

*Am I My Brother's Keeper?:
The Moral and Economic Costs
of Criminalizing Mental Illness*

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And the Lord said unto Cain, Where is Abel thy brother? And he said, I know not: Am I my brother's keeper?

—*Genesis 4:9*

INTRODUCTION

Darren Rainey,¹ Christopher Lee Lopez,² Timothy Souders.³ Each of these men suffered from mental illness and each had been incarcerated for crimes often associated with serious mental illness.⁴ Rainey was serving a sentence for possession of cocaine,⁵ Lopez was serving a

¹ Julie K. Brown, *Behind Bars, a Brutal and Unexplained Death*, MIAMI HERALD (May 17, 2014), <http://www.miamiherald.com/news/local/community/miami-dade/article1964620.html>.

² Chris Vanderveen, *Mentally Ill Inmate's Death Prompts Federal Lawsuit*, KUSA (June 19, 2014), <http://www.9news.com/story/news/investigations/2014/06/19/mentally-ill-death-lawsuit/10882089/>.

³ Pat Shellenbarger, *State Settles \$3.25 Million Lawsuit Over Timothy Sauders Death in Prison*, MLIVE (July 1, 2008, 6:29 PM), http://blog.mlive.com/grpress/2008/07/state_settles_325_million_laws.html.

⁴ For the purposes of this paper, unless otherwise indicated, the term “mental illness” refers only to what are commonly considered serious mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, and similar illnesses that have severe symptoms that cause tremendous difficulty—often insurmountable if untreated—in maintaining an attachment to reality and living anything resembling a “normal” life.

⁵ Brown, *supra* note 1. Substance abuse and mental illness often go hand-in-hand; the rates of substance use among the mentally ill are substantially higher than that of the general population. *Mental Illness and Substance Abuse*, NAT'L BUREAU ECON. RESEARCH, <http://www.nber.org/digest/apr02/w8699.html> (last visited Apr. 6, 2015) (“[W]hen other factors are held constant, mental illness does increase use of addictive goods -- relative to use by the overall population -- by 20 percent for alcohol, 27 percent for cocaine, and 86 percent for cigarettes.”); Andrew Wasicek, *Palliative Exceptions: Substance Abuse, Mental Illness, and Drug Courts*, 10 CONN. PUB. INT. L.J. 199, 210-11 (2010) (“The comorbidity of addiction and severe mental illness is prevalent . . . [o]ne study of drug

sentence for trespassing,⁶ and Souders was serving a sentence for resisting arrest and destroying police property.⁷ Each of these men died while incarcerated. Rainey, 50 years old, was locked for more than an hour in a scalding hot shower where he was scalded to death as punishment for defecating in his cell.⁸ Lopez, 35 years old, was found unresponsive in his cell following nine months of solitary confinement; corrections officers and medical personnel shackled him to a chair and put a hood over his head, watching and idly chatting—even laughing—as he suffered two grand mal seizures and died.⁹ Souders, 21 years old, was shackled to a cement slab in solitary confinement for four days and left to die of dehydration and heat exhaustion.¹⁰

These disturbing anecdotes are but a small glimpse at a much larger mosaic of misunderstanding and tragedy that stems from the use of criminal detention facilities as de facto mental institutions, a process referred to as the criminalization of mental illness.¹¹ Given the dramatic difference in the rate of mental illness within incarcerated populations as compared to

treatment programs found that 68 percent of patients qualified for a psychiatric diagnosis besides substance dependency . . . evidence that shows that addiction is especially endemic in schizophrenic populations. Individuals with schizophrenia are six times more likely to abuse illicit drugs than persons without mental illness. Moreover, certain drugs addictions are associated with particular mental illnesses. In one study, between one-third and one-half of patients addicted to opiates met criteria for major depression. Other studies have indicated that cocaine addiction is strongly associated with affective disorders (especially bipolar disorder)” (citations omitted);

⁶ Vanderveen, *supra* note 2. NEV. DIV. PUB. & BEHAVIORAL HEALTH, MENTAL ILLNESS AND THE CRIMINAL JUSTICE SYSTEM: CLARK COUNTY, NEVADA 1 (2013), *available at* http://health.nv.gov/PDFs/Publications/Prevalence_MentalIllnessAmongDetainees_CCDC_2011.pdf (“Among individuals who were both admitted to an MHDS psychiatric hospital and detained at CCDC in 2011, the most common criminal charge was trespassing, which accounted for 87.4 percent of all charges”); BARBARA COLLINS & GEORGE PARKER, *RECOGNIZING MENTAL ILLNESS IN THE COURTROOM* 46 (2006), *available at* <http://www.in.gov/judiciary/center/files/jedu-lib-social-recognize-mental-illness-presentation.pdf> (recognizing that trespassing, substance abuse, disorderly conduct, and resisting arrest are among the most common charges against mentally ill defendants).

⁷ Shellenbarger, *supra* note 3. Kevin J. Novak & Robin S. Engel, *Disentangling the Influence of Suspects’ Demeanor and Mental Disorder on Arrest*, 28 *POLICING* 493, 506 (2005) (noting that “mentally disordered suspects were significantly more likely to be disrespectful and resistant toward officers compared to non-mentally disordered suspects”).

⁸ Brown, *supra* note 1.

⁹ Vanderveen, *supra* note 2.

¹⁰ Shellenbarger, *supra* note 3. As a related matter, one might find it disturbing that the warden who presided over Mr. Souders’ horrific death is still working for the Michigan Department of Corrections as a warden. John S. Hausman, *Sherry Burt Named Warden of Muskegon Correctional Facility When it Reopens*, *MLIVE* (June 28, 2012, 4:13 PM), http://www.mlive.com/news/muskegon/index.ssf/2012/06/sherry_burt_named_warden_of_mu.html.

¹¹ RISDON N. SLATE, ET AL., *THE CRIMINALIZATION OF MENTAL ILLNESS* 43 (2013).

the general public and the lack of adequate staff and training to handle the particular needs of such a population, such grim results should not come as a surprise.¹² This practice is a very high price to pay in order to enjoy the “convenience” of being isolated from the mentally ill, or to feel secure from the incredibly remote possibility that such a person might visit harm upon us.¹³ The mentally ill are our friends, our family, our neighbors; yet so many are content to absolve themselves of responsibility, to do nothing in the face of their suffering, to abandon the mentally ill and deny them their humanity.

Many mentally ill people are incarcerated for crimes committed without full knowledge of what they were doing, out of irrational fear, or in search of sustenance or relief from their symptoms.¹⁴ Such states of mind hardly fit into the mold of the *mens rea*—the guilty mind—for which our criminal justice system seeks to correct. By continuing the widespread incarceration of our mentally ill, we undermine the legitimacy of our criminal justice system and the integrity of our society.¹⁵ Part II of this paper takes a closer look at the moral costs associated with the criminalization of mental illness.

The costs of the criminalization of mental illness are not only ethical, but also economic. The average cost in Florida is about \$20,500¹⁶ per year to keep an inmate in prison. It costs

¹² See discussion *infra* Sections I.A, B.

¹³ See discussion *infra* Section I.C.

¹⁴ This characterization applies to those mentally ill offenders who are driven by symptoms of their illnesses to engage in behavior that violates some law; those whose illnesses are controlled sufficiently by a course of treatment and who make a rational decision to violate a law cannot be said to lack knowledge or understanding of what they are doing any more than any other person. However, given that treatment and support tends to dramatically reduce the recidivism rates of mentally ill offenders, and given the correlation between untreated mental illness and criminal behavior, the most logical inference is that—in most cases, but not all—criminal behavior is a product of untreated illness and the surrounding circumstances. See notes 79, 162 *infra* and accompanying text. For those who, despite a successful course of treatment, engage in criminal behavior, there is little justification for treating them differently than any other offender.

¹⁵ See discussion *infra* Part II.

¹⁶ NAT'L INST. CORR., *Corrections Statistics by State: Florida*, <http://nicic.gov/statestats/?st=FL> (last visited Apr. 8, 2015).

Colorado about \$30,400¹⁷ per year to house a prisoner. It costs Michigan about \$28,100¹⁸ per year to house a prisoner. Depending upon the location and the needs of the patient, any of those amounts could be reduced by 50% up to 90% by diverting them to community mental health treatment programs instead of incarcerating them.¹⁹ Part III of this paper will examine the economic disincentives for the continued incarceration and failure to treat the mentally ill.

The move toward community mental health treatment and the use of diversionary techniques and specialized mental health courts to try and keep mentally ill persons out of the criminal justice system has been painfully slow. A wide variety of models to achieve the aim of building a more appropriate infrastructure to treat the mentally ill have been tried with varying degrees of success. Part IV of this paper will examine some of these models, and suggest an alternative that adopts elements of the sequential intercept model, the use of mental health courts, and the approaches taken by Indian tribal peacemaking courts and sentencing circles.

I. A BRIEF HISTORY OF THE TREATMENT OF THE MENTALLY ILL IN AMERICA

In order to address the future of the American criminal justice system's handling of the mentally ill, it is necessary to address the historical difficulties that this nation as a whole has faced in dealing with the mentally ill. From the Colonial era through the present, American authorities have gradually learned that doing nothing is far too costly, but have struggled to

¹⁷ NAT'L INST. CORR., *Corrections Statistics by State: Colorado*, <http://nicic.gov/statestats/?st=CO> (last visited Apr. 8, 2015). Colorado's cost-per-inmate for 2012 was the median figure for all 50 states in 2012. *Id.*

¹⁸ NAT'L INST. CORR., *Corrections Statistics by State: Michigan*, <http://nicic.gov/statestats/?st=MI> (last visited Apr. 8, 2015).

¹⁹ See discussion *infra* Part III. DAVID CLOUD & CHELSEA DAVIS, TREATMENT ALTERNATIVES TO INCARCERATION FOR PEOPLE WITH MENTAL HEALTH NEEDS IN THE CRIMINAL JUSTICE SYSTEM: THE COST-SAVINGS IMPLICATIONS 2-3 (2013) available at <http://www.vera.org/sites/default/files/resources/downloads/treatment-alternatives-to-incarceration.pdf>; Stephanie Soucheray, *NC State Study Shows Why It Costs Less to Treat Mentally Ill Than Incarcerate Them*, N.C. HEALTH NEWS (July 1, 2013), available at <http://www.northcarolinahealthnews.org/2013/07/01/nc-state-study-shows-why-it-costs-less-to-treat-mentally-ill-than-incarcerate-them/>; Liz Szabo, *Cost of Not Caring: Nowhere to Go*, USA TODAY (May 12, 2014), <http://www.usatoday.com/story/news/nation/2014/05/12/mental-health-system-crisis/7746535>; Amanda C. Pustilnik, *Prisons of the Mind: Social Value and Economic Inefficiency in the Criminal Justice Response to Mental Illness*, 96 J. CRIM. L. & CRIMINOLOGY 217 (2005).

identify a method to address the needs of the mentally ill that is both morally and economically sound.²⁰ A brief examination of this struggle reveals that there are two primary factors responsible for most of the problems associated with caring for the mentally ill. First and foremost is the fact that no one really understands what causes mental illness and because of this there has been substantial difficulty in treating mental illness.²¹ The second factor, perhaps itself a consequence of the first, is that confusion and misunderstanding on the part of the general public tends to militate against any “solution” that does not involve the isolation of the mentally ill from the rest of the population.²²

A. From Colonial America through the 1970s

America has struggled to deal with its mentally ill since its humble beginnings as a British colony. Through the 19th century, Britain equated mental illness with being a wild beast; that is, having no more control over one’s faculties than an animal or an infant.²³ In the Thirteen Colonies, a similar conception of mental illness prevailed. Colonial America’s puritanical ethos equated work and industry with morality, and those unable to work were subject to punishment for their indigence or, at best, viewed as unsalvageable burdens on their families.²⁴ The mentally ill were sometimes treated as lazy roustabouts, subject to whippings “aimed at compelling [them] to labor” under prevailing laws at the time.²⁵ At best, a court might have seen fit to relieve the burden of caring for an ill relative from a poor family, and ordered that a small structure be built

²⁰ See discussion *infra* Sections I.A, B.

²¹ See discussion *infra* Section I.B. Though some—perhaps most famously Michel Foucault and Thomas Szasz—have disputed the way in which we approach mental illness, or even the existence of such a thing as mental illness entirely, this paper proceeds on the assumption that current conception of mental illness is reasonably accurate. Those interested in such theories may see *generally* Thomas Szasz, *Mental Illness: Psychiatry’s Phlogiston*, 27 J. MED. ETHICS 297 (2001).

²² See discussion *infra* Section I.C.

²³ HENRY F. FRADELLA, FROM INSANITY TO DIMINISHED CAPACITY 17-19 (2007).

