The University of California, Santa Barbara

Resolving the Revolving Door: The Legal System's Efforts in Mitigating the Mental Health Crisis in the Criminal Justice System

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Introduction

"All I have are negative thoughts" – Arthur Fleck, *Joker* (2019)

The Joker is considered one of the most iconic supervillains in comic book history with his terrifying eyes, painted white face, and blood-red lips painted to resemble a demonic grin. DC Comics's Bill Finger, Bob Kane, and Jerry Robinson created the Joker to fashion a complex antagonist that proved a real threat to the seemingly unbeatable Batman.[1] The most recent portrayal of the sinister mastermind came from Todd Phillips's *Joker* (2019) with Joaquin Phoenix starring as the title character. On the surface, the film tells the Joker's origin story. The plot centers on Arthur Fleck, a downtrodden, mentally ill individual residing in the fictitious Gotham City during the 1980s.

Underneath the surface, *Joker* (2019) delivered a powerful message about mental illness. With his dreams of becoming a stand-up comedian, he aimed to bring joy and laughter to the cold, dark world. Instead of receiving laughter for his funny jokes, Arthur received laughter from the audience because of his bizarre behavior--the uncontrollable laughing, choking sounds, and the inability to stand still. The constant bullying from his peers combined with the social service cuts enabled Arthur to cultivate the Joker personality. The film was not just the story of someone's downward spiral towards a life of crime but paints a grim picture of the harsh realities of living with a severe mental illness and how the pervasive effects on everyday lives can lead to disastrous consequences if left untreated.

In the current state of affairs, the mentally ill are among the most disadvantaged members of our society. A high proportion of mentally ill individuals are homeless. In San Francisco and Los Angeles, the homeless mentally ill are prominent in the Tenderloin District and Skid Row,

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[1] Robert Moses Peaslee and Robert G. Weiner, *The Joker: A Serious Study of The Clown Prince of Crime* (Jackson, Mississippi: University Press of Mississippi, 2015), 2.

respectively.[2] When they seek care and medication to combat their symptoms, the hospital administrators turn them away and they have no choice but to flock to the streets. In addition to the large number of mentally ill in the homeless population, there is also a disproportionate number of mentally ill in the criminal justice system. The country's three largest centers for mental health care are not hospitals or clinics, but county jails.[3] Prisons and jails became the new psychiatric inpatient system. In the same way, sheriffs and police officers now act as de facto mental health care providers. Law enforcement has expanded its role from protecting communities to also engaging in crisis response and intervention.

While the Joker represents a fictional character in a fictional universe, his tragic story of neglect, ostracism, and descent into madness to an extent resembles real-life experiences of individuals living with mental illnesses. Some of these people, much like Arthur, rely on social services for their treatment. When budget cuts prevent them from ordering their medication, their symptoms persist and put a strain on their relationships with those around them. Others are even turned away from admittance into a psychiatric hospital or at the very least placed on a year-long waitlist for treatment. They are neglected by the institutions designed to help them. Arthur's story serves as the ideal opening to this project as it not only serves to provide context to my discussion of mental illness, deinstitutionalization, and the criminal justice system, but also establishes a framework that would guide readers through my central arguments about the country's mental health crisis.

This project provides a historical context behind this crisis by shedding light on a few key developments. A major turning point in mental health policy occurred throughout from the 1960s

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[2] E. Fuller Torrey, *American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System* (New York: Oxford University Press, 2014), 167.
[3] Alisa Roth, *Insane: America's Criminal Treatment of Mental Illnesses* (New York: Basic Books, 2018), 3-4.

and 1970s with the deinstitutionalization phenomenon, or the closure of mental health hospitals across the country. The most telling development in mental health care history is the mere fact that as the number of mentally ill held in hospitals decreased as a result of the closures, the number of mentally ill in prisons increased dramatically beginning in the 1980s. Given that the mental health crisis is most pronounced in the criminal justice system, another goal for this paper is to explore the initiatives by the legal system to attempt to combat the crisis in the criminal justice system. Further research introduced me to the pioneering efforts of legal scholars like David Wexler and Bruce Winick in developing therapeutic jurisprudence, which in turn became the leading philosophy behind the creation of specialized courts for addressing the needs of offenders with mental illnesses. In this paper, I argue that the growing consciousness of mental health issues among the members of the legal community and discontent with the adversarial, one-size-fits-all approach to criminal cases prompted a paradigm shift towards therapeutic and client-centered approaches to justice. In response, a group of reform-minded judges, attorneys, and legal scholars designed specialized courts to resolve this mental health crisis in the criminal justice system.

Little exploration has been done to assess this rather dramatic shift from the 1980s mentality of "law and order" and use of punitive punishments to the implementation of therapeutic approaches for these defendants. Previous literature on the growth of MHCs tend to view their growth and efficacy through a sociological lens rather than that of a historian. The bulk of the research stemmed from assessments of their efficacy or comparative analyses of MHCs from different regions as opposed to *how* and *why* they came to be in the first place. The value of studying the mental health crisis and the legal system's efforts to combat the crisis from a historical perspective rests on the idea that establishing this narrative can assist in bringing

awareness to how the decisions rendered by people in power who never truly understood the severity of mental illnesses and the persistent stigma surrounding mental health led to their relegation as second-class citizens. Additionally, tracking the history of mental health care and the legal system's attempts to address the disproportionate amount of mentally ill in the criminal justice system allows for us to assess what worked and what could be improved upon.

In Chapter 1, I provide a brief history of the mental health care system beginning with the establishment of the modern-day psychiatric asylums and concluding with the deinstitutionalization movement of the 1960s and 1970s. The chapter tracks the developments that catalyzed deinstitutionalization, including the exposés of the horrid conditions in the state psychiatric hospitals, Dr. Robert Felix's proposal to shift the responsibility of mental health care from the states to the federal government, and the advances in psychiatry. The next half of the chapter introduces how the theory of deinstitutionalization differed from how its efforts worked in practice. The first chapter helps to set the stage for the discussion on the mental health crisis by showing how exactly the crisis happened in the first place. Community opposition, errors in program coordination, and lastly, "hyperoptimism" from a coalition of ill-informed psychiatrists and politicians left many discharged mentally ill patients without some form of care or medication.

In Chapter 2, I continue the discussion about deinstitutionalization by shedding light on the legal system's role in its failed efforts. The hyperoptimism about the advances in medical science, the proposed community-based mental health care centers, and the preventative research also manifested in the attempts of civil rights attorneys and other legal actors during the 1960s and 1970s to liberate involuntary committed patients from the psychiatric hospitals. This led to the expanded rights of psychiatric patients and stricter standards to commit a person to a hospital

against their will. Though the legal system's efforts were well-intended to protect the civil liberties of the patients, the stricter standards coupled with the community opposition to creation of the alternative mental health centers and errors in program coordination contributed to the disaster of deinstitutionalization. When the hospitals closed, the former patients had no other place to go. Some lived with their families, but they often lacked the means and knowledge to care for them. Others were not so lucky and flocked to the streets or got involved in the criminal justice system.

The second chapter also discusses the paradigm shift in the legal field and education from the punitive approach to justice to more sympathetic, client-centered approaches. Between the Reagan and Clinton presidencies, the criminal justice system experienced profound changes that contributed to the mass imprisonment of offenders with mental illnesses. After the hospital closures, the discharged patients left without care and treatment often engaged in misdemeanor crimes, such as trespassing, public urination, and other petty crimes. As the public encountered more people with mental illnesses in the streets, they often contacted law enforcement when they witnessed out-of-the-ordinary behaviors. As a result, criminal courts found themselves overloaded with cases pertaining to drug use and mental illness. In this segment, I argue of a paradigm shift that compelled members of the legal community to develop a new attitude and approach to justice. They recognized the need to reform the system that only created a revolving door effect and made matters worse for vulnerable populations like the mentally ill by confining them to a jail cell. This shift is evidenced in the development of new judicial theories, expressions of discontent by law students and other scholars with the punitive approach in law reviews and editorials, and most importantly, the creation of problem-solving courts.

In Chapter 3, I discuss the influence of therapeutic jurisprudence and the problem-solving court movement on the creation of mental health courts. These mental health courts serve as alternative criminal courts that aim to reduce reoffending among its participants. Rather than confining mentally ill offenders in jail cells, these courts divert participants to resources that would improve their mental conditions. In 1997, Judge Ginger Lerner-Wren pioneered the first mental health court in the country. This chapter explores some of the cases heard in the court and Judge Lerner-Wren's vital role in the effort. Lastly, the segment discusses the philosophy of holistic defense, another example of an effort by the legal system to attend to the needs of the mentally ill.

Chapter 4 explores the various forms and function of a typical mental health court and the research behind their efficacy helps in evaluating what has worked and what aspects of the court can be improved. For the most part, these different courts have the same objective, but they attempt to reach these goals in different ways. The last chapter will discuss the broader implications of the crisis in today's climate and provides my own recommendations for initiatives to assist those with mental illnesses, including better education and training from members of the general public and the key players in the criminal justice system (lawyers, judges, police, probation officers, etc.) about mental health.

Chapter 1: The Beginning of a Nightmare

Setting the Stage for Deinstitutionalization

Prior to the 19th century, very few public asylums for the treatment of mental disorders existed across the United States. Many mentally ill persons were housed in county jails for charges of vagrancy and disorderly conduct, while others found themselves in unsanitary and overcrowded almshouses. In response to these appalling conditions, medical reformer Dorothea Dix spearheaded a campaign during the 1840s for the establishment of institutions dedicated exclusively to caring for the mentally ill. She aimed to provide a more humane alternative to the jails and almshouses.[4] According to Eric T. Carlson and Norman Dain, these institutions aimed to provide shelter from the stressors of the outside world (hence the adoption of the word "asylum") and create an environment through which patients can obtain treatment and later return to their communities.[5] Pressured by the efforts of reformers like Dix, the states assumed responsibility for the care of indigent mentally ill persons and soon launched the construction of these asylums across the country.

Dix's vision for these asylums as a place of refuge for the mentally ill unfortunately failed to materialize due in large part to the lax qualifications for a patient's admission to these new asylums. Over time, concerned families or friends turned to these hospitals to care for their loved ones with mental illnesses. Most superintendents of these facilities had only one sole requirement for entry: the individual in question must be "in need of or likely to benefit from treatment."[6] If the family member believed their loved one would in fact benefit from the treatment, then asylum supervisors admitted the person to the hospital without consulting a

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4 Paul Appelbaum, *Almost a Revolution: Mental Health Law and the Limits of Change* (New York: Oxford University Press, 1994), 19.
5 Appelbaum, *Almost a Revolution*, 18-19.
6 Appelbaum, *Almost a Revolution*, 20.

mental health expert. As a result, this lax qualification for patient commitment to these treatment centers contributed to overcrowded rooms, overworked nurses and other attendees, and dismal maintenance of the facilities.

