How U.S. Society Has Treated Those With Mental Illnesses

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Michael Mullan, an S.J.D Candidate at American University Washington College of Law, passed away on November 23, 2020. He was working on his dissertation entitled, “Abolishing the Insanity Defense – An American Criminal Law and Human Rights Perspective” making significant progress and publishing in his field while undergoing treatment for cancer. Michael aspired to create meaningful legal change through his academic work.

Mr. Mullan, originally from Ireland, spent the past number of years living in Boston. His legal education began at Trinity College Dublin, where Michael graduated with a first-class honors in Law and Business. Michael’s legal interests and passion were at the intersection of criminal law and disability. Michael completed an LL.M at Harvard Law School, receiving a number of scholarships, such as the JFK Fund scholarship and a Cancer for College scholarship. At Harvard Law School, Michael specialized in criminal law and justice, disability law and human rights jurisprudence. He received the Graduate Student’s Humanitarian Award for his voluntary work with Harvard’s Project on Disability and Harvard’s Prisoners Legal Assistance Fund. Michael’s work is widely published in Ireland and in the U.S. on a variety of criminal law and justice topics.
Persons with mental illness are incarcerated in prisons across the United States at disproportionate rates compared to the general population. Understanding why this is so requires an examination of how society in general has treated persons with mental illnesses. This article relates a history of neglect and stigmatization in examining the entities responsible for care of persons with mental illnesses, including the family, asylums and prisons. The article identifies trends of institutionalization, deinstitutionalization, and transinstitutionalisation, whereby large amounts of inpatients with mental illnesses moved out of psychiatric institutions, into the streets, and then into the criminal justice system. The article also analyses socioeconomic factors bearing on mental illness as a cause of crime, the high arrest rates and prison conditions experienced by those with mental illness, and public perceptions and myths about persons with mental illnesses.

The article claims the impact of social control via the criminal justice apparatus – policing, imprisonment, and subsequent labeling – is a predominant cause of the high rates of imprisonment. It is suggested that in order to reverse the trend towards the mass incarceration of those with mental illnesses, we should reject calls for a return to the asylum. Instead, our focus should be on providing community-based treatment and interventions that address the socioeconomic causes of crime.

INTRODUCTION

In order to understand how the criminal law treats defendants with mental illnesses, it is important to understand how society more generally has treated persons with mental illnesses in the United States. Persons with mental illnesses have a history marked with minority status, discrimination, stigma, abuse, inequality, and ill-treatment. As the academic Gostin outlines, “[d]espite countless promises for a better life by national commissions, governments and the international community, there has evolved a worrying

1 See Elaine Brohan et al., Experiences of mental illness stigma, prejudice and discrimination: a review of measures, 10 BioMED CENT. HEALTH SERVS. RESCH. 1, 1 (2010).
2 Id.
3 Tom Fryers et al., Social inequalities and the common mental disorders: A systematic review of the evidence, 38 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 229, 229 (2003); see Vikram Patel & Arthur Kleinman, Poverty and Common Mental Disorders in Developing Countries, 81 BULL. WORLD HEALTH ORG. 609, 609 (2003).
cycle of neglect, abandonment, indignity, cruel and inhuman treatment, and punishment of persons with mental illness.”5 This population has experienced a “shameful history of benign, and sometimes malignant, neglect.”6 Persons with mental illnesses have traditionally faced significant barriers towards full integration and full participation in society, through legal, governmental, social policy, criminal justice and other societal mechanisms.7 This is a partial explanation for the poorer quality of life that persons with mental illnesses experience.8 This article will explain the historical treatment of those with mental illnesses by U.S. society, particularly in the criminal law apparatus. This involves looking at the various entities that have been primarily responsible for looking after and dealing with persons with mental illnesses., including the family, asylums and prisons.

Four hundred and fifty million people worldwide suffer from mental illnesses.9 And, a recent study in 2016 estimated that over 44 million U.S. adults over 18-years-old have a mental illness.10 This represents 18% of the U.S. adult population. The study also estimated that 10.4 million, or 4.2%, of U.S. adults, have a severe mental illness.11 Furthermore, in another governmental study, it was found that 3.7% of the US population over 18 years of age have experienced serious psychological distress (a broader term than mental illness) in the prior month.12 In fact, a similar finding was established in a 2017 study by Weismann et al., at 3.4%.13

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5 Gostin, supra note 4.
6 Id.
7 Id.
8 Heinz Katschnig, Quality of life in mental disorders: challenges for research and clinical practice, 5 WORLD PSYCHIATRY 139, 143–44 (2006); Janice Connell et al., Quality of life of people with mental health problems: a synthesis of qualitative research, 10 HEALTH & QUALITY LIFE OUTCOMES 1, 1 (2012); Suprakash Chaudhury et al., Quality of life in psychiatric disorders, 1 J. TRENDS IN BIOMEDICAL RSCH. 1, 1 (2018); Amy L. Barnes et al., Health-Related Quality of Life and Overall Life Satisfaction in People with Serious Mental Illness, 2012 SCHIZOPHRENIA RSCH. & TREATMENT 1, 1 (2012); Carol C. Choo et al., Quality of Life in Patients with a Major Mental Disorder in Singapore, 9 FRONTIERS PSYCHIATRY 1, 1 (2019); Sherrill Evans, The impact of mental illness on quality of life: A comparison of severe mental illness, common mental disorder and healthy population samples, 16 QUALITY LIFE RSCH. 17, 17 (2017); Frank Holloway & Jerome Carson, Quality of Life in Severe Mental Illness, 14 INT’L REV. PSYCHIATRY 175, 176 (2003).
11 Id.
13 Judith Weissman et al., Disparities in Health Care Utilization and Functional Limitations Among Adults
Part I of this piece looks at this history until after the period of institutionalization. Part II then continues this historical analysis, discussing the trend of deinstitutionalization and its causes. Part III analyses one consequence of deinstitutionalization, namely transinstitutionalisation. Part IV then transitions to examine how mental illness can be a cause of crime, including the role of socioeconomic factors. Part V looks at how those who have a mental illness are disproportionately arrested by police. Penultimately, Part VI discusses the prison conditions that prisoners with mental illness face and the harsh legal ramifications they experience. Finally, Part VII briefly examines the public perceptions, including myths, that the public has about persons with mental illnesses.

I. History of Mental Illness

A. Family & Local Community

Traditionally, the care of persons with mental illnesses was seen to be the responsibility of the family. However, over time, the state has taken over this role, due to the federal government’s welfare responsibility. As a result of this federal government involvement, American society began to see substantial confinement of persons with mental illnesses in institutions, such as psychiatric hospitals. Before this, during the pre-civilization era of history, at the earliest of the stone ages, early tribal groups believed that mental illnesses were a manifestation of evil spirits. At this time, managing and treating these individuals was the family’s or the clan’s responsibility. Another method of dealing with persons with mental illnesses in early times was to banish them from the community or even kill them.

With Serious Psychological Distress, 2006-2014, 68 Psychiatric Servs. 653, 655 (2017) (noting that in 2009 and 2014, the weighted percentage of serious psychological distress among adults ages 18 to 64 years was 3.4%).


Risdon N. Slate et al., The Criminalization of Mental Illness: Crisis and Opportunity for the Justice System 30 (Carolina Acad. Press 2d ed. 2013); The History & Evolution of Mental Health
B. Ancient Civilizations

There was a development of scholarly interest in what was referred to at the time as ‘madness’ during the periods of the ancient civilizations, for example in the works of Plato and Hippocrates. Importantly, it was the ancient Greeks and Romans who progressively determined that persons with mental illness required care and treatment from the government. Mental illness acted as a “criminal excuse” under Roman law.

C. Middle Ages

The Middle Ages brought the advent of religion, which established a link between mental illness and demonology. In fact, historically, in certain faiths such as Judaism and Hinduism, the link between evil spirits and mental illness was so strong that some of the persons with mental illnesses were subject to exorcisms. In regards to medieval society, although most persons with mental illnesses took an active part in society, some of those with mental illnesses were confined in custodial centers.

D. Violence Leads to Institutionalization

Similarly, there were between 600,000 to 9 million persons with mental illnesses outcasted, tortured and killed during the witch hunts known as Malleus Maleficarum. This was particularly the case at the end of the 1600s.

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19 Slaté et al., supra note 18, at 20 (noting that Plato “proposed that the body and soul were distinct, yet interdependent, entities”).
20 Id. (stating Hippocrates believed in distinct physical cause of mental illness, namely imbalanced bodily fluids).
21 Id. at 20-21.
23 See Alexis Bridley & Lee W. Daffin, Jr., ESSENTIALS OF ABNORMAL PSYCHOLOGY 1.3.3 (Carrie Cutler ed., 1st ed. 2018) (ebook). In this way, control of crime and control of persons with mental illnesses have similar historical underpinnings, with criminal punishment originally seen as a method to remove the evil spirit and sins of the offender. See Harry E. Barnes, THE STORY OF PUNISHMENT: A RECORD OF MAN’S INHUMANITY TO MAN 39 (Stratford Co. 1930).
24 Slaté et al., supra note 18, at 21.
26 A custodial center can be any institution used to control, change, or stop certain behaviors. See Aaron Rosenblatt, Providing Custodial Care for Mental Patients: An Affirmative View, 48 PSYCHIATRIC Q. 14, 15 (1974); Guy Geltner, Medieval Prisons: Between Myth and Reality, Hell and Purgatory, 4 HIST. COMPASS 261, 264 (2006); William C. Cockerham, SOCIOLOGY OF MENTAL DISORDER 13 (Routledge 10th ed. 2017).
27 Slaté et al., supra note 18, at 21–22.
28 See Beatriz Quintanilla, Witchcraft or Mental Illness?, PSYCHIATRIC TIMES (June 21, 2010), https://www.psychiatrictimes.com/view/witchcraft-or-mental-illness.
During the Renaissance, there was a movement to institutionalize persons with mental illnesses as opposed to torturing and executing them. As Appleman points out, from the beginning of European society, persons with mental illnesses were confined and isolated, often in asylums. However, despite some good intentions when establishing these public institutions, many inpatients were chained, abused and tortured under the premise of therapy.