²⁴ SAMUEL JAN BRAKEL, ET AL., THE MENTALLY DISABLED AND THE LAW 12 (1985). Of course, this sets aside theories of mental illness that attribute the suffering of the mentally ill to religious explanations (e.g., demonic possession) or some “imbalance of humors.” Lawrence Osborn, *From Beauty to Despair: The Rise and Fall of the American State Mental Hospital*, 80 PSYCHIATRIC Q. 219, 220 (2009).

²⁵ BRAKEL, ET AL., *supra* note 24, at 12.

to isolate them and allow their families to work.²⁶ If mentally ill persons had no family to care for them, they were left to their own devices; this usually meant roaming from town to town—perhaps in small groups—making a living by begging.²⁷

It was not until the mid-18th century that the first organized response to the problem posed by the mentally ill was attempted. Benjamin Franklin drafted a petition to the Pennsylvania Assembly in 1751 to establish the first hospital in the Colonies to care for the “care of lunatics” and of the poor.²⁸ In 1773, the first American hospital dedicated exclusively to the “care” of the mentally ill was founded in Williamsburg, Virginia,²⁹ and a handful of similar institutions were opened in the following decades.³⁰ Persons exhibiting signs of mental illness were subject to involuntary commitment in these institutions for any aberrant behavior—not necessarily violent behavior—and the courts were the channels through which the mentally ill flowed into them.³¹ While these hospitals or asylums were nominally chartered to “care” for the ill, there was no real impetus to care for those unfortunate enough to be locked away; the purpose of such confinement was not therapeutic, but rather to detain and isolate the ill from the general public.³² This was a product of the prevailing medical sentiment at the time regarding biological determinism; that is, that mental illness—among an array of other maladies or perceived maladies—was an immutable product of a person’s biology: a mere accident of birth.³³ Thus, since there was nothing that could change a patient’s biology, why bother with attempts at

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Id.* at 13. That institution, the Pennsylvania Hospital in Philadelphia, still stands and is widely renowned for the quality of the medical care that it affords its patients. U. PENN., *History of Pennsylvania Hospital*, <http://www.uphs.upenn.edu/paharc/features/creation.html> (last visited Apr. 4, 2015).

²⁹ BRAKEL, ET AL., *supra* note 24, at 13.

³⁰ *Id.* at 14.

³¹ *Id.*

³² *Id.*

³³ SLATE, ET AL., *supra* note 11, at 25.

therapy or rehabilitation?³⁴ These institutions were little more than jails and given how few of them existed, the primary means of separating the mentally ill from the general public was, in fact, to jail them in correctional institutions.³⁵

The conditions in jails and prisons at the time were appalling, and mentally ill prisoners were kept in deplorable conditions and monitored by guards and wardens ill-suited to deal with their needs.³⁶ Dorothea Dix—famous for her crusade to remove the mentally ill from jails, prisons, and poor houses and to provide facilities that would aid rather than simply isolate them—described horrific scenes of abuse in these facilities.³⁷ Following Dix’s efforts in the mid-19th century, the number of state-run institutions dedicated solely to housing the mentally ill multiplied dramatically, and the number of mentally ill persons housed in criminal detention facilities correspondingly decreased.³⁸ However, due to frustration at the inability of medical professionals to effectively treat or cure the mentally ill, these asylums became nothing more than “warehouse[s] [for] the mentally ill.”³⁹ These facilities were chronically underfunded, overcrowded, patients were subject to torturous “treatments,” and were often subject to brutal physical and mental abuse; the asylums were only a marginal improvement at best.⁴⁰ Medical

³⁴ *Id.* at 26.

³⁵ Daniela Peterka-Benton & Brian Paul Masciadrelli, *Legitimacy of Corrections as a Mental Health Care Provider: Perspectives from U.S. and European Systems*, 2013 J. INST. JUST. INT’L STUD. 171, 172 (2013) (“Public psychiatric institutions were few and far between during the early 1800s and most poor or indigent mentally ill persons were confined to poor houses and jails.”).

³⁶ DORTHEA DIX, MEMORIAL 3-4 (1843).

³⁷ *Id.* at 5-23. Mentally ill prisoners were subject to a variety of evils, including: being chained naked to floors; being confined to small cages for so long that their muscles atrophied; being deprived of food and sunlight; being physically and sexually abused; and so on. *Id.*

³⁸ Robert Rigg, *“Are There No Prisons?” Mental Health and the Criminal Justice System in the United States*, 4 U. DENV. CRIM. L. REV. 103, 107-10 (2014).

³⁹ *Id.* at 109.

⁴⁰ *Id.* at 109-110; Michael L. Perlin, *“Wisdom Is Thrown into Jail”: Using Therapeutic Jurisprudence to Remediate the Criminalization of Persons with Mental Illness*, 17 MICH. ST. U. J. MED. & L. 343, 348-49 (2013). See also SLATE, ET AL., *supra* note 11, at 30-31.

consensus at the time condoned the use of electroshock treatment, hydrotherapy,⁴¹ insulin therapy,⁴² and lobotomies, among other barbaric treatments, in order to try and treat mental illness.⁴³

By the mid-20th century, medical consensus began to move away from the more barbaric treatments such as lobotomy and electroshock treatment and to move toward the use of psychotropic medications.⁴⁴ While new medications like Thorazine offered the promise of docile and compliant patients,⁴⁵ psychiatrists were still uncertain as to why most medications were more or less effective, because the underlying causes of mental illness—aside from the fact that brain structure or chemistry plays some part—remained a mystery.⁴⁶ By the 1960s and 1970s, the civil rights movement expanded to encompass the rights of the mentally ill, and this manifested in two principal ways: the Kennedy administration’s push for community mental health services (as opposed to “anachronistic state public health institutions”), and the right to treatment litigation in

⁴¹ This involved either giving patients baths, spraying them with water, or packing them with wet towels or sheets. The nature of this treatment varied from what amounted to a long, hot bath to being confined for hours or days to a tub of water or being wrapped in towels or sheets soaked in cold water and restrained so that the wet cloth could not be removed. Carla Johnson, *Water Treatments*, INSANITY & AM. HISTORY (Feb. 22, 2015), http://cantonasylumforinsaneindians.com/history_blog/water-treatments/; see also RESTORING PERSPECTIVE: LIFE AND TREATMENT AT THE LONDON ASYLUM, *Hydrotherapy*, <https://www.lib.uwo.ca/archives/virtualexhibits/londonasylum/hydrotherapy.html> (last visited Apr. 6, 2015).

⁴² Insulin therapy was simply overdosing patients with insulin to induce a coma. PBS.ORG, *Primary Sources: Insulin Coma Therapy*, http://www.pbs.org/wgbh/amex/nash/filmmore/ps_ict.html (last visited Apr. 6, 2015).

⁴³ Rigg, *supra* note 38, at 109; Osborn, *supra* note 24, at 228.

⁴⁴ Osborn, *supra* note 24, at 228; SLATE, ET AL., *supra* note 11, at 31-32.

⁴⁵ The story of the rapid spread of the use of Thorazine (chlorpromazine), a very powerful drug which induces very docile, almost zombie-like behavior in many of the patients that receive it, is itself an interesting story of greed and political maneuvering. Those who have seen a patient under its influence dragging their feet in what is sometimes referred to as “the Thorazine Shuffle” can attest to how unnervingly vacant those dosed with Thorazine appear. Slate, et al., provide a concise summary of Thorazine’s rise to prominence. SLATE, ET AL., *supra* note 11, at 31-32.

⁴⁶ Indeed, the precise causes of mental illness still elude the medical profession. The prevailing medical understanding of mental illness is that the root cause or some proclivity toward mental illness can be identified by the physical and chemical structure of the brain as well as a person’s genetic makeup, but environmental factors also play an important part. See NAT’L INST. MENTAL HEALTH, *Schizophrenia*, <http://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml> (last visited Apr. 6, 2015); Kirsten Weir, *The Roots of Mental Illness*, 43 MONITOR ON PSYCH. 30 (2012) available at <http://www.apa.org/monitor/2012/06/roots.aspx>; see also SLATE, ET AL., *supra* note 11, at 78.

the 1970s.⁴⁷ The success of the right to treatment cases increased the costs associated with housing patients in asylums by compelling the asylums to make actual efforts to care for their patients; this development, coupled with the push by several successive administrations to move away from the custodial institutional care model, resulted in deinstitutionalization.⁴⁸

B. Modern Trends – Deinstitutionalization and Gaps in Community Care

As the failures of the custodial institutional model of “care” become more and more apparent,⁴⁹ policies shifted toward the closure of these facilities with the goal of shifting to a community treatment model.⁵⁰ This model was to be enacted in three steps: the establishment of community treatment services, followed by the transitioning of institutionalized patients into the community facilities, and lastly the diversion of individuals who would otherwise be institutionalized into these community facilities.⁵¹ However, due to a reluctance to fund the community treatment services and facilities, step one was effectively skipped and the mentally ill were turned out into the streets in droves; between 1965 and 1980, the number of patients in state-run institutions dropped more than 80%.⁵² Since there was nothing in place to help these people transition from institutional environments—in many cases, they lacked the means to care for themselves simply because they had been hospitalized for decades and had no personal or

⁴⁷ SLATE, ET AL., *supra* note 11, at 34-37. Kennedy, whose sister had been lobotomized, had personal reasons for including mental health reform in his New Frontier agenda. *Id.* at 37. The right to treatment movement can be succinctly described as the idea that if people are to be forcibly institutionalized then they have a right to adequate treatment for their illness; mental asylums could not just be custodial institutions where the sick were locked away and left to rot. *Id.* at 34-36.

⁴⁸ *Id.* at 36-38.

⁴⁹ Perlin, *supra* note 40, at 343-44 (“[S]tate hospital systems were being overused inappropriately and in ways that consigned tens of thousands of citizens to the equivalent of lifetime sentences in substandard, dangerous prison-like facilities (characterized by an expert witness, without rebuttal, in discussing a facility that was at the heart of a famous law reform case, as ‘Dachau, without ovens’). Such facilities often provided little more than custody and often exacerbated the underlying psychosocial disabilities that led to institutionalization in the first place.”) (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1 (1981)).

⁵⁰ SLATE, ET AL., *supra* note 11, at 38.

⁵¹ *Id.*

⁵² *Id.*

marketable skills to fall back on—they found themselves without treatment and with nowhere to turn.⁵³ These people were treated as though they were toxic waste; they were cast aside and left to their own devices and many fell into homelessness, many were scooped up by the criminal justice system, and many died.⁵⁴ This phenomenon, whereby the mentally ill were released with nowhere to go, is referred to as deinstitutionalization.⁵⁵

A consequence of deinstitutionalization is what has been referred to as transinstitutionalization—that is, the shift of the mentally ill from state-run mental health institutions to other publicly funded institutions, namely nursing homes and criminal detention facilities.⁵⁶ While transinstitutionalization describes part of the current state of affairs, this description is incomplete. Community mental health services are subject to tight budgetary constraints and are limited in the amount of support that they can offer to their communities; this results in the mentally ill who are seeking treatment to turn to other facilities that cannot turn them away: hospital emergency rooms.⁵⁷ Since at least the early 1990s, there has been a dramatic

⁵³ *Id.* at 38-39.

⁵⁴ *Id.* at 39.

⁵⁵ *Id.* at 38-39. Studies have placed the proportion of the mentally ill in jails all over the map, depending upon how the studies were controlled; figures range from 6% to 64% of all inmates (for any mental illness), with figures consistently around 16% for inmates with serious mental illness (i.e., schizophrenia, schizoaffective disorder, bipolar disorder, or major depression). *Id.* at 228-230. People with serious mental illness comprise only about 1% of the general population. *Id.* at 80; *but see* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMINISTRATION, BEHAVIORAL HEALTH BAROMETER 11 (2015) *available at* http://www.samhsa.gov/data/sites/default/files/National_BHBarometer_2014/National_BHBarometer_2014.pdf (noting that, in 2013, 4.2% of adults in the U.S. self-reported having serious mental illnesses). One study attributes 7% of the meteoric rise in the jail and prison population from 1980 to 2000 simply to deinstitutionalized mental patients, with an increase of 14-26% of the incarcerated population of persons with serious mental illness. Steven Raphael & Michael A. Stoll, *Assessing the Contribution of the Deinstitutionalization of the Mentally Ill to Growth in the U.S. Incarceration Rate*, 42 J. LEGAL STUD. 187, 219 (2013). *See also* Mark R. Munetz, M.D. & Jennifer L.S. Teller, Ph.D., *The Challenges of Cross-Disciplinary Collaborations: Bridging the Mental Health and Criminal Justice Systems*, 32 CAP. U. L. REV. 935, 937-39 (2004) (discussing the explosion in the number of people incarcerated in the U.S. and the disproportional number of mentally ill people among those incarcerated).

