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DON'T CALL ME CRAZY: A SURVEY OF AMERICA'S MENTAL HEALTH SYSTEM

JUSTIN L. JOFFE

INTRODUCTION

Although she retired from show business in 2012, actress and former child star Amanda Bynes' odd behavior has kept her in the spotlight in recent years. A child star growing up to be a strange adult is certainly not unusual, but Amanda's behavior has crossed the line between "strange" and mentally ill. Her actions have been well documented. She has had numerous driving offenses such as DUI's, hit-and-runs, and police chases, along with other brushes with the law.¹ However, her concerning behavior has most noticeably manifested via Twitter. In 2013, Amanda began posting bizarre and unintelligible tweets such as revealing photos; obsessive statements about her diet and appearance; inappropriate revelations about past relationships; and angry, nonsensical tirades directed at friends, family, the police, and other celebrities.² Most notably, in October 2014, Amanda posted statements accusing her father of verbally, physically, and sexually assaulting her,³ and a short time later, a friend recorded her threatening to murder her parents.⁴

Some may dismiss Amanda Bynes as a washed-up celebrity crying out for attention, but observers should take her situation seriously. This is not tabloid fodder. Rather, it is a public example of the struggle faced by millions of Americans who suffer from serious mental illness. Amanda has stated that she has been diagnosed as bipolar.⁵ Like her,

1. Saeed Ahmed, *Amanda Bynes' Bipolar Diagnosis Turns Murky*, CNN (Nov. 16, 2014), <http://www.cnn.com/2014/11/04/showbiz/amanda-bynes-tweets>.

2. See Amanda Bynes (@amandabynes), TWITTER, <https://twitter.com/amandabynes> (last visited Apr. 18, 2016). Amanda frequently deletes these statements later on.

3. Ahmed, *supra* note 1.

4. Shaunee Flowers, *Amanda Bynes Confesses She Wants to Slit Dad's Wrists and Throw Him in a Ditch*, EXAMINER (Nov. 15, 2014), <http://www.examiner.com/article/amanda-bynes-confesses-she-wants-to-slit-dad-s-wrists-and-throw-him-a-ditch>. Amanda said that she wanted to "slit [her father's] wrists," and "lead him into a ditch," adding that "nothing would give me greater pleasure than like [sic] slitting his throat." *Id.* The recording also says that these threats were a joke. *Id.*

5. Ahmed, *supra* note 1.

more than a quarter of American adults suffer from mental illnesses such as dementia, schizophrenia, depression, bipolar disorder, attention deficit disorder, and autism.⁶ Beginning in the 1950s, the vast majority of state-run mental hospitals were closed, a phenomenon that made it very difficult for mentally ill individuals (hereinafter “MIIs”) to receive treatment.⁷ This difficulty is further compounded by the stigma surrounding mental illness, which both discourages MIIs from seeking treatment and deters the public from fully supporting MIIs and the mental health system in general.⁸ The unfortunate prevalence of highly publicized acts of violence perpetrated by MIIs has given many Americans the false impression that most MIIs are darkly disturbed and violent.⁹ However, in reality, most MIIs are not violent and are not likely to become violent.¹⁰ Rather, most are like Amanda: obviously impaired and in need of help, but struggling to obtain it because of a complicated and inefficient mental health system.

Of course, there are some significant differences that make Amanda unusual compared to the majority of MIIs. Obviously, most MIIs do not have the safety net of wealth and fame beneath them. Furthermore, many MIIs do not have family and friends that are both willing and able to watch out for them. Despite Amanda’s death threats and false accusations, her parents have worked hard to get her help. In 2014, they managed to have Amanda involuntarily committed to a treatment facility, only to see her released a short time after because Amanda decided she did not want to stay there.¹¹ Their inability to convince Amanda to accept treatment frustrated her parents.¹² This frustration, however, is not unusual, but is a common conundrum facing families of MIIs: the only way to help their relative is by getting them treatment in

6. Kasey Mahoney, *Addressing Criminalization of the Mentally Ill: The Importance of Jail Diversion and Stigma Reduction*, 17 MICH. ST. U. J. MED. & L. 327, 327–28 (2013).

7. *Id.* at 332.

8. Patrick W. Corrigan & Amy C. Watson, *Understanding the Impact of Stigma on People with Mental Illness*, 1 WORLD PSYCHIATRY 16, 16–17 (2002).

9. Jeneen Interlandi, *When My Crazy Father Actually Lost His Mind*, N.Y. TIMES (June 22, 2012), <http://www.nytimes.com/2012/06/24/magazine/when-my-crazy-father-actually-lost-his-mind.html>.

10. *Id.*

11. *Amanda Bynes Confesses She Wants to Slit Dad’s Wrists and Throw Him in a Ditch*, EXAMINER, <http://www.examiner.com/article/amanda-bynes-confesses-she-wants-to-slit-dad-s-wrists-and-throw-him-a-ditch> (last updated Nov. 15, 2014).

12. Rebecca Davison & Shyam Dodge, *Amanda Bynes’ Parents to ‘Surrender Conservatorship in the Next Few Days and Plan to Move Away to Texas’*, DAILYMAIL.COM (Nov. 6, 2014), <http://www.dailymail.co.uk/tvshowbiz/article-2823322/Amanda-Bynes-parents-surrender-conservatorship.html>.

a hospital, but often the relative refuses to be hospitalized because they are unaware that they are ill.¹³ Without a patient's consent, involuntary commitment to the hospital is only lawful for a short period of time.¹⁴

Patients must meet the state's requisite legal standard for involuntary commitment—often a showing that the patient presents a danger to themselves or others—or they will be released from the hospital.¹⁵ Upon release, those without families to take them in, or those whose families do not know where they are, will be left to fend for themselves. Given their condition, many MIIs are not able to function in society without assistance, and as a result, many end up homeless or in prison.¹⁶ Not surprisingly, prisons provide MIIs with inadequate care, which in turn creates a “revolving door” phenomenon: mentally ill inmates are released after short prison terms, but because their symptoms have not been treated, they subsequently commit minor crimes that land them back in prison.¹⁷ Recognizing the prison system's inability to rehabilitate MIIs, many jurisdictions have created jail diversion programs, such as mental health courts, which aim to keep MIIs out of jail by addressing their treatment needs.¹⁸ These jail diversion programs are relatively new, but have seen great success thus far.¹⁹

This Note surveys the current state of America's mental health system, commenting on the causes and effects of past policies and their implications on present policy, and proposes various alterations that can be made to improve the system. Part I provides an overview of the history of America's mental health system, focusing on the original system of mass institutionalization and the subsequent policy of deinstitutionalization that dramatically changed mental health treatment in the mid-twentieth century. Part II discusses the issue of involuntary commitment and examines the pros and cons of strict versus lenient involuntary commitment laws. Part III examines the phenomenon of

13. *See id.*

14. *See* Dan Moon, *The Dangerousness of the Status Quo: A Case for Modernizing Civil Commitment Law*, 20 WIDENER L. REV. 209, 221 (2014).

15. *Id.* at 213.

16. Theresa Clarke, *State Institutions Without Walls: Chronic Homelessness for People with Mental Illness Can Be Brought to an End*, 16 SCHOLAR: ST. MARY'S L. REV. ON RACE & SOC. JUST. 187, 188 (2013); Mahoney, *supra* note 6, at 333.

17. Mahoney, *supra* note 6, at 337.

18. *Position Statement 53: Mental Health Courts*, MENTAL HEALTH AM. (Dec. 6, 2014), <http://www.mentalhealthamerica.net/positions/mental-health-courts>.