E. Historical Treatment by U.S. Society

Both Dershowitz and Appleman, two prominent legal academics and lawyers, provide thorough descriptions of how U.S. society has treated persons with mental illnesses throughout American history. During early American colonial society, persons with mental illnesses were often not incarcerated. Instead, they were treated within the community as any other dependent.

Again, persons with mental illnesses were the responsibility of the family and were traditionally contained in the family home’s attic or basement. If this was not possible, the town or village became responsible for confining those with mental illnesses in a shack or hut in the middle of the commons. Occasionally, they were confined in a poor almshouse or prison. The enforcement of poor laws was largely to blame for this initial trend of imprisoning persons with mental illnesses, with peace and stability of the community being the primary goal.

F. The Shift to Institutionalization

There was then a societal shift in responsibility from the community to the institution. America’s first public hospital housed those with mental

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29 BRIDLEY & DAFFIN, JR., supra note 23, at 1.3.4.
31 See Appleman, supra note 30, at 422.
33 Dershowitz, supra note 32, at 786.
35 Id. This was an attempt by the local community to house and separate those who were mentally ill from the rest of society. Sometimes this was well intended, and at other times, it was used as a form of social control. Appleman, supra note 30, at 423.
36 Dershowitz, supra note 32, at 786–87.
37 Frontline: Deinstitutionalization (PBS television broadcast May 10, 2005).
38 ROTHMAN, supra note 34.
39 See generally id.
illnesses in its basement. This was followed by the first psychiatric hospital and other public psychiatric hospitals opening in urban areas along the east coast. The U.S. established its first asylum in Williamsburg, Virginia, which introduced treatment instead of punishment. This marked a move from taking care of persons with mental illnesses within the family home to institutionalization in the form of safe confinement for those who failed to fit into the ‘normal’ expectations of societal standard behaviors.

At this stage in history, asylums were seen as a “first resort.” The focus was placed on disciplining deviancy. Therefore, asylums were used to spatially exclude a population that was unfamiliar and unlike the rest of society. However, due to overcrowding (in turn, largely caused by urbanization) and poor quality of doctors, there was an end to the ‘moral treatment’ approach (that focused on individualized treatment, rather than just confinement during early American society). Instead, the practice became warehousing persons with mental illnesses.

Around this time in history, Dorothea Dix, an early pioneering legal advocate, began to publicize the plight of prisoners with mental illnesses in U.S. jails, prisons, and asylums. Her efforts led to the creation of at least thirty public, state psychiatric hospitals across the U.S. Unfortunately, these efforts inadvertently and effectively erased persons with mental illnesses from society. They contributed to the institutionalization of many who had previously been “tolerated” in the community in the name of quasi-community care. “[C]rowded, understaffed and underfunded,” these institutions created poor and often dangerous living conditions for their patients. In terms of

40 See Powers, supra note 30.
42 Slate et al., supra note 18, at 24.
43 Appleman, supra note 30, at 427.
44 Rothman, supra note 34.
45 Appleman, supra note 30, at 428.
48 Torrey, supra note 41, at 82.
51 Dershowitz, supra note 32, at 807.
52 Id.
53 Appleman, supra note 30, at 433.
social control theory, at this point in history asylums were used to reorder society.\textsuperscript{54} Again, the psychiatric institutions were an agent of society and of the government to reinforce an existing strict social hierarchy.\textsuperscript{55}

\textit{G. Eugenics}

Despite the efforts by early reformists, such as Louis Dwight, Benjamin Rush, Dorothea Dix, and some progressive politicians, to bring about humane treatment of this population, there was a growing movement that believed persons with mental illnesses could not be treated and their deviant behavior could not be changed.\textsuperscript{56} This resulted in efforts to sterilize, i.e., undergoing a forced medical procedure that would prevent procreation,\textsuperscript{57} those who had a mental illness,\textsuperscript{58} as well as attempts to use lobotomies, eugenics, and euthanasia against this population.\textsuperscript{59} Eugenicists wanted to stop the reproduction of ‘degenerate’ populations.\textsuperscript{60} Given that Cesare Lombroso, an influential criminologist at the time whose work was well received by many in power,\textsuperscript{61} believed that the criminal mind was inherited and the hereditary criminal\textsuperscript{62} was deemed necessary to be eliminated by stopping the criminal class’ ability


\textsuperscript{55} Appleman, supra note 30, at 425 (citing Nancy Isenberg, \textit{White Trash: The 400 Year-Old Untold History of Class in America} 102 (2016)).


\textsuperscript{58} Such as in the infamous case of \textit{Buck v. Bell}, which concerned a person with an intellectual disability. 274 U.S. 200, 205 (1927). In \textit{Buck v. Bell}, the U.S. Supreme Court stated that “(i)t is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind.” \textit{Id.} at 207. As Young points out, “(a)s recently as 1983, 15 states had compulsory sterilization laws for people with disabilities.” Lauren Young, \textit{Decriminalizing Disability}, \textit{52 Md. B.J.} 62, 64 (2019).

\textsuperscript{59} \textit{See generally} William Gronfein, \textit{Psychotropic Drugs and the Origins of Deinstitutionalization}, \textit{32 SOC. PROBS.} 437, 443–44 (1985) (describing lobotomies and other therapies that were used to treat the mentally ill).

\textsuperscript{60} Appleman, supra note 30, at 437–38.


\textsuperscript{62} \textit{See} Marvin E. Wolfgang, \textit{Pioneers in Criminology: Cesare Lombroso}, \textit{4 J. CRIM. L. CRIMINOLOGY & POLICE SCI.} 361, 368 (1961)
to reproduce. These developments led to a form of social Darwinism, and subsequently, more incarceration for disability than crime.

H. Compulsory Confinement

Custodial care orders were also extremely common due to the widespread belief that if society could segregate the inferior class (using incarceration, institutionalization and sterilization) then this class of individuals would “eventually die out.” Thus, in an effort to completely eliminate persons with mental illness, around the mid-1800s, there were large numbers of civil, involuntary commitments to mental institutions. However, it wasn’t until the 1960s that we saw the mass confinement of criminals and persons with mental illnesses in United States prisons.

II. Deinstitutionalization

A. The Emergence of Deinstitutionalization

Prior to the civil rights movement, a new trend of “deinstitutionalization” began. This trend focused on releasing persons with mental illnesses from psychiatric institutions, with the objective of getting treatment in the community. At the time, Foley and Sharfstein outlined the rationale behind deinstitutionalization:


See generally Appleman, supra note 30, at 430-32 (describing the commonality of compulsory confinement).

Id. at 446.

See id. (“As concern mounted over the ever-rising numbers of feebleminded and mentally ill, permanent correctives began to be sought. Doctors, lawyers, and state legislators agreed that one of the best solutions to this social problem was the establishment of asylums and farm colonies, to house and segregate the ‘defective’ individuals.”)


See generally Cahalan, supra note 64 (showing the increase in the number of individuals in U.S. prisons in the 1960s); see also Appleman, supra note 30, at 456 (describing the shift in treating mental illness as a medical decision to treating it as a legal decision as well).


It will be possible within a decade or two to reduce the number of patients now under custodial care by 50 percent or more. Many more mentally ill can be helped to remain in their homes without hardship to themselves or their families. Those who are hospitalized can be helped to return to their own communities... Central to a new mental health program is comprehensive community care. Merely pouring Federal funds into a continuation of the outmoded type of institutional care which now prevails would make little difference.72

This began with the 1963 Community Mental Health Act.73 The Act aimed to create 1500 local community mental health centers.74

B. Causes of Deinstitutionalization

1. The Development of Pharmaceutical Drugs

Certain pharmaceutical developments played a large role in deinstitutionalization.75 The development of psychotropic drugs, like Thorazine, meant that certain symptoms of mental illness, such as psychosis, could be curtailed, making it easier for the patients who used such drugs to be treated in the community, yet remain under the control of medical professionals.76

2. Poor Conditions in Asylums

Another driving force of the deinstitutionalization movement was the media’s coverage of the dire and deplorable conditions of some psychiatric hospitals and asylums.77 Other causes of deinstitutionalization include broader social reform,78 a combined effort towards decarceration and deinstitutionalization,79 lessons learned from the civil rights movement,80 the high cost of...
running asylums, and the rise of individualism and individual rights. Some factors combined to encourage social change generally (such as the Civil Rights Movement), and others, in particular within the mental healthcare setting like the rise of rights in this context. Finally, a number of the other factors contributed by shedding light on the plight of those stuck in mental psychiatric institutions, such as developments in WWII related to PTSD and media coverage.