⁵⁶ Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s*, 9 OHIO ST. J. CRIM. L. 53, 87 (2011). Nursing homes, while generally privately owned and operated, receive federal funds in the form of Medicare and Medicaid. *Id.*

⁵⁷ SLATE, ET AL., *supra* note 11, at 70-71.

increase in the number of persons suffering from mental illness who turn to ERs for treatment.⁵⁸

These circumstances do not describe a group of people doomed to bounce from institution to institution; they describe a group that is more than a little lost and desperately seeking help.

While it is beyond argument that a large number of the mentally ill do end up in nursing facilities or in criminal custody, the implied narrative behind these discussions suggests that the mentally ill are just “waste” that needs to be stored. Even though some people with mental illness may only be able to survive (or may benefit most) if they are in a structured, institutional treatment environment,⁵⁹ the goal should not simply be to find a place to put the sick where they will not trouble the general public. This type of thinking is a product of the irrational stigma associated with mental illness.⁶⁰

The products of the failure to complete the first step of the deinstitutionalization process—establishing community mental health facilities—is and has been quite noticeable to law enforcement, courts, and interested observers as the mentally ill find themselves in regular contact with the criminal justice system.⁶¹ The police are often the unwilling first responders to the mentally ill when their symptoms result in disruptive behavior, and they are often untrained to handle the situation.⁶² Judges often lack sufficient understanding to effectively deal with the

⁵⁸ *Id.* “Between 1992 and 2003, there was a 56% increase . . . in the number of persons with mental illness visiting emergency room departments across the country. One North Dakota hospital’s ER recently reported that the number of patients with [some form of] psychosis as their primary diagnosis, not even including those in which psychosis is secondary, has doubled . . . [and] 70% of 6,000 ERs surveyed across the U.S. ‘boarded’ patients with mental illness for ‘hours or days,’ with some even reporting holding them for weeks.” *Id.* at 70 (citations omitted).

⁵⁹ Lois A. Weithorn, *Mental Hospitalization of Troublesome Youth: An Analysis of Skyrocketing Admission Rates*, 40 STAN. L. REV. 773, 787-88 (1988); Osborn, *supra* note 24, at 229.

⁶⁰ See discussion *infra* Section I.C.

⁶¹ SLATE, ET AL., *supra* note 11, at 183-85, 377-78.

⁶² This is not to say that law enforcement is unconcerned with the well-being of the mentally ill. Studies suggest just the opposite: that police are more empathetic toward the mentally ill than the general public. *Id.* at 184. A person with mental illness who is symptomatic and acting out simply presents a difficult situation for an officer who has not been trained to deal with such circumstances. *Id.* at 183-85. “The two most common misperceptions held by police about persons with mental illnesses are that they are all incapable of reasoning and are violent.” *Id.* at 184. As discussed in Part IV *infra*, providing officers the necessary training to handle such situations is critical to any attempt at reform.

mentally ill in their courtrooms, and this tends to be deleterious to both the mentally ill offender and to the local fisc.⁶³ Jails are often ill-equipped to handle mentally ill inmates; despite this, among facilities that house the mentally ill, the three locations nationally that house more mentally ill persons than any other—including any psychiatric institutions—are jails.⁶⁴ The effects are just as visible to the general public, as the mentally ill comprise somewhere between 1/3 and 2/3 of the homeless population in the U.S.⁶⁵ Furthermore, approximately 25% of all families in the United States are directly affected by some mental illness, whether serious or otherwise, in that it impacts a relative.⁶⁶ One would think that the sheer number of individuals affected by the failure to appropriately divert the mentally ill from the criminal justice system and to offer them adequate treatment would prompt some coordinated and organized response to the problem. While there has been a push in recent years towards community mental health treatment, a persistent lack of funding and the stigma associated with mental illness have presented serious obstacles in the establishment of effective community mental health resources. While the failure to adequately fund community mental health services is perhaps a case of being pennywise and pound foolish—a decision that may not be inherently irrational, but just a very poor choice—the persistent stigma attached to mental illness is entirely irrational.

⁶³ By way of example, a personal anecdote described in Slate, et al. describes how a county judge in Florida “did not appreciate the use of profanity” by a mentally ill defendant in the courtroom, so he held the defendant in contempt of court and sent him to jail for 179 days. *Id.* at 388. As discussed *infra* Part II, it is quite expensive to house any prisoner and it is even more costly to house a mentally ill prisoner, to say nothing of the moral or ethical questions raised by a night-into 6-month jail sentence for failing to observe decorum in a courtroom.

⁶⁴ *Id.* at 227, 237.

⁶⁵ *Id.* at 80-81.

⁶⁶ See NAMI ILL., *Facing the Facts*, <http://il.nami.org/facts.html> (last visited Apr. 8, 2015) (“One out of four American families has a relative who has a mental illness.”); Andrea Reupert, PhD & Darryl Mayberry, PhD, *Families Affected by Parental Mental Illness*, 77 AM. J. ORTHOPSYCHIATRY 362, 362 (2007) (“It has been estimated that there are approximately 21% to 23% children living in households where at least one parent has a mental illness.”).

C. *A Few Words on Stigma – Do You Live in Fear of Being Killed by Lightning?*

Mental illness has always carried with it a stigma.⁶⁷ Rather than view persons with mental illness for what they are, people who are sick and would benefit from treatment just as any other sick person would, the mentally ill are viewed as somehow being fundamentally different from everyone else; they are blamed for their conditions; they are inaccurately regarded as being generally dangerous; they are perceived as being useless and incompetent⁶⁸ and they are freely exploited in sensationalist stories without repercussion.⁶⁹ While each of these views is harmful in its own right,⁷⁰ perhaps none is more harmful or absurd as the perception of the mentally ill as being dangerous and violent.

The large body of research on the relationship between mental illness and violence reveals that the reported rates of violence among the mentally ill vary from study to study (depending upon the methodology and the definition of mental illness) from as low as 1% to as high as 50%, with a rate of only 2% to 13% of patients receiving outpatient care—e.g., community mental health treatment.⁷¹ However, the bulk of the research over the past fifteen to twenty years has “[o]verwhelmingly . . . demonstrated that most violent acts are not committed by persons with mental illness” and that “the vast majority of persons with mental illnesses will

⁶⁷ See Wendy F. Hensel & Gregory Todd Jones, *Bridging the Physical-Mental Gap: An Empirical Look at the Impact of Mental Illness Stigma on ADA Outcomes*, 73 TENN. L. REV. 47, 50-56 (2005) (“Perhaps no stereotype is more embedded in the American psyche than that of the dangerously unpredictable mental patient.”).

⁶⁸ *Id.* at 54.

⁶⁹ SLATE, ET AL., *supra* note 11, at 58-59, 72-73.

⁷⁰ Stigma perpetuates isolation, and the increasing social distance between the general public and the mentally ill reinforces the view that they are somehow ever the “other,” which makes it incredibly difficult for the mentally ill to participate meaningfully in society, whether they are undergoing treatment and are asymptomatic or not. *Id.* at 72. Mental illness (and mental impairment generally) is so thoroughly stigmatized that the mentally ill are looked down upon even by others with disabilities instead of viewed as kindred in a mutual effort to achieve full participation in society. Hensel & Jones, *supra* note 67, at 48-49 (“There is a hierarchy of position and social acceptance within the disabled community, and in virtually every meaningful way, individuals with psychiatric disorders fall at the bottom of the pecking order. The stigma that continues to adhere to mental illness impedes the recognition of people with disabilities as a collective social minority and encourages individuals with physical impairments to distance themselves from their mentally impaired brethren.”).

⁷¹ SLATE, ET AL., *supra* note 11, at 75.

never commit an act of violence.”⁷² This is true despite the fact that “news coverage of mental health matters . . . is consistently dominated by discussions of violence and crime committed by the mentally ill” and “that 72.1% of all characters in primetime television who were portrayed as mentally ill either hurt or killed others.”⁷³

The reality of the situation is quite the opposite: the probability of being murdered by a stranger with mental illness is about one in a million, which is comparable to the risk of being struck and killed by a bolt of lightning.⁷⁴ Furthermore, the risk of being assaulted by a person who is not mentally ill, but is abusing substances, is seven times greater than the likelihood of being victimized by someone with mental illness.⁷⁵ While the greatest risk of violent victimization from the mentally ill is associated with offenders who are both seriously mentally ill and suffering from substance abuse problems—which is very common among those suffering serious mental illness⁷⁶—even the co-occurrence of these conditions is nowhere near the strongest predictor of violence.⁷⁷ The variables that are more predictive of violent acts include: adverse childhood events, age, sex, divorce or separation in the past year, and parental criminal

⁷² *Id.* (emphasis added).

⁷³ Hensel & Jones, *supra* note 67, at 52-53.

⁷⁴ SLATE, ET AL., *supra* note 11, at 75. The risk of being murdered by a stranger generally, looking at the number of reported murders by strangers in 2013 (1281) and measuring that against the population estimate for 2013 (315,091,138), that gives us a rate of about 4 in a million to be murdered by a stranger generally. *See Uniform Crime Reports: Murder Circumstances by Relationship, 2013*, FEDERAL BUREAU OF INVESTIGATION, (2014), http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2013/crime-in-the-u.s.-2013/offenses-known-to-law-enforcement/expanded-homicide/expanded_homicide_data_table_10_murder_circumstances_by_relationship_2013.xls; Robert Schlesinger, *U.S. Population 2013: More Than 315 Million People*, US NEWS (Dec. 28,2012), <http://www.usnews.com/opinion/blogs/robert-schlesinger/2012/12/28/us-population-2013-more-than-315-million-people>. What this should tell us is that fearing homicide by stranger generally is ridiculous, and fearing that such a stranger will be mentally ill is especially ridiculous. While it is true that, if a study fails to implement controls as described *infra* note 79, the rate of violent behavior (including murder) among the mentally ill appears significantly higher than the rate for non-mentally-ill, non-substance-abusing members of the general public, this disparity is really only reflected in the victimization rates for persons who are closely related to persons with mental illness, such as immediate family members and persons involved directly in the mentally ill person’s care. SLATE, ET AL., *supra* note 11, at 75-76.

⁷⁵ SLATE, ET AL., *supra* note 11, at 75.

⁷⁶ “Up to 70% of those with serious mental illness exhibit . . . substance abuse and/or dependence.” *Id.* at 84.

⁷⁷ *Id.* at 75.

history.⁷⁸ While lack of treatment is associated with an increased likelihood of violent behavior due to the increased manifestation of severe symptoms, particularly when coupled with substance abuse, the mentally ill are still incredibly unlikely to engage in violent behavior against members of the general public.⁷⁹

The truth of the matter is that the mentally ill are far more likely to be the *victims* of crime rather than the perpetrators.⁸⁰ Mentally ill persons are somewhere between *11 and 14 times more likely* to be victims of a violent crime than persons without mental illness.⁸¹ This disparity is closely related to substance abuse, severity of symptoms, and to homelessness.⁸²

Other prevalent stigmas associated with mental illness include perceptions of incompetence (meaning immaturity or stupidity) and perceptions that the mentally ill are simply malingers seeking to avoid responsibility for their own actions.⁸³ It turns out the old adage that “there is a fine line between genius and madness” is grounded in truth: there is a correlation

⁷⁸ *Id.*

⁷⁹ *Id.* at 75-76. In fact, if a person with mental illness is not also dealing with a substance abuse problem, they are not likely to be any more violent than anyone else in their community. David B. Kopel & Clayton E. Cramer, *Reforming Mental Health Law to Protect Public Safety and Help the Severely Mentally Ill*, 58 HOWARD L.J. (forthcoming 2015) (manuscript at 12), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2564680. In fact, mentally ill persons appear statistically significantly more likely to engage in violent behavior only when one does not control for the factors that increase the likelihood of violence for *anyone*. (“[A] study of over 34,000 persons in the United States (including controls, who were not mentally ill), [found] that severe mental illness alone did not predict future violence; [violence] was associated instead with historical (past violence, juvenile detention, physical abuse, parental arrest record), clinical (substance abuse, perceived threats), dispositional (age, sex, income), and contextual (recent divorce, unemployment, victimization) factors. In other words, the same factors that are associated with greater violence in the general population.”). *Id.* at 14-15.

⁸⁰ SLATE, ET AL., *supra* note 11, at 77.

⁸¹ *Id.* (“[Mentally ill persons are] 8 times more likely to be robbed, 15 times more likely to be victims of assault, 23 times more likely to be victims of rape, and 140 times more likely to have property stolen from their person.”).