The Second World War (WWII) had an especially devastating impact on the hospitals. Many male staff members were drafted. Other workers left the institutions to work in the higher-paying defense industries. In turn, few mental health care providers and attendants remained at the hospitals. More people also flooded the facilities after the end of the war. Families and friends of returning soldiers noticed drastic changes in their loved one's behavior. *Soldiers of the War Returning* followed the story of Michael Gold, a WWII veteran who suffered from horrible night terrors. In his sleep, his legs flailed and kicked violently under the sheets. His face and body would be covered in sweat and his eyes filled with tears. His wife Linda expressed her worries about his well-being as his behavior got him into trouble in other situations. Michael's relationship with others dwindled as a result of his antics, especially when he randomly engaged in a sudden outburst. One specific instance involved him refusing to leave his seat on an airplane after the flight touched down and resulted in the police taking him into custody for refusing to follow orders.[7]

Public consciousness grew of the squalid conditions and brutality in the hospitals. After touring several hospitals, Albert Q. Maisel published Bedlam 1946: Most U.S. Hospitals are a Shame and a Disgrace," a sensational twelve-page exposé detailing the inhumane treatment of the patients and the heinous conditions of the facilities. According to his account, "We jam-pack men, women, and sometimes even children into hundred-year-old firetraps in wards…while thousands more sleep on ticks…hundreds spend twenty-four hours a day in stark and filthy

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[7] Thomas Childers, *Soldier from the War Returning: The Greatest Generation's Troubled Homecoming from World War II* (Boston: Houghton Mifflin Harcourt, 2009), 264-268.

nakedness."[8] Maisel used accompanying images of naked patients sitting on the stone-cold floor, the rooms teemed with beds, and the patients engaging in forced menial labor. That same year, Mary Jane Ward's semiautobiographical novel called *The Snake Pit* provided a glimpse of the nightmarish conditions at the state hospitals, such as the use of electroshock therapy and the water treatment.

As the public gained awareness of atrocities behind the asylum walls, a great backlash prompted federal government involvement to search for an alternative solution to the asylums. On September 18, 1945, Congress decided to conduct hearings to discuss a national mental health plan. The Surgeon General of the U.S. Public Service Health Service asked Dr. Robert Felix to design a national mental health program, which would transfer the burden of mental health care from the states to the federal government. His 1945 paper proposed that the federal government create a research center devoted towards the detection, treatment, and ultimately the prevention of mental illness.[9]

Felix gained inspiration for early prevention research from psychoanalysts like Sigmund Freud, who believed that early childhood trauma, if left untreated, led to aggravated problems in adulthood, including the development of severe mental illnesses like schizophrenia and bipolar disorder.[10] Assuming symptoms of mental illness can be easily detected, Felix believed that early experiments and mental health screenings in schools would prevent major problems from developing later. Much of the contents in his paper were incorporated in a bill he wrote with his colleagues. In 1946, President Harry Truman signed this bill that became known as the National

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[8] Albert Q. Maisel, "Bedlam 1946: Most U.S. Hospitals are a Shame and a Disgrace" *Life Magazine* (1946). http://www.pbs.org/wgbh/americanexperience/features/primary-resources/lobotomist-bedlam-1946/.
[9] Torrey, *American Psychosis,* 21-22.
[10] Torrey, *American Psychosis*, 21.

Mental Health Act, which established the research center—National Institute of Mental Health (NIMH).

Advances in psychiatry reached its apex with specific breakthroughs that instigated a growing enthusiasm faith in the "magic of science" to cure the mentally ill. In 1950, a research team headed by Dr. Paul Charpentier synthesized chlorpromazine at the French chemical company Rhone Poulenc in Paris. While the group intended for the drug to serve as an antihistamine, Jean Delay and Pierre Deniker, psychiatrists at the Sainte-Anne mental hospital asked the company for some samples to test the effects of the drug on its patients. Delay and Deniker provided a report of the drug's "magic powers," as it supposedly tempered the patients' psychotic episodes, including the intrusive hallucinations and delusions.[11] After hearing of chlorpromazine's wondrous effects, in 1954 a Philadelphia-based pharmaceutical company marketed the drug as Thorazine in the United States. In its first eight months of release, state hospitals across the country administered the drug to more than two million individuals. The drug's sedating effects guided the previously agitated, psychotic patients towards a state of tranquility.

Months afterwards, other chemists initiated their quests for alternative treatments of mental illness, especially for schizophrenia. In 1958, *The New York Times* hailed reserpine, a similar tranquilizer as the new "miracle drug."[12] The search also led to the discovery of antidepressant medication. Although imipramine intended to treat schizophrenics, the drug produced improvement in depressed patients.[13] The proliferation of these psychotropic drugs

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[11] Torrey, *American Psychosis*, 53.
[12] Charles Lee, "A Miracle-Drug Called Reserpine." *New York Times* (1958). https://search-proquest-com.proxy.library.ucsb.edu:9443/docview/114581466?accountid=14522.
[13] Bruce Winick, "Psychotropic Medication and Competence to Stand Trial," *American Bar Foundation Research Journal* 2, no. 3 (1977): 785.

even further generated the possibility and appeal of closing the mental hospitals and releasing the patients into society with the appropriate prescriptions.

To implement his other major objective of replacing the hospitals with community-based mental health treatment centers, Felix joined an interagency task force of lawyers, economists, and sociologists formed by President John F. Kennedy, called the Interagency Committee on Mental Health. Due to his personal connection to mental health concerns, it only seemed right for President Kennedy to participate and advocate for such a project. Some might have known that his sister Rosemary suffered from intellectual disabilities that prevented her from passing the first grade. Later, she developed schizophrenic symptoms in adulthood. In 1941, neurosurgeons Walter Freeman and James Watt performed a lobotomy on Rosemary, in an attempt to cure her illness. However, the operation resulted in disaster—putting Rosemary in a permanent vegetative state.[14]

After consulting with the Interagency Committee, another issued a final report in 1961, *The Action for Mental Health.* The report called for a national program to treat people with mental illness in community mental health centers (CMHCs) focusing on early intervention and prevention.[15] The CMHCs would replace the problematic state hospitals, thereby sparing psychiatric patients from the supposed dreadful consequences of institutionalization. After the rest of the committee approved Felix's national plan, the committee members met at the White House to draft the president's message to Congress, which would ultimately turn the proposal into legislation.

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[14] Torrey, *American Psychosis*, 12.
[15] Risdon N. Slate, Jacqueline K. Buffington-Vollum, and W. Wesley Johnson, *The Criminalization of Mental Illness: Crisis and Opportunity for the Criminal Justice System.* Second ed. (Durham, North Carolina: Carolina Academic Press, 2013), 37.

The Disaster of Deinstitutionalization

In 1963, President Kennedy signed the Community Mental Health Act into law. The Community Mental Health Act appropriated $150 million dollars to the states to create a community mental health centers (CMHCs) in localities across the country.[16] The censuses of the state hospitals decreased dramatically throughout the 1970s, even to the point of closure in some cases. From 1955 to 1980, the resident population in these hospitals fell markedly from 559,000 to 154,000.[17] Unfortunately, the legislation would later prove fatally flawed. According to Torrey, the CMHC Act encouraged the closing of the state hospitals, later known as the phenomenon called deinstitutionalization, "without any realistic plan regarding what could happen to the discharged patients…focused resources on prevention when nobody understood enough about mental illnesses to know how to prevent them."[18]

In theory, the deinstitutionalization movement of the late-20th century consisted of three sequential processes: 1) the establishment of specialized halfway houses and community residences for people with mental illness, 2) the release of persons residing in state psychiatric hospitals to alternative community treatment facilities, and 3) the development of specialized services and treatment of the newly deinstitutionalized individuals.[19] However, in practice, specific hurdles arose that delayed the process of deinstitutionalization or contributed significantly to its faulty implementation. Retaliation from the localities, errors in program coordination, and "hyperoptimism" from a coalition of ill-informed and overconfident

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[16] Ann Braden Johnson, *Out of Bedlam: The Truth About Deinstitutionalization* (New York, NY: Basic Books, 1990), 31.
[17] Henry Koyanagi, "Learning from History: Deinstitutionalization of People with Mental Illness as a Precursor to Long-Term Care Reform" (Washington, D.C.: Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, 2007), 6.
[18] Torrey, *American Psychosis,* 58.
[19] Leon L. Bachrach, "Deinstitutionalization: An Analytical Review and Sociological Perspective" (Rockville, Md: National Institute of Mental Health, 1976), 1.

psychiatrists and civil rights lawyers all worked in tandem to discharge hundreds of thousands of mentally ill in the communities without proper adequate care. In turn, closing the state institutions and the failed establishment of an adequate number of alternative treatment centers contributed greatly to the high volume of mentally ill individuals in the homeless population and eventually the criminal justice system.

Community opposition in cities across the country prevented the establishment of the proposed alternative treatment centers. When plans to establish these group homes for newly discharged patients circulated throughout the United States, community residents employed a high number of strategies to prevent their construction. According to clinical psychologist Judith Rabkin, the resistance was "vocal, effective, and widespread, leading to the passage of municipal ordinances and legal barriers to the establishment of local facilities."[20] In 1979, *The New York Times* contributor David Kirkwood reflected on the local opposition displayed in Westchester County of New York to the proposed treatment centers for the discharged Willowbrook State Hospital patients. To give the residents a fair warning of the propositions, the state legislature amended the Mental Hygiene Law in 1978, which required the state to notify a municipality of its intentions to open a center and give locals 40 days to decide where to build these sites.

Citizens often formed site-search committees, in which they selected and proposed locations for these treatment centers. While the law supposedly allowed municipalities more of a voice in the process, many residents in cities like Westchester exploited this opportunity to engage in the same level of hostility, if not more than before the enactment of the law.[21] In the village of Larchmont, the chairperson of its site-search committee reported that upon selection of

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[20] Judith Rabkin, "Criminal Behavior of Discharged Mental Patients: A Critical Appraisal of the Research". Psychological Bulletin, 86 (1979), 1-5.