3. Public Interest Litigation

To a large extent it was the courts, at the behest of civil libertarian groups like the American Civil Liberties Union (ACLU), that had a significant role to play in deinstitutionalization, through public interest litigation. Courts required the usage of the least restrictive setting (which required that those institutionalized for their mental illness must be confined in the least invasive possible), and required procedural safeguards for psychiatric inpatients in the form of “heightened due process.” Advocating for an “ideological shift,” legal activism by liberal legal advocates stemming from the
civil rights movement\textsuperscript{94} also challenged the involuntary treatment and involuntary confinement of this population\textsuperscript{95} and made such state involuntary practices more difficult.\textsuperscript{96} \textit{Wyatt v Stickney}\textsuperscript{97} recognized the constitutional right to treatment and \textit{Lessard v Schmidt}\textsuperscript{98} found that involuntary confinement could only occur if there were an extreme likelihood of immediate harm to himself or others. The \textit{Lessard} case also importantly established that a person being faced with involuntary commitment must have the same procedural rights as a criminal defendant.\textsuperscript{99} This made civil commitment more difficult for states, and, therefore, contributed to deinstitutionalization.\textsuperscript{100} Additionally, the Americans with Disabilities Act (“the ADA”) was fundamental in building on the progress of the deinstitutionalization movement.\textsuperscript{101} Although Title II came later, it importantly had an integration mandate, that required public services, including housing, to be provided in the most integrative manner possible.\textsuperscript{102} Based on the ADA, the Supreme Court held in \textit{Olmstead v. L.C.}, that “unjustified isolation” constituted discrimination.\textsuperscript{103} The lack of resources that followed deinstitutionalization, such as the lack of availability of housing resources for those recently discharged from institutions, had a number of significant consequences.\textsuperscript{104} For instance, although 1500 community mental health centers were going to be built as part of the 1963 Community Mental Health Act, only half of these centers were actually built and none were fully funded.\textsuperscript{105}

\textsuperscript{95} Id.
\textsuperscript{96} Markowitz, supra note 93.
\textsuperscript{99} See id. at 1087–88.
\textsuperscript{100} ALISA ROTH, INSANE: AMERICA’S CRIMINAL TREATMENT OF MENTAL ILLNESS 91 (Basic Books ed., 2018).
\textsuperscript{101} See Bagenstos, supra note 87, at 5–6.
\textsuperscript{102} 28 C.F.R. § 35.130(d) (2016).
C. Extent of Deinstitutionalization

It should be noted that between 1965 and 1975, the number of individuals becoming inpatients in local psychiatric hospitals fell almost 60%. More broadly, in 1955 over 500,000 severely mentally ill patients were in public psychiatric hospitals, and this was reduced to just over 70,000 in 1994. In terms of the corresponding incarceration rates, since the 1970s, it has grown by nearly 400%. These statistics effectively demonstrate the most immediate impacts of the deinstitutionalization movement.

D. Is the Criminalization Argument Correct?

Certain statistics undermine the criminalization hypothesis—that persons with mental illnesses were primarily released from mental health institutions and without effective and widespread access to community mental healthcare, ended up being institutionalized in criminal justice prisons and jails. For example, from 1950 to 2000 the proportion of people with serious and persistent mental illnesses living in psychiatric institutions dropped by 23%, whereas the proportion living in correctional institutions rose only 4%. The rise in incarceration rates for those with severe and persistent mental illnesses follows a predictable pattern, remaining at 1% from 1950 to 1970, but rising to 3% by 1990 and 5% by 2000.

As one can see, a significant number of formerly institutionalized individuals did not end up going directly from psychiatric into criminal justice institutions. That being said, there was “an overall increase (from 8 percent to 11 percent) in the percentage of prison inmates with prior mental hospitalization between 1968 and 1978”, demonstrating that some individuals did move from mental healthcare institutions into the criminal justice institutions. Currently in U.S. prisons and jails, there are “over 350,000 inmates with serious

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106 Harcourt, supra note 14, at 70 (citing William Gronfein, Incentives and Intentions in Mental Health Policy: A Comparison of Medicaid and Community Mental Health Programs, 26 J. HEALTH & SOC. BEHAV. 192, 196 (1985)).
107 TORREY, supra note 41, at 8–9.
110 Skeem et al., supra note 109.
111 Markowitz, supra note 93, at 48.
mental illness compared to approximately 70,000 patients with serious mental illness in hospitals.”

III. Transinstitutionalization

Despite the good intentions behind deinstitutionalization, there was insufficient financial and political support given to community treatment plans. This resulted in many former inpatients “falling through the cracks” of community-based psychiatric support. Although it is more costly to institutionalize those with a mental illness in psychiatric hospitals or prisons, it is far cheaper to intervene earlier in the form of community mental healthcare. As Slate et al. argue, deinstitutionalization occurred with the best of intentions and for the right reasons, but ultimately was an abysmal failure resulting in transinstitutionalization.

A. Monetary Support for Deinstitutionalization

Around the time of the deinstitutionalization movement, there was a shift in fiscal policy, whereby the financial responsibility of providing psychiatric services, and providing public welfare aid such as Medicare, Medicaid, and Social Security Disability, was transferred from the states to the federal government. This shift in responsibility did not correspond with a shift insufficient financial resources, and instead, there were many budget cuts and an underfunding of public mental health services.

113 See John A. Talbott, Deinstitutionalization: Avoiding the Disasters of the Past, 55 PSYCHIATRIC SERVS. 1112, 1112–113 (2004).
115 Markowitz, supra note 93, at 45.
117 SLATE ET AL., supra note 18, at 8.
118 Markowitz, supra note 93, at 47.
119 Id. at 45, 47.
B. Extent of Transinstitutionalization

This trend can again be illustrated statistically, as Abramson, one of the leading academics in the area, demonstrates: “[b]etween 1880 to 1960, the percentage of prisoners with mental illnesses ranged from 0.7% to 1.5%.”

Today approximately 15-20% of all prisoners have a serious mental illness.

The problem has become so extensive, that critics now argue we have entered into a period characterized by the “criminalization of mental illness.”

1. Criminalization

The asylums supervised persons with mental illnesses and ensured they took their medications, but when patients were discharged and released into the community, many stopped taking their medication and failed to received adequate follow-up treatment. This argument assumes that medication was helpful in most or all cases, which is not necessarily true. In some instances, mentally ill individuals’ behavior in the community became so problematic that it arose to a criminal justice problem. The lack of public psychiatric hospital beds has led to a direct increase in both homelessness and the criminalization of the mentally ill.

2. Changing Views of What Influences Criminal Behavior

Criminal law is slowly embracing the underlying premises of psychiatry and psychology, which allows for both individual accountability, but also examines the biological, neurological, and social influences on criminal behavior. In this way, the behavioral sciences—neuroscience in particular—are changing the way we think about the responsibility of individuals whose

121 TORREY ET AL., supra note 109, at 7.
122 See Marc F. Abramson, The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a New Mental Health Law, 23 HOSP. & COMTY. PSYCHIATRY 101, 104–05 (1972); see also Christopher G. Fichtner & James L. Cavanaugh, Malignant Criminalization: From Hypothesis To Theory, 57 PSYCHIATRIC SERVS. 1511 (2006); see also Megan L. Davidson & Jeffrey W. Rosky, Dangerousness or Diminished Capacity? Exploring the Association of Gender and Mental Illness with Violent Offense Sentence Length, 40 AM. J. CRIM. JUST. 353, 354 (2015); SLATE ET AL., supra note 18, at 43.
123 Markowitz, supra note 93, at 45, 47.
124 See generally Rennie v. Klein, 462 F.Supp. 1131, 1144 (D.N.J. 1978); see also Rogers v Okin, 634 F.2d 650, 656 (1st Cir. 1980) (holding that forcible non-consensual medicating of persons with mental illnesses who are civilly committed must be limited to emergency extreme situations where there is a substantial risk of injury to the patient or to others).
125 See ERICKSON & ERICKSON, supra note 77, at 37.
126 TORREY ET AL., supra note 109.
127 See generally Harcourt, supra note 14, at 54–55 (noting the progression in criminal law in terms of understanding mental illness).
brains, cognitive understandings of right and wrong, and decision-making capacities are all influenced by underdeveloped parts of the brain associated with certain mental illnesses. These changes impact our response to crimes influenced by mental illness symptoms such as earlier mental health interventions, rather than reacting later when a crime has been committed or hospitalization is required.

IV. Cause of Crime: Questioning Criminalization of Mental Illness

Some question the criminalization hypothesis which argues that persons with mental illnesses end up becoming involved in the criminal justice system because they have inadequate access to mental healthcare. One study showed mental illness and its symptoms rarely directly cause a crime (approximately in only 4-12% of cases). It is more likely that mental illness is indirectly related to crime, in that certain criminogenic factors affecting most criminals in our jails and prisons such as poverty, homelessness, unemployment, undereducation, drugs, lack of prosocial attachments, etc., are experienced disproportionately by this population. Draine et al. argue that, in particular, “poverty moderates the relationship between serious mental illness and social problems” such as criminal behavior.