⁸² *Id.*

⁸³ Hensel & Jones, *supra* note 67, at 54-56. The fact that people with mental illness, though they suffer from a chronic illness, normally experience times of relative lucidity that contrast with periods where their symptoms are severe and extremely visible likely contributes to this perception. *Id.*

between academic achievement and creative or mechanical aptitudes and serious mental illnesses such as bipolar disorder and schizophrenia.⁸⁴

The idea that the mentally ill are mere malingerers seeking to avoid responsibility is clearly a product of either a lack of information or willful ignorance.⁸⁵ The stigma attached to mental illness and the nature of treatment for mental illness—truthfully, just some of the side effects of commonly prescribed psychotropic medication—should be more than enough to

⁸⁴ Matthew Mientka, *Why Smarter People Are More Likely To Be Mentally Ill*, MED. DAILY (Feb. 24, 2014), <http://www.medicaldaily.com/why-smarter-people-are-more-likely-be-mentally-ill-270039> (noting the correlation between academic achievement and bipolar disorder); Nicholas Peditakis, MD, *The Association Between Major Mental Disorders and Geniuses*, PSYCHIATRIC TIMES (Sept. 25, 2014), <http://www.psychiatrictimes.com/major-depressive-disorder/association-between-major-mental-disorders-and-geniuses> (“The absence or deficiency of the social algorithms in brain function frees enormous power in the brains of these temperamentally lopsided individuals. This power then becomes available for creative processes in the right individual. Creative persons are now able to think in alternatives, and conciliate and synthesize patterns to come up with novel solutions to seemingly intractable problems and/or create stirring works of art that emotionally mobilize us to narratives of human predicaments. Moreover, creative geniuses envision new and comprehensively applicable paradigms of nature’s workings. They bypass our evolutionary limits of comprehension and invent ways to access the mathematical arrangement of nature, thereby conceiving, for example, quantum mechanics.”).

⁸⁵ Similarly, people may be inclined to blame the mentally ill for their illness; in addition to being completely unreasonable (would it be appropriate to blame people with another chronic illness, like multiple sclerosis, for their condition?), this type of thinking tends to correlate with the idea that people with mental illness are somehow deserving of punishment for the “moral failing” of having such an illness. SLATE, ET AL., *supra* note 11, at 53. While some persons undoubtedly mangle, there are an array of methods that can be employed to detect such malingering, which range from the simple and relatively inexpensive (particular methods of questioning) to the scientifically sophisticated (brain scans). See M. Nicholas Coppola, et al., *Medical Malingering and Disability*, in MALINGERING, LIES, AND JUNK SCIENCE IN THE COURTROOM 35, 50-56 (Jack Kitaeff ed., 2007) (note that the piece fails to discuss the rates of “false positives” for malingering using many of these methods). Furthermore, there are certain attributes that a defendant may have that militate for or against a conclusion of malingering; for example, mental illness among men typically manifests sometime between a man’s early teens to early twenties—a forty-year-old man with no prior history indicating mental illness may be a more likely malingerer than a nineteen-year-old who has no such prior history. See generally Ronald C. Kessler, et al., *Age of Onset of Mental Disorders*, 20 CURRENT OPINIONS PSYCHIATRY 359 (2007) (noting that the age of onset for most psychotic disorders (i.e., serious mental illnesses) is between 14 and 27, with most being between 15 and 17). Similarly the nature of the offense, family history of mental illness, and a number of other factors might suggest that some investigation into malingering is either merited or would be a waste of time and money. The decision whether to investigate claims of mental illness for malingering should be a matter of prosecutorial discretion in cases where the offender has no prior diagnosis. Furthermore, incredibly few malingerers actually have any success in perpetuating their ruse. FRADELLA, *supra* note 23, at 16-17 (“There is also much public concern about defendants who fake their mental illnesses in order to escape a conviction and who simply hire clinicians to engage in an expert battle with the prosecution at trial. While these cases make for good media play, they are the rare exception and not the rule. In fact, there is overwhelming agreement on a clinical diagnosis between clinicians on both sides of the criminal dispute. One study put the clinician agreement rate at 88%; another at 92%. Moreover, the media and Hollywood exacerbate the fears of a defendant feigning mental illness to avoid criminal punishment. However, such fears are ill-founded. In practice, modern diagnostic instruments and procedures allow clinicians to distinguish correctly those who are truly mentally ill and those who are faking between 92% and 95% of the time. Thus, when defendants fake mental illness, it is extraordinarily difficult for them to ‘get away with’ it.”) (citations omitted).

dissuade a would-be malingerer from maintaining a pretense of mental illness. Milder side effects of commonly prescribed antipsychotics include: tiredness, dry mouth, sexual dysfunction, diminished metabolism, and dramatic weight gain;⁸⁶ serious side effects include such delightful experiences as akathisia (discomfort, frequent limb movements, and “non-localized pain”), dystonia (sudden and involuntary muscle contractions), parkinsonism (symptoms similar to Parkinson’s disease), tardive dyskinesia (uncontrollable muscle jerks and rocking that can affect the entire body and may become permanent) and agranulocytosis (loss of white blood cells; potentially fatal).⁸⁷ Add to these the permanent stigma associated with a diagnosis of serious mental illness, as well as the chance of being subject to involuntary civil commitment if the malingerer takes the ruse too far, and there is more than enough to convince any person of average intelligence that faking mental illness probably weighs heavier on the cost side of the scale than the benefit side.⁸⁸ This is equally, perhaps especially, true in the cases of criminals seeking to “fake” their way into an insanity plea.⁸⁹

While the facts make it abundantly clear that the stigma imposed upon the mentally ill is undeserved, the fact that it is somewhat ingrained in the public imagination makes it difficult to overcome.⁹⁰ A look at our moral obligations to our mentally ill, along with an examination of the economic costs of this stigma, may help in shedding it. Ideally, we should be able to cast it far enough aside to attempt a more humane, constructive approach to dealing with the mentally ill.

⁸⁶ SLATE, ET AL., *supra* note 11, at 89-90.

⁸⁷ *Id.*

⁸⁸ A common concern seems to be that otherwise healthy criminals will fake mental illness to get off easy; this is far more difficult than one might think. Of the approximately 1% to 5% of defendants who plea insanity, only between 7% and 13% (average of about 10%) gain the support of the mental health professionals evaluating them; Michigan defendants had the lowest rate of support at 7%. *Id.* at 354. Of those 10% who have the support of their evaluators, only 15% to 25% are actually acquitted. *Id.* Additionally, those who commit violent crimes and are acquitted by reason of insanity are confined to mental health institutions—which are not necessarily any less unpleasant than prison, and where they will have a chance to enjoy all of the wonderful side effects of their psychotropic medications—for years longer than they would have been in prison; depending upon the jurisdiction, they may spend *twice* as long confined than they otherwise would have. FRADELLA, *supra* note 23, at 43.

⁸⁹ See *supra* note 88.

⁹⁰ See *supra* notes 72-73 and accompanying text.

II. THE MORAL COSTS OF THE CRIMINALIZATION OF MENTAL ILLNESS

A hallmark of a free society is a fair and just criminal justice system.⁹¹ A criminal justice system in a free society must serve the needs of every member of a society in a fair, just and impartial manner.⁹² This is especially true of those most vulnerable to abuses within that system: society's least powerful members.⁹³ Since the mentally ill—who are frequently among the poorest in society—are among those whose “liberty, dignity, and bodily integrity” are most susceptible to infringement without due consideration, special attention to the treatment of the mentally ill by the criminal justice system is well warranted.⁹⁴ The failure of the criminal justice system to punish only those persons whose punishment is morally justifiable and to protect those vulnerable to harm results in a loss of moral credibility for law enforcement and the courts.⁹⁵ This loss of credibility results in lack of respect for the law and the mechanisms by which it is enforced; the failure to appropriately enforce even inarguably just laws will result in a perception of illegitimacy with regard to the criminal justice system, which itself undermines the efforts to compel compliance with the law across the board.⁹⁶ Thus, to have any chance of effectiveness in protecting and serving the public, law enforcement and the courts must have moral justification—in addition to legal justification—for targeting and punishing a person. Section A will examine common theories upon which criminal punishment is morally justified, and will endeavor to demonstrate why none of them is appropriate when applied to mentally ill offenders.

⁹¹ Robert F. Schopp, *Verdicts of Conscience: Nullification and Necessity As Jury Responses to Crimes of Conscience*, 69 S. CAL. L. REV. 2039, 2059-61 (1996) (discussing how deception in the criminal justice system undermines the criminal justice system's “embodiment of public morality” and how such a decline itself undermines the place of every individual in a free society).

⁹² Sharon Dolovich, *State Punishment and Private Prisons*, 55 DUKE L.J. 437, 463-65 (2005).

⁹³ *Id.*

⁹⁴ *Id.* at 465.

⁹⁵ Jeffrey Fagan, *Legitimacy and Criminal Justice*, 6 Ohio St. J. Crim. L. 123, 129-131 (2008).

⁹⁶ *Id.* at 126.

Section B will address the more general moral obligation of a society to aid those who cannot care for themselves.

A. Morality and Theories of Punishment

As a preliminary measure, it is important to distinguish between moral and legal justifications for punishment. A legal justification for punishment is relatively straightforward: if it can be proven before a fair and impartial tribunal that a person has violated some law, then it is legally justifiable to subject them to whatever sanction is set forth in that law. Put differently, the mere fact that someone has committed a crime is a justification for punishing them, but it is not a moral justification, only a legal justification. Simple moral umbrage at person's failure to follow codified rules is not enough to offer a moral justification; there must be something more. Otherwise, the distinction collapses and we may conclude that generations of thinkers who have promulgated the various theories of punishment have just been wasting their time—each theory attempts to offer moral authority for punishing a wrong based not simply upon its illegality, but upon the substance of the act and the reason for so acting.⁹⁷ A moral justification for punishment must offer a different insight; it must provide a reason above and beyond the law itself for turning the coercive power of the state on a putative offender.

Many perceive mental illness as a character trait that requires the intervention of some controlling authority and as a handicap that can only be corrected with a strong hand. While these perceptions are grounded in some measure of truth in certain cases—for example, a person who, despite its effectiveness, consistently refuses treatment to their own detriment⁹⁸ and as a

⁹⁷ Perhaps a more fundamental question is whether the existence or scope of a particular law is itself is morally justifiable, but that question is beyond the scope of this paper.

⁹⁸ As discussed *supra* Section I.C, there are a number of side effects that might motivate people to discontinue certain medications without the recommendation of their doctor, no matter how effective they may be. Somewhere between 40% and 90% of those with mental illness also experience anosognosia. SLATE, ET AL., *supra* note 11, at 89. Anosognosia may be simply defined as a failure to possess any insight into one's own illness and a nigh-unto unshakeable corresponding belief that one's behavior is neither particularly abnormal nor a product of anything

consequence regularly suffers avoidable harm—these perceptions also become the premise upon which we punish everyone with mental illness. That we perceive mental illness as anything other than an illness, and that we treat the mentally ill as “toxic waste” rather than as sick people who need aid, is somewhat incoherent as explained in Part I above.⁹⁹ However, even if we accept the faulty premise that mental illness is an ingrained character trait, then it still fails as a sound reason for punishment.

Some theorists suggest that the body of criminal law attempts to correct for inherently criminal character flaws by punishment.¹⁰⁰ However, given that we lack any means of reliably measuring character aside from the acts and, perhaps, the statements made by a particular individual, character theory essentially becomes a theory upon which we measure a person’s inherent goodness or badness based upon an examination of some small sample of that person’s actions, often viewed in isolation, and punish them accordingly, which leads to dubious results.¹⁰¹ In any context, using a person’s character traits as a justification for punishing them runs afoul of both the notion that persons enjoy some measure of inherent equality between one another and of American jurisprudence regarding the punishment of a person based upon his or her “status” rather than upon his or her actions alone.¹⁰² Thus, a person should suffer punishment

other than one’s own choice. *Id.* While this was long believed to be nothing more than denial, it is now believed to be associated with a particular neurological defect associated with damage in a particular part of the brain. *Id.* “As such, anosognosia is a *symptom* of mental illness. Indeed, what a cruel disease. Mental illness affects the very part of our bodies that enables us to recognize that we have an illness—our brains.” *Id.* (emphasis in original).

⁹⁹ See discussion *supra* Part I.

¹⁰⁰ Ekow N. Yankah, *Good Guys and Bad Guys: Punishing Character, Equality and the Irrelevance of Moral Character to Criminal Punishment*, 25 CARDOZO L. REV. 1019, 1037-40 (2004)

¹⁰¹ *Id.* at 1036-37, 1051-52.