19. *Id.*

criminalization and the burdens it imposes on MIIs. Part IV analyzes the modern trend of using jail diversion programs, particularly mental health courts, to combat criminalization and provide MIIs better access to treatment. Finally, Part V addresses the pervasive stigma surrounding mental illness and proposes various strategies that can help reduce this stigma.

I. THE HISTORY OF THE AMERICAN MENTAL HEALTH SYSTEM

An analysis of the contemporary mental health system requires an understanding of the historical approaches to mental illness and how those approaches have changed over time. Past policies and attitudes illuminate how the system has evolved alongside advancements in social norms, technology, and the law, and give insight as to how the system will continue to evolve.

A. Early Mental Health Treatment Practices

During most of America's existence, the mental health system has reflected society's rudimentary medical knowledge and social intolerance toward mental illness.

1. Mass Institutionalization

MIIs were originally confined in prisons, but this practice began to change in the early nineteenth century due to the emerging belief that mental illness could be effectively treated by hospitalization in state-run asylums.²⁰ At that time, the stereotype that MIIs were violent and dangerous was even more prevalent than it is today, and the accepted theory was that "the protection of the mentally ill and society demand[ed] that [MIIs] be kept in a quiet and secluded residence, guarded by watchful attendants and not exposed to the public."²¹ The need for "protection" also extended to MIIs who were non-violent, but whose "being at large [was] inconsistent with the comfort of society, and their own welfare."²²

20. Mahoney, *supra* note 6, at 329.

21. John E. Cummings, *The Cost of Crazy: How Therapeutic Jurisprudence and Mental Health Courts Lower Incarceration Costs, Reduce Recidivism, and Improve Public Safety*, 56 LOY. L. REV. 279, 282 (2010) (internal quotation marks omitted).

22. LeRoy L. Kondo, *Advocacy of the Establishment of Mental Health Specialty Courts in the Provision of Therapeutic Justice for Mentally Ill Offenders*, 28 AM. J. CRIM. L. 255, 267 (2001) (internal quotation marks omitted). These are the words of John Conolly, a renowned nineteenth century psychiatric commentator who advocated that "out-of-control persons who exhibit public

This policy, known as mass institutionalization, continued into the latter half of the twentieth century.²³ The purpose was to provide care for MIIs in state asylums, but limited government funding hindered the achievement of this goal and caused asylums to provide sub-standard care and sub-human living conditions.²⁴ Investigations of asylums revealed severe overcrowding and patients that were malnourished, neglected, abused, and subjected to questionable treatment practices, such as lobotomies and electric shock therapy.²⁵ As time went on, the goal of providing care was largely ignored as hospitals became “focused more on containing MII outside of the community rather than providing actual mental health therapy.”²⁶ In theory, mass institutionalization made sense: MIIs would be better off receiving treatment in state asylums than receiving no treatment at all in prison or in the community. In practice, however, funding and managing the massive institutional system proved to be unrealistic.

2. Eugenics and Forced Sterilization

One of the most infamous aspects of the mass institutionalization era was the disturbingly common practice of sexual sterilization of the mentally ill. Sterilization, the practice of forcing asylum patients to undergo surgical procedures that rendered them unable to reproduce, was driven by the science of eugenics.²⁷ The archaic eugenics theory embraced the notion that “like breed like,” meaning that parental and other ancestral traits, such as mental illness, will reappear in one’s children and the descendants of those children.²⁸ Thus, the goal of “positive” eugenics was to encourage the “best” humans to mate and procreate with each other, whereas the goal of “negative” eugenics was to discourage and prevent those with disfavored traits from procreating.²⁹ Indeed, mental illness was considered a highly disfavored trait.³⁰

explosions of anger, lack of personal hygiene, drunkenness, or other conduct disruptive to the smooth functioning of society should be placed in protective treatment facilities.” *Id.*

23. *Id.* at 268–69.

24. Mahoney, *supra* note 6, at 329; Kondo, *supra* note 22, at 268. The conditions in some hospitals were so bad that they were referred to as “snake pits” as depicted in the classic book and film *One Flew Over the Cuckoo’s Nest*. *Id.*

25. Mahoney *supra* note 6, at 329.

26. *Id.* at 329–30.

27. Edward J. Larson, *Putting Buck v. Bell in Scientific and Historical Context: A Response to Victoria Nourse*, 39 PEPP. L. REV. 119, 121 (2011).

28. *Id.*

29. *Id.* “More children from the fit, less from the unfit,” was the motto of early twentieth century eugenicists. *Id.* at 122.

By the 1920s, eugenics and sterilization had gained widespread acceptance in the United States.³¹ This consensus led most states to enact compulsory eugenic sterilization statutes, the constitutionality of which were upheld by the Supreme Court in *Buck v. Bell*.³² *Buck* involved a due process challenge to a Virginia asylum's plan to sterilize Carrie Buck, a mentally ill woman who allegedly had a mentally ill mother and her own mentally ill daughter.³³ In upholding Virginia's sterilization statute, Justice Oliver Wendell Holmes infamously reasoned,

It 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. . . . Three generations of imbeciles are enough.³⁴

Despite scientific advancements and the abominable application of the eugenics theory in Nazi Germany,³⁵ the practice of sterilizing the mentally ill continued well into the 1960s.³⁶ At the time *Buck* was decided in 1927, 8,500 eugenic sterilizations had been performed in the United States.³⁷ By 1963, over 63,000 had been performed.³⁸ The average annual number of sterilizations "peaked at 2,273 during the 1930s and decreased only slightly to 1,636 during the 1940s before falling to 993 during the 1950s."³⁹ However, this average for the 1950s was still higher than any other decade prior to or including the 1920s when *Buck* was decided.⁴⁰

30. See *id.* at 126. Criminality was the other "disfavored" trait. However, eugenicists never reached a consensus that criminal behavior was an inheritable trait and thus the sterilization of criminals was much less common. *Id.* at 126–27. In *Skinner v. Oklahoma*, the Supreme Court struck down a criminal sterilization program but preserved the constitutionality of sterilizing the mentally ill. 316 U.S. 535 (1942).

31. See Larson, *supra* note 27, at 122–23. Eugenics and sterilization was embraced by prominent members of the medical community, distinguished professionals such as Alexander Graham Bell, wealthy philanthropists, and powerful political leaders including Presidents Theodore Roosevelt, William Howard Taft, Woodrow Wilson, and Calvin Coolidge. "Even the era's most famous American with disabilities, Helen Keller, who became blind and deaf from a childhood illness, favored eugenic remedies for those born with severe disabilities." *Id.* at 123.

32. See *Buck v. Bell*, 274 U.S. 200 (1927).

33. *Id.* at 205. Indeed, Carrie Buck's categorization as mentally ill would not have met modern standards, and it was subsequently discovered that Buck's daughter, Vivian, was not actually mentally retarded as was claimed. Larson, *supra* note 27, at 126.

34. *Buck*, 200 U.S. at 207.

35. See Larson, *supra* note 27, at 126.

36. *Id.* at 128 n.72.

37. *Id.*

38. *Id.*

39. *Id.*

40. *Id.*

Although the *Buck* Court and all supporters of eugenics at the time were constrained by scientific ignorance, their views reflect society's prevailing attitude towards the mentally ill for much of American history: MIs were sub-human and were not entitled to the same rights and freedoms as "normal" members of the population.⁴¹ Due to unsettling enthusiasm and promotion by some of the most prominent and influential Americans, the weakest and most vulnerable members of society were forced to undergo an invasive surgical procedure that deprived them of one of life's essential functions.⁴² Thankfully, America eventually rejected this barbarous practice, as well as the other appalling practices that define the unfortunate era of mass institutionalization.