A. Mental Illness as a Direct & Indirect Cause of Crime

One study has demonstrated that 8% of participants had been arrested for an offense that was caused either directly or indirectly by their mental illness. When it comes to the criminalization hypothesis and to crimes that are a direct cause of a mental illness, we can see the impact that certain symptoms of specific mental illnesses, like mania and severe depression with bipolar disorder, and hallucinations and delusions with schizophrenia, have on committing certain crimes. Schizophrenia, bipolar disorder, and severe

128 See id. at 75.
129 See id. at 71–72.
130 GROB, supra note 15.
132 Jillian Peterson & Kevin Heinz, Understanding Offenders with Serious Mental Illness in the Criminal Justice System, 42 MITCHELL HAMLIN L. REV. 537, 546–47 (2016).
133 Draine et al., supra note 131.
134 Id.
135 See John Junginger et al., Effects of Serious Mental Illness and Substance Abuse on Criminal Offenses, 57 PSYCHIATRIC SERVS. 879, 881 (2006).
137 Peterson & Heinz, supra note 132, at 546–48.
depression are the types of mental illness that typically qualify for an insanity defense.\(^{138}\)

**B. Social Control of Mentally Ill Individuals as a Cause of Crime**

One of the more critical and insightful rationales put forward in an effort to explain the high rates of incarceration of mentally ill persons is the social control hypothesis. Historically, we have attempted to “control those on the margins,” namely the poor, minorities and the disabled, also referred to as the ‘undesirable other’, and the mentally inferior.\(^{139}\) More recent commentators, like Loury and Clear, believe that punishment of criminals and persons with mental illnesses has now become an *essential* part of the U.S. social contract.\(^{140}\) Perlin believes that “[s]ince the mid-1970s, the dominant strategy for addressing violations of social rules has been imprisonment”\(^{141}\) and nowhere is this truer than its use against persons with mental illnesses.\(^{142}\) Interestingly, Clear has argued that “deficits in informal social controls that result from high levels of incarceration are, in fact, crime-promoting. The high incarceration rates in poor communities destabilize the social relationships in these places and help cause crime rather than prevent it.”\(^{143}\)

Building upon social control theory, it becomes apparent how prison and psychiatric confinement, and in particular, their collateral consequences\(^{144}\) (related to such issues such as housing and employment)\(^{145}\) operate as a way

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138 Andrew Donohue et al., *Legal Insanity: Assessment of the Inability to Refrain*, 5 PSYCHIATRY 58, 64 (2008); Peterson et al., supra note 136, at 440.
139 Appleman, *supra* note 30, at 419–21.
142 See Melissa Thompson, *Race, Class, Gender, and Mental Disorder in the Criminal Justice System*, 53 SOCIO. PERSP. 99, 100 (2010).
144 Interestingly, as noted by Cobos, *The National Conference of Commissioners of Uniform State Laws* has concluded that the collateral consequences that attach to a criminal conviction are mostly felt in the civil law area. The National Conference of Commissioners said that such collateral consequences of criminal pleas arise “largely outside of the criminal justice system” and that “[c]ourt decisions have not treated them as criminal punishment, but mere civil regulation.” Nat’l Conf. of Comm’rs on Uniform State Laws, Uniform Collateral Consequences of Conviction Act 3 (2010), https://www.uniform-laws.org/viewdocument/final-act-with-comments-11?CommunityKey=74d99914-f15e-49aa-a5b0-f15f6e5f258a&tab=librarydocuments (citing Gabriel J. Chin, *Are Collateral Sanctions Premised on Conduct or Conviction?: The Case of Abortion Doctors*, 30 FORDHAM URB. L.J. 1685, 1686 n. 10 (2003)). See Michael O’Hear, *Mass Incarceration: The Fiscal and Social Costs*, Wis. L. (June 1, 2018), https://www.wisbar.org/NewsPublications/WisconsinLawyer/Pages/Article.aspx?Volumes=91& Issue=6&ArticleID=26397, for general collateral consequences, and the fiscal costs of such consequences.
of labeling\textsuperscript{146} those who do not conform to ordinary behavior and ordinary norms\textsuperscript{147} as the “deviant other.”\textsuperscript{148} Labeling an individual as an offender or mentally ill can cause the individual to “internalize the negative expectations and social practices that majoritarian society identifies as characteristically endemic to the labeled group.”\textsuperscript{149} Like crime, mental illness is seen as a form of deviance, as their behavior diverges from the expectations and experiences of the rest of society.\textsuperscript{150} With harsh implications, mentally disordered offenders are doubly labeled as both a criminal offender and as being mentally ill.\textsuperscript{151}

C. If Mental Illness is Rarely a Direct Cause of Crime, What Does This Mean for the Criminalization and Transinstitutionalization Hypotheses?

Prins makes a compelling argument that the criminalization and transinstitutionalization hypotheses are too simplistic and reductionist.\textsuperscript{152} Under this argument, increasing institutionalization and increasing the number of

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\textsuperscript{146} Bruce G. Link et al., \textit{The Effectiveness of Stigma Coping Orientations: Can Negative Consequences of Mental Illness Labeling be Avoided?}, 32 J. HEALTH & SOC. BEHAV. 302, 302 (1992); Bard, supra note 114, at 1, 25.


\textsuperscript{148} Paul Root Wolpe, \textit{Explaining Social Deviance} 93 (The Teaching Company 1994); see Appleman, supra note 30.


\textsuperscript{150} Bard, supra note 114, at 1, 25.

\textsuperscript{151} H. Richard Lamb et al., \textit{The Police and Mental Health}, 53 PSYCHIATRIC SERVS. 1266, 1266–67, 1269 (2002).

\textsuperscript{152} See Seth J. Prins, \textit{Does Transinstitutionalization Explain the Overrepresentation of People with Serious Mental Illnesses in the Criminal Justice System?}, 47 CMTY. MENTAL HEALTH J. 716, 716, 720 (2011).
psychiatric beds and access to mental healthcare will have a minimal effect on the number of persons with mental illnesses in the criminal justice system. A more nuanced approach is required, otherwise we are wasting expensive resources that should instead be put into community-based treatment and invested in education, poverty alleviation, employment, housing, and other social programs that would be more effective.153 Prins believes that other factors are at play may explain the disproportionate representation in areas such as high arrest rates, lack of housing, and underfunded community treatment.154

D. Interventions & Reforms Thus Far

Most interventions in this debate have failed to work when we consider the disproportionate representation of persons with mental illnesses in our jails and prisons.155 When we consider the driving force of most of these new interventions (such as police diversion programs, transition planning, specialized probation and parole, and mental health courts) are the criminalization and transinstitutionalization hypotheses, perhaps our underlying understandings of this problem are not as solid as some believe.

Intervention programs usually focus solely on mental illness symptoms and treatment, but these programs have been proven to be ineffective at reducing recidivism.156 To be effective at recidivism reduction, these interventions need to be more comprehensive, addressing not only mental health treatment, but also the true underlying causes of crime including poverty and other socioeconomic forces.157 These programs should require cooperation between criminal justice, medical, and social services’ actors. “While these programs are expensive, they will ultimately save costs.”158 One such comprehensive reentry program in Maryland that brought about a “5.6% drop in arrest rates resulted in a savings of $7.2 million for the state. A cost-benefit analysis showed . . . [a] state . . . return of $3 for every $1 spent on the program.”159

153 Id.
154 Id. at 717. The same can be said for the higher incarceration rates of other minority groups such as persons of color and Native Americans. Devah Pager et al., Sequencing Disadvantage: Barriers to Employment Facing Young Black and White Men with Criminal Records, 623 ANNALS AM. ACAD. POL. & SOC. SCI. 195, 197, 199 (2009); U.S. COMM’N ON C.R., BROKEN PROMISES: CONTINUING FEDERAL FUNDING SHORTFALL FOR NATIVE AMERICANS 44 (2018), https://www.usccr.gov/pubs/2018/12-20-Broken-Promises.pdf.
155 Prins, supra note 152, at 717.
156 Peterson & Heinz, supra note 132, at 558–59.
157 Id. at 558, 560.
158 Id. at 562.
159 Id. at 562–63 (citing JOHN ROMAN ET AL., IMPACT AND COST-BENEFIT ANALYSIS OF THE MARYLAND REENTRY PARTNERSHIP INITIATIVE 18 (Urb. Inst. Just. Pol’y Ctr. ed., 2007)).
V. The Disproportionate Effects of the Criminal Justice System on Mentally Ill Individuals

A. Policing and Arrests of Mentally Ill Persons

One way that the government exhibits its social control over this vulnerable population, in addition to prisons, jails, asylums, and labeling, is through the police arresting persons with mental illnesses. In fact, mentally ill persons are seven times more likely to be arrested than their able-bodied counterparts. One study has shown 42-50% of persons with mental illnesses will be arrested in their lifetime. And, another study found that persons with mental illnesses are 20% more likely to be arrested than persons without a mental illness. These individuals’ initial arrests will be recorded and “may influence the actions of the police in subsequent encounters with the individual and reinforce the tendency to choose the criminal justice system over the mental health system. The mentally ill person has now been criminalized.” Their arrest and the conviction that may follow will have lasting effects on their life and livelihood, partly due to the collateral consequences that come with a conviction. It is also worth noting, as Myers explains, that “people with severe mental illness are at least sixteen times more likely to be killed during a police encounter than other individuals.” Even more striking, it is estimated that between a third and a half of persons killed by police have a mental illness. This is most likely due to the disproportionately high arrest...
rates and poor police procedures and training in dealing with the mentally ill. Often, the police misunderstand the symptomatic behavior of persons with mental illnesses and then, misinterpret these behaviors as aggression.

