCRA, more needs to be done to adequately account for violent mentally ill offenders. Treating violent mentally ill offenders, otherwise appropriate for diversion programs under MIOTCRA, under traditional criminal procedures is neither effective nor efficient. While a case such as Eric Clark’s involves the extreme violent act of murder, it demonstrates the loopholes in the health system and the need to ensure that appropriate mentally ill offenders, even after committing violent offenses, receive effective treatment. Incarcerating offenders with treatable mental illnesses, of which their crime was the product, serves no deterrent or rehabilitative purpose. It costs society more, both in terms of finances and safety, to continue to fail to appropriately treat this population of offenders.

While many diversion programs exist without MIOTCRA funding, and therefore are not subject to its non-violent limitation, MIOTCRA should still be amended. MIOTCRA was designed to determine ways to reduce recidivism and better protect society from breakdowns in the health system. Under MIOTCRA’s own purpose and goals, in addition the requirements of the Eighth Amendment, violent mentally ill offenders should not be automatically excluded from diversion programs. Also, MIOTCRA cannot exclude diversion programs from experimenting with violent offenders if its duty to provide a list of “best practices” for handling the mentally ill is going to truly be fulfilled. While it may be politically easier and safer to exclude

\(^{300}\) Awards, *supra* note 283, at 1315.

\(^{301}\) Nathaniel Project, *supra* note 24, at 2.

\(^{302}\) *Id.* at 2.

\(^{303}\) *Id.*
violent offenders, Congress needs to be accountable and do what is necessary to make society aware of "the enormous social and financial costs associated with the irrationality of charging and sentencing persons whose severe mental disorders are manifested as criminal conduct to an unending cycle of incarceration, decompensation, release, reoffense, arrest, sentencing, and reincarceration."^304

304. Stone, supra note 86, at 358.