B. Deinstitutionalization

MIs were certainly better off after the policies of mass institutionalization ended, but their struggle continued due to the difficulty of establishing an alternative treatment system and the persistence of ignorant attitudes towards mental illness.

1. The Shift to Deinstitutionalization

Mental health care changed drastically in the 1950s and 1960s as a result of deinstitutionalization, the policy of closing state mental asylums.⁴³ In 1961, the Joint Commission on Mental Illness and Health issued a report to Congress detailing the state of the American mental health system.⁴⁴ The Commission found that by 1955, the number of people in mental hospitals had surpassed the number of people in prisons.⁴⁵ Noting the "horrific" conditions in these institutions, the Commission recommended a program that would "shift mental health care from public hospitals to community-based treatment facilities."⁴⁶ In response to the Committee's report and the emphatic support of President John F. Kennedy, Congress passed the 1963 Mental Retardation Facilities and Community Health Act (MRFCHA), which sought to

41. See Cummings, *supra* note 21, at 282; Kondo, *supra* note 22, at 268; Mahoney, *supra* note 6, at 329.

42. Larson, *supra* note 27, at 123.

43. See Arthur J. Lurigio, *Examining Prevailing Beliefs About People with Serious Mental Illness in the Criminal Justice System*, 75 FED. PROBATION 11, 12 (2011).

44. Mahoney, *supra* note 6, at 330.

45. Cummings, *supra* note 21, at 283.

46. Mahoney, *supra* note 6, at 330 (internal quotation marks omitted).

establish community mental health centers throughout the country.⁴⁷ The passage of the MRFCHA marked the decisive shift from mass institutionalization to deinstitutionalization and initiated the development of the contemporary American mental health system.⁴⁸

The MRFCHA made a significant impact, but the process of deinstitutionalization had actually begun before its passage.⁴⁹ The initial movement toward deinstitutionalization occurred in the 1950s and was fueled by a combination of factors including “journalistic exposés of patient abuse, effective new medications to treat severe mental illness, federal entitlement programs that paid for community-based mental health services[,] and the availability of insurance coverage for inpatient psychiatric care in general hospitals.”⁵⁰ The introduction of chlorpromazine in 1955, the so-called “wonder drug,” stood as the most significant medical advancement and allowed for more effective mental health treatment outside of hospitals.⁵¹ Also, federal litigation led to more restrictive involuntary commitment laws that placed an emphasis on the constitutional right of MIs to live in the community regardless of whether they choose to seek treatment for their illness.⁵²

The process of deinstitutionalization took place on a dramatic scale. When the institutionalized population was at its peak in 1955, there were 559,000⁵³ patients in state hospitals out of a total national population of 165 million.⁵⁴ By 2000, that number was down to only 55,000 out of a national population of over 275 million.⁵⁵ Of the deinstitutionalized population, between fifty and sixty percent were schizophrenic, ten to fifteen percent had manic-depressive illness, another ten to fifteen percent had organic brain diseases such as epilepsy or Alzheimer’s disease, and the rest suffered from conditions such as mental retardation, autism, and alcohol and drug addiction with concurrent brain damage.⁵⁶

47. *Id.*

48. *Id.*

49. See Lurigio, *supra* note 43, at 12.

50. *Id.*

51. Mahoney, *supra* note 6, at 330. These drugs would later prove to be less successful than originally thought, which made it difficult to treat patients outside of a hospital atmosphere. *Id.* at 332.

52. *Id.* at 330.

53. Some estimate that this number is actually as high as 819,000. Kondo, *supra* note 22, at 386.

54. Mahoney, *supra* note 6, at 330.

55. *Id.* at 330–31.

56. *Deinstitutionalization: A Psychiatric “Titanic”*, PBS FRONTLINE: THE NEW ASYLUMS (May 10, 2005), <http://www.pbs.org/wgbh/pages/frontline/shows/asyllums/special/excerpt.html>.

2. The Failure of Deinstitutionalization

Deinstitutionalization was based on the principle that the mentally ill should be treated in the least restrictive setting, and the policy was intended to maintain “the greatest degree of freedom, self-determination, autonomy, dignity, and integrity of body, mind, and spirit for the individual while he or she participates in treatment or receives services.”⁵⁷ Despite this admirable goal, deinstitutionalization has been dubbed “the largest failed social experiment in twentieth-century America.”⁵⁸ Although deinstitutionalization effectively reduced the use of state asylums, it failed to provide alternative outpatient treatment for MIIs that were trying to return to community life.⁵⁹

As with mass institutionalization, one major reason deinstitutionalization failed was a lack of government funding.⁶⁰ The plan was to shift funds from shuttered state hospitals to community care centers, but the amount of funding was ultimately not enough to sustain these community treatment programs.⁶¹ During the first years of deinstitutionalization, Congress was distracted by major events such as the Vietnam War and the Watergate scandal and paid little attention to the lack of funding for community mental health care.⁶² But even without these distractions, mental health care never became a congressional priority, and by 1997 mental health funding contributions were thirty percent lower than they were in 1955.⁶³ With no community treatment option, MIIs could not receive treatment unless they could pay for private services themselves.⁶⁴

In shifting from mass institutionalization to deinstitutionalization, policymakers made the same mistake twice. Mass institutionalization failed because state asylums were underfunded;⁶⁵ more money would have enabled hospitals to provide effective treatment in a humane environment. Deinstitutionalization failed for the same reason: a lack of funding for community care centers that were supposed to fill the treatment void left after the asylums closed.⁶⁶ Until legislatures and the

57. *Id.*

58. Cummings, *supra* note 21, at 283.

59. Kondo, *supra* note 22, at 269.

60. Mahoney, *supra* note 6, at 331.

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.*

65. *Id.* at 329.

66. *Id.* at 331.

American people prioritize the provision of mental health care, funding for treatment will continue to lag behind ever-present “distractions.”

II. Involuntary Commitment

The deinstitutionalization movement was also spurred on by the enactment of more stringent involuntary commitment laws. The Fourteenth Amendment to the United States Constitution guarantees that “[n]o State shall . . . deprive any person of life, liberty, or property, without due process of law.” Despite this protection, the law recognizes that there are certain situations where the deprivation of a person’s liberty is necessary in order to ensure both that individual’s safety and the safety of society.⁶⁷ In most states, the legal standard that must be met in order to involuntarily commit someone for mental health treatment is excessively high because it prevents many MIIs from receiving the treatment they need.

Originally, MIIs were often involuntarily committed absent judicial oversight.⁶⁸ By the mid-nineteenth century, however, concerns over the abuses that could occur without judicial supervision led many states to adopt civil commitment laws.⁶⁹ These laws varied in stringency but were generally relaxed around the time of the Great Depression to require only a showing that the individual had a “need for treatment.”⁷⁰ However, in the 1960s and 1970s, patient advocates championing the belief that good intentions to treat MIIs cannot supersede constitutional due process protections pushed back against these relaxed commitment standards.⁷¹

Contemporary involuntary commitment laws were significantly influenced by the Supreme Court’s 1975 decision in *O’Connor v. Donaldson*.⁷² The case was brought by Kenneth Donaldson, a purported schizophrenic who was kept in a Florida state mental asylum for almost fifteen years despite his repeated requests for release and his assurances that he was not a danger to himself or others.⁷³ The Court held in favor of Donaldson and set forth the constitutional standard that must be met in order to involuntarily commit and confine some-

67. Moon, *supra* note 14, at 211.

68. *Id.* at 212.