[21] David Kirkwood. "Home Sites for the Retarded Still Raises Fears," The New York Times, July 15, 1979. Retrieved from https://search-proquest-com.proxy.library.ucsb.edu:9443/docview/120777895?accountid=14522.

an appropriate location, opposed neighbors purchased the proposed site within two days. The same method of buying real estate to block the establishment of these treatment homes also took place in other towns in the county, including Harrison and Ardsley. Similarly, during these public meetings held by these committees, the residents raised concerns of the unpredictable, impulsive, and violent behavior from these people with a mental health condition. Critics of the law believed that the site-selection law "pitted neighbor against neighbor," as residents in one neighborhood proposed a site in another neighborhood much to its dismay.[22]

Kirkwood's report on the controversy called attention to one main reason deinstitutionalization occurred at an unusually slow pace. Community opposition posed a challenge for the first step in the process. Many other citizens from several municipalities across the country enacted legal barriers and ordinances to half the establishment of a community mental health center in their neighborhoods. As a result, the plans to create a brilliant network of halfway houses, rehabilitation centers, and the other alternatives to mental hospitals never cohesively materialized in some cities. Amidst community opposition throughout the 1960s and 1970s, municipalities still managed to build a small number of community mental health centers, but only less than half than initially intended.[23]

The next problem with deinstitutionalization involved the errors in program coordination. The rhetoric from NIMH officials made it seem as though the CMHCs would replace the hospitals as the primary means of treatment and early prevention. However, investigations into the CMHCs revealed that the coordinators never had a cohesive plan to divert the discharged hospital patients to these new centers. Instead, the optimistic leaders and key players in the deinstitutionalization effort pulled the trigger too soon and encouraged the closure of the

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[22] Kirkwood, "Home Sites for the Retarded Still Raises Fears."
[23] Slate, *The Criminalization of Mental Illness,* 38.

hospitals before the adequate number of CMHCs could be established. As a result, without these centers in place, thousands of persons with severe mental illness, many of whom did not have the means nor the resources after spending years in the hospital to care for themselves or seek out treatment, were released into society. Furthermore, those who desperately needed access to mental health resources found themselves experiencing extremely pervasive symptoms. Depending on the severity of their conditions, their symptoms can range from auditory hallucinations, or "voices in their heads," to threatening delusions.

In summary, this chapter aimed to demonstrate how the idea of deinstitutionalization came about, as well as two reasons for its failed efforts. Robert Felix's proposals seemed as though they would solve the mental illness crisis with the right resources, the adequate funding, and the right time. Unfortunately, Felix could not predict the circumstances following the passage of the 1963 Community Mental Health Act. Although well-intentioned and optimistic, he failed to take into account the public's prevailing attitudes about the mentally ill and launched a federal mental health plan without coordinating with the entities necessary for ensuring its success.

With the lack of CMHCs available for the discharged patients to continue their treatment, thousands of untreated mentally ill patients became homeless. The following chapter showcases the third reason for the failure of deinstitutionalization—the involvement of legislative and judicial actions that created strict standards for patient admittance into the state hospitals. Eventually, these new standards complicate the narrative due in large part to its role in pushing some of these former patients into the criminal justice system, creating the mental health crisis that the legal system would soon attempt to solve.

Chapter 2: War and Peace

The Right to Counsel, The Right to Treatment

The intersection between mental health and the law began during the influential Civil Rights era. While black civil rights activists started major initiatives to call attention to their experiences with racial discrimination and university students protested the Vietnam War draft, legal scholars and practitioners fought for the civil liberties of the mentally ill. Even though the deinstitutionalization efforts closed down some state hospitals, a few still remained. Those who showed evidence of a mental illness, especially if they posed a danger to themselves and others, were admitted to a hospital against their will. During the 1960s and 1970s, two key legal actions brought attention to the limited rights of those involuntarily admitted to the state hospitals. The decisions rendered in these cases introduced these patients to the right to treatment and created specific standards for state hospitals to uphold in their treatment processes.

Unfortunately, committed patients claimed during their time in these hospitals that they did not receive the sufficient treatment. In *Rouse vs. Cameron* (1966), the plaintiff Charles Rouse challenged his confinement to Saint Elizabeth's Hospital by filing a petition for *habeas corpus*, a legal action demanding the detainee to appear before the court to ensure that the person had not been unlawfully detained.[24] Although his sentence called for a maximum of one year at Saint Elizabeth's Hospital in Washington D.C., he spent more time there than stipulated. In his petition, he argued that when committed to Saint Elizabeth's that he did not receive adequate care nor treatment to better his mental condition. The court's opinion on the case, written by Judge David Bazelon, held that people involuntarily committed or held in the mental hospitals

[24] Risdon N. Slate, "Deinstitutionalization, Criminalization of Mental Illness, and the Principle of Therapeutic Jurisprudence," *Southern California Interdisciplinary Law Journal* 26 (2017): 3.

because they were found not guilty by reason of insanity had a "right to treatment."[25] These facilities had an obligation to provide psychiatric care that met the needs and conditions specific to the patient. Bazelon also added that the lack of resources like staff or facilities cannot be used to justify the failure to provide adequate care for patients. Additionally, to hold the hospitals accountable, the ruling mandated hospital staff to keep thorough records of the medical and psychiatric care each patient received. However, the case did little in terms of enforcing this "right to treatment," possibly because the court did not establish clear-cut standards for care in the hospitals.[26] Rouse vs. Cameron did, in fact, set the stage for another case.

A similar situation arose in *Wyatt vs. Stickney* (1972). In Alabama, the revenues from a cigarette tax helped fund the state's mental hospitals. A decrease in the tax's revenues prompted the downsizing of 99 employees from the Bryce State Hospital. These ex-employees filed a class action suit against the hospital asking for the reinstatement to their respective positions. The plaintiffs of the suit argued that their loss of employment would result in the inadequate treatment and care for the psychiatric patients residing at Bryce. In fact, the legislative appropriations in this state for the mental hospitals were already quite meager and thus the condition of the institutions resembled the run-down, overcrowded, and understaffed "snake pits." The termination of these staffers only added salt to the wound. While the U.S. District Court of Alabama ultimately dismissed the case, the plaintiffs then recruited an involuntarily committed resident of Bryce named Ricky Wyatt and filed another suit on his behalf.

During the trial, Ricky Wyatt testified about his terrible experience and the abysmal conditions of the hospital, verifying the staff member's claims. As a result of his startling

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[25] Slate, "Deinstitutionalization, Criminalization of Mental Illness, and the Principle of Therapeutic Jurisprudence," 3.

[26] Slate, "Deinstitutionalization, Criminalization of Mental Illness, and the Principle of Therapeutic Jurisprudence," 3-4.

testimony, the court's ruling established minimum constitutional standards for treatment of the mentally ill in Alabama and a human rights committee to oversee the changes take place as planned. The minimum standards were listed as follows: 1) human physical and psychological environments under the least restrictive conditions necessary, 2) qualified staff in numbers sufficient to administer treatment, and 3) individualized treatment plans. These new standards reinforced an involuntary committed patient's right to treatment and introduced a patient's right to refuse certain treatments, like the painful electroshock therapy. For instance, patients had the right to exclude themselves from "excessive or unnecessary medications, and from restraint or seclusion."[27]

Both cases revealed the sad reality of the conditions at the hospitals. These institutions failed to provide the services they were built for. Still, the rulings set standards on how hospitals should function to ensure that the patients received the care they need. However, some legal scholars believed that securing the right to treatment and the creation of minimum treatment standards in the hospitals did not do enough to advocate for mentally ill patients. These scholars considered the involuntary commitment on account of mental illness as a violation of civil liberties. Led by Bruce Ennis, attorneys from the American Civil Liberties Union (ACLU) formed the Mental Health Law Project in 1972, which became a center to liberate the mental patient from the "legislators, judges, and psychiatrists who persecute them in the name of mental health."[28] Rather than simply improving the hospital conditions through safeguards and regulations, Ennis aimed to close the hospitals altogether, abolish involuntary commitment, or at the very least create hurdles that will make it difficult to commit people against their will. In his

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[27] Slate, "Deinstitutionalization, Criminalization of Mental Illness, and the Principle of Therapeutic Jurisprudence," 4.

[28] Ralph Slovenko, "Hospitalization of the Mentally Ill Revisited," *The Pacific Law Journal* 24, no 3 (April 1993): 1112.

book *Prisoners of Psychiatry*, Ennis claimed that the hospitals were places "where sick people get sicker and sane people go mad."[29]

During the 1970s, the Mental Health Law Project and other legal initiatives engaged in efforts to incorporate the due process requirements of criminal justice procedures into the civil commitment process. While other cases ruled in favor of increasing rights for the civilly committed, one Supreme Court case changed the narrative dramatically by instituting a stricter standard to involuntarily hold someone against their will. Ennis played a significant role in this case known as *O'Connor vs. Donaldson*. He advocated on behalf of Kenneth Donaldson, a patient involuntarily admitted to Florida State Hospital, who refused to take any medication due to his Christian Science beliefs. Donaldson charged his attending physician J.B. O'Connor and other hospital staff for robbing him of his constitutional right to liberty by confining him against his will. In 1975, the Supreme Court ruled unanimously that a "state cannot constitutionally confine a non-dangerous, mentally ill person capable of living outside of a mental health facility."[30] This case threatened the involuntary commitment system altogether.

In addition to these two major legal cases in mental health law, even state legislatures began to institute legislation that would limit civil commitment. The most important legislation, even considered by some as the "Magna Carta of the mentally ill," is California's Lanterman-Petris-Short Act of 1967. Much in line with the objective of the community mental health treatment centers (CMHCs) proposed by the Interagency Committee on Mental Health years before, the Act would "protect the civil liberties of persons alleged to be mentally ill" and to shift the trend toward community-based treatment as an alternative to involuntary hospitalization.

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[29] Slovenko, "Hospitalization of the Mentally Ill Revisited," 1112.
[30] Slate, "Deinstitutionalization, Criminalization of Mental Illness, and the Principle of Therapeutic Jurisprudence," 5.

This law mandates that a person who poses a "danger to others, or to himself or herself" be taken into custody for up to 72 hours for "assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services."[31]

However, while these lawyers, legal scholars, and legislators demonstrated good intentions on behalf of the involuntarily committed patients, their focus on the negative aspects of the civil commitment system overshadowed the benefits these hospitals provided their patients. Some law students and even law professors wrote editorials that mentioned the benefits of the state hospitals despite the public perceptions of them as "snake pits" and overtly criticized the efforts of Ennis and other civil rights lawyers. In one article written in 1976, Professor Emanuel Tanay wrote this statement in critique of those he called the anti-commitment crusaders, "Anyone who has developed a sense of empathy with a psychotic patient will be able to recognize the state hospital as a place where 'living is possible.' Involuntary hospitalization is a treatment and care modality essential to the wellbeing of the psychotic."[32] In other words, while the hospitals were in grim condition, they provided what the CMHCs, nursing homes, and the streets could not—the necessary 24-hour supervision, food, and shelter. Throughout his piece, Tanay argued that legal actors like Ennis may aim to advocate for the rights of the mentally ill, but they simply lack the qualifications necessary to comprehend their true needs. Yet again, though well-intentioned, ill-informed and unqualified individuals in power are partly responsible for the disaster of deinstitutionalization.