In regard to reasonable accommodations, unfortunately the United States Supreme Court in City & County of San Francisco v. Sheehan refused to establish a test to ascertain when police can and should put in place reasonable accommodations under the ADA during an arrest situation. The circuit courts are currently split on this issue, necessitating Supreme Court clarification at some point in the future. In response to this divide, Levin, in his role as academic, proposes a new practical test which he calls a “sliding scale test.” Under this test, the police would be obliged to provide increased accommodations to persons with all disabilities, which would include persons with mental illness, as a situation becomes more secure and less dangerous.

The 9th Circuit, in Vos v. City of Newport Beach, recently extended the applicability of the Title II reasonable accommodation requirement of the ADA to situations of police shootings and wrongful death. The court was clear in pointing out the need to first recognize mental illnesses, and second, accommodate for mental illnesses during a situation where the mentally ill person (in this case schizophrenia) is clearly suffering from a psychotic

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172 See id. at 212.


174 Vos v. City of Newport Beach, 892 F.3d 1024, 1037 (9th Cir. 2018).
break. Because Vos was acting in an aggressive manner, the court held that
the fatal shooting was not unlawful due to the qualified immunity of the of-

ficers. Importantly, the court noted that police knowledge of a suspect’s
mental illness might reduce the need for deadly force. It also stated that a
reasonable accommodation of specialized help should be used when a sus-
pect’s mental illness is at issue, such as de-escalation tactics.

Along with the higher arrest rates, approximately 10% of police calls in-
volve someone with a mental illness. Finally, certain police misconcep-
tions about persons with mental illnesses, including the myth of dangerous-
ness, can also be blamed for the high arrest rates of mentally ill persons. It
is worth acknowledging that the police are often misinformed, and are there-
fore unable to recognize that a member of the public who they are interacting
with, has a mental illness. Draine et al. believe that one cause of the higher
arrest rates of those with mental illnesses is the drastic misunderstanding by
police of symptoms. Meanwhile, Markowitz believes that it is not only due
to police discriminatory behavior toward persons with mental illnesses, but
also due to the greater likelihood of “arrest-generating behavior.” Addition-
ally, there are numerous barriers inhibiting proper police response, including
a lack of sufficient training to identify and accommodate mental disabilities,
resource and time constraints, and the widespread misperception that “per-
sons with a mental illness are more prone to violence.” Furthermore, police
are more likely to patrol and enforce laws within the deprived social environ-
ments where persons with mental illnesses tend to live. Another more hu-
mane and therapeutic rationale for arresting individuals with mental illnesses
comes in the form of “mercy bookings” whereby police arrest an individual
with a mental illness with the intention of getting them into treatment.

175 Id. at 1036.
176 Id. at 1035–36.
177 Id. at 1034.
178 Id. at 1037.
179 Avery, supra note 167; Randy Borum et al., Police Perspectives on Responding to Mentally Ill People
in Crisis: Perceptions of Program Effectiveness, 16 BEHAV. SCI. & L. 393, 393–94 (1998); FULLER ET
AL., supra note 168.
180 Fischer, supra note 161, at 171–72.
181 Amy C. Watson et al., Police Responses to Persons With Mental Illness: Does the Label Matter?, 32
J. AM. ACAD. PSYCHIATRY & L. 378, 383 (2004); Draine et al., supra note 131, at 566; Teplin, supra note
162, at 799.
182 Draine et al., supra note 131, at 566.
183 Markowitz, supra note 93, at 50.
184 See Fischer, supra note 161, at 172; Myers, supra note 160, at 1395–96.
185 See generally LINDA A. TEP LIN, NAT’L INST. OF JUST. J., KEEPING THE PEACE: POLICE DISCRETION
AND MENTALLY ILL PERSONS 9 (2000) (noting that law enforcement is more prevalent in areas of mental
illness).
186 See Markowitz, supra note 93, at 49.
“Police are now one of the main sources of referral of persons into mental health treatment,” which, in turn, has led to an increase in mentally ill inmates in the U.S. criminal justice system.  

B. High Levels of Mental Illness in the Criminal Justice System

We now turn to the disproportionate rates of mental illness in the U.S. criminal justice system. The most reliable quantification of the rates of criminal justice inmates having mentally ill inmates is a study conducted by the Department of Justice’s Bureau of Justice Statistics, which collected data between 2002 and 2004. This study found that 56% of state prisoners, 45% of federal prisoners, and 64% of jail inmates had a recent history or symptoms of a mental illness. Another, more recent, Bureau of Justice Statistics 2017 study showed that almost 15% of U.S. prisoners and over 25% of jail inmates have a serious mental illness.

We can see the disproportionality of prisoners who have a mental illness, when we compare the previously mentioned studies on the general U.S. population with general prevalence rates of approximately 20%. Now, there are likely three to ten times more individuals with serious mental illnesses in U.S. prisons than U.S. mental hospitals.

In fact, it has been said that “America’s jails and prisons have become our new mental hospitals.” We should also consider the numbers associated with civil confinement. According to the Prison Policy Initiative:

22,000 people are involuntarily detained or committed to state psychiatric hospitals and civil commitment centers. Many of these people are not even convicted, and some are held indefinitely. 9,000 are being evaluated pre-trial or treated for incompetency to stand trial; 6,000 have been found not guilty by reason of insanity or guilty but mentally ill.

It is important to note the increasing percentage of civilly committed individuals who are of a “forensic” nature. In other words, such individuals are being committed to mental institutions due to a criminal justice decision. To this end, a recent report has found that the overall national trend lines show

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187 See id.
189 Id.
192 Torrey et al., supra note 109, at 1.
a “76 percent increase in the number of forensic patients in state hospitals from 1999 to 2014.”

While most commentators focus on the incarceration rates of persons with mental illnesses, it is also worth considering the broader footprint of the criminal justice system that impacts this vulnerable population in the form of criminal justice supervision through probation and parole. In terms of the broader criminal justice system, incorporating those on parole and probation in addition to prison and jail inmates, there are approximately 6,613,500 people under the control of the criminal justice system at the end of 2016. An older study in 2009 estimated that the “number of people under correctional supervision in the USA recently reached an all-time high of 7.3 million.” In terms of a broader analysis of the complete criminal justice footprint, 26.6% of probationers in one study reported having some mental illness. During a congressional debate on persons with mental illnesses in the criminal justice system, one congressman estimated that “[o]n any given day, at least 284,000 schizophrenic and manic depressive individuals are incarcerated, and 547,800 are on probation.” Furthermore, “a meta-analysis of 62 studies suggests that 14% of offenders suffer from a major mental illness. If so, then there are over one million individuals with mental illness in the USA in jail, in prison, on probation, or on parole.”

C. Reasons for the High Number of Mentally Ill Individuals in the Criminal Justice System

The underlying issues surrounding the disproportionate representation of persons with mental illnesses in U.S. prisons and jails are not amenable to simple explanations. The previously discussed theories of criminalization and deinstitutionalization err on the side of being too simplistic and mask the more complex, underlying causes of the imprisonment of persons with mental illnesses. As explained above, certain criminogenic factors can help explain why there are such high numbers of persons with mental illnesses involved in the criminal justice system. These include poor education, etc.
university dropouts due to mental health problems triple, THE GUARDIAN (May 23, 2017), https://www.theguardian.com/society/2017/may/23/number-university-dropouts-due-to-mental-health-problems-trebles, for similar linkages between mental illness and U.K. university drop-out rates. Historically, students with disabilities, including those with mental illnesses have been disciplined and sometimes refused admission to U.S. schools. Erica Bell, Disciplinary Exclusion of Handicapped Students: An Examination of the Limitations Imposed by the Education For All Handicapped Children Act of 1975, 51 FORDHAM L. REV. 168, 175–76 (1982). Legislation such as the Education of All Handicapped Children Act of 1975 has brought the exclusion of those with disabilities to a halt. Id. at 177–78. But the school-to-prison pipeline is still a significant problem for those with mental illnesses and for students of color. Matt Leistra, Mental Health and The School to Prison Pipeline, SHARED JUST. (Dec. 5, 2017), http://www.sharedjustice.org/domestic-justice/2017/12/5/mental-health-and-the-school-to-prison-pipeline; Marisol Garcia, Disrupting the School-to-Prison Pipeline, AM. BAR ASS’N (Sept. 24, 2018), https://www.americanbar.org/groups/litigation/committees/childrens-rights/articles/2018/fall-2018-disrupting-the-school-to-prison-pipeline. This problem is exacerbated if both of these discriminated labels are combined, i.e. students who are colored and also have a disability such as a mental illness. U.S. COMM’N ON C.R. TO PRESIDENT DONALD J. TRUMP BEYOND SUSPENSIONS: EXAMINING SCHOOL DISCIPLINE POLICIES AND CONNECTIONS TO THE SCHOOL-TO-PRISON PIPELINE FOR STUDENTS OF COLOR WITH DISABILITIES 4 (2019). In one instance, a twelve-year-old black student was hand-cuffed and sent to a juvenile detention center after refusing to go to class, even though he had a known mental illness along with an individualized education program. Jessica Bliss, A Mother’s Saga: School, Police, Arrests and a Son with a Mental Illness, THE TENNESSEAN (Sept. 10, 2018), https://www.tennessean.com/story/news/2018/09/10/mental-illness-child-arrests-metro-nashville-publicschool-police-passage/1012290002. Additionally, a recent settlement occurred between the U.S. Department of Justice and Wicomico County regarding education in the Maryland county. Settlement Agreement Between the U.S. and Wicomico County Public Schools (Jan. 19, 2017) (on file with the Civil Rights Division, Educational Opportunities Section). Wicomico County was criticized for its discriminatory discipline of its students of color and students with disabilities and also for arresting its students based on behavior that was symptomatic of their mental illnesses. Tim Prudente, Wicomico schools settle with feds after complaints of discrimination, BALTIMORE SUN (Feb. 1, 2017), https://www.baltimoresun.com/education/bs-md-wicomico-doj-agreement-20170201-story.html. As part of the agreement, Wicomico County agreed to provide the Justice Department with up-to-date detailed data on its disciplinary actions against students. It also agreed to form a crisis intervention team in each school district and establish mental health services for all students. Settlement Agreement Between the U.S. and Wicomico County Public Schools, supra note 201, at 12, 35, 46. The harsh treatment of students with mental illnesses reached an all-time low according to a report by the U.S. Department of Education, which reported that a teacher, who was aware of the student’s mental illness and of the student’s previous attempts of suicide, proceeded to taunt the student in a crowded school hallway and told the student that s/he should kill him/herself. U.S. DEP’T OF EDUC., OFF. FOR C.R., SECURING EQUAL EDUCATION OPPORTUNITY 38 (2016), https://www2.ed.gov/about/reports/annual/ocr/report-to-president-and-secretary-of-education-2016.pdf. Olivia Herrington also underlines the importance of providing mental healthcare within the school setting when she states that “[s]tudents are 21 times more likely to use a school health center’s mental health services than similar services offered elsewhere in a community, since they feel more comfortable when they are familiar with the setting in which they receive care.” Olivia Herrington, Out of Detention: How to Stop the School-to-Prison Pipeline, HARV. POL. REV. (Mar. 2, 2015), https://clbb.mgh.harvard.edu/out-of-detention-how-to-stop-the-school-to-prison-pipeline. In order to take advantage of this behavior, Nancy Heitzeg explains that “[s]chools must utilize their mental health experts—school psychologists, counselors and social workers—to research and develop discipline policies and positive behavior training strategies.” Nancy A. Heitzeg, F. ON PUB. POL’Y, EDUCATION OR INCARCERATION: ZERO TOLERANCE POLICIES AND THE SCHOOL TO PRISON PIPELINE 17 (2009), https://files.eric.ed.gov/fulltext/EJ870076.pdf.
unemployment, unstable housing, homelessness, poverty, addiction issues, and discrimination. Regarding reforms of the system, another