69. *Id.*

70. *Id.*

71. *Id.*

72. See *O’Connor v. Donaldson*, 422 U.S. 563 (1975).

73. *Id.* at 566–67.

one: the individual must be a danger to himself or others and must be incapable of living safely under the supervision of family or friends.⁷⁴

In enacting their own laws to meet the Supreme Court's requirements, the states have applied *Donaldson's* dangerousness standard in varying ways. Some states interpret "dangerousness" to require only that the committed individual is unable to care for him or herself, while other states focus on the immediacy of the threat of physical violence to the individual or to others.⁷⁵ At one end of the spectrum, states like Ohio mandate that the danger posed be immediate and require evidence of suicide attempts or other violent behavior, or evidence that the individual faces an immediate risk of harm because they are unable to provide for their basic physical needs.⁷⁶ At the other end of the spectrum, states like Minnesota have relaxed their involuntary commitment standard to allow for commitment when the danger posed by the individual is not immediate.⁷⁷ Other states, like Arizona, have taken a middle ground approach, requiring that a reasonable practitioner be able to foresee harm coming to the committed individual or to others.⁷⁸ Notably, Wisconsin has adopted the most progressive involuntary commitment standard.⁷⁹ Wisconsin's standard considers whether there is a "substantial probability" that if an individual is left untreated, that will lead to that individual's "loss of the ability to function independently in the community or loss of cognitive or volitional control."⁸⁰

While there are pros and cons to adopting either stringent or lenient commitment requirements, lenient standards better serve the interests of MIIs. While a stringent approach, like that used in Ohio, reduces the risk that committed individuals will be wrongfully deprived of their freedom like Kenneth Donaldson was, there are already mechanisms in place to prevent that from happening. For example, many states require that committed individuals receive periodic judicial hearings at their request or at designated intervals to review the appropriateness of their continued confinement.⁸¹ State statutes also

74. *Id.* at 575.

75. Moon, *supra* note 14, at 218.

76. OHIO REV. CODE ANN. § 5122.01(B) (West 2015).

77. MINN. STAT. § 253B.02, subdiv. 17 (2014).

78. ARIZ. REV. STAT. ANN. §§ 36-501(5)-(6) (2015).

79. Moon, *supra* note 14, at 220 n.99.

80. WIS. STAT. § 51.20(1)(a)(2)(e) (2015).

81. Moon, *supra* note 14, at 213.

limit the length of commitment to statutorily prescribed terms in order to prevent wrongful confinement.⁸²

Furthermore, adopting a strict approach creates the risk of failing to confine a dangerous person who technically does not meet the commitment standard, but who still needs to be committed.⁸³ This is a serious risk that outweighs that of wrongfully, but temporarily, depriving individuals of their freedom. Many observers, such as the patient advocates who originally championed more stringent commitment laws in the 1960s and 1970s, would argue that an individual's constitutionally protected rights cannot be sacrificed just because there is a chance they may become violent.⁸⁴ However, one's freedom from confinement is not an absolute right, and the deprivation of freedom is justified if the individual potentially, although not definitely, poses a danger to him or herself or others.

III. THE CRIMINALIZATION OF THE MENTALLY ILL

MIIs have a difficult time functioning in the community without proper treatment, which causes them to commit and recommit minor crimes and become charges of the criminal justice system.⁸⁵ According to the "hydraulic hypothesis," a constant segment of the mentally ill population will always require institutional care.⁸⁶ Thus, when the population of state mental hospitals decreased after deinstitutionalization, the prison population was bound to increase.⁸⁷ It is no secret that MIIs are overrepresented in the American prison system. Compared to the general population, the number of inmates with serious illnesses such as schizophrenia, bipolar disorder, and major depression is more

82. *Id.*

83. For example, Jared Loughner, a schizophrenic man who shot twelve people and killed six at a 2011 meet-and-greet with Arizona Congresswoman Gabrielle Giffords likely would not have met Arizona's "middle ground" approach, which requires a reasonable practitioner to foresee harm coming to the individual or others. Despite his strange and erratic behavior, Loughner had done nothing prior to the shooting to suggest that he was prone to violence. However, if Loughner were analyzed according to Wisconsin's standard, perhaps his behavior could have been deemed sufficient to create a "substantial probability" that he would lose the ability to function if left untreated. *Id.* at 209–10.

84. *Id.* at 211.

85. Lurigio, *supra* note 43, at 12.

86. *Id.* at 13. The "hydraulic hypothesis" was developed by Lionel Penrose, a British psychiatrist known for his pioneering work on the genetics of mental retardation. *Id.*; see also Thomas Bewley, Correspondence, *Lionel Penrose, Fellow of the Royal Society*, 24 *PSYCHIATRIC BULL.* 469, 469 (2000).

87. Lurigio, *supra* note 43, at 13.

than three times higher for men and almost twice as high for women.⁸⁸ As a result, large city jails such as the Los Angeles County Jail, New York City's Rikers Island Jail, and Chicago's Cook County Jail have become some of the largest mental health care providers in the country.⁸⁹

The phenomenon of "criminalization" occurs when MIIs with no desire to break the law are arrested for minor crimes or ordinance violations, such as nuisance offenses or disorderly conduct.⁹⁰ Studies show that mentally ill perpetrators of minor crimes are more likely to be arrested than people who commit the same crimes but show no signs of mental illness.⁹¹ This discrepancy can partially be attributed to "mercy bookings," arrests made by police officers looking to ensure that mentally ill offenders obtain a meal and a safe place to sleep.⁹² While this kind of thoughtful police service should be applauded, the benefit of mercy bookings is significantly limited because they do not address the underlying need for treatment.⁹³ In addition, criminalizing behaviors that are symptomatic of mental illness poses a significant burden on the criminal justice system as it creates more inmates that overload prison systems that are already unable to provide adequate treatment to large populations of mentally ill inmates.⁹⁴

Prisons and jails have proven incapable of providing adequate mental health treatment to inmates.⁹⁵ The Cruel and Unusual Punishments Clause of the Eighth Amendment has been interpreted to require that prisons address the medical needs of their inmates.⁹⁶ However, only one-third of state prisoners and one-fourth of federal prisoners actually receive mental health treatment while incarcerated, and those that do are usually treated with medication only.⁹⁷ As was the case with state-run asylums during the mass institutionalization era, the lack of adequate care in prisons can mainly be attributed to limited prison resources in the face of a growing demand for care.⁹⁸ Due to a lack of funding, mental health care programs in prisons are

88. Mahoney, *supra* note 6, at 333.

89. *Id.* at 334.

90. Lurigio, *supra* note 43, at 11.

91. *Id.*

92. *Id.*

93. *See id.*

94. Cummings, *supra* note 21, at 286.

95. *Id.*

96. *Id.* at 288.

97. Mahoney, *supra* note 6, at 334–35.

98. *Id.* at 335.

chronically understaffed and the staff that are available are often underpaid, making it difficult to attract quality professionals.⁹⁹ This lack of funding also means that essential components of mental health care, such as case management programs, are unavailable in prisons and jails.¹⁰⁰

Aside from the inadequacy of mental health care in prisons, the hardship of incarceration itself weakens the condition of mentally ill inmates.¹⁰¹ The punitive prison environment is not easy: inmates live in close quarters, lack privacy, and cannot maintain regular contact with family and friends.¹⁰² These high-stress living conditions would be difficult for anyone, but can be overwhelming for MIIs and can result in their decompensating to the point of psychiatric collapse.¹⁰³ The stress is exacerbated when corrections officers, inexperienced in dealing with mental illness, punish mentally ill inmates for belligerent behaviors, such as fighting, that are caused by their symptoms but can be misinterpreted as rebellious behavior to the untrained eye.¹⁰⁴ Because corrections officers tend to punish this behavior regardless of its origin, mentally ill inmates often face longer and harsher prison sentences and are further deprived of treatment to address the condition that triggered the deviant behavior in the first place.¹⁰⁵

In addition to the lack of community-based treatment following deinstitutionalization, two other factors have helped drive the criminalization of the mentally ill. The first is poverty. Studies demonstrate that there is a correlation between socioeconomic status and mental illness:

[P]eople of lower socioeconomic status are more likely than those of higher socioeconomic status to be diagnosed with a serious mental disorder. The unrelenting stress of poverty increases the risk of mental illness. Mental illness can also pull a person downwards into poverty because the symptoms of mental illness can interfere with going to school and finding and maintaining employment. In addi-

99. *Id.* Note that it is difficult to attract health care workers to work in prisons in general.