¹⁰² *Id.* at 1053-59. “The focus of punishment in this paradigm is to sanction the actor for having autonomously committed a wrong . . . [t]he Court’s analysis clearly indicates that the prohibition on punishing for status cannot be located in the voluntariness of the status. Rather, the prohibition on punishing status is exactly conceptualized by the Court as grounded in the need for an act that justifies the state’s political power . . . [m]erely being a bad person is not enough to invite punishment. Nor is the general goal of social or moral education. Though punishment may be for an act that evidences poor character or flawed moral reasoning, state power is not premised on that character or flawed reasoning. The state needs a greater justification for imposing punishment.” *Id.* at 1054, 1056-57.

solely because of the nature of his or her autonomous¹⁰³ actions and never because of some inherent character trait; to do otherwise would be to undermine whatever moral authority that the court may have in meting out punishment.¹⁰⁴

Any morally sound theory of punishment must be premised upon the voluntary, autonomous actions of an offender. The traditional theories of punishment, for the most part, recognize this distinction. The only one that arguably fails to—retributivism—permits punishment based upon the moral desert of the offender; that is, because the offender did something morally wrong, they possess some measure of bad character and are thus deserving of punishment on those grounds.¹⁰⁵ However, “[b]ecause punishment is reserved for those who choose to violate the law, individuals without free will—infants, the mentally ill, and so on—are not subject to sanctioning” under a retributivist theory of punishment anyway.¹⁰⁶

The remaining traditional theories of punishment are generally referred to as the consequentialist or utilitarian theories of punishment: deterrence, rehabilitation, and incapacitation.¹⁰⁷ Deterrence targets the rationality of individual potential offenders and of the general pool of potential offenders by imposing sanctions for criminal conduct that tips the cost-benefit analysis against criminal conduct, regardless of the gain that could be realized from a criminal act.¹⁰⁸ Since persons with mental illness are typically motivated by the symptoms of their illness to commit a particular offense and thus are not engaging in any sort of rational cost-

¹⁰³ “[P]unishing the criminal’s act embodies a respect for the criminal’s rational capacity. In Hegelian terms the punishment responds to the will. The punishment respects the criminal’s autonomy by holding him or her responsible.” *Id.* at 1060.

¹⁰⁴ *Id.* at 1053-59.

¹⁰⁵ Erik Luna, *Punishment Theory, Holism, and the Procedural Conception of Restorative Justice*, 2003 UTAH L. REV. 205, 216 (2003); Russell L. Christopher, *Deterring Retributivism: The Injustice of "Just" Punishment*, 96 NW. U. L. REV. 843, 859-60 (2002).

¹⁰⁶ Luna, *supra* note 105, at 216. While the characterization of the mentally ill as people without free will is not entirely accurate, the sentiment conveyed by the statement—that the mentally ill often lack moral agency because of the irrationality of their motives and actions—is accurate.

¹⁰⁷ *Id.* at 208-09.

¹⁰⁸ *Id.* at 209.

benefit analysis, knowledge of future punishment or witnessing examples of such punishment will have little to no deterrent effect on them.

While rehabilitation seems an appealing justification for incarcerating the mentally ill—inasmuch that they may be compelled to receive some treatment while confined—the practical realities of incarceration offer no support for this theory. Jails—if they even have some mechanism for provision of mental health service—and prisons are generally very poorly equipped to treat mentally ill inmates.¹⁰⁹ These facilities typically lack the resources to confer any lasting benefit,¹¹⁰ if any benefit at all, to the mentally ill inmate insofar as his or her rehabilitation is concerned.¹¹¹ The goals of treatment are not to enable the mentally ill inmate to reintegrate into society generally and to afford them an opportunity to live a normal, productive life outside of the prison walls; the aim is generally to merely stabilize the mentally inmate sufficiently to reintroduce him or her to the general inmate population so that they do not consume any further specialized resources.¹¹² The theory of rehabilitation has as its aim that an offender be released back into society as a law-abiding citizen, and criminal detention facilities have consistently failed to achieve this aim across the board.¹¹³ This may be because such facilities are not adapted to effectively treat the mentally ill, or it may be because the model of rehabilitation by punitive sanction followed by compulsory treatment is simply not an effective

¹⁰⁹ SLATE, ET AL., *supra* note 11, at 237, 244, 437. This is particularly disheartening when one takes into account the fact that the mentally ill constitute a considerably larger proportion of prisoners than of the general public. Jessica Burns, *A Restorative Justice Model for Mental Health Courts*, 23 S. CAL. REV. L. & SOC. JUST. 427, 433 (2014).

¹¹⁰ E.g., sufficient psychiatric staff, the resources to foot the bills for expensive psychotropic medications, the space to house mentally ill inmates away from the general population without locking them away in solitary confinement (which is arguably cruel when done to any inmate, but tends to be especially harmful when done to one suffering from mental illness).

¹¹¹ SLATE, ET AL., *supra* note 11, at 237, 244, 437.

¹¹² *Id.* at 437.

¹¹³ *Id.* at 447-49. Whether jails and prisons are in any way effective in rehabilitating *any* offenders regardless of their mental health is a question for another day; suffice it to say that it is dubious whether “correctional” facilities have any corrective effect on the behavior of offenders that reduces recidivism.

one no matter how well equipped a criminal detention facility may be. To say that rehabilitation justifies punishment of the mentally ill is to lie to them and to ourselves.

Incapacitation as a theory of punishment suggests that society benefits most by the removal of criminal offenders from its midst and placing them somewhere where they can no longer inflict themselves upon the general public.¹¹⁴ For those who maintain an irrational fear of the mentally ill, this may be justification enough; so long as the mentally ill are neither seen nor heard, everyone else realizes a benefit in terms of the added sense of safety, peace, and quiet that comes from not having to worry about what they may do.¹¹⁵ However, given that most criminal offenses committed by the mentally ill are minor and petty in nature,¹¹⁶ and that the mentally ill are themselves far more likely to be victims of crime than perpetrators, this justification for incapacitating them seems more than a bit thin.¹¹⁷ When considered in conjunction with the fact that prisons and jails are environments in which the mentally ill receive, at most, substandard treatment and where they are often unable to satisfy the expectations imposed upon them to adhere to strictly regimented rules that they may not understand, it seems that incarceration, even with the aim of incapacitation, is little more than an infliction of harm upon the mentally ill in response to their criminal conduct.¹¹⁸ In this way, it still looks a lot more like retribution, even if that is not what we intended. Bearing in mind that non-punitive civil commitment proceedings, whether inpatient or outpatient, are available as an alternative to prevent the mentally ill person from harming him or herself or possibly another, incapacitation by incarceration seems entirely

¹¹⁴ Luna, *supra* note 105, at 209.

¹¹⁵ See discussion *supra* Section I.C.

¹¹⁶ See *supra* notes 5-7 and accompanying text.

¹¹⁷ See discussion *supra* Section I.C.

¹¹⁸ See Peterka-Benton, et al., *supra* note 35, at 174.

pointless.¹¹⁹ Much like rehabilitation, incapacitation fails because as a practical matter it is a morally untenable justification for punishing the mentally ill.

In addition to the traditional theories of punishment, there is a relatively new theory which seeks to apply a more collaborative, problem-solving, victim-focused approach: restorative justice.¹²⁰ Restorative justice focuses less on what can be done to an offender and more on how an offender can make amends to a victim, by performing some act in restitution to the party harmed by their conduct, with the goal of rebuilding social bonds between victim and offender and reintegrating the offender into the community.¹²¹ This theory of punishment is related to a concept referred to as therapeutic jurisprudence, which suggests that the law should be “administered and applied in a way that incorporates therapeutic goals” by “identifying and treating the underlying causes of specific defendants' troubles, which may be drug abuse, mental illness, homelessness, or any number of other issues.”¹²² Restorative justice itself may align neatly with the normative interests of the criminal justice system in appropriately addressing the needs of mentally ill offenders. It is hardly difficult to imagine that a response from a victim of one of the most common crimes perpetrated by the mentally ill, trespass,¹²³ would be to insist that the person adhere to a course of treatment to decrease the likelihood of future trespass. Since restorative justice is focused more on mending fences and accountability than on adherence to norms regarding punitive sanctions, it lends itself readily to “punishments” that would focus on

¹¹⁹ Georgia Lee Sims, *The Criminalization of Mental Illness: How Theoretical Failures Create Real Problems in the Criminal Justice System*, 62 VAND. L. REV. 1053, 1070-72 (2009)

¹²⁰ Burns, *supra* note 109, at 446-47; Caitlin T. Harrington, *Breaking the Cycle and Stepping Out of the "Revolving Door": Why the Pre-Adjudication Model Is the Way Forward for Illinois Mental Health Courts*, 2013 U. ILL. L. REV. 319, 329-30 (2013).

¹²¹ Burns, *supra* note 109, at 446-47; Harrington, *supra* note 120, at 329-30.

¹²² Harrington, *supra* note 120, at 327-28. Therapeutic jurisprudence is not itself a theory of punishment, but rather a theory as to how the law is best applied by judges. *Id.* The thought behind this theory forms some of the basis of the proposal in Part IV.

¹²³ *See supra* note 6.

treatment rather than incarceration.¹²⁴ While the end result of applying principles of restorative justice may very well be that mentally ill offenders are diverted to treatment in lieu of being placed in criminal detention facilities, restorative justice still relies to some degree upon the rationality of the offender; the idea is that an offender is able to tie his or her restitution or service directly to the consequences of his or her actions.¹²⁵ Restorative justice is far more suitable for application to mentally ill offenders than the traditional theories of punishment, but it is not quite right, because it still justifies channeling the mentally ill through the criminal justice system rather than a system designed to treat the ill.

The failure of these theories does not mean that the mentally ill can never be processed through the criminal justice system under any circumstances; after all, if they have committed a crime, that act must be given due consideration. If a person with mental illness has been pursuing a successful course of treatment, then in all likelihood they will be in largely the same position as any other offender: that person will be aware of the nature of his or her conduct and that person will have made a choice that is approximately as rational and autonomous as anyone else.¹²⁶ However, a person who is not making any kind of rational choice that results in a violation of the law is hardly in the same position; to maintain otherwise is to try and justify moral condemnation for acts made by a person who is not morally culpable.¹²⁷ Even if a mentally ill defendant is to be

¹²⁴ See notes 52-53 and accompanying text.

¹²⁵ Harrington, *supra* note 120, at 329-30.

¹²⁶ See *supra* note 14. Furthermore, there will be circumstances where a person is mentally ill, but the evidence demonstrates that their symptoms did not drive them to engage in behavior that ran afoul of the law, or that indicates that they were in a period of lucidity. There will invariably be certain circumstances where incarceration of mentally ill persons is morally defensible, but such circumstances represent the exception rather than the rule. While there is a place for incarceration in dealing with certain mentally ill offenders, incarceration should not be used as it is now—as the primary means of addressing criminal matters involving the mentally ill. Rather, our criminal justice system should be cognizant of its own failings in that regard and perhaps demonstrate some reluctance to be the preferred forum in such matters, but instead seek to direct its efforts toward matters in which its moral authority is strongest and in which it may accomplish the most good while channeling the majority of mentally ill offenders into a system better equipped to deal with the issues that are unique to that population.

¹²⁷ Robert F. Schopp, *Mental Illness, Police Power Interventions, and the Expressive Functions of Punishment*, 39 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 99, 112 (2013) (“[B]y charging, convicting, and punishing a specific

tried for such conduct, the courts have long held in reserve an exculpatory affirmative defense for just these sorts of matters: excuse.¹²⁸ While the common law defense of excuse¹²⁹ appears to have gone out of vogue,¹³⁰ more than likely due to stigma and sensationalism,¹³¹ it exists precisely to protect the legitimacy and moral authority of courts as well as certain defendants by preventing the punishment of those who are not morally culpable for their actions. Excuse has long been recognized as a defense in precisely the circumstances that surround most crimes committed by mentally ill offenders and this means *something*; if nothing else, it should suggest to us that there has long been at least a tacit understanding that there is something very wrong

offender for a specific offense, society condemns this individual offender as a culpable wrongdoer. By convicting and punishing this person for this offense, society rejects any claim that the conduct was justified in the circumstances, and it explicitly reaffirms the expression of reprobation and resentment toward this offender as one who culpably engaged in wrongful conduct.”).