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[31] California Legislative Information, "The Lanterman-Petris-Short Act." California Law, https://leginfo.legislature.ca.gov/faces/codes_displayexpandedbranch.xhtml?tocCode=WIC&division=5.&title=&part=1.&chapter=&article=

[32] Emanuel Tanay, "Law and the Mentally Ill." *Wayne Law Review* 22, no. 3 (March 1976): 812.

Combined with the community opposition in establishing the CMHCs, the errors in planning patient diversion from the hospitals to the CMHCs, and this misplaced optimism from these psychiatrists and civil rights lawyers, the failed efforts of deinstitutionalization created a major crisis in the mental health care system. The stricter standards to patient commitment as enforced by legislation like Lanterman-Petris-Short Act and the rulings from cases like *O'Connor vs. Donaldson* further complicated the potential outcomes for the mentally ill in that they brought the mentally ill to a place that would only exacerbate their symptoms, a more nightmarish place than even the so-called snake pits.

Crime and Punishment

On June 1971, President Richard Nixon declared drug abuse as "America's public enemy number one" and declared a "War on Drugs," which would later become known as a worldwide offensive to combat recreational drug usage, substance abuse, and addiction in an address to Congress. He proposed a government-led initiative to engage in substance abuse research and increase federal funding to drug-control agencies to combat the negative consequences of drug use in the country. Concerns of drug addiction emerged in part due to the increase in heroin use among 15-20% of American soldiers in Vietnam.[33] This in turn led to the fear of returning soldiers with severe heroin addiction who would then spread addiction and crime within the United States.

Though Nixon coined the term "War on Drugs," and utilized the term as a political ploy to gain support for his agenda, President Ronald Reagan transformed the rhetorical war into a literal one in the beginning of the 1980s. His administration abandoned the government's plans

[33] Daniel Weimer, "Drugs-as-as-Disease: Heroin, Metaphors, and Identity in Nixon's Drug War." *Janus Head* 6, no. 2 (2003): 261. https://pdfs.semanticscholar.org/969b/3bca6287f0cd7bd1ec0acd2c6ac4e9c9f7f3.pdf

to institute substance abuse prevention and treatment in favor of strengthening law enforcement efforts to crack down on communities and reduce drug supplies. States instituted mandatory-minimum sentencing and three-strikes laws and terms of incarceration for drug dealers even exceeded the punishments for manslaughter. During this period, the American criminal justice system shifted in favor of punitive jurisprudence, characterized by major legal institutions, organizations, and other activities communicating the central idea of identifying and punishing wrongdoers. These punitive practices served the primary purpose of controlling and preventing harm to the general public.

The War on Drugs and the punitive policies transformed the country into a new penal regime centered around the so-called "prison-industrial complex." Between 1978 and 2000, coinciding with the time period characterized with the 90% decline in state psychiatric hospital censuses, the number of jail and prison inmates increased to a dramatic percentage of approximately 400%.[34] People with mental illnesses became a new target for incarceration. With a lack of alternative treatment centers to replace the closing mental hospitals, thousands with serious mental illnesses released from the hospitals found solace on the streets. Some discharged patients returned home to their families, who unfortunately lacked the necessary tools in which to understand and tend to their loved one's individual needs.[35] As former untreated patients drifted to the streets, the general public became exposed to the bizarre behaviors exhibited by these mentally ill persons: talking to oneself, yelling obscenities, and removing one's clothing. These deviant behaviors subjected them to great public scrutiny.

While these behaviors often represented the manifestations of their symptoms, the public interpreted them as threatening and unpredictable and turned to law enforcement to respond to

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[34] Slate, *The Criminalization of Mental Illness*, 42.
[35] Koyanagi, "Learning from History: Deinstitutionalization," 6.

the issue. Police officers turned into “street-corner psychiatrists," a term used to describe how police became the primary gatekeepers of the high volume of mentally ill individuals.[36] Law enforcement’s encounters with these individuals resulted in arrests for often minor offenses. Retreating back to the discussion of stricter commitment standards, sometimes law enforcement officers resort to “mercy bookings,” which is the concept of arresting persons with mental illnesses to ensure they had a place with shelter, food, and water. Police officers found it more expedient to process the person into the criminal justice than the civil commitment process. With the stricter standards set in place, the limited vacancies in the remaining state psychiatric hospitals, and the lack of alternative sources for treatment, police officers recognized that these individuals might be rejected from commitment or released back to the streets only to encounter them again for another criminal charge. As opposed to the civil commitment system, the criminal justice will not refuse these individuals.[37] Consequently, historians and social scientists believed that this period known as “deinstitutionalization” should instead be referred to as “transinstitutionalization.” Rather than receiving treatment and care in the proposed community clinics, many mentally ill found themselves housed in the county jails for petty crimes like trespassing, robbery, and other charges related to disruption of the peace.

Amidst the unprecedented rise in the number of state and federal prisons during the 1980s and the Reagan administration’s emphasis towards maintaining “law and order,” the proportion of prisoners with mental illnesses grew dramatically.[38] According to a meta-analysis by the Bureau of Justice Statistics, prisons conducted surveys in the early 2000s in order to assess the prevalence of mental illness within the prison population as compared to community samples.

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[36] Koyanagi, “Learning from History: Deinstitutionalization,” 801.
[37] Slate, “Deinstitutionalization, Criminalization of Mental Illness, and the Principle of Therapeutic Jurisprudence,” 7.
[38] Slate, *The Criminalization of Mental Illness,* 45.

These surveys estimated the prevalence 3 to 12 times higher than the comparison samples, reaching as high as 64%.[39] Yet another appalling statistic details how one in four fatal police shootings involve a person with a mental illness. In the same way that law enforcement became *de facto* mental health care providers and first responders, prisons became *de facto* mental health care facilities. As of now, the three largest mental health care facilities in the United States are housed in county jails across the country rather than psychiatric hospitals.

Persons with mental illness face grueling conditions in the jails. To them, prison is a truly stressful, brutal, and toxic environment. Mentally ill offenders tend to suffer from a range of debilitating symptoms, including delusions, hallucinations, and mood swings beyond their control. These symptoms often created challenges in the relationships between fellow inmates and the correctional officers. Those with the most severe symptoms create disruptions when they become delusional, hallucinate, or are unable to communicate. When they are experiencing their symptoms, they might not have the ability to understand and abide by the prison's standards of behavior. In turn, correctional officers tend to respond with force and sometimes violence as a form of disciplinary action. Furthermore, in the same way that members of the general public viewed their symptoms as threatening, other inmates who interpreted these manifestations in that way retaliated with physical and even sexual violence. Studies demonstrated that persons with mental illness in custody have been found to be twice as likely to be physically by those in custody and three times as prone to being sexually violated. Physical and sexual violence by staff has been found to be even higher than that of those in custody.[40] With their symptoms left untreated, the grueling conditions of the prisons only exacerbated their mental health issues.

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[39] Seth Prins. "Prevalence of Mental Illnesses in U.S. State Prisons: A Systematic Review." *Psychiatric Services*, 2014, 1.

[40] Slate, "Deinstitutionalization, Criminalization of Mental Illness, and the Principle of Therapeutic Jurisprudence," 7.

In *Insane: America's Criminal Treatment of Mental Illness*, journalist Alisa Roth recounted her experiences investigating this mental health crisis in the courts, jails, and prisons. To her horror, she discovered the lack of training provided to members of law enforcement on working with this particular population and the horrific conditions of the jails themselves. Prisoners with severe mental illnesses are denied proper treatment for their concerns, taunted and abused by ignorant guards, and punished for their bizarre behaviors. When recalling the heartbreaking case of eighteen-year-old Jamie Wallace housed in the Donaldson Correctional Facility, she uncovered the devastating truth that the mental health professionals in his residential treatment unit visited him only every two months for a routine check, lasting only five to ten minutes long.[41] Just like the many others with severely untreated mental illnesses in the jails, Jamie took his own life in his cell. Much of this evidence of abuse and neglect against the mentally ill in the criminal justice system begs the question as to how such an institution built around discipline and punishment can provide the type of environment necessary for effective rehabilitation and treatment.

From Punitive to Problem-Solving

Beginning in the late 1980s, a new generation of courts called problem-solving courts stemmed out of concerns with the punitive, adversarial approach to criminal cases and created a revolving door phenomenon. In the context of law and crime, the revolving door problem refers to the back and forth movement of an individual from the criminal justice system to the community. In other words, spending time in jail does not deter people from committing the same crimes. Additionally, the War on Drugs and the mass incarceration period of the 1980s

[41] Alisa Roth, *Insane: America's Criminal Treatment of Mental Illnesses*. New York: Basic Books, 2018. 153.

resulted in overwhelming caseloads of drug-related offenses, crowded courtroom dockets, and frustrations over the slow nature of criminal proceedings. The strain on both the resources of local law enforcement and criminal courts prompted legal scholars, attorneys, and judges to seek out new approaches to criminal justice, especially in the way the courts address problems related to crime, drug use, and mental illness.

The Reagan administration's mandatory sentencing on drug possession and heightened crackdown on communities led to an increased number of drug-related offenses and caseloads for the attorneys. In response, a new type of criminal court called drug courts emerged in 1989 with the intention of reducing or even breaking the link between drug use and criminal behavior. In a general survey of police departments across the country, police department administrators noticed repeated calls from the same general areas. Even after spending time in jail, individuals continued committing the same petty crimes. Some departments discovered that attempting to address the underlying problems in addition to making the necessary arrests resulted in fewer crimes, arrests, and calls from these same locations.[42]

Drug courts seek to assist addicted offenders in achieving sobriety from abuse of alcohol and other drugs through community-based treatment and rehabilitation as an alternative to incarceration. Though entry in these courts is entirely voluntary, once deemed eligible for entry, the participants must agree to abide by a comprehensive treatment plan with frequent progress checks. Once these individuals successfully completed the treatment program, these courts may have reduced sentencing, offered a less punitive penalty, dismissed the charge entirely, or a combination of these.[43] The first drug court emerged in Dade County, Florida in 1989. Shortly

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[42] W. Clinton Terry, *The Early Drug Courts : Case Studies in Judicial Innovation*. Drugs, Health, and Social Policy Series; 7 (Thousand Oaks, Calif.: Sage Publications, 1999), 14-15.
[43] Terry, *The Early Drug Courts*, 15.

after the establishment of the Dade County drug court, similar treatment courts arose in the late-1990s in Oakland and Portland.