100. Case management designates a professional who is responsible for the mentally ill offender's care. The case manager formulates and monitors the offender's treatment plan and serves as an advocate for the offender. H. Richard Lamb & Linda E. Weinberger, *Persons with Severe Mental Illness in Jails and Prisons: A Review*, 49 *PSYCHIATRY SERVS.* 4, 483 (1998).

101. Mahoney, *supra* note 6, at 336.

102. *Id.* at 335-36.

103. *Id.*

104. *Id.* at 336.

105. *Id.* "Statistics have shown that mentally ill inmates in state prisons are more likely to face discipline for rule violations, and can serve up to four months longer than inmates who do not have a mental illness." *Id.*

tion, most poor people have no or limited insurance coverage for primary mental health care. Therefore, their symptoms go untreated, producing irreversible clinical deterioration and recurrence of more severe episodes of psychiatric disease.¹⁰⁶

As a result of these circumstances, MIIs tend to live in “highly criminogenic and impoverished environments” characterized by unemployment, residential instability, under-education, and gang influences.¹⁰⁷ These circumstances exert pressures on mentally ill inhabitants to engage in criminal behavior.¹⁰⁸

The second factor that has contributed to criminalization is America's War on Drugs. There is a high rate of comorbidity between drug use and mental illness, which partially accounts for the large numbers of MIIs in the criminal justice system.¹⁰⁹ In the 1980s, law enforcement began placing an overwhelming emphasis on combatting the use and sale of illegal drugs, which resulted in a dramatic increase in America's arrest and incarceration rates.¹¹⁰ Because of the large population of MIIs in poor neighborhoods where illegal drugs are more easily obtained and where there is an increased police presence, MIIs are more likely to be arrested for drug use and possession.¹¹¹ Furthermore, MIIs who also use illicit drugs are more likely to become violent and thus more likely to be arrested than MIIs who do not use drugs.¹¹²

Similar to MIIs who were released from state mental hospitals during deinstitutionalization, MIIs today face many challenges when they are released from jail that make it highly likely that they will soon be re-incarcerated.¹¹³ For example, newly released MIIs often face loss of housing, unemployment, and difficulty maintaining social relationships.¹¹⁴ Most significantly, however, the failure to provide MIIs with community-based treatment means that the symptomatic behavior that landed the individual in jail in the first place will not be alleviated.¹¹⁵ Moreover, a criminal record makes it even more difficult to find

106. Lurigio, *supra* note 43, at 13.

107. *Id.*

108. *Id.*

109. Lurigio, *supra* note 43, at 14.

110. *Id.*

111. *Id.*

112. *Id.*

113. “[I]n 2004, approximately half of mentally ill state prisoners and forty-two percent of mentally ill jail inmates had three or more incarcerations or probations.” The number for non-mentally ill offenders is only 28%. Mahoney, *supra* note 6, at 337 (internal quotation marks omitted).

114. *Id.*

115. *Id.*

treatment in the community because many community treatment facilities will not accept MIIs who have a criminal history.¹¹⁶ However, even if an individual finds a community facility that will treat them, they may be unable to afford treatment due to problems that can arise in accessing public benefits, such as Medicaid or Social Security, when one has a criminal record.¹¹⁷ These circumstances trigger the “revolving door effect” in which MIIs return to the community still exhibiting behavior symptomatic of their mental illness that puts them at greater risk for re-arrest.¹¹⁸

Greater efforts should be made to reverse the criminalization phenomenon. Some of the factors that cause criminalization can be easily addressed. For example, laws have been rewritten to punish minor drug offenses with less harsh sentences that do not involve jail time.¹¹⁹ As a result, fewer people, including MIIs, are receiving drug-related prison sentences, and America’s prison population has started to decline in recent years.¹²⁰ Also, policymakers and prison officials can easily address certain aspects of prison life that exacerbate mentally ill inmates’ condition while they are incarcerated. For example, prisons can train corrections officers to better recognize behavior that is symptomatic of mental illness and institute policies that punish infractions caused by such behavior differently than infractions committed by inmates who are not mentally ill.

Other causes of criminalization, however, are more difficult to remedy. For example, the link between mental illness and poverty has several different causes—psychological, social, and economic—that cannot be fixed by simply changing laws and policies. The lack of funding for community treatment and prison mental health treatment programs is not easily remedied either. Insufficient funding for mental health care has been a major problem since the early days of mass institutionalization, and there is no reason to believe that legislators and

116. *Id.*

117. *Id.*

118. *Id.*

119. Sarah Childress, *Feds to Reconsider Harsh Prison Terms for Drug Offenders*, PBS FRONTLINE (Apr. 9, 2014, 12:50 PM), <http://www.pbs.org/wgbh/pages/frontline/criminal-justice/locked-up-in-america/feds-to-reconsider-harsh-prison-terms-for-drug-offenders>. As of 2014, forty states have passed laws easing mandatory sentences for drug crimes, and seventeen states have invested in reform programs that provide treatment and supervision. These reforms have gained popular support: according to a Pew Research Center poll, sixty-seven percent of respondents “said that states should focus on treatment, rather than punishment, for people struggling with addiction to illegal drugs.” *Id.*

120. *Id.*

taxpayers are now willing to increase mental health funding to sufficient levels.¹²¹

Considering these difficulties, reversing the criminalization of the mentally ill will likely require a slow, piecemeal process. If the hydraulic hypothesis holds true, a large population of MIIs will remain in, and continue to enter, the criminal justice system until adequate community-based treatment is in place that will prevent MIIs from committing crimes and going to jail. Achieving that goal will take time. But in the interim, jail diversion programs, such as mental health courts, have shown to be an effective remedy for criminalization as they work to keep MIIs out of jail cells and provide them with treatment instead.¹²²

IV. MENTAL HEALTH COURTS

Many jurisdictions have set up mental health courts in an effort to reduce criminalization. A mental health court is a type of problem solving court¹²³ that specializes in handling mentally ill offenders by redirecting them from the criminal justice system to supervised community-based treatment.¹²⁴ Mental health courts have been shown to reduce the time mentally ill offenders spend in jail,¹²⁵ successfully link them to community mental health services, and increase the rate at which they properly follow their prescribed medication schedules.¹²⁶ Furthermore, mental health courts avoid the significant public cost of incarceration by keeping mentally ill offenders out of jail.¹²⁷

A. The Expansion of Mental Health Courts in the United States

The popularity of mental health courts, and the amount of funding they receive, has increased as their effectiveness has become more broadly recognized.¹²⁸ In 1997, there were only four mental health

121. Mahoney, *supra* note 6, at 329, 331.

122. Lurigio, *supra* note 43, at 15.

123. Problem solving courts, such as mental health courts, drug courts, and domestic violence courts, are "criminal judicial proceedings that attempt to address defendants' actions at a causal level by imposing remedial discipline rather than retributive punishment. . . ." M. Gomez, *Developments in the Law—The Law of Mental Illness*, 121 HARV. L. REV. 1114, 1168 n.4 (2008).