¹²⁸ Paul H. Robinson, *A System of Excuses: How Criminal Law's Excuse Defenses Do, and Don't, Work Together to Exculpate Blameless (and Only Blameless) Offenders*, 42 TEX. TECH L. REV. 259, 259-60 (2009) (“Another reason why excuses are such an interesting topic is because of what they say about criminal law's dominant purpose. Even in the heyday of general deterrence, rehabilitation, and incapacitation of the dangerous, when recognizing excuse defenses was commonly inconsistent with these distributive principles, the criminal law nonetheless always kept the doctrines of excuse. Thus, the unbroken recognition of excuse defenses stands as a testament to criminal law's steadfast commitment to desert as at least a central part of its foundational distributive principle.”).

¹²⁹ Paul H. Robinson, *Criminal Law Defenses: A Systematic Analysis*, 82 COLUM. L. REV. 199, 221, 222 (1982) (“Excuses admit that the deed may be wrong, but excuse the actor because conditions suggest that the actor is not responsible for his deed . . . Society is generally willing to excuse an actor under four types of conditions: (1) when the conduct constituting the offense is simply not the product of the actor's voluntary effort or determination (e.g., the actor is having a seizure); (2) when the conduct is the product of the actor's voluntary effort or determination, but he does not accurately perceive the physical nature or consequences of the conduct (e.g., the actor thinks the gun is a paint brush, or accurately sees the physical characteristics of the gun but does not know that the gun shoots bullets that injure people); (3) when the actor accurately perceives and understands the physical nature of the conduct, its physical results, and physical surroundings, but does not know that the conduct or its results are wrong or criminal (e.g., the actor thinks God has ordered him to sacrifice a neighbor for the good of mankind, or believes, because of paranoid delusions, that the man waiting for a bus is about to assault him); or (4) when the actor perceives the conduct accurately and fully, understands its physical consequences, and knows its wrongfulness or criminality, but the actor lacks the ability to control his conduct (e.g., because of an insane compulsion or duress) to such an extent that it is no longer proper to hold him accountable for it.”).

¹³⁰ Henry F. Fradella, *How Clark v. Arizona Imprisoned Another Schizophrenic While Signaling the Demise of Clinical Forensic Psychology in Criminal Courts*, 10 N.Y. CITY L. REV. 127, 151, 152 (2006) (“Given how the Supreme Court's decision in Clark[, a case involving a schizophrenic who was convicted of murder committed while highly symptomatic and not allowed to introduce evidence pertaining to his illness,] limited criminal defendants' ability to argue defenses of excuse, there is every reason to believe the sad trend of incarcerating mentally ill people in prisons, rather than treating them in mental hospitals, will continue to increase . . . both the language used in Clark and the underlying rationale do not bode well for the future of defenses of excuse based on mental illness. Indeed, the decision calls into question the future admissibility of, and weight to be accorded to, forensic behavioral science evidence. While that is a shame since the behavioral sciences have much to offer the law, the real tragedy concerns Eric Clark and those like him.”).

¹³¹ *Id.* at 127-28; see also discussion *supra* Section I.C.

with processing the sick through the criminal justice system. This does not mean that we deny that a crime has been committed, but it does mean that we recognize that this is not an appropriate channel through which to process such matters.¹³²

Absent the creation of some theory of punishment devised solely to justify the incarceration of the mentally ill, which in itself seems like an exercise in immorality,¹³³ it is difficult to offer a convincing justification for the continued use of the criminal justice system for the processing of the mentally ill in need of treatment. If there is no moral justification for punishing them, then the courts compromise their legitimacy by so doing.¹³⁴ It is imperative that we take measures to cease using the criminal justice system for this purposes, both to preserve the integrity of the criminal justice system and to demonstrate some humanity in the way that we treat the mentally ill.

B. Morality and Rendering Aid to Those Who Cannot Care for Themselves

At the dedication of the Hubert H. Humphrey building in 1977, Humphrey said that “[t]he moral test of government is how it treats those who are in the dawn of life, the children; those who are in the twilight of life, the aged; and those in the shadows of life, the sick, the needy and the handicapped.”¹³⁵ Truly, if the measure of a society is how it treats those who cannot care for themselves, then we should find our society to be deficient. Since the mentally ill who are left untreated and without other aid will generally find themselves homeless, hungry,

¹³² This should be something that we collectively understand and act upon, but it is a doubly important prerogative for law enforcement officers and prosecutors. *See* discussion *infra* Part IV.

¹³³ At least, it seems as much if we believe that it is immoral to devise a *sui generis* rationale for punishing a particular class of people. Since it is not hard to imagine people recoiling from a justification specifically for punishing black people, women, or people with a physical disability, it seems safe to say that most would find such a thing to be repugnant.

¹³⁴ *See supra* notes 91-96 and accompanying text.

¹³⁵ Remarks at the dedication of the Hubert H. Humphrey Building, November 1, 1977, Congressional Record, November 4, 1977, vol. 123, p. 37287

incarcerated, or dead¹³⁶ it should be apparent that they are lacking (or suffer severely diminished) capacity to care for themselves. With treatment and support, most of those same people will not only enjoy alleviation of much of their hardship, but will also enjoy the restoration of some or all of their capacity to provide for themselves.¹³⁷ Whether the matter is approached from a virtue ethics or utilitarian/consequentialist perspective, it is morally superior to provide for the treatment of the mentally ill.

Virtue ethics says that a “right action” is an action that a person could choose and that a person of perfect character would choose under the circumstances before them.¹³⁸ In this way, virtue ethics is not so much goal oriented as it is process oriented; it asks whether we are improved by pursuing an end rather than being concerned with the finer points of the outcomes of our actions.¹³⁹ If we take such an approach to evaluating how we, as a society, treat others, we must ask whether we have made the best choices possible in pursuit of a society that is emblematic of a certain virtue. While there may be some virtues whose value or rightness we disagree upon, there are certain virtues whose pursuit is probably uniformly regarded as laudable, such as honesty, good humor, or compassion. For purposes of this analysis let us assume that we, collectively, value pursuit of one such particular virtue: compassion.¹⁴⁰

¹³⁶ See discussion *supra* Section I.B.

¹³⁷ SLATE, ET AL., *supra* note 11, at 391-94.

¹³⁸ ROSALIND HURSTHOUSE, ON VIRTUE ETHICS 25, 51 (1999).

¹³⁹ *Id.* at 51; Sherman J. Clark, *Law as Communitarian Virtue Ethics*, 53 BUFF. L. REV. 757, 760 (2005)

¹⁴⁰ Virtue ethics is admittedly focused on guiding the behavior of individuals rather than of society as a whole; however, an individual who seeks to pursue a particular virtue would presumably wish to live in a society that reflects and reinforces that pursuit; the statement that a “society” is in pursuit of a particular virtue is merely the expression of the aggregate pursuit of its individual members rather than a societal command that everyone in that society pursue that virtue. See Clark, *supra* note 139, at 764 (“The fundamental difference is that in my view, virtue ethics is better suited to introspection than judgment—more useful in guiding one's own behavior than in evaluating that of others, since evaluations of others is essentially instrumental to the construction of one's own character and identity.”).

Compassion can be defined as “sympathetic consciousness of others’ distress together with a desire to alleviate it.”¹⁴¹ The mentally ill, when untreated, are typically in a state of distress that takes no particular insight to detect; those who perceive such persons will be conscious of their distress.¹⁴² So, in order to pursue compassion for them, one must conduct oneself in a fashion that demonstrates a desire to evince sympathy and with the aim of alleviating their distress. This amounts to seeing these people for what they are, a sick person in need of care,¹⁴³ and acknowledging and internalizing the distress caused by the absence of care. The natural consequence that flows from this pursuit is to take action that amounts to an earnest effort to provide the care that will alleviate the mentally ill person’s distress. If someone is a psychiatrist, then offering to treat that person without expectation of payment would demonstrate the pursuit of compassion. For a member of the general public, a simple act of kindness—like feeding such persons if they are hungry or sheltering them from the cold—would demonstrate the pursuit of compassion. The best possible choice, the one that a person of perfect compassion would make, would be to provide for their treatment and their need for food and shelter until they could do so for themselves. This is so not only because it represents the best means of alleviating their distress, but also because, once that person’s fundamental needs are met, they themselves will be in a position to pursue compassion and thus add their contribution to the collective aspiration of a compassionate society.

As with virtue ethics, utilitarianism—the paradigmatic example of consequentialism—operates from a relatively simple premise: that the best decision or action is the one that will

¹⁴¹ *Compassion*, MERRIAM-WEBSTER, <http://www.merriam-webster.com/dictionary/compassion> (last visited Apr. 14, 2015).

¹⁴² See discussion *supra* Section I.B.

¹⁴³ See discussion *supra* Sections I.B, C.

confer the greatest benefit to the largest number of people.¹⁴⁴ If an action confers some net benefit to society, that action can be morally justified by its consequences. Part III below discusses the substantial net economic benefits of diverting the mentally ill from the criminal justice system, and that alone should pass utilitarian muster since it decreases the amount of resources that we must collectively dedicate to addressing the problems associated with mental illness *and* it improves the quality of outcomes for the mentally ill themselves.¹⁴⁵ However, a more abstract view on the matter offers further justification for the decriminalization of mental illness.

A prominent modern consequentialist, John Rawls, conceives of a “good” society as one that is stable, unified, and flourishing.¹⁴⁶ Under this consequentialist theory, in order to achieve such a state of goodness, there are certain principles that must be satisfied, one of which requires that any inequalities in society that are to be allowed must make everyone better off than if they were completely equal, must be equally available, and that such inequalities benefit the worst off more than anyone else.¹⁴⁷ This idea takes into account that some inequalities are to everyone’s advantage, but requires that nobody better their situation at the expense of those who have the very least, such that any improvement should be a net improvement across the board.¹⁴⁸ Since the best society is one in which every improvement represents a net gain, the best society is one that accounts for the marginal utility of resources in deciding matters of distribution. The benefit or detriment that a person will experience in terms of happiness or ability to provide for themselves as a consequence of any change in their resources scales directly with the amount

¹⁴⁴ STANFORD ENCYCLOPEDIA OF PHILOSOPHY, *Consequentialism*, <http://plato.stanford.edu/entries/consequentialism/> (last visited Apr. 11, 2015).

¹⁴⁵ See discussion *infra* Part III.

¹⁴⁶ Bruce M. Landesman, *The Responsibilities of the Liberal State: Comprehensive vs. Political Liberalism*, 2010 UTAH L. REV. 171, 174-76 (2010)

¹⁴⁷ *Id.* at 174-75.

¹⁴⁸ STANFORD ENCYCLOPEDIA OF PHILOSOPHY, *John Rawls*, <http://plato.stanford.edu/entries/rawls/> (last visited Apr. 11, 2015).

that they already possess.¹⁴⁹ For example, if someone with \$100 to their name either gains or loses \$20, that gain or loss will have a substantially greater effect than that same gain or loss would have if they had \$200, \$1,000, or \$10,000. While the objective value of that \$20 does not change, the marginal value of that \$20 to the individual changes depending upon what they have at any given time.

What this means is that a society that is good is one that recognizes this difference and acts accordingly by sanctioning distributive schemes that maximize net utility across the board. If someone is sick, homeless, and hungry, a good society sees an opportunity to improve itself by providing treatment, housing, and food if the cost of doing so has a smaller marginal detriment (or generates a net societal benefit) as opposed to allowing the person to continue to suffer. Given the enormous wealth of our society, the costs in terms of happiness and ability to provide for one's needs that would be imposed by transferring small amounts of resources from those who have the most to such a person that has nearly nothing represents a distribution that offers a substantial net benefit to society. The sick, homeless, and hungry person's happiness and ability to care for themselves is drastically improved by the provision, even temporarily, of services to meet those needs and the net cost in happiness and resources (from the perspective of marginal utility) is spread out so that the aggregate detriment is negligible and the detriment to each individual is even smaller.¹⁵⁰ Thus, if we believe that a good society is one that maximizes the utility extracted from its available resources, then we should act to care for those who cannot care for themselves.

III. THE ECONOMIC COSTS OF THE CRIMINALIZATION OF MENTAL ILLNESS

¹⁴⁹ Donna M. Byrne, *Progressive Taxation Revisited*, 37 ARIZ. L. REV. 739, 767 (1995)

¹⁵⁰ This considers only the costs and benefits of alleviating the suffering of others. If a person receives treatment and temporary assistance they may then become capable of supporting themselves. This additional benefit represents the value to society of treating the mentally ill in terms of an investment in future productivity.

While the moral justifications for channeling the mentally ill away from the criminal justice system should stand on their own as sufficient to justify the ends, there will invariably be some who perceive such actions as being somehow soft on crime or morally unjustifiable because they do not believe that it would be fair to victims.¹⁵¹ A more cynical person might suggest that it is not politically expedient to stand up for the rights of the mentally ill when there are plenty of voting members of the general public who are still captive to the irrational stigma associated with mental illness.¹⁵² To those who would take such a position, the substantial cost savings to the public as a whole and to the criminal justice system and families affected by mental illness should provide sufficient justification on its own.