205 CHRISTOPHER J. MUMOLA & JENNIFER C. KARBERG, BUREAU OF JUST. STATS., NCJ213530, DRUG USE AND DEPENDENCE, STATE AND FEDERAL PRISONERS, 2004 (2006) (tracking drug dependence in correctional facilities); Keith Humphreys & Julian Rappaport, From the Community Mental Health Movement to the War on Drugs, 48 AM. PSYCH. 892, 895 (1993) (exploring the connection between jails and substance abuse treatment in the context of the War on Drugs); JAMES & GLAZE, supra note 188, at 3; KIDEUK KIM ET AL., URBAN INST., THE PROCESSING AND TREATMENT OF MENTALLY ILL PERSONS IN THE CRIMINAL JUSTICE SYSTEM: A SCAN OF PRACTICE AND BACKGROUND ANALYSIS 9–10, (2015); Theodore M. Hammert et al., Health-Related Issues in Prisoner Reentry, 47 CRIME & DELINQ. 390, 390 (2001); SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., SUBSTANCE USE DISORDER TREATMENT FOR PERSONS WITH CO-OCcurring DISORDERS 170 (2020); see generally SARRA L. HEDDEN ET AL., SUBSTANCE ABUSE AND
commentator, has stated that “[d]iversion programs not only improve public safety and public health, but they are also consistent with the purpose of the Americans with Disabilities Act (ADA) and with the landmark decision in *Olmstead v. L.C.*” Current there is an ongoing lawsuit in New York in which the plaintiffs allege that the authorities have violated the ADA’s integration mandate by continuing to place them in prison after they have served

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**Mental Health Services Administration, Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health** (2015) (discussing the prevalence of behavioral health disorders such as substance abuse in the United States).

207 Vetta L. Sanders Thompson et al., *Stigmatization, Discrimination, and Mental Health: The Impact of Multiple Identity Status*, 74 AM. J. ORTHOPSYCHIATRY 529, 530 (2004); Patrick Corrigan et al., *Perceptions of Discrimination Among Persons With Serious Mental Illness*, 54 PSYCHIATRIC SERVS. 1105, 1105–06 (2003); Heather Stuart, *Mental Illness and Employment Discrimination*, 19 CURRENT OPINION PSYCHIATRY 522, 522 (2006); Lurigio, supra note 205; Deborah K. Padgett et al., *Housing First Services for People Who Are Homeless with Co-Occurring Serious Mental Illness and Substance Abuse*, 16 RSCCH. SOC. WORK PRACTICE 74, 75 (2006); see generally Draine et al., supra note 131 (emphasizing that research on mental illness in relation to crime fails to recognize that the experience of those individuals is contextualized in disadvantaged social settings); see Davidson & Rosky, supra note 122; see Christopher G. Hudson, *Socioeconomic Status and Mental Illness: Tests of the Social Causation and Selection Hypotheses*, 75 AM. J. ORTHOPSYCHIATRY 3, 3 (2005). One form of discrimination includes the ban on some of the population of persons with mental illnesses to vote. U.S. COMM’N ON C.R., COLLATERAL CONSEQUENCES, supra note 164, at 156. Thirteen states bar voting by those who are “under guardianship” i.e. a court finding of incompetency or incapacity must be established. These thirteen states are Alabama, Arizona, Louisiana, Massachusetts, Minnesota, Missouri, Oklahoma, South Dakota, Tennessee, Utah, Virginia, and West Virginia. BLAZEN CTR. FOR MENTAL HEALTH L. ET AL., VOTE: IT’S YOUR RIGHT – A GUIDE TO VOTING RIGHTS OF MENTAL DISABILITIES 12 n.45 (2018). Twenty-two states and D.C. require a specific finding of lacking the capacity to vote. These states are Alaska, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Hawaii, Iowa, Kentucky, Maryland, Maine, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Texas, Washington, Wisconsin, and Wyoming. Id. at 12–13 n.46. Four states have laws that bar voting by individuals who are “non compos mentis,” although what is meant by this term varies across the states. These four states are Nebraska, Hawaii, Rhode Island, and Mississippi. Id. at 13 n.47. Nebraska law defines “non compos mentis” as meaning “mentally incompetent.” Neb. Rev. Stat. § 32-312 (2020).

Hawaii has taken the term to mean a specific incapacity to vote. Haw. Rev. Stat. § 11-23(a) (2018). Under Mississippi law, the term “unsound mind” includes “persons non compos mentis.” Miss. Code Ann. § 1-3-57 (2020). While Rhode Island doesn’t define what the term means, Rhode Island’s state election board overturned a local election officials’ decision to bar two individuals from voting based on the fact that they were found to be not guilty by reason of insanity. BLAZEN CTR. FOR MENTAL HEALTH L. ET AL., supra note 207, at 13 n.47 (citing David Scharfenberg, *Election Board Won’t Take Away Men’s Vote*, PROVIDENCE J. (May 29, 2008), http://www.projo.com/news/content/INSANE_VOTERS_05-29-08_3HA708_v17.349e81a.html). Seven states use outdated and insulting terms such as “idiots,” “insane persons,” and “of unsound mind” to determine who is barred from voting based on incompetency. The states whose laws use such terms are Alaska, Arizona, Kentucky, Minnesota, Mississippi, Montana, and Ohio. These laws are rarely enforced as they are very difficult to understand and apply. BLAZEN CTR. FOR MENTAL HEALTH L. ET AL., supra note 207, at 13 n.48. A similar ban, that is more widespread restriction on voting rights, applies to felons across the United States. Christopher Uggen & Jeff Manza, *Democratic Contraction? Political Consequences of Felon Disenfranchisement in the United States*, 67 AM. SOCIO. REV. 777, 781 (2002).


their respective prison sentences and are only being held in prison because of the lack of mental health housing programs in the community.\textsuperscript{210}

In this regard, we must contextualize the imprisonment of persons with mental illnesses within their socially disadvantaged background.\textsuperscript{211} When we look at the so-called ‘central eight’ criminogenic factors that explain criminal behavior risk of all offenders, those with mental illnesses often experience these factors too, at minimum, the same, or most often to a greater, degree than those offenders who do not have a mental illness. These central eight risk factors are: (1) history of antisocial behavior; (2) antisocial personality pattern; (3) antisocial cognition; (4) antisocial associates;\textsuperscript{212} (5) troubled


\textsuperscript{211} For example, some authors believe that imprisonment can act as a breeding ground for future criminal behavior. Here, the individual who is incarcerated is exposed to a network of offenders who they may not have met outside of prison and may conspire to commit crime outside the prison walls. Clemmer calls this the “prisonization” of inmates. See DONALD CLEMMER, THE PRISON COMMUNITY 299 (1958).