124. Jill A. Gordon et al., *The Dual Treatment Track Program: A Descriptive Assessment of a New "In-House" Jail Diversion Program*, 70 FED. PROBATION 9, 9 (2006).

125. One 2010 study found that mental health courts reduced the chances of re-arrest by approximately 15%. Mahoney, *supra* note 6, at 339.

126. *Id.*

127. *Id.* Releasing defendants from jail costs the public about \$3 per day, while incarceration costs about \$100 per day. *Id.*

128. Gomez, *supra* note 123, at 1168.

courts in the United States, but that number has grown to over 300 today with programs found in almost every state.¹²⁹

The first mental health court was created in 1997 in Broward County, Florida.¹³⁰ The Broward Mental Health Court has since been hailed as the national model and best practice for other jurisdictions to follow when setting up their own mental health courts.¹³¹ Due to her extensive experience with mental health and disability law, Judge Ginger Lerner-Wren was specially selected to preside over the Broward court.¹³² As Judge Lerner-Wren explained, the Broward model “strives to promote a humanistic quality and emphatic understanding that the plight of those with mental illness is real and that the messages to counter and reduce stigmatization are clear and strong.”¹³³ Judge Lerner-Wren and the Broward court have been very influential, and other jurisdictions have followed their lead by working to promote this humanistic quality and positive attitude in their mental health court programs.¹³⁴

In the early days of mental health courts, high start-up costs prevented poor communities from setting up these programs.¹³⁵ However, this changed with the establishment of President George W. Bush's New Freedom Commission on Mental Health, an investigative commission created “to conduct a comprehensive study of the United States mental health service delivery system, including public and private sector providers, and to advise the President on methods of improving the system.”¹³⁶ The Commission recommended increased federal funding to mental health facilities, particularly mental health courts, which led to the enactment of a 2004 grant program aimed at funding mental health courts.¹³⁷ This program helped sustain steady growth in the number of mental health courts throughout the country.¹³⁸

129. *Mental Health Courts*, JUST. CTR. OF THE COUNCIL OF STATE GOVTS, <http://csgjusticecenter.org/mental-health-court-project> (last visited Feb. 13, 2016).

130. Ginger Lerner Wren, *Mental Health Courts: Serving Justice and Promoting Recovery*, 19 ANNALS HEALTH L. 577, 587 (2010). As of 2010, more than 10,000 individuals had appeared before the court. *Id.* at 590.

131. *Id.* at 577.

132. *Id.* at 589.

133. *Id.* at 591.

134. *See id.*

135. Gomez, *supra* note 123, at 1173.

136. *Id.*

137. *Id.* at 1174.

138. *Id.*

B. The Basic Features of Mental Health Court

Mental health courts are uniquely designed to achieve their goal of redirecting mentally ill offenders from the criminal justice system to community-based treatment. Mental health courts primarily focus on treatment, and many of the criteria for entrance and completion of the programs concern a defendant's treatability.¹³⁹ Many mental health courts promise to clear a defendant's criminal record as an incentive for compliance with the program.¹⁴⁰ Compliance typically requires that defendants "receive outpatient treatment at local clinics, have regular meetings with court or probation officers, make appearances in court to confer with the judge over their treatment progress,¹⁴¹ and participate in group counseling programs."¹⁴² If defendants fail to comply, they will either be incarcerated for a pre-designated period of time, or they will return to the regular court system where their original charges will be reinstated.¹⁴³

Mental health courts are typically run by a judge, a prosecutor, a public defender, caseworkers, and various mental health professionals, each of whose entire docket consists only of mental health court defendants.¹⁴⁴ These individuals are all thoroughly trained in mental illness and treatment and understand how mental illness leads to criminal behavior.¹⁴⁵ The training and dedication of mental health court personnel gives these courts "a unique character as a place where therapy can actually begin, not merely be prescribed."¹⁴⁶ For example, unlike a traditional courtroom, the prosecutor and defense attorney work together, which produces a less adversarial and more

139. *Id.* at 1172. Another important criterion for entrance is the severity of the crime committed. Early mental health court programs did not accept defendants who were charged with felonies, instead focusing on those who had committed misdemeanors. *Id.* at 1171. However, in recent years many mental health courts have become more willing to accept defendants charged with minor felonies, but violent criminals and sexual offenders generally are still not permitted to participate in mental health court programs. *Id.* at 1171-72.

140. Caitlin T. Harrington, *Breaking the Cycle and Stepping Out of the "Revolving Door": Why the Pre-Adjudication Model Is the Way Forward for Illinois Mental Health Courts*, U. ILL. L. REV. 319, 345 (2013). "In some cases, however, the conviction remains on the defendant's record even if the treatment is successfully completed." *Id.* at 346.

141. These subsequent court appearances are more like therapeutic appointments than adversarial criminal proceedings. Gomez, *supra* note 123, at 1171.

142. *Id.*

143. Harrington, *supra* note 140, at 346.

144. Gomez, *supra* note 123, at 1170.

145. *Id.*

146. *Id.* at 1170-71.

relaxed courtroom atmosphere.¹⁴⁷ All participants must be committed to this collaborative, therapeutic, and creative process in order to maximize the effectiveness of the program.¹⁴⁸

Keeping mental health courts staffed with dedicated and trained judges, attorneys, and mental health professionals comes at a high cost, which has forced some jurisdictions to cut back on funding for mental health courts and other similar programs.¹⁴⁹ However, those jurisdictions that manage to keep their mental health courts running often see big reductions in recidivism rates, which eases the burden on law enforcement, the criminal court system, and the mental health court system.¹⁵⁰ Furthermore, reduced recidivism keeps people out of jail and in the community, and leads to increased employment, a more educated population, and an influx of stable, working individuals to support the jurisdiction's tax base.¹⁵¹ Recognizing these benefits, some jurisdictions have come up with creative ways to fund mental health court programs. For example, Illinois imposes a uniform ten-dollar "mental health court charge" in its court costs on both participants and non-participants of mental health courts.¹⁵² Imposing this limited financial burden is certainly justified by the substantial benefits mental health courts provide.

C. Potential Concerns About Mental Health Courts

Despite their success, observers have raised various concerns about mental health courts. One concern is that releasing these individuals back into the community poses a safety threat.¹⁵³ However, this concern is unfounded because mental health court participants have much lower rates of re-offense while on probation than offenders with similar backgrounds who are incarcerated.¹⁵⁴ Another concern is that mental health courts coerce defendants into accepting treatment because their only alternative is criminal prosecution and a looming jail sentence.¹⁵⁵ Although coercive treatment in a mental health court pro-

147. *Id.* at 1171 nn.12–13.

148. Anne Harper & Michael J. Finkle, *Mental Health Courts: Judicial Leadership and Effective Court Intervention*, 51 NO. 2 JUDGES' J. 4, 6 (2012).

149. Gomez, *supra* note 123, at 1172.

150. Harper & Finkle, *supra* note 148, at 5.

151. Harrington, *supra* note 140, at 360.

152. Gomez, *supra* note 123, at 1172.

153. *Id.*

154. *Id.*

155. *Position Statement 53*, *supra* note 18.

gram is likely better than inadequate treatment in prison, mental health courts should strive to mollify this element of coercion. One way to do this is to make sure that defendants know that they are not being forced to enter the mental health court and ensure them that they can opt out and return to the regular criminal court system at any time.¹⁵⁶ Another way to reduce coercion is to refrain from using jail as a sanction for a defendant's failure to comply with the mental health court's ordered treatment program.¹⁵⁷ Instead, the criminal charges against the defendant could be dropped with the recognition that a subsequent re-arrest represents another opportunity for the offender to enter supervised treatment.