Out of this judicial innovation came the spark that ignited what some scholars refer to as the "quiet revolution," a term used to describe the proliferation of a new generation of criminal courts.[44] After drug courts arose in other cities, other specialized courts sprung forth, including domestic violence, prisoner reentry, veteran affairs, and lastly, mental health courts. These alternative courts utilized a more holistic approach by "linking the individual to the larger social context and the broader genesis of criminal behavior."[45] By creating separate institutions and court systems catered towards addressing specific issues, proponents of problem-solving courts hoped to reduce recidivism, and attend to the specific needs of the client, and to enhance public safety.

In the neighboring Broward County, just a few miles from Dade County, Chief Public Defender Howard Finkelstein conceived the idea of the nation's first diversionary mental health court. After working with several clients with mental illnesses and speaking to their families, he soon realized that a pattern between untreated mental illness and frequent run-ins with the criminal justice system. He watched as the criminal justice system trapped his clients for crimes committed as a result of addiction, homelessness, and mental illness. In the same way that offenders with drug problems are often subject to the revolving door, those with mental illnesses continue to get arrested for the same petty crimes and do not experience improvements in their mental health.[46]

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[44] Karen A. Snedker, *Therapeutic Justice: Crime, Treatment Courts, and Mental Illness* (Cham: Springer International Publishing: Imprint: Palgrave Macmillan, 2018), 8.
[45] Snedker, *Therapeutic Justice,* 8.
[46] Snedker, *Therapeutic Justice,* 13.

Finkelstein came to the conclusion that the current system of criminal justice did little to address the underlying issue of mental illness. He viewed that the true culprit of cases involving mentally ill offenders was the failure of the mental health system to provide adequate treatment for their concerns, which can contribute to their involvement in the criminal justice system. Had his clients been provided with medication, therapy, and other treatment methods, he assumed that they would not be committing criminal acts in the first place. With the help of mental health experts, Finkelstein wrote an extensive, ten-page letter to the Broward County Grand Jury, expressing his concerns and ultimately asking for a formal investigation of the county's mental health system. The grand jury approved his request.[47]

After a comprehensive eight-month review of Broward's mental health system, the grand jury's investigation resulted in a 153-page report that described Broward's mental health system as "deplorable and chronically underfunded," and identified a revolving door problem of people with mental illnesses cycling between jail, homeless shelters, nursing homes, and the streets. The report concluded with recommendations for accountability, collaboration, and the need for expanded resources to provide those who suffered from mental illnesses with continuous care.[48] The grand jury's recommendation and findings prompted the criminal justice and mental health scholars to create a mental health criminal justice task force consisting of mental health advocates, lawyers, judges, and community treatment providers to streamline the jail processing procedures for those arrested with mental illnesses. By Finkelstein's request and administrative order by Chief Circuit Judge Ross, the task force evolved into the nation's first mental health court.

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[47] Judge Ginger Lerner-Wren, *A Court of Refuge: Stories from the Bench of America's First Mental Health Court* (Boston: Beacon Press, 2018), 8.
[48] Lerner-Wren, *A Court of Refuge,* 8.

Chapter 3: A Change of Heart

Therapeutic Jurisprudence: Using Law as Therapy

The mental health law discipline focused primarily on the civil liberties of mentally ill offenders. Born out of the civil liberties revolution of the 1960s, legal education and scholarship advocated for expanded rights for criminal defendants, prisoners, and ultimately mental patients in civil commitment proceedings. However, these early civil commitment cases separated mental health and law into two separate entities with little consideration of how each can have a major influence on the other. Attorneys working on involuntary commitment cases, using the O'Connor ruling as precedence, questioned the constitutionality of their client's involuntary commitment to a mental hospital because the act deprived the client of their constitutional right to liberty. The lawyer merely emphasized legal doctrine, constitutional rights of the patient, and precedence without taking into account how these decisions may affect the mentally ill and their loved ones. In other words, although the discipline is called mental health law, lawyers and other legal actors focused primarily on the law side and less on the mental health side.

During the 1970s and 1980s, mental health law scholars like Bruce Winick and David B. Wexler made this very observation. In 1977, Bruce Winick addressed the major antitherapeutic consequences of the automatic bar rule, a practice adopted by some courts that prohibited the defendants held in hospitals for treatment from returning to trial. Judges in these courts implemented this rule with the belief that patients under the influence of psychotropic drugs still did not possess the right state of mind to participate in trial. He argued that the rule only created a revolving door effect. Winick had a major impact on David Wexler's research much later. After reading Winick's critique of mental health law, Wexler clarified his research objectives

and reassessed his interests.[49] Throughout his research, Wexler noticed a common trend in the mental health law literature. In his view, the teaching and practice of mental health law has been "doctrinal, constitutional, and rights-oriented" and that the discipline lacked an "interdisciplinary law and behavioral science approach."

Wexler's research also led him to believe that the law acted as a social force that produced therapeutic and antitherapeutic consequences to some individuals. In his writings, he provided examples of how the law could contribute to psychological dysfunction by discouraging a person from seeking needed treatment, encourage a person to receive unnecessary treatment, and lead a person to regard themselves as dysfunctional. He used his findings to formulate a new concept in legal scholarship that would serve as the judicial philosophy that governed the form and function of mental health courts. Assigned with the task of writing a paper in the general area of law and therapy for the National Institute of Mental Health (NIMH), Wexler instead decided to write on his ideas for a new approach to the law called therapeutic jurisprudence. Rather than viewing mental health and law as two separate entities—law and therapy—Wexler advocated for the perspective of using the law *as* therapy.[50] Therapeutic jurisprudence not only acknowledged that legal decisions affect one's emotional life and psychological well-being long after a person's contact with the justice system is over, but also explored the possibility that the law could be "made or applied in a more therapeutic way so long as other values, such as justice and due process, can be fully respected."[51]

Another direction in the therapeutic jurisprudence approach focused on the role of actors in the legal system, such as judges, lawyers, and law enforcement. Therapeutic jurisprudence

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49 Lynda E. Frost and Richard J. Bonnie, *The Evolution of Mental Health Law*. 1st ed. *Law and Public Policy* (Washington, DC: American Psychological Association, 2001), 253.
50 Frost and Bonnie, *The Evolution of Mental Health Law*, 53.
51 Frost and Bonnie, *The Evolution of Mental Health Law*, 253-254.

called for a heightened sensitivity on the part of these legal actors to the way they act in applying the law. In the traditional attorney-client relationship, the role of counsel is to protect the client's legal interests, not attend to their mental health. Still, attorneys can take precautions in the way they interact with a client that aligns with the philosophy of therapeutic jurisprudence, such as using a warm tone, showing compassion for their concerns, and referring them to the correct mental health resources if needed. Before engaging in negotiations with the oppositions, the attorney should also consider how the ultimate decisions can affect their client's well-being. Wexler maintained that "if lawyers are to be effective in advising clients to handle legal situations in therapeutically beneficial ways, they must develop sensitivity to these situations…clients must be persuaded to come for a consultation in the first place."[52]

Throughout the 1990s and 2000s, Wexler began wrote more about therapeutic jurisprudence and discussed its implications, including examples of the concept in practice, new methods to implement the concept into practice, and visions for the future of the legal field. In *Essays in Therapeutic Jurisprudence,* Wexler compiled many different works written by himself and other legal scholars on this topic, including Winick. The last two chapters of *Essays* discussed how therapeutic jurisprudence might be applied in law schools and other interdisciplinary settings, as well as how it can help craft a new research agenda in the mental health law discipline.[53] Wexler believed that in order for students to obtain a well-rounded legal education that law students should obtain training in law and the behavioral sciences. In his view, the law is much more than conceptual doctrine. The law shapes society, but in turn society shapes the law.[54] Familiarizing law students with disciplines like psychology and sociology help

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[52] Frost and Bonnie, *The Evolution of Mental Health Law*, 254.
[53] David B. Wexler and Bruce J. Winick, *Essays in Therapeutic Jurisprudence* (Durham, N.C.: Carolina Academic Press, 1991), 16.
[54] Wexler, *Essays in Therapeutic Jurisprudence,* 293-294.

them realize the value of viewing the law through the lens of social science. At times, policymakers and attorneys use social science data in public policy disputes and trials in support of their argument. Studying social science methodology allows law students can spot weaknesses in an opponent's argument by pointing out certain biases and faulty data collection methods that contributed to such numbers.[55]

Little evidence suggests that the therapeutic jurisprudence philosophy resulted in the creation of the first problem-solving courts during the 1990s, like the drug and juvenile courts. Each may have come into the legal lexicon independent of the other, but they both arose during the same time period and share similar goals. Scholars writing on the topic suggest that the problem-solving courts are simply manifestations of therapeutic jurisprudence in action, because the structure of the problem-solving courts acknowledges the aspects that may have led to criminal justice involvement and the courtroom proceedings promote a recovery-based environment for a client. Other mental health law scholars claim the two are not one in the same, and that the problem-solving courts often only use the principles of therapeutic jurisprudence to enhance their functioning.[56] However, therapeutic jurisprudence played a significant role in the creation and development of the nation's first mental health court, an invaluable contribution to the cause of justice for the mentally ill.

The Pie Chart with the Person in the Center

Early in her career, Judge Ginger Lerner-Wren served as a staff attorney for the Florida Advocacy Center for Persons with Disabilities, where she represented plaintiffs with disabilities

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[55] Wexler, *Essays in Therapeutic Jurisprudence*, 294.

[56] Bruce J. Winick, "Problem Solving Courts and Therapeutic Jurisprudence." *Fordham Urban Law Journal* 30 (2003): 1064.

in a specific class action lawsuit against the South Florida State Hospital. Through her work as a Public Guardian for the 17th Judicial Circuit, she also served as a legal guardian for disabled, indigent adults by collaborating with mental health care facilities to create treatment plans for her clients. She even attended to their concerns with social, housing, and economic matters. Recognizing her skillset and expertise in disability rights and mental health law, Chief Judge Ross Dale selected Judge Lerner-Wren to preside over the nation's first mental health court, a specific court dedicated towards decriminalizing the mentally ill in the criminal justice system and linking these individuals to proper treatment facilities within their communities.[57] Through the recommendation of a special task force that investigated the surge of those with severe mental illnesses incarcerated for low-level offenses, the Florida legislature allocated $1.5 million to establish the court with the ultimate goal of reducing recidivism among the mentally ill offenders by diverting them from the criminal justice system into community-based treatment.