CRIMINOLOGY 311, 316-17 (1950) (noting the “criminalistic ideology in the prison community”); Lyynne Vierraits et al., The Criminogenic Effects of Imprisonment, 6 CRIMINOLOGY & PUB. POL’Y 589, 593 (2007) (noting that prison “may provide inmates with an education in crime”); John Schmitt & Kris Warner, CTR. FOR ECON. & POL’Y RSCH., EX-OFFENDERS AND THE LABOR MARKET 8 (2010), http://cepr.net/documents/publications/ex-offenders-2010-11.pdf (noting inmates are provided with “new social networks that make criminal activity more likely”); Paul Gendreau et al., THE EFFECTS OF PRISON SENTENCES ON RECIDIVISM 4–5 (1999), https://www.prisonpolicy.org/scans/gendreau.pdf (discussing the belief that prisons are “schools of crime”); Allison Schrag, In America, Mass Incarceration Has Caused More Crime Than It’s Prevented, QUARTZ (July 22, 2015), https://qz.com/458675/in-america-mass-incarceration-has-caused-more-crime-than-its-prevented/ (noting the risk that small offenders can become career criminals due to extended time in prison); see Jeff Smith, Mr. Smith Goes to Prison: What My Year Behind Bars Taught Me About America’s Prison Crisis 131, 241 (2015) (noting “the prison system is practically designed to encourage the terrible outcomes we get,” such as recidivism); J. Robert Lilly et al., CRIMINOLOGICAL THEORY: CONTEXT AND CONSEQUENCES 140 (7th ed. 1995) (describing prisons as a breeding ground for crime); Dorothy R. Jaman et al., Parole Outcome As A Function of Time Served, 12 British J. CRIMINOLOGY 5, 6–7, 26, 30 (1972) (theorizing that shorter prison sentences are more effective because the longer an individual is in prison, the more likely he or she is to “acquire the attitudes and values that characterize the prison culture”); Eric Schlosser, The Prison-Industrial Complex, THE ATLANTIC (Dec. 1998), https://www.theatlantic.com/magazine/archive/1998/12/the-prison-industrial-complex/304669/ (“[P]risons can be ‘factories for crime.’”); Nigel Walker, The unwanted effects of long-term imprisonment, in PROBLEMS OF LONG-TERM IMPRISONMENT 196 (Anthony E. Bottoms & Roy Light eds., 1987); Peter J. Carrington, Crime and Social Network Analysis, in THE SAGE HANDBOOK OF SOCIAL NETWORK ANALYSIS 240 (John Scott & Peter J. Carrington eds., 2014); Joanna M. Weill, Incarceration and Social Networks: Understanding the Relationships That Support Reentry 103 (Dec. 2016) (Ph. D. dissertation, University of California Santa Cruz) (on file with the California Digital Library, University of California) (noting that formerly incarcerated persons are more likely to have a network of formerly incarcerated individuals). However, it should be noted that this “school of crime” hypothesis is questionable and largely unsubstantiated by empirical data. For example, in a Swedish study of 3810 prisoners, only two percent of the study’s participants subsequently committed a crime with a former inmate they knew from prison. See Lena Roxell, Co-Offending Among Prison Inmates, 91 PRISON J. 366, 375 (2011); see also Stanton E. Samenow, Do Prisons Really Make Offenders Worse?, PSYCH. TODAY (Apr. 9, 2011), https://www.psychologytoday.com/us/blog/inside-the-criminal-mind/201104/do-prisons-really-make-offenders-worse; Stephen Farrall & Adam Calverley, UNDERSTANDING DISTANCE FROM CRIME 75–77 (2005); Albert J. Reiss, Jr. & David P. Farrington, ADVANCING KNOWLEDGE ABOUT CO-OFFENDING: Results from A Prospective Longitudinal Survey of London Males, 82 J. CRIM. L. & CRIMINOLOGY 360, 393–94 (1991). Having said that, there is some support for the argument that prisons are a breeding ground for radicalization and terrorist crimes. COUNCIL OF EUROPE, PRISON: A BREEDING GROUND FOR RADICALISATION AND VIOLENT EXTREMISM? 21 (2018). More generally, it is well documented that positive social bonds are essential for reducing crime, reducing recidivism and improving mental health. See Jennifer E. Cobban et al., Men, Women, and Postrelease Offending: An Examination of the Nature of the Link Between Relational Ties and Recidivism, 58 CRIME & DELINQ. 331, 347 (2012); see also Derek A. Kreager et al., Toward a Criminology of Inmate Networks, 33 JUST. Q. 1000, 1009 (2016). Cf. Warren Dennis, Prisons as Schools of Crime - a Myth Debunked?, 2 BRITISH J. FORENSIC PRAC. 19, 21–22 (2000).
family and marital relationships; substance abuse was a problem with school or work; leisure and/or recreation problems; and substance abuse. These central eight risk factors can act as an indirect link between criminal behavior and mental illness, rather than mental illness symptoms directly causing crimes, which occurs in much fewer crimes. Mental illness, in some cases, has acted as an aggravating circumstance at trial, rather than a mitigating factor, contributing to the disproportionate numbers of prisoners with mental illness. In fact, a study found longer sentences were given if a defendant had a mental illness. Similarly, in regards to forensic psychiatric institutionalization, insanity acquittees have been found to spend almost double the amount of time in confinement, i.e., longer time spent in psychiatric hospitals, rather than prison. One of the more concerning potential causes of the mental illness:

213 There is an increased likelihood of poor mental health if that individual has had a parent spend time in prison. Joseph Murray et al., Campbell Systematic Revs., Effects of Parental Imprisonment on Child Antisocial Behaviors and Mental Health: A Systematic Review 57 (2009); Todd R. Clear et al., U.S. Dep't of Just., Predicting Crime Through Incarceration: The Impact of Rates of Prison Cycling on Rates of Crime in Communities 11–12 (2014); Lauren Aaron & Danielle H. Dallaire, Parental Incarceration and Multiple Risk Experiences: Effects on Family Dynamics and Children's Delinquency, 39 J. YOUTH & ADOLESCENCE 1471, 1472 (2010) (describing how children with incarcerated parents are at a higher risk for mental illness and often experience troubled family relationships); Stewart Gabel & Richard Shindlebecker, Characteristics of Children Whose Parents Have Been Incarcerated, 44 Hosp. & CMTY. PSYCHIATRY 656, 656–57 (1993) (describing how children with incarcerated parents are significantly more likely to experience family dysfunction and parental substance abuse).

214 See D.A. Andrews et al., The Recent Past and Near Future of Risk and/or Need Assessment, 52 CRIME & DELINQ. 7, 11 (2006); see also James Bonta et al., The Prediction of Criminal and Violent Recidivism Among Mentally Disordered Offenders: A Meta-Analysis, 123 PSYCHOL. BULL. 123, 124 (1998) (describing how “age, criminal history, anti-social peers, and substance abuse” can be “predictors for criminal conduct”); Arthur J. Lurigio, Examining Prevailing Beliefs About People with Serious Mental Illness in the Criminal Justice System, in 75 FED. PROB. J. (2011) (describing how homelessness, crime, under-education, and unemployment exert pressures on people with serious mental illness (PSMI) to become engaged in criminal behavior); Junginger et al., supra note 135 (indicating that substance abuse was a more likely causal factor for criminal offending than mental illness); Hudson, supra note 207, at 16 (describing how the poorer one’s socioeconomic conditions are, the higher one’s risk is for mental disability and psychiatric hospitalization).

215 See Peterson & Heinz, supra note 132, at 547 (describing how symptoms of mental illness only cause crime in a small minority of cases).


217 Davidson & Rosky, supra note 122, at 374 (finding that males with mental illness reported longer sentences than non-mentally ill men); Mirko Bagaric, A Rational (Unapologetically Pragmatic) Approach to Dealing with the Irrational - The Sentencing of Offenders with Mental Disorders, 29 HARV. HUM. RTS. J. 1, 6 (2016) (“[M]entally ill offenders are, in fact, sentenced more harshly than other offenders.”); Victoria Harris & Christos Dagadakis, Length of Incarceration: Was there parity for mentally ill offenders?, 27 INT’L J. L. & PSYCHIATRY 387, 391 (2004) (finding that mentally ill offenders were incarcerated for a longer period of time for felony crimes).

218 Joseph H. Rodriguez et al., The Insanity Defense Under Siege: Legislative Assaults and Legal Rejoinders, 14 RUTGERS L.J. 397, 403–04 (1983) (describing how defendants with mental illness spend more time in confinement than other criminal defendants); see also Grant T. Harris et al., Length of Detention in Matched Groups of Insanity Acquittees and Convicted Offenders, 14 INT’L J. L. & PSYCHIATRY 223, 234 (1991) (“[T]his underlines the significant impact that their convicted
high rates of imprisoning persons with mental illnesses is that persons with mental illnesses are more vulnerable to false confessions, wrongful arrest, and wrongful convictions. These trends may be partly attributable to the poor representation of these clients by counsel. It may also be caused by the inability of some persons with mental illnesses to assist their own lawyers in establishing a defense to the criminal charge and their inadequate understanding of police questioning, court procedures and plea deals.