An additional worry is that mental health court programs could also become the only way for MIIs to receive treatment.¹⁵⁸ For example, if an individual cannot afford community-based treatment or cannot find a treatment facility that will accept them, mental health courts could become a way to "jump the line" and receive preferential access to treatment in favor of those who are also unable to access community-based treatment, but have not committed crimes.¹⁵⁹ Observers also believe that mental health courts may be used to expand the scope of the criminal justice system in an effort to criminalize social issues such as homelessness or loitering, which are caused by society's failure to provide decent housing, mental health treatment, and other social services.¹⁶⁰ Observers further stress that mental health courts should only file criminal charges against defendants as a last resort because the stigma of criminal charges and conviction makes it more difficult for people to find employment, housing, and pursue recovery.¹⁶¹

All of these concerns are valid and should be seriously examined by every jurisdiction with a mental health court program. However, none of these concerns are serious enough to outweigh mental health courts' proven effectiveness at eliminating criminalization and getting MIIs quality treatment that is unavailable in prisons and jails. Given these benefits, every jurisdiction in America should aspire to set up and maintain a high functioning and properly funded mental health court system.

156. *Id.*

157. *Id.*

158. *Id.*

159. *Id.*

160. *Id.*

161. *Id.*

V. REDUCING THE STIGMA SURROUNDING MENTAL ILLNESS

Although America's mental health system has come a long way since the infamous days of mass institutionalization, the stigma surrounding mental illness stubbornly persists. This stigma continues to hamper the system's improvement and makes life even more difficult for MIIs. As President Barack Obama explained at the 2013 White House conference on mental illness, "[w]e whisper about mental health issues and avoid asking too many questions. The brain is a body part, too. We just know less about it. And there should be no shame in discussing or seeking help for treatable illnesses that affect too many people that we love."¹⁶² It is critical that we alleviate the stigma of mental illness, and we should heed President Obama's words by undertaking and supporting stigma reduction efforts.

A. *The Stigma Surrounding Mental Illness*

Stigma occurs when society views someone in a negative way because that person has a certain distinguishing characteristic or personal trait that is perceived as, or actually is, a disadvantage.¹⁶³ In effect, MIIs are "challenged doubly,"¹⁶⁴ meaning that in addition to the challenges associated with the symptoms of their illness, MIIs are faced with prejudice stemming from the stigma of their illness.¹⁶⁵ This prejudice can deprive them of crucial elements of a quality life such as jobs, housing, satisfactory health care, and interpersonal relationships.¹⁶⁶ Other harmful effects of stigma include reluctance to seek help or treatment; lack of understanding by family, friends, and co-workers; fewer career and educational opportunities; bullying, physical violence or harassment; health insurance that does not cover mental health care; and "[t]he belief that [one] will never be able to succeed at certain challenges or that [one] can't improve [one's] situation."¹⁶⁷ Further-

162. Melissa Thompson, *Let's End the Stigma of Mental Illness*, HUFFINGTON POST (July 2, 2013), http://www.huffingtonpost.com/melissa-thompson/lets-end-the-stigma-of-mental-illness_b_3522563.html.

163. *Mental Health: Overcoming the Stigma of Mental Illness*, MAYO CLINIC, <http://www.mayoclinic.org/diseases-conditions/mental-illness/in-depth/mental-health/art-20046477> (last updated May 17, 2014).

164. Corrigan & Watson, *supra* note 8, at 16.

165. *Id.*

166. *Id.*

167. *Mental Health: Overcoming the Stigma of Mental Illness*, *supra* note 163.

more, stigma affects not only the afflicted individual, but also that individual's family members and friends.¹⁶⁸

Mental illness stigma has three components: stereotypes, prejudice, and discrimination.¹⁶⁹ Stereotypes are collectively agreed upon notions of groups of persons, but one's knowledge of a set of stereotypes does not necessarily mean that they agree with them.¹⁷⁰ Examples of stereotypes include the belief that MIIs are violent and dangerous and the perception that MIIs are in control of their disabilities.¹⁷¹ Prejudice, however, is a "negative attitude toward a person or group" (e.g., one's unwillingness to become friends with or work with MIIs).¹⁷² Discrimination is the behavioral result of prejudice and stereotypes and includes acts of social avoidance, as well as "laws, policies, and practices that treat persons with mental illness unfairly" (e.g., limiting the parental rights of MIIs).¹⁷³ Social avoidance is the most extreme form of discrimination and occurs when members of the public strive not to interact with MIIs at all.¹⁷⁴

An examination of recent research indicates that while perhaps slightly improving, stigma towards mental illness strongly persists in the United States. A 2010 study published in the *American Journal of Psychiatry* showed that although Americans have become more aware of the neurological basis of mental illness, the social stigma associated with mental illness has actually been increasing.¹⁷⁵ For example, between 1996 and 2006, researchers found that people had become more supportive of the idea that someone suffering from depression should see a psychiatrist (up from seventy-five percent to eighty-five percent).¹⁷⁶ However, in 2006, nearly one in three adults still endorsed

168. Thompson, *supra* note 162.

169. See REBECCA L. COLLINS ET AL., INTERVENTIONS TO REDUCE MENTAL HEALTH STIGMA AND DISCRIMINATION 2 (2012),

http://www.rand.org/content/dam/rand/pubs/technical_reports/2012/RAND_TR1318.pdf; Corrigan & Watson, *supra* note 8, at 16.

170. Corrigan & Watson, *supra* note 8, at 16.

171. *Id.*

172. COLLINS ET AL., *supra* note 169, at 3.

173. *Id.*

174. Corrigan & Watson, *supra* note 8, at 16.

175. Jason Millman, *A Better Understanding of Mental Illness Hasn't Reduced the Stigma Around It*, WASH. POST: WONKBLOG (Aug. 12, 2014),

<http://www.washingtonpost.com/blogs/wonkblog/wp/2014/08/12/a-better-understanding-of-mental-illness-hasnt-reduced-the-stigma-around-it>; Bernice A. Pescosolido et al., "A Disease Like Any Other"? A Decade of Change in Public Reactions to Schizophrenia, Depression, and Alcohol Dependence, 167 AM. J. PSYCHIATRY 1321, 1323 (2010).

176. Millman, *supra* note 175.

the idea that schizophrenia and depression are the result of “bad character.”¹⁷⁷ Furthermore, most people said that that they would not want to socialize with someone with schizophrenia, or have a schizophrenic person as a neighbor, or marry into their family.¹⁷⁸ Although people were more accepting of people with depression, about half of the respondents rejected the idea of working with a person with depression, or having a depressed person marry into their family.¹⁷⁹

The false belief that MIIs are violent and dangerous also persists as one of the most common mental illness stereotypes.¹⁸⁰ As the *American Journal of Psychiatry* study revealed, most people believe that MIIs are likely to be violent towards themselves and others.¹⁸¹ In 2006, eighty-four percent of respondents believed people with schizophrenia would harm themselves, and sixty percent believe they would harm others.¹⁸² As for depression, seventy percent believed people with depression would harm themselves, and thirty-two percent believed they would harm others.¹⁸³ These results are consistent with a separate survey conducted in 1990, which found that the majority of respondents felt that “[a]lthough some people who have been patients in mental hospitals seem all right, it is important to remember they may be dangerous,” and fifty-nine percent thought that “[i]t’s only natural to be afraid of a person who is mentally ill.”¹⁸⁴

In addition to the public stigma perceived by the general population, those suffering from mental illness often experience self-stigma, which is prejudice that MIIs turn against themselves.¹⁸⁵ However, it should be noted that this is not always the case, and research indicates that a mentally ill person’s experience with stigma can lead to two different internalized reactions.¹⁸⁶ On one hand, instead of being diminished by the stigma, many people become righteously angry, a reaction that empowers them to seek treatment more actively and push for improvements in the quality of their care.¹⁸⁷ On the other hand, MIIs

177. COLLINS ET AL., *supra* note 169, at 3.

178. *Id.* at 4.