The judge admitted to the major influence that therapeutic jurisprudence played not only in enhancing the court's functioning but its creation. She expressed her goals of designing the mental health court as a court of refuge, to "leverage the law to reach a therapeutic outcome" and promote the law's "potential to heal."[58] She consulted the expertise of the father of therapeutic jurisprudence himself—David Wexler, along with Bruce Winick and Michael L. Perlin, a specialist in disability rights law to act as expert consultants on the court process. Lerner-Wren implemented the tenets of therapeutic jurisprudence into practice by mainly changing her role as a judge within the process.[59] The judge in a traditional criminal court acts as an independent, impartial decision-maker and overseer of a case in the pursuit of justice with minimal interaction

[57] Lerner-Wren, *A Court of Refuge*, 1-12.
[58] Lerner-Wren, *A Court of Refuge*, 23.
[59] Lerner-Wren, *A Court of Refuge*, 26.

with the client. Instead, Lerner-Wren transformed the courtroom as a welcoming environment rather than a punitive one by directly engaging in active listening with clients, demonstrating empathy and understanding, and describing the mission of the mental health court with authenticity and comprehensive language.

Prior to a client deciding on whether or not to partake in a mental health court treatment program, Lerner-Wren would draw a pie chart with six slices. Each slice of the pie represented the key features of the recovery process: medication, talk therapy, psychosocial services (day treatment, community case management, peer support), nutrition and fitness, enrichment activities (hobbies, creative pursuits, social activities), and lastly education and career goals. The lines separating the pie slices reveals a stick figure in the center, which she interpreted as the shape of a person. The significance of drawing this chart helps clients to understand the importance and function of mental health court treatment in a way that is easy for them to understand. She hoped they would see that the recovery process required the management of all these different pieces of the pie and that the mental health court team aimed to assist them in balancing all these aspects on their individual road to recovery. The person in the center of the circle symbolizes that the treatment plans created by the court are person-centered, meaning that the plan is intended to revolve around their specific wants, needs, and goals and that these specific aspects will assist in creating a vision for recovery.[60] By devoting time to reassure mental health court participants of the recovery process, paying attention to her tone and presence when speaking to them, and her use of a person-centered treatment program, the judge adapted the concept of therapeutic jurisprudence to pioneer a new problem-solving court dedicated to assisting incarcerated individuals with mental illnesses.

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[60] Lerner-Wren, *A Court of Refuge*, 34.

Her memoir *A Court of Refuge* recalled some rather heartbreaking stories about her time on the bench. Lerner-Wren recalled the story of Aaron Wynn.[61] Wynn got involved in a terrible car accident that resulted in a severe blow to his head. Furthermore, the head injury also led to a decline in his memory and cognitive functions. The once easy-going, committed, and quiet-tempered young man turned angry, volatile, and despondent. During one of his psychiatric episodes, he could not control his emotions during an encounter with the police and assaulted an officer. Two years later, during another episode, things took a turn for the worse when Wynn rushed out a grocery store and collided with an eighty-year-old woman who hit her head on the concrete. The woman died from her injuries and the authorities arrested Wynn charging him with first degree murder.

On the surface level, a jury might find Wynn guilty of the charge. What a jury might not know about is Wynn's persistent struggle with his mental illness. After his family noticed the drastic change in his behavior, they tried desperately to obtain the appropriate mental health care services. His parents called multiple mental health agencies but to no avail. Even with an attempt to commit him to a state psychiatric hospital, they were told that there was a two-year wait list. Aaron Wynn continued to live with an untreated mental illness. In a traditional adversarial court, this aspect of Aaron's story might have remained unspoken. The jury's role is to listen to the facts of the case and make a decision based on them. On the other hand, Aaron's persistent struggle with mental health issues and the lack of services available to him are vital pieces of information in a mental health court because they provide additional context. Spending time in jail did not prevent Aaron from running yet again into the criminal justice system, nor did the

[61] Lerner-Wren, *A Court of Refuge*, 8-11.

time prevent other mentally ill offenders. The underlying cause of their actions remained untreated.

Similar heartbreaking stories of individuals who suffered through their pervading mental health issues are heard often by a judge in a mental health court. Like other problem-solving courts, the main goal of MHCs are to put a halt to the revolving door problem, or to reduce the chances of future run-ins with the criminal justice system.[62] However, the main difference between these preceding problem-solving courts is the added objective of linking mentally ill individuals to mental health services and treatment. While the main factor of almost all drug treatment courts involved the diversion to substance abuse prevention resources, mental health courts focused instead on linking individuals to a team consisting of clinical psychologists, therapists, psychiatrists, and social workers to assist them in the path to mental wellness. The standard legal actors—lawyers, judges, and probation officers also play key roles in this process as moral support for a person in recovery. The structure of mental health courts and their variations in design will be addressed in more detail in the next chapter.

Holistic Defense

In response to the rise of problem-solving courts, the criminal justice system continued to evolve into different types of courts designated to help specific clients and those designed to take on specific offenses. They also led to the creation of new judicial philosophies that expanded the works of Wexler and Winick. One such philosophy became known as holistic defense sprung from the Bronx Defenders in New York City in the 1990s. The holistic defense model stemmed in part due to widespread criticism of the existing institutions set in place for indigent defense

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[62] Snedker, *Therapeutic Justice*, 31-32.

and also in response to the problem-solving movement. The traditional indigent defense model features a single lawyer working on the case to ensure the client has a fair jury trial and adequate representation.

On the other hand, in addition to the leading attorney on the case, the new holistic defense model connects defendants with an interdisciplinary team consisting of social workers, housing advocates, mental health specialists, and other attorneys with specializations in civil, immigration, and family law. This new paradigm in legal representation serves to provide additional benefits to indigent defendants by linking them to community resources that may address any underlying causes and other legal consequences to criminal justice involvement.[63] The establishment of this judicial philosophy and the examples of its practice in law offices across the country demonstrates the commitment to a new client-centered approach to legal education and practice.

In 1997, the same year as the creation of the first U.S. mental health court, a group of eight public defenders in the Bronx pioneered the practice of holistic defense in their client advocacy. According to Robin Steinberg, one of the eight attorneys, the group realized that only by listening to their client's stories, understanding their needs, and giving voice to their concerns can an attorney defend their clients powerfully and effectively.[64] Furthermore, the group came to the conclusion that clients seemed more concerned with the consequences of a criminal case rather than the case itself. Clients developed anxieties over the threat of deportation or finding a job and housing after their criminal charge. Upon hearing their stories, these attorneys felt

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63 Robin Steinberg, "Heeding Gideon's Call in the Twenty-First Century: Holistic Defense and the New Public Defense Paradigm." *Washington & Lee Law Review* 70, no. 2 (2013): 963, http://search.ebscohost.com.proxy.library.ucsb.edu:2048/login.aspx?direct=true&db=a9h&AN=87911730&site=ehost-live.

64 Steinberg, "Heeding Gideon's Call in the Twenty-First Century," 964.

inspired to tackle these additional problems and would later create a new defense model that would revolutionize public defense going into the 21st century.

The holistic defense model comprises of four main pillars: 1) seamless access to services that meet legal and social support needs, 2) dynamic, interdisciplinary communication, 3) advocates with an interdisciplinary skill set, and 4) a robust understanding of, and connection to, the community served.[65] The first pillar mandates the additional requirement for attorneys to learn about the available community resources relevant to their client's needs, whether a client requires assistance with their immigration status or obtaining mental health services. Attorneys must also learn to ask the right questions during arraignment to gain an assessment of these specific needs and divert them to the appropriate resources. Sometimes certain offices practicing holistic defense might not have the financial means nor the resources to provide this additional training and must therefore seek the expertise of specialists with the skills and education to conduct these arraignment questionnaires. In tandem with the first pillar, the second pillar advocates for this specific practice of calling upon these experts along with dynamic communication between the specific members of the defense team. The defense team often consists of social workers, investigators, civil attorneys, and other advocates who also work together to meet the needs of the client.

The third pillar involves individual advocates at a holistic defender office cultivate an interdisciplinary skill set through cross-training. In a holistic defense office, newly hired criminal attorneys should obtain basic training in other types of law, including family, housing, employment, and immigration law. In other words, attorneys should not only familiarize themselves with the legal terminology and caseload, but also the nonlegal issues critical to their

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[65] Steinberg, "Heeding Gideon's Call in the Twenty-First Century," 987-1002.

ability to meet the client's needs. The last pillar calls for the holistic defense office to have a deep understanding of the community they serve. By developing rapport with clients and getting a firm understanding of their life story, struggles, and their needs, defenders have the ability to contextualize their client's criminal charges and get a better understanding of the systemic issues that play a role in a person's involvement with the criminal justice system.

Holistic defense offices use various methods in which to put the four pillars into action. A prime example of holistic defense in action is in the local Santa Barbara community. In 2014, the Santa Barbara Public Defender's Office established the Community Defender Division (CDD) who firmly believes in the idea of holistic defense.[66] The unit consists of specialized attorneys in different treatment courts varying from mental health to substance abuse. In addition to providing representation for their clients, the attorneys also link them towards resource specialists from Americorps to help them obtain affordable housing and access to various treatment programs for their conditions. Clients of holistic defenders are not only confined to one specific problem-solving court. Oftentimes, those with mental illnesses also suffer from substance abuse issues and have limited access to housing and employment opportunities due to their conditions. In this unit, clients are asked to partake in a resource diversion interview with either a social worker or community defense advocate to assess the client's needs and wants, whether they be mental health services or housing needs. Once their needs are determined, the attorneys work with judges, probation officers, and the clients themselves to construct a plan for their recovery in all aspects. Participants can take part in a drug treatment program, while also simultaneously participating in intensive therapy and support groups.

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[66] In this segment, I am referring to my own experiences as an intern working at the Santa Barbara Public Defender's Office. All this information is based on my extensive knowledge about the unit. I did not use any sources.