A. The Costs of Incarceration Versus the Costs of Community Treatment

As noted in the Introduction, the costs of incarcerating any one person for a year are quite substantial, with costs per state ranging from a low \$14,603 in Kentucky to \$60,076 in New York.¹⁵³ The average cost per inmate is \$32,142;¹⁵⁴ enough to provide for a family of 4 at 133% of the federal poverty guidelines.¹⁵⁵ These figures are for inmates generally; the cost of incarcerating a person with mental illness is substantially greater—up to 75% more per person.¹⁵⁶ That would translate to an average cost of \$56,248.50 per mentally ill inmate. In addition to the higher cost per-inmate per-year, mentally ill persons who are incarcerated tend to be incarcerated longer, both because they tend to receive longer sentences and because they tend to “act out” as a

¹⁵¹ See *contra* Burns, *supra* note 109, at 430-37 (arguing that mentally ill offenders are as much victims as those who are harmed by their offenses because they have been continuously set up, almost directed, to fail).

¹⁵² See discussion *supra* Section I.C.

¹⁵³ NAT'L INST. CORR., *Corrections Statistics by State*, <http://nicic.gov/statestats/> (last visited Apr. 8, 2015) (cost figures from 2012).

¹⁵⁴ *Id.* It is important to note that these figures combine the costs for inmates in jails and inmates in prison.

¹⁵⁵ Annual Update of the HHS Poverty Guidelines, 80 Fed. Reg. 3236 (January 22, 2015) available at <https://www.federalregister.gov/articles/2015/01/22/2015-01120/annual-update-of-the-hhs-poverty-guidelines>.

¹⁵⁶ *The Mentally Ill Offender Treatment and Crime Reduction Act of 2003: Hearing Before the Comm. On the Judiciary*, 108th Cong. 1, 59-60 (2003) (testimony of Reginald A. Wilkinson, President, Association of State Correctional Administrators).

consequence of their illness.¹⁵⁷ Thus, not only does it cost more per person each year to incarcerate a mentally ill offender, but those higher costs are sustained for longer periods. In addition to the direct costs of incarcerating and failing to adequately treat the mentally ill, there are considerable indirect costs in the form of lost productivity of both mentally ill persons and those close to them that provide care, which are estimated to be somewhere in the neighborhood of \$79 billion for the entire U.S. population in a given year.¹⁵⁸

These figures do not compare favorably with the costs associated with community mental health treatment. In terms of per-person costs, effective community mental health treatment costs a fraction of incarceration; various estimates place the cost at about 1/2 to 1/3 the cost of incarceration, all the way down to less than 1/10 the cost of incarceration.¹⁵⁹ Routine outpatient treatment can cost as little as \$10 per person, per day.¹⁶⁰ Even inpatient treatment, which is uniformly more costly than outpatient community treatment, offers significant savings to the public fisc over incarceration.¹⁶¹ In addition, treatment reduces the likelihood that a person will be incarcerated in the future: coordination of release from a criminal detention facility with the provision of services including community mental health services can reduce recidivism rates dramatically. Maryland reduced the recidivism rate among mentally ill offenders from an 80%

¹⁵⁷ Pustilnik, *supra* note 19, at 234; SLATE, ET AL., *supra* note 11, at 235-36. This “acting out” often comes in the form of suicide attempts; suicide rates among prison inmates are substantially higher among mentally ill inmates, and mentally ill inmates are more likely to “succeed” in killing themselves. SLATE, ET AL., *supra* note 11, at 424. They are also more likely to engage in self-injurious behavior. *Id.* at 425-26. While data about jail inmates is spotty, the evidence suggests that suicide in jails correlates with both substance abuse and with “single-cell occupancy” (i.e., solitary confinement, which is commonly used to segregate the mentally ill from the general jail population). *Id.* at 251. The increased likelihood of self-harm in prisons not only underscores the cruelty of criminalizing the mentally ill, but undoubtedly plays no small role in the cost differential by contributing even more to medical costs.

¹⁵⁸ Pustilnik, *supra* note 19, at 235. *See also* Szabo, *supra* note 19 (“Although some may believe mental illness doesn’t affect them, Insel notes that it costs the country at least \$444 billion a year. Only about one-third of that total goes to medical care, Insel says. The bulk of the cost to society stems from disability payments and lost productivity. That total doesn’t include caregivers’ lost earnings or the tax dollars spent to build prisons. These losses are especially tragic, Insel says, because of growing evidence that early intervention can prevent mentally ill people from deteriorating, halting what once seemed like an inevitable decline.”).

¹⁵⁹ CLOUD & DAVIS, *supra* note 19, at 2-3.

¹⁶⁰ Soucheray, *supra* note 19.

¹⁶¹ *Id.*

re-arrest rate within a year down to 4% simply by coordinating mental health services and housing for mentally ill prisoners upon release.¹⁶² Not only does it cost less in immediate terms to provide mental health services in lieu of incarceration, but it reduces the likelihood of incarceration generally. Furthermore, it stands to reason that treatment will diminish indirect costs in terms of lost productivity by enabling at least some mentally ill people to work¹⁶³ and by decreasing the amount of time spent by families caring for their sick siblings, children, or parents.

On a related note, we already know that the availability of community mental health treatment also reduces the number of emergency room visits by the mentally ill.¹⁶⁴ Texas, one of the states to recently engage in fairly comprehensive criminal justice reform,¹⁶⁵ including the implementation of community mental health treatment, estimates the cost of incarceration at \$137 per day, the cost of an emergency room visit at \$986 per visit, and the cost of community mental health at about \$13 per day.¹⁶⁶ Each emergency room visit costs more than two months of community care; the numbers speak for themselves.

B. A Look at the Benefits of Decriminalization of Mental Illness to Michigan

The State of Michigan's spending per inmate is a little below the national average at \$28,117.¹⁶⁷ Michigan does not have an especially high incarceration rate, though it is somewhat above average; at 441 per 100,000 people, it ranked 19th in the nation for 2013.¹⁶⁸ However,

¹⁶² SLATE, ET AL., *supra* note 11, at 464-66.

¹⁶³ *Id.* at 391-94.

¹⁶⁴ *See supra* notes 57-58 and accompanying text.

¹⁶⁵ Tierney Sneed, *What Texas Is Teaching the Country About Mass Incarceration*, U.S. NEWS & WORLD REPORT (Nov. 19, 2014), <http://www.usnews.com/news/articles/2014/11/19/texas-georgia-mississippi-set-conservative-example-for-criminal-justice-reform>.

¹⁶⁶ HEALTH MANAGEMENT ASSOCIATES, *IMPACT OF PROPOSED BUDGET CUTS TO COMMUNITY-BASED MENTAL HEALTH SERVICES* 3 (2011).

¹⁶⁷ NAT'L INST. CORR, *supra* note 153.

¹⁶⁸ *Id.*

Michigan spends a portion of its budget on corrections that is outrageously high relative to most other states.

Between 2012 and 2014, Michigan spent between 4.4% and 4.6% of all expenditures on corrections; only California spent a consistently higher proportion of its funds on corrections.¹⁶⁹ This amounted to an average of about \$2,226,000,000 each year.¹⁷⁰ Corrections made up 21.3% to 23.6% of all general fund expenditures during that time; this is far and away the highest, with Arizona and Oregon being the closest behind at 10.9% to 11.4% and 11.2 to 13.5% respectively.¹⁷¹ Michigan spends more on corrections than either of its more populous regional neighbors, Ohio and Illinois, by a considerable margin;¹⁷² this is true despite the fact that Michigan's incarceration rate and per-inmate cost is comparable to Ohio's and its per-inmate costs are substantially lower than Illinois'.¹⁷³ Michigan's high rate of expenditure is not related to capital outlay for new construction or maintenance,¹⁷⁴ and though it is difficult to locate accurate itemized figures, the consensus seems to be that the unusually high costs stem from two factors: personnel costs and *medical care of inmates*.¹⁷⁵ If any state could benefit from a reduction in its jail population, particularly a reduction of the inmates that are most expensive to maintain, that state is Michigan.

By diverting the mentally ill to community mental health services instead of incarcerating them, and by utilizing a well-crafted model of community mental health treatment and sound

¹⁶⁹ NAT'L ASS'N STATE BUDGET OFFICERS, STATE EXPENDITURE REPORT: EXAMINING FISCAL 2012-2014 STATE SPENDING 57 (2014).

¹⁷⁰ *Id.* at 56.

¹⁷¹ *Id.* at 58. Furthermore, there has been both a decrease in federal corrections funding and an increase in Michigan's corrections spending during this same period. *Id.* at 60.

¹⁷² *Id.* at 56.

¹⁷³ NAT'L INST. CORR, *supra* note 153.

¹⁷⁴ U.S. DEP'T JUSTICE, State Corrections Expenditures, FY 1982-2010 12 (2014) available at <http://www.bjs.gov/content/pub/pdf/scefy8210.pdf>.

¹⁷⁵ Paul Egan, *Michigan Corrections Costs Remain High Despite Drop in Inmates, Staffing*, DETROIT FREE PRESS, February 14, 2013, available at <http://archive.freep.com/article/20130214/NEWS15/302140134/Michigan-corrections-costs-remain-high-despite-drop-in-inmates-staffing>.

diversionary tactics, Michigan could see its corrections costs plummet. If 16%¹⁷⁶ of Michigan's inmate population (61,923)¹⁷⁷ is seriously mentally ill, and if that was reduced by half, that would mean a savings of at least \$139,291,618, and that is assuming that each mentally ill prisoner costs the same as the average prisoner.¹⁷⁸ Such a policy correcting the mistreatment of the mentally ill is not only morally sound for Michigan, it is economically sound.

IV. EFFECTING THE CHANGE – SEQUENTIAL INTERCEPT, ALTERNATIVE ADJUDICATION, AND COMMUNITY MENTAL HEALTH

In order to successfully correct for decades of funneling the mentally ill into criminal detention facilities, fairly comprehensive reforms will be necessary. The community mental health system that should have been set up prior to deinstitutionalization needs to be assembled incorporating the lessons of the past several decades.¹⁷⁹ Many states and counties have begun to implement mental health courts¹⁸⁰ and training on interactions with the mentally ill for police officers,¹⁸¹ and have begun to channel more resources into community mental health initiatives.¹⁸² While these efforts are laudable, a more coordinated approach that is specifically geared toward giving the mentally ill the best possible chance of avoiding being caught up in a criminal justice system that cannot adequately handle them requires something more. This section proposes the use of the sequential intercept model in conjunction with substantial police training and with the use of mental health courts modeled after Indian tribal peacemaking courts and sentencing circles as a means of providing the best opportunities to the mentally ill.

¹⁷⁶ See note 55 *supra*.

¹⁷⁷ NAT'L INST. CORR., *supra* note 153.

¹⁷⁸ If Michigan's mentally ill inmates do cost 75% more than their non-mentally-ill counterparts, then this figure would be something more like \$243,760,332. See note 156 *supra* and accompanying text.

¹⁷⁹ See *supra* notes 49-55 and accompanying text.

¹⁸⁰ Burns, *supra* note 109, at 438-39.

¹⁸¹ SLATE, ET AL., *supra* note 11, at 185-95.

¹⁸² SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMINISTRATION, THE N-MHSS REPORT 2 (2014).

The sequential intercept model is beautifully simple: it identifies five stages at which law enforcement, the courts, and (if necessary) corrections personnel should coordinate with community mental health services to intercept mentally ill persons to prevent their unnecessary incarceration or, if they are incarcerated, to prevent any future incarceration.¹⁸³ The stages at which interception should occur are: prior to arrest, after arrest but before adjudication, after adjudication and sentencing, upon release from detention, and once the person has returned to the community.¹⁸⁴ While each stage offers opportunity to divert a mentally ill person into treatment and away from incarceration, the greatest benefit to the mentally person, and the least costly to the taxpayer, is to divert that person prior to trial, whether prior to arrest or sometime shortly thereafter.¹⁸⁵ In order to effect this optimal outcome, police departments will have to train their officers in effectively dealing with the mentally ill.

While the best option would be to train every member of a police force comprehensively on the best practices of dealing with the mentally ill, a less costly alternative that would be easier to implement involves two tiers of training: a baseline skills course for all officers in best practices in recognizing the signs of mental illness and applying communication skills tailored to dealing with the mentally ill, and an advanced crisis intervention program to offer specialized training to a smaller group of officers that can be deployed to address more sensitive situations.¹⁸⁶ For many officers, identifying the signs of mental illness in persons who appear at first to simply be noncompliant and aggressive, and possessing the skills to defuse those situations, will suffice.¹⁸⁷ This will allow them to effectively intercept the mentally ill person

¹⁸³ Munetz & Teller, *supra* note 55, at 942-43.