VI. Prison Conditions and Legal Ramifications Affecting Mentally Ill Prisoners

Dostoevsky once alleged that “the degree of civilization of a country can be judged by entering its prisons.” Unfortunately, our current U.S. society would be deemed quite uncivilized if assessed by the way it treats its prisoners, and in particular by the way it treats its prisoners who have mental illnesses. When a person is convicted and has a mental illness that does not rise to the level of criminal insanity, they are sent to prison. However, despite the partial reluctant move back towards a rehabilitative prison system, today’s prisons are particularly dangerous for inmates who have a mental illness. Often, the prison environment exacerbates the inmate’s mental illness and the symptoms for those with pre-existing mental illnesses. The prison environment can also lead to the development of new mental illnesses, and those with underlying genetic vulnerabilities. Mentally ill inmates are more likely to be sent to solitary confinement, which has catastrophic consequences for their mental health due to the heightened likelihood of false confessions, wrongful arrest, and wrongful convictions.
inmates being disciplined in prison. These factors, in addition to the facts that they are disproportionately sexually and physically abused by other prisoners and correctional officers, overcrowding, the stressful nature of prison, and that they receive inadequate or no mental healthcare while incarcerated, mean that inmates with mental illnesses are at “a very high risk of harm and death” while incarcerated. Not only is the lack of healthcare and the placement of people with mental illnesses in prisons unfair, “confine ment without treatment is against society’s interest, because a large number of prisoners are eventually released and returned to society.” Studies have shown that ex-prisoners who have a mental illness are “significantly more likely to fail the terms of their probation and parole” and “around twice as likely to have their parole suspended.” Part of this problem is their poor treatment in prison, but also the additional technical requirements that parolees and probationers with mental illnesses often have attached to their probation or parole, such as the requirement to remain on medication or attend certain types of treatment.

Despite the widespread calls for decarceration of persons with mental illnesses, there is a small subpopulation of persons with mental illnesses that are undeterrable and that subpopulation of individuals should be confined, just in a much more humane way than the current prison confinement method.

VII. Public Perceptions About Mentally Ill Persons

The social and criminal justice mistreatment of persons with mental illnesses is largely caused by societal myths surrounding those with mental

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228 Peterson & Heinz, supra note 132, at 538–39.
231 Bard, supra note 114, at 2.
232 Heyrman, supra note 226.
233 HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 94 (2003); Harcourt, supra note 14, at 56.
234 Gostin, supra note 4, at 911.
235 Bard, supra note 114, at 3.
236 Peterson & Heinz, supra note 132, at 539 (citing Nina Messina et al., One Year Return to Custody Rates Among Co-Disordered Offenders, 22 BEHAV. SCI. & L. 503, 515 (2004)).
237 Id. at 551.
238 See Bard, supra note 114, at 5–7.
illnesses, such as perceived dangerousness and incompetency.\textsuperscript{240} Furthermore, these myths “continue to dominate political and social discourse.”\textsuperscript{241} Some believe that mental illness is the ‘ultimate stigma.’\textsuperscript{242} This belief is often caused by the media’s coverage of stories involving persons with mental illnesses, which has a tendency to be sensationalized.\textsuperscript{243} This mental illness stigma is defined as “an attribute that is deeply discrediting and leads the person to be reduced…from a whole and usual person to a tainted or discounted one.” Mental illness, like the stigma surrounding a criminal conviction, is categorized as a “blemish of individual character.”\textsuperscript{244} The impact of mental illness stigma on this population should not be underestimated.\textsuperscript{245} In particular, the manner in which it acts as a major barrier to mental healthcare\textsuperscript{246} with 35-50\% of people with a mental illness in high-income countries receiving no mental health treatment.\textsuperscript{247}

In particular, the myth of dangerousness plays a particularly harmful role in the legal justice system, both civil and criminal.\textsuperscript{248} Perceived

\textsuperscript{240} Gostin, supra note 4.
\textsuperscript{241} Perlin, supra note 221, at 2–3.
\textsuperscript{242} Gerhard Falk, Stigma: How We Treat Outsiders 39 (Prometheus Books 2001).
\textsuperscript{245} For instance, the mental illness stigma acts as a barrier to wider social integration. See Stephen P. Hinshaw, The Mark of Shame: Stigma of Mental Illness and an Agenda for Change ix-x (2007). In particular, the mental illness stigma can be a barrier to housing. See Joy Hammel et al., Rental Housing Discrimination on the Basis of Mental Disabilities: Results of Pilot Testing vii (2017); see also Steven P. Segal et al., Neighborhood Types and Community Reaction to the Mentally Ill: A Paradox of Intensity, 21 J. HEALTH & SOC. BEHAV. 345, 345 (1980); Steward Page, Effects of the Mental Illness Label in 1993: Acceptance and Rejection in the Community, 7 J. HEALTH & SOC. POL’Y 61, 64–65 (1995). The mental illness stigma can also act as a barrier to employment. See Terry Knupa et al., Understanding the stigma of mental illness in employment, 33 WORK 413, 413 (2009); Elaine Brohan & Graham Thornicroft, Stigma and discrimination of mental health problems: workplace implications, 60 OCCUPATIONAL MED. 414, 414 (2010); James E. Bordieri & David E. Drehrmer, Hiring Decisions for Disabled Workers: Looking at the Cause, 16 J. APPLIED SOC. PSYCH. 197, 198 (1986); Bruce Link, Mental Patient Status, Work, and Income: An Examination of the Effects of a Psychiatric Label, 47 AM. SOCIO. REV. 202, 203-04 (1982); Naz Beheshti, Stigma About Mental Health Issues In The Workplace Exists: Here’s What Companies Can Do About It, FORBES (May 8, 2019), https://www.forbes.com/sites/nazbeheshi/2019/05/08/stigma-about-mental-health-issues-in-the-workplace-exist-heres-what-companies-can-do-about-it/#7556fc5f31e7.
\textsuperscript{247} World Health Org., Mental Health, Poverty and Development 3 (2009).
\textsuperscript{248} Patrick W. Corrigan et al., Challenging Two Mental Illness Stigmas: Personal Responsibility and Dangerousness, 28 SCHIZOPHRENIA BULL. 293, 295 (2002) (“Several studies have found a specific relationship between perceiving persons with serious mental illness as dangerous and fearing them. Fear about a
dangerousness based on a defendant’s mental illness has led to mental illness acting as an aggravating rather than a mitigating factor in many criminal trials. It has also been used as a justification for civil commitment to a psychiatric hospital. This population, aside from sex offenders,249 are the only persons who can be institutionalized without committing a crime250 or being committed after serving their prison sentence—again, justified by their perceived danger to themselves and society.251 In reality, those who have a mental illness are “no more dangerous than other populations, and … the vast majority of violence is committed by persons without mental illness.”252

Given the stigmatizing effect of the continuous media inaccuracies and that the “media are the most common sources of information about mental illnesses,”253 it is important to note the role the media can play in influencing public opinion, attitudes, and policies towards persons with mental illnesses. Particularly, the media’s coverage of mass shootings254 is perpetuating the myth of dangerousness that surrounds this population.255 In fact, those who have a “mental illness are actually less likely to be violent.”256

CONCLUSION

Persons with mental illness are incarcerated at disproportionate rates in prisons and jails across the United States. We have traced the treatment of persons with mental illnesses across history, from being a familial or community responsibility, through institutionalization and deinstitutionalization, and finally ending with transinstitutionalization. The transinstitutionalization person’s dangerousness, in turn, yields avoidant behaviors.”); CORRIGAN & KLEINLEIN, supra note 246, at 16–17; David B. Feldman & Christian S. Crandall, Dimensions of Mental Illness Stigma: What About Mental Illness Causes Social Rejection?, 26 J. SOC. & CLINICAL PSYCH. 137, 139–40 (2007).
240 See Andrew J. Harris et al., Sex Offending and Serious Mental Illness, 37 CRIM. JUST. & BEHAV. 596, 599 (2010) (noting that “sexually violent predators” will be involuntarily committed).
250 See Gostin, supra note 4.
251 Id. at 907.
252 Id. at 906.
253 Zexin Ma, How the media cover mental illnesses: a review, 117 HEALTH EDUC. 90, 90 (2017); Andrew B. Borinstein, Public Attitudes Toward People with Mental Illness, 11 HEALTH AFFAIRS 187, 189 (1992). Kim & Stout found that the era of social media and mass participation in the media is having a positive impact on reducing the stigma put forward by the traditional sources of media. Hyojin Kim & Patricia A. Stout, The Effects of Interactivity on Information Processing and Attitude Change: Implications for Mental Health Stigma, 25 HEALTH COMM’N 142, 150–51 (2010).
254 McGinty et al., found that most people learn about mental illness from the media’s coverage of mass shootings and that, as opposed to mental health diagnosis, other factors are more casually related to gun violence, such as gun access. Emma E. McGinty et al., News Media Framing of Serious Mental Illness and Gun Violence in the United States, 1997-2012, 104 AM. J. PUB. HEALTH 406, 406, 410–11 (2014).
256 Peterson & Heinz, supra note 132, at 541.
movement, whereby large amounts of inpatients with mental illnesses moved out of psychiatric institutions, into the streets, and then into the criminal justice system, has left disproportionate numbers of mentally ill prisoners. That being said, certain causes of imprisonment for mentally ill individuals are not as clear-cut and simple as they may first appear. However, the impact of social control as administered through the criminal justice apparatus, such as policing, imprisonment, and subsequent labeling should not be underestimated as a predominant cause of the high rates of imprisonment of this population. In order to reverse the trend towards the mass incarceration of those with mental illnesses, we, as a society, should be concerned with calls for a return to the asylum.257 Our focus should be on providing community-based treatment and to the same extent, focusing on interventions that address the socio-economic causes of crime such as poverty, unemployment, undereducation and addiction issues.

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