Proponents of the model believe that application of the four pillars and the diversion of clients to different community resources to address their needs will improve case outcomes and reduce the chance of recidivism, or the likelihood of a client to reoffend or commit similar crimes again. By addressing any underlying issues, including a lack of access to mental health care services or a history of addiction and frequent drug use, there is a hope that getting clients connected to the appropriate resources will help them recognize the impact their problems have on their well-being and criminal justice involvement. In turn, they will become inspired to take better care of themselves. While it is inconclusive as to the role that drug use or a mental health concern may play in a crime, the likelihood of a person to commit a crime under the influence or whilst experiencing a severe case of their symptoms, like delusions or mania, is significantly higher than when sober or not experiencing any of the symptoms of their disorder.[67]

The emergence of holistic defense alongside the development of problem-solving courts demonstrates a paradigm shift in law practice towards more client-centered approaches. The judicial philosophy of therapeutic jurisprudence played a role in creating the mental health court model, but the philosophy of holistic defense serves as the means in which to sustain mental health courts and other problem-solving courts across the United States. Offices practicing holistic defense create a network between the various problem-solving courts, including mental health treatment and drug courts. Benefactors of units like the CDD in Santa Barbara and the Bronx Defenders in New York that practice holistic defense have access to a wide array of resources. Holistic defense helped to put therapeutic jurisprudence into practice, and also increases the accessibility of mentally ill individuals to more services to meet their specific needs.

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[67] Snedker, *Therapeutic Jurisprudence,* 8-10.

Chapter 4: Mental Health Courts—Form and Function

Mental Health Courts Today

Thanks to the pioneering efforts of Judge Lerner-Wren and her fellow colleagues in Broward County, there are now more than 300 mental health courts (MHCs) nationwide and even more in Canada, Australia, and England. The dramatic upsurge in MHCs began promptly in the 2000s in what scholars consider waves.[68] The first wave of MHCs targeted nonviolent misdemeanor offenses, but the second wave of MHCs evolved in scope and practice. The second generation of MHCs opened their doors to felony cases and also address co-existing or comorbid disorders. Some localities even established specialized MHCs, like juvenile MHCs and gender-specific MHCs. Although the treatment methods and judicial processes of these courts might differ based on defendant characteristics, funding sources, and the political and cultural climate of the region's criminal justice system, the MHCs follow a standard model of operation with regard to the selection and screening process and the nature of client participation.

The selection process in MHCs involves a few stages. The first stage consists of a client's referral to an MHC and a court liaison's initial assessment to determine participant eligibility. Referrals can come from a variety of sources, including attorneys, police officers, or family members. Once the defendant is referred, court liaisons determine the criteria for participation in terms of the criminal charge and the psychiatric diagnosis of an Axis I mental illness. Axis I mental illnesses are characterized by their "severe and persistent" symptoms. These illnesses include schizophrenia, major depression, and bipolar disorder. Once the court liaison determines a defendant eligible, the defendants engage in a screening process to allow the liaison to identify those most willing and motivated to engage in treatment. The purpose of this phase is to not only

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[68] Snedker, *Therapeutic Justice*, 66.

assess the eligibility, but the amenability of the defendant. The testimony of one court liaison stressed the importance of the amenability, "They can have the diagnosis, but if they are not eager or willing to take the steps to get the treatment, I can't make people do that. It is not fair to them, and it is not a good use of resources."[69]

Liaisons and other members of an MHC team conducting these screenings often use the motivational interviewing technique. As opposed to giving advice on how to change their current behaviors or habits, motivational interviewing has been shown to promote behavioral changes in mostly health-care settings by using a guiding style to "engage with patients, clarify their strengths and aspirations, and evoke their own motivations for change and promote autonomy of decision making."[70] In this setting, the team member asks the defendant to verbalize their motivations, which are usually to get out of jail, stay away from jail, or better their mental conditions. After the screening, the court liaison works with other team members of the MHC, including the defendant's attorney, the judge, social workers, and mental health care professionals to draft a treatment plan. Once the final treatment plan is approved by the team and the defendant reaches the approval stage for participation, the defendant must then voluntarily agree to participate in community-based mental health treatment instead of the traditional jail time, come to the regularly scheduled hearings for check-ins on their progress, and to abstain from drugs and alcohol.

The duration of MHC participation depends largely on the nature of the offense and the severity of the client's mental condition. If the hearings prove that the participant stopped going to therapy, refused to take their medication, or engaged in other activities that did not follow their treatment plan, the MHC team members in charge of the case adjust the treatment plan

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[69] Snedker, *Therapeutic Justice,* 87.
[70] Snedker, *Therapeutic Justice,* 84.

accordingly. Some MHCs developed sanctions to enforce compliance with the court orders and treatment plan. At the extreme, some MHC cases can even be terminated for noncompliance and transferred back to the traditional criminal court, where the client may serve jail time.[71] However, if the MHC participant obeyed all court orders, showed significant improvement in their emotional wellness, desisted from criminal activity, and demonstrated the capability to live independently, then this participant graduates from the program. The graduation ceremony is very much reminiscent of a high school or college graduation, in which the client receives a certificate, the judge rather than the chancellor or principal comes down from the bench and shakes the client's hand, and the audience applauds.[72] Depending on the MHC and the nature of the client's case, additional rewards for completion can also include food vouchers, job training, and even the dismissal of the criminal charges.

Both the collaborative nature of MHC functioning and the supportive role of the judges and other legal actors in a participant's recovery process are reminiscent of therapeutic jurisprudence. The law indeed becomes a therapeutic agent. The court transforms its approach from the adversarial, punitive approach to one with the ultimate goals of promoting mental health treatment and reducing the chances of reoffending. Judges, lawyers, probation officers, and other major legal actors become more aware of their speech and actions to ensure that they do not yield any antitherapeutic outcomes towards an MHC participant.

Efficacy of Mental Health Courts

Throughout the 2000s, counties conducted a series of program evaluations to assess the efficacy of MHCs. Whether or not an MHC is considered effective largely depends on the

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[71] Snedker, *Therapeutic Justice,* 175.
[72] Snedker, *Therapeutic Justice,* 198-202.

court's objectives, which can vary by division. For the most part, legal sociologists tend to consider an MHC effective if the programs result in lower recidivism rates and better mental health outcomes. Different research methods to assess efficacy range from a pre-participation to post-participation assessment of mental health conditions to collecting testimonials from current and former MHC participants.

While there are too many to cite, many individual evaluations of MHCs and some longitudinal studies have shown positive recidivism outcomes. One longitudinal study from 2011 covering MHCs in San Francisco, Minneapolis, Indianapolis, and Santa Clara County concluded that the MHC program participation lowered both post-treatment arrest rates and days in incarcerated when compared to prior participants' involvement in the court.[73] In a 2012 evaluation of two MHCs in New York, MHC participants from the Bronx and Brooklyn were less likely to be re-arrested than those with mental illnesses processed in the traditional courts.[74] Lastly, in 2015, a group of researchers investigated the outcomes of youth participants in a judicial mental health court as part of the Juvenile Behavioral Diversion Program (JBDP) in Washington, D.C. Recidivism rates and psychiatric outcomes were assessed among 108 predominantly African American youth aged 12-18. As hypothesized, the participants of the judicial mental health court resulted in significantly lower re-conviction and re-arrest rates compared to a control group, which consisted of clinically similar to the juvenile MHC participants but did not participate in the court program.[75]

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[73] Slate, *The Criminalization of Mental Illness,* 398.
[74] Slate, *The Criminalization of Mental Illness,* 398.
[75] Aaron M. Ramirez, James R. Andretta, Michael E. Barnes, Malcolm H. Woodland, "Recidivism and Psychiatric Symptom Outcomes in a Juvenile Mental Health Court," *Juvenile and Family Court Journal* 66, no. 1: 40-42. https://doi.org/10.1111/jfcj.12025

While much research has evaluated the efficacy of mental health courts, not too much has been done to assess exactly which specific aspects of MHCs have contributed to their success in lowering recidivism rates. Recently, two scholars employed methods to test which characteristics were vital to the success of an MHC. In 2017, Karen A. Snedker, a sociology professor from Seattle Pacific University conducted a quantitative analysis on 136 defendants who graduated in 2008 from an MHC situated in the West coast.[76] She was primarily interested in the influence of both one's charges dropped will have lower rates of criminal reoffending compared to non-MHC defendants. Snedker's analysis confirmed her hypothesis. The offer to dismiss charges after participating in an MHC had a strong effect on reducing criminal reoffending among MHC graduates. Based on one statistical model, those who were offered a dismissal of charges had "77% lower odds of being charged compared with those who did not," which is considered a significant result in sociological research.[77]

Michelle Edgely wrote a similar research paper but focused on broader aspects that account for the success of MHCs. Rather than evaluating one aspect of success, she argued that there is a confluence of elements that work in tandem to support successful MHCs. She argued that the judge plays a critical role as a therapeutic ally by communicating to MHC participants with respect, actively listening to their concerns, and providing empathetic responses to their issues. In addition to having adroit extralegal skills, Edgely also advocated for judges to have some soft-skill training in interpersonal communication and motivational psychological practices.[78] She also stressed the importance of adopting a holistic approach to rehabilitation.

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[76] Snedker, Karen A, Lindsey R Beach, and Katie E Corcoran. "Beyond the 'Revolving Door?': Incentives and Criminal Recidivism in a Mental Health Court." *Criminal Justice and Behavior* 44, no. 9 (2017): 1141-162. https://doi-org.proxy.library.ucsb.edu:9443/10.1177%2F0093854817708395

[77] Snedker, "Beyond the Revolving Door," 1144.

[78] Michelle Edgely, "Why Do Mental Health Courts Work? A Confluence of Treatment, Support & Adroit Judicial Supervision." *International Journal of Law and Psychiatry* 37, no. 6 (2014): 578. https://doi-org.proxy.library.ucsb.edu:9443/10.1016/j.ijlp.2014.02.031

Offering treatment by means of therapeutic drugs can only address one aspect of the problem—the symptoms of mental illness.[79] In reality, there are other compelling issues that these MHC participants face. Some have struggles with finding housing, maintaining their relationships with loved ones, and securing employment with a criminal record. Edgely believed that in addition to treatment, MHC participants should also be provided psychosocial assistance with these struggles so that they may address these other underlying problems.[80]

Research tends to fall into two categories: basic and applied research. The rationale for basic research rests on the idea of contributing to theory, while applied research is that which contributes to practice. While both Snedker and Edgely's research could play a role in contributing to the theory behind using MHCs, the significant findings from both studies also lends itself to application. Studying the factors responsible for the effectiveness of mental health courts allows for us to assess what has worked and what could be improved. Snedker's research demonstrated that the use of incentives could favor well in those courts that do not have these incentives for potential MHC graduates. For courts that did not yet establish an MHC within their division, we gathered from her research that implementing these courts can significantly lessen criminal reoffending among those with mental illnesses, especially if these defendants are offered the possibility of their charges being dropped upon MHC completion. For those that do have MHCs, the research is just as valuable. Those MHCs without incentives for their participants can utilize this research to further improve their court programs. However, while the research is telling, the results from their findings are limited in scope. Snedker's research involved a limited sample from only one mental health court in an undisclosed West Coast city. The sample collected from this project might not be representative of all the other MHCs across

[79] Edgely, "Why Do Mental Health Courts Work," 573-574.
[80] Edgely, "Why Do Mental Health Courts Work," 578.

the United States. Therefore, it is possible that more research still needs to be done to assess their efficacy.