¹⁸⁴ *Id.* at 943.

¹⁸⁵ Kasey Mahoney, *Addressing Criminalization of the Mentally Ill: The Importance of Jail Diversion and Stigma Reduction*, 17 MICH. ST. U. J. MED. & L. 327, 339 (2013) (noting that pretrial release costs around \$3 per day, whereas incarceration costs more than 30 times that amount).

¹⁸⁶ SLATE, ET AL., *supra* note 11, at 186-191.

¹⁸⁷ *Id.* at 186-187, 190.

prior to arresting them (provided they do not pose any immediate danger) and to help that person find the assistance that they clearly require. In situations where there is obvious and imminent danger, the specialized crisis intervention teams can prevent harm to persons or property, and if necessary can arrest, detain, and stabilize the mentally ill person while locating the appropriate resource, and then take that person to it.¹⁸⁸ Since this option routes the mentally ill person to the treatment that they need at the earliest opportunity, and costs the least, this is the most desirable stage at which to intercept such a person. For those who are familiar to police due to frequent interactions with law enforcement, this will provide an alternative that allows for more efficient and compassionate handling of the matter that cuts out the “middle man” that is the court.

The second-best stage at which to execute an intercept would be post-arrest, but pre-adjudication. The person best able to perform this intercept is the person responsible for deciding whether to charge the person with a crime: the prosecutor. The prosecutor, like the police officer, will need adequate training on what to look for in a candidate for diversion to an alternative mental health tribunal: whether that person has been diagnosed with a mental illness; what type of behavior landed the person in police custody; whether the person has been able to avail him or herself of any treatment and if so when, by whom, and if the person is currently following a treatment plan; how the person has behaved while in custody, etc. The prosecutor can evaluate the options and make a decision that confers the greatest benefit to the courts, the offender, and the victim. While prosecutorial diversion is not optimal in that it still incurs costs that are perhaps unnecessary and may further delay treatment for someone who needs it, it does afford an opportunity for those skeptical of an offender’s status to observe and deliberate regarding the best course of action.

¹⁸⁸ *Id.* at 191-204; Munetz & Teller, *supra* note 55, at 943-44.

The diversion to mental health resources at the earliest possible time is critically necessary, but more important is what happens following diversion. The sequential intercept model only works if there is a capable entity that can manage the mentally ill persons that are channeled to it, that is staffed with people whose skills reflect the needs of those it serves, and who have backgrounds that reflect the world in which the mentally ill person lives. While mental health courts attempt this, and while the environment is a far cry from a traditional court and one that is far better suited to addressing mentally ill offenders,¹⁸⁹ it still involves a judge—someone unlikely to understand the position that the offender finds him or herself in—presiding over that person. A look at the model presented by sentencing circles, a traditional practice common to many American Indian tribes and Canadian First Nations,¹⁹⁰ as well as Navajo peacemaking courts, offers insight on how to construct an alternative model for adjudication of these cases.

Sentencing circles, though they certainly predate by centuries the concepts of restorative justice and therapeutic jurisprudence, employ methods that strongly resemble those concepts.¹⁹¹ Sentencing circles “are composed of respected individuals from the offender's community, who guide conversation among the victim, offender, and family and community members from both sides.”¹⁹² Each person is allowed to speak freely in turn, which should allow for a broad perspective on the matter at hand.¹⁹³ These conversations focus on how best to achieve a just outcome, and require consensus to take action.¹⁹⁴ While the goals of sentencing circles are rehabilitative rather than punitive, they are not lenient; the sentence must fit the crime.¹⁹⁵

¹⁸⁹ SLATE, ET AL., *supra* note 11, at 391-94.

¹⁹⁰ Megan Lynn Johnson, *Coming Full Circle: The Use of Sentencing Circles As Federal Statutory Sentencing Reform for Native American Offenders*, 29 T. Jefferson L. Rev. 265, 275-76 (2007)

¹⁹¹ *Id.*

¹⁹² *Id.* at 276.

¹⁹³ *Id.*

¹⁹⁴ *Id.*

¹⁹⁵ *Id.* at 276, 285.

Similarly, Navajo peacemaking courts take a “practical approach to rehabilitation, treatment, and preventing a violent act from reoccurring.”¹⁹⁶ These courts are concerned with recognizing and removing barriers to a successful life.¹⁹⁷ To that end, peacemaking courts, much like sentencing circles, take commentary from all parties involved as a group, and each is allowed to express candidly what is on his or her mind before a designated peacemaker.¹⁹⁸ The peacemaker is a member of the community selected because that person is respected for his or her wisdom, leadership, and thoughtfulness.¹⁹⁹ The peacemakers are not prosecutors or even people that necessarily have any formal legal education, they are not distanced socially from either the victim or the offender, and they are brought in because they are suited both to teaching from experience and acting as an arbiter.²⁰⁰

Both these models have worked in their communities because the approach that they take is both constructive and familiar to the communities in which they operate; they are tailored to the people that they serve.²⁰¹ Similarly, a tribunal to adjudicate offenses by mentally ill persons should be one that is grounded in the community that it serves, takes a collaborative and rehabilitative approach, does not deal leniently,²⁰² and is made up of persons qualified to deal with these matters. The goal is to take the community engagement aspects of those models and apply to them to the unique circumstances faced by the mentally ill—to involve members of their “mental health community” to create a forum that takes an integrated, holistic approach by

¹⁹⁶ Hon. Robert Yazzie, *Navajo Peacekeeping: Technology and Traditional Indian Law*, 10 ST. THOMAS L. REV. 95, 98-100 (1997)

¹⁹⁷ *Id.* at 99.

¹⁹⁸ *Id.*

¹⁹⁹ *Id.*

²⁰⁰ *Id.* at 99-100.

²⁰¹ The description above of sentencing circles and peacemaking courts is not comprehensive by any means; there are significant cultural elements unique to the individual communities where they are employed that play an important role in their operation. The description above is intended to demonstrate reasons that such approaches work that can be universalized to apply to circumstances such as these.

²⁰² This does not mean in terms of “punishment,” but rather in terms of taking an aggressive approach in establishing a plan for treatment and reintegration into the community, and being diligent in assuring the participant’s compliance.

including those who have personal attachments to that person and those who have dedicated their careers to engaging with the mentally ill with the aim of alleviating their illnesses and the attendant problems caused thereby.²⁰³ Such tribunals should not be adversarial; they are not criminal courts and they should not require the involvement of prosecutors or other parts of the criminal justice apparatus. For those who are diverted at stage two or later, the case should be removed entirely from the criminal docket and the proceeding dismissed, or at least, if it remains on the docket, the proceeding should be stayed pending dismissal, depending upon the level of oversight the court desires.²⁰⁴ This has the incidental benefit of preserving prosecutorial resources so that prosecutors may better focus on crimes that are more deserving of their attention.²⁰⁵ There may need to be some trial and error in deciding what the optimal composition of such a tribunal should be, but such a tribunal might operate as follows.

Prior to standing before a tribunal, a mentally ill offender should be stabilized so that they can participate meaningfully in the process.²⁰⁶ A panel of perhaps five people, each fulfilling a different role, and each engaged in issues impacting the mentally ill in the community outside of the tribunal, should preside over the matter. One person should be someone who is a judge or

²⁰³ The reasoning here is that this will have the same power as engaging the community more generally does in the peacemaking and sentencing circle models. However, given the stigma attached to mental illness, the “community” that is best suited to observe and participate are those closest to the “barrier” to the offender’s attainment of a successful life: their illness. It would make little sense to have a neighbor who sees the offender only as a frightening manifestation illness participate, whereas the participation of objective professionals who see the illness for what it is—a persistent though surmountable barrier—who by their immersion in the lives of those who suffer from such illnesses make up a community of which the offender is a member in a much more meaningful way. *See VOICES OF EXPERIENCE: NARRATIVES OF MENTAL HEALTH SURVIVORS 2-5* (Thurstine Basset & Theo Stickley, eds. 2010).

²⁰⁴ Ideally, such oversight will be phased out entirely if the tribunals prove to be a more effective alternative. The author understands that this will likely be a “tough sell,” but the tribunals should remain as separate as practicable from the criminal justice system.

²⁰⁵ This is not to say that prosecutors or criminal courts should be isolated entirely from the process; since they are accountable to the public that they serve, they must be kept apprised of the affairs of such a tribunal and prosecutors must be given the opportunity to intervene if necessary. At the very least, each tribunal should be required to compile data and render reports to the criminal courts from whence offenders were diverted, and perhaps to the police precincts that channel offenders there.

²⁰⁶ There must be a measure of lucidity on the part of the offender in order for this process to have its intended effect, and in order to attain that lucidity, the offender must receive sufficient treatment and some education regarding the process in which they are involved and why. *See SLATE, ET AL., supra* note 11, at 321-22.

magistrate and who has had experience dealing with the mentally ill, to ensure that the process is fair and so that the tribunal has the power to issue binding orders when necessary.²⁰⁷ Another might be a psychiatrist or psychologist, one who would have clinical insight into the medical obstacles faced by the offender. Another should be a substance abuse counselor, since substance abuse is prevalent among the mentally ill and aggravates symptoms and correlates with criminal behavior.²⁰⁸ One might be a social worker who could identify services that may be necessary in addition to treatment; for example, Medicaid coverage so that the person will be able to sustain a prescribed treatment regimen²⁰⁹ or housing assistance, which has been associated with greatly improved outcomes when used in conjunction with community mental health treatment.²¹⁰ Another might be a rotating seat, wherein sits a prior “graduate” of the tribunal who is close enough to such circumstances to offer insight. Lastly, if there is a victim,²¹¹ the victim should be included, but only if they so desire. The families of the victim and offender should be encouraged to attend as well. A group so composed is one that is setup to engage as many of the factors influencing the offender’s behavior is possible, and to solidify a plan to address whatever caused the criminal conduct. The offender will, for once, not be held at the margins, and the

²⁰⁷ It is important that the tribunal have some authority to issue orders, as they are sometimes necessary to compel insurers and medical care providers to act. *Id.* at 387-88.

²⁰⁸ See notes 5, 6, 76, 79, 82, 157 *supra* and accompanying text.

²⁰⁹ Many with mental illness want very badly to adhere to a treatment regimen, whether to care for themselves or for their families; however, even with a course of treatment to follow and a desire to do so, they may be unable to make the choice to do so because they have no means of paying for their medicine. See SLATE, ET AL., *supra* note 11, at 183, n. 6.

²¹⁰ See note 162 *supra* and accompanying text. This affords transparency to parties affected by the offender’s behavior; even if the offender is unable to make the type of causal connection that would be necessary to justify a conventional restorative justice approach, the victim will be able to have his or her voice heard, to see that this tribunal does not exist to “coddle” someone who has wronged them, to see how the cause of that wrong is an underlying illness rather than a “guilty mind,” and to see that actions are taken to avoid similar problems in the future. In this way, these tribunals could shed some light on the offender’s illness, and perhaps diminish any prejudices that the victim may hold with respect to persons with mental illness instead. See discussion *supra* Section I.C. The failure to include the victim may satisfy certain privacy concerns, but if the victim’s only interaction with the offender is the wrong perpetrated, this may further ingrain whatever prejudices the victim may have instead of taking advantage of an opportunity to diminish or dispel them.

²¹¹ Certain crimes, like nonviolent drug offenses, have no real victim; “society” can hardly occupy the seat, and anyone who presumes to do so should probably not be given this type of authority over another person.

victim will have the satisfaction in playing a substantial role in the resolution of his or her own matter, instead of being forced to abdicate that authority to a stranger in the prosecutor's office. The tribunal would be able to adopt a resolution that not only affords the offender treatment for comorbid mental illness and substance abuse,²¹² but would invest the offender in his or her own rehabilitation and in the remedial needs of the victim.

CONCLUSION

The protracted history of abuse and mistreatment of the mentally ill is finally abating, but new solutions are necessary to ensure not only that the mentally ill are treated rather than incarcerated, but that they and their communities are fully invested in their treatment and recovery. By changing the course of our treatment of our mentally ill, we can fortify the moral authority under which our courts operate and of our society as a whole. As an ancillary benefit, we can save a tremendous amount of taxpayer money in the process. The movement toward decriminalization of mental illness is in its youth and gaining steam; now is the time for novel ideas. When asked where our mentally ill brothers and sisters have gone, we will no longer respond "am I my brother's keeper," but rather "I am my brother's keeper, and my brother is beside me."

²¹² See notes 5, 6, 76, 79, 82, 157 *supra* and accompanying text.