Chapter 5: One in Four

"The worst part of having a mental illness is people expect you to behave as you don't" – Arthur Fleck, *Joker* (2019)

In our discussion of mental health care history, we first explored how the "hyperoptimism" from lawyers, politicians, and other advocates along with the not-in-my-backyard (NIMBY) syndrome among community residents contributed to the disaster of deinstitutionalization. In theory, deinstitutionalization seemed a good idea. Any initiative that detracted the mentally ill out of the "snake pits" would serve as a viable option. Unfortunately, the situation turned for the worst and most mentally ill now reside in places much worse than the psychiatric hospitals. At least in these asylums, they had access to 24-hour supervision from health care staff and provided the basic needs including food, water, and shelter.

In hindsight, the hospitals should have never closed. Instead, the Joint Commission of Mental Illness should have advocated that funding and other major resources instead go to improving these psychiatric hospitals, or the *treatment* of the disorders rather than in engaging in research about *early prevention*—a difficult task considering the struggle of identifying a mental illness as compared to a physical ailment. People with mental illnesses do have wounds, but they are not as visible or obvious as a physical cut or burn. How can those with little knowledge of mental illnesses even identify when there is a problem? How exactly would they monitor an early onset of mental illnesses?

Next, we tracked the evolution of the intersection between the law and mental health. During the 1960s and 1970s, mental health law scholarship and practice focused primarily on increasing the civil liberties of involuntarily committed patients, or the legitimacy of the insanity defense. Later on, as the legal system turned towards more punitive practices during the War on Drugs, court dockets flooded with criminal cases pertaining to drug abuse and mental health issues. Legal scholars and practitioners noticed that the adversarial system of justice did not do much to address a potential underlying cause of criminal behavior. The same offenders continue to find themselves trapped in a revolving door, cycling between the streets and the prison system.

The legal field shifted away from the punitive, adversarial system of justice towards more therapeutic, client-centered approaches as evidenced in the works of Bruce Winick and David Wexler and actors like Howard Finkelstein and Judge Ginger Lerner-Wren to advocate for systematic change in the judicial system. The law recognized that they only contributed to the problem by forcing the mentally ill into the criminal justice system whose primary actors are ill-equipped to care for their concerns and whose toxic environment only worsened their mental conditions. As a result, a new innovation known as problem-solving courts decided to use the law to mandate treatment for potential underlying causes, including a history of drug abuse and mental health concerns.

Mental health courts became one of the latest of these courts with the ultimate goals of increasing access to community-based treatment for the mentally ill defendant and reducing the defendant's future contact with the criminal justice system. The factors largely responsible for this new development involved new perceptions of the mental health system. As demonstrated in this paper, advocates of the "quiet revolution" in criminal justice aimed to use the law to solve problems as opposed to contributing to them. The errors and complications in providing an

alternative source of treatment for thousands of mentally ill individuals discharged from the state hospitals was a leading cause in turning the jails into the de facto state hospitals. Sympathetic lawyers, judges, and other advocates worked together to address the problems that the mental health system failed to solve for some patients and developed a court of refuge. The court's structure and its key members promote an environment that fosters dignity, trust, and hope in its participants to better their circumstances.

However, while these new initiatives by the legal system are worthy of commendation and signify a step in the right direction, much work still needs to be done to address the needs of the mentally ill in the United States. More specifically, I believe new efforts should be taken to educate both the general public and the key players of the legal system, including judges, lawyers, and police officers about how best to support those with mental health concerns. In the case of the general public, various forms of media should avoid using mental illness as a ploy to entertain rather than educate its viewers. Compromising authenticity and accurate mental health portrayals, films in the latter end of the 20th century tend to sensationalize mental illness by associating the symptoms with violence. Later on, evidence shows a significant shift in mental health portrayals in film and television away from the homicidal maniac with no remorse to a person suffering from severe challenges that prevent them from moving forward with their daily lives. These new perceptions and portrayals may also signify a shift in attitudes towards those with mental illnesses.

While evidence suggests this shift, problematic portrayals of mental illness still exist today. For instance, M. Night Shyamalan's *Split* (2016) echoed *Psycho*'s (1960) premise of someone with multiple personalities going on killing sprees, but sensationalized dissociative identity disorder to the extreme. Norman Bates had only one other personality—the homicidal

"mother." However, *Split* (2016) implies that one of the separate personalities can evolve into a cannibalistic "Beast" with superhuman capabilities.[81] If the entertainment industry continues to churn out films that continue to hint at the violent tendencies of those with mental health concerns, this will only add to the stigma of the mentally ill as unpredictable, erratic, and violent.

On another note, the growing acceptance of mental health in the media birthed a new problematic issue—romanticizing mental illness. The most striking example of this in recent times is Netflix's hit drama series *13 Reasons Why,* which sparked a profound debate within the mental health community for a couple of reasons. The series told the story of Hannah Baker who, before taking her own life, recorded and delivered thirteen cassette tapes to specific individuals explaining why they were partially responsible for her death. Each episode revealed several heartbreaking experiences that ultimately led to her suicide, including the spread of a salacious rumor and her rape. While some mental health professionals praised the series for "starting a conversation about taboo topics," they also condemned the series for romanticizing suicide.[82] By responding to the individuals who caused her severe harm through the cassette tapes, she played into a teen revenge fantasy and also discouraged people having suicidal thoughts or dealing with depression to seek out help. Representatives from the national suicide prevention hotlines even reflected on the numerous times they received a call from a someone saying something along the lines of "Well, Hannah killed herself and those around her finally paid attention, so I should do it too."[83] Therefore, in addition to stopping the spread of the problematic stigma of the violent and impulsive mentally ill person, TV series and film should avoid romanticizing mental illness.

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[81] Carolyn Todd, "Here's What 7 Mental Health Experts Really Thinking about 13 Reasons Why," *Self,* May 9, 2018. Retrieved from https://www.self.com/story/13-reasons-why-season-two-mental-health-experts-commentary
[82] Todd, "Here's What 7 Mental Health Experts Really Thinking."
[83] Todd, "Here's What 7 Mental Health Experts Really Thinking."

Yet another initiative of further educating the public involves recognition of the problematic language used in everyday conversation. Words like “crazy,” “insane,” and “psycho” only perpetuate the association between violence and mental illness even further, at least in some contexts that imply a negative connotation. Moreover, people tend to incorrectly diagnose those around them when in fact they know very little about the mental health disorder to make such a claim. An individual’s actions might prompt others to quickly jump to conclusions to explain their behaviors. For instance, when we notice a friend taking the time to organize his locker, someone might make a comment that he has obsessive-compulsive disorder (OCD). Another example involves people incorrectly diagnosing themselves. When these individuals notice how their mood changed dramatically over the course of a day, they might think they developed bipolar disorder. In simplest terms, we should be aware of the language we use in our everyday lives. By making such comments, we are demonstrating insensitivity to those suffering from these illnesses. Therefore, in addition to educating people in school and the workplace on racist, homophobic, and transphobic language, providing awareness on stigmatizing language could also help ensure that we are sensitive to people’s struggles with these symptoms.

As for the key actors in the legal system, there should be more training for police officers and probation officers. I do understand, in fact, that law enforcement already has a great deal of responsibility on their plate. However, given the severity of the mental health crisis in prisons and jails across the country, they should have some knowledge on first-responder training. They must learn to use kind and compassionate language when responding to a person in trauma or suffering from a psychotic episode before resorting to force. Local police centers could also collaborate with nearby mental health clinics with trained responders to be the first point of

contact when certain calls involve a person with severe mental illness. My last suggestion rests on applying the tenets of therapeutic jurisprudence to all types of cases, not just the specialized cases that involve domestic violence, drug abuse, or mental health. In other words, I advocate for lawyers across the country to act as holistic defenders. In addition to appearing on behalf of their clients in court or negotiating other terms with the prosecution, attorneys should tend to the client's other needs. They do not necessarily have to be experts in mental health or drug abuse, but they should have a basic knowledge of the various resources they could refer their clients to. By actively listening to their concerns, validating their feelings, and taking the time to address their needs, the lawyer becomes a champion for mental health advocacy.

One in four individuals in the United States suffer from a mental illness.[84] The spectrum ranges from depression and anxiety to schizophrenia and dissociative identity disorder. At some point in our lives, we might encounter someone with a mental illness, whether in public or at home. For those in the streets, we should show compassion as opposed to fear. As we learned in our discussion of mental health care history, the system failed them and put them in that position without adequate treatment. Fortunately, the legal system recognized the need to establish specialized courts that aimed to combat the revolving door problem. By referring their clients to therapists and psychiatrists, lawyers and the other major judicial actors work together to address the potential underlying causes of criminal behavior. Instead of mocking their clients, these staunch advocates for mental health demonstrate compassion, understanding, and empathy—the main drivers of human connection. Echoing the rhetoric of the Civil Rights era, the law becomes an instrument for social change. In this situation, the law transforms into a therapeutic agent that assists individuals in their everyday battles with their inner demons.

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[84] Roth, *Insane: America's Criminal Treatment of Mental Illness,* 13.

As for our friends and family, there are many ways you can support them as they suffer from their pervasive symptoms and unpleasant side effects from medication. One thing we can do is learn to educate ourselves to the best of our abilities about the signs and symptoms of mental illness, as well as resources in our communities to help our loved ones. Once we educate ourselves about their symptoms and learn to recognize some of the warning signs, we could potentially save a life by directing them towards proper resources. We can also support anyone with a mental illness by showing empathy and compassion. Although we might not understand what they are going through if we do not suffer from the symptoms ourselves, we can reflect to a time when we felt isolated or in pain and channel those thoughts to recognize a person's feelings. Empathy allows for a person to find something within themselves that enabled people to take in the perspective of others, remove themselves from judgment, and validate their feelings. By educating ourselves and demonstrating unconditional love and compassion, we build meaningful relationships with those around us and create lasting connections.

If you or a loved one is experiencing suicidal thoughts, please don't hesitate to reach out if you need help. You are not alone. Help is available.

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