179. *Id.*

180. See Interlandi, *supra* note 9.

181. COLLINS ET AL., *supra* note 169, at 5.

182. *Id.*

183. *Id.*

184. *Id.*

185. Corrigan & Watson, *supra* note 8, at 16.

186. *Id.*

187. *Id.*

may internalize these stigmatizing ideas and believe that their illness makes them less valued.¹⁸⁸ As a result, their self-esteem and confidence will suffer.¹⁸⁹ An individual's "perception of the legitimacy of stigma" and "identification with the larger group of individuals with mental illness" are two important factors that affect which response the individual will have.¹⁹⁰

B. Strategies for Reducing the Stigma Surrounding Mental Illness

Reducing stigma is critical to improving the mental health system because stigma prevents the general population from recognizing the importance of providing quality mental health treatment and also discourages MIIs from seeking treatment in the first place. As a threshold matter, it is important to acknowledge the reality that stigma is an internal phenomenon in that it can only lead to negative effects if the individual who perceives the stigma allows it to do so. Therefore, the ideal strategy for combatting stigma is for people to make a conscious effort to resist its negative effects. However, as a practical matter, we cannot force people to think and feel a certain way. Thus, society must work to influence people's attitudes externally. There are various strategies that can effectively help reach this goal.

First, those suffering from mental illness must recognize the potential presence of their own self-stigma and develop their own strategies to counter its negative effects. The best thing that someone experiencing self-stigma can do is to get treatment if there is an adequate treatment option available.¹⁹¹ Aside from alleviating symptoms that can diminish quality of life, proper treatment can help MIIs understand the nature and cause of their illness and also provide hope for the future.¹⁹² Also, certain treatment options, such as group therapy, connect MIIs with others who are suffering in similar ways and can help them build self-esteem and overcome shame.¹⁹³ Furthermore, speaking out against stigma and associated discrimination, whether via the Internet, a periodical, or at an event, can alleviate self-stigma, help

188. *Id.*

189. *Id.*

190. *Id.*

191. *Mental Health: Overcoming the Stigma of Mental Illness, supra note 163.*

192. *Id.*

193. *Id.*

educate the public, and instill courage in others dealing with mental illness.¹⁹⁴

As for public stigma, “contact” and “education” strategies have been shown to be effective and easily-implemented methods for positively influencing people’s attitudes.¹⁹⁵ “Contact involves video or direct, in-person contact with people with mental illness.”¹⁹⁶

“Educational approaches to reducing mental health stigma aim to provide factual information about mental illness and recovery to replace inaccurate stereotypes and beliefs and to increase affirming attitudes (e.g., about recovery, empowerment, [and] social inclusion).”¹⁹⁷ As the American Psychological Association noted, “those who believe that human nature is changeable, as compared to static, tend to be less prejudiced,” which suggests that education emphasizing the ability to recover from mental illness is critical to stigma reduction.¹⁹⁸

Programs that implement contact and education approaches can be divided into two categories: training interventions and mass media campaigns coupled with broad, multifaceted training interventions.¹⁹⁹ Training interventions can consist of both contact and education strategies, but usually involve an educational component in which a speaker educates a small to moderate-sized group about the causes of mental illness, treatment, and the experiences of MIIs in an effort to counteract stigma and promote positive attitudes about mental illness.²⁰⁰ Training interventions are aimed at a wide array of audiences including students and the general public.²⁰¹ Because many people first experience mental illness during adolescence, secondary school students are often the targets of training interventions.²⁰² These student interventions have generally yielded positive results.²⁰³ Trainings have also been specifically directed at “key power groups’ such as employ-

194. *Id.* While this type of protest can be an effective way to reduce self-stigma, some observers believe it can actually be ineffective and even result in increased public stigma. “That is, when a person who harbors negative beliefs about mental illness works vigilantly to avoid those thoughts, a regular monitoring of the mind for inappropriate thoughts is required. The ironic effect is that he or she becomes more focused on these beliefs, and they are more likely to come into play in his or her interactions.” COLLINS ET AL., *supra* note 169, at 8.

195. COLLINS ET AL., *supra* note 169, at 8.

196. *Id.* at 7–8.

197. *Id.* at 8.

198. *Id.*

199. *Id.* at 9.

200. *Id.* at 9–10.

201. *Id.* at 10.

202. *Id.*

203. *Id.* at 10.

ers, landlords, criminal justice [officers], health care providers, policy-makers, and the media.”²⁰⁴ The results of these interventions have also been encouraging. For example, trainings for police officers have resulted in increased knowledge and positive attitudes towards mental illness as well as officers feeling more comfortable working with MIIs who are in crisis.²⁰⁵ Furthermore, these trainings were shown to have reduced the use of unnecessary force and arrests, and increased referrals to psychiatric facilities, which suggests that they could also help curtail criminalization.²⁰⁶

Like training interventions, mass media campaigns work to educate the public about the causes, symptoms, prevalence, and treatability of mental illness, but address a much wider audience.²⁰⁷ Often mental health professionals, celebrities, or people who have experienced mental health problems help deliver this information.²⁰⁸ However, mass media campaigns are most effective when they are paired with large-scale efforts to deliver training interventions in the community.²⁰⁹ Such programs launched in other countries have been effective, but none have been evaluated in the United States.²¹⁰ For example, the Scottish *See Me* campaign, launched in early 2014, combined mass media methods, such as commercials and social media postings, with intervention strategies such as conferences, focus groups, speaker engagements, grant programs, and even a speech about mental illness stigma given to the Scottish Parliament.²¹¹ *See Me* has yielded positive results that have held steady.²¹²

Another impressively effective program was the *Nuremberg Alliance Against Depression*, which was conducted from 2001 to 2002.²¹³ In addition to a public media campaign, the Nuremberg program involved training interventions targeted at MIIs and their families, as

204. *Id.*

205. *Id.*

206. *Id.*

207. *Id.* at 11.

208. *Id.* at 11–12. In the latter situation, contact can be said to be involved as well as education. *Id.* at 12.

209. *Id.*

210. *Id.*

211. *See* SEE ME, <http://www.seemescotland.org> (last visited Feb. 10, 2016).

212. COLLINS ET AL., *supra* note 169, at 12. These results have held steady despite recent instances of negative media coverage surrounding mental health in Scotland. For example, *See Me* took a strong stance against negative reporting in the media following Robin Williams' suicide. *See Reporting on the Death of Robin Williams*, SEE ME (Aug. 15, 2014), <http://www.seemescotland.org/news/reporting-on-the-death-of-robin-williams>.

213. COLLINS ET AL., *supra* note 169, at 13.

well as community leaders such as police, clergy, and teachers.²¹⁴ Compared to the nearby city of Wurzburg, which served as a control, “residents of Nuremberg exhibited more positive attitudes toward antidepressants, increased awareness of depression, and diminished beliefs that depression was due to a lack of self-discipline.”²¹⁵ Furthermore, results indicated that this increased awareness and perceived treatability resulted in greater treatment-seeking among those suffering from depression.²¹⁶ As a result, “Nuremberg demonstrated a greater reduction in suicidal acts compared to Wurzburg, the effects of which persisted a year after the intervention had ended.”²¹⁷ It is unclear why similar programs have not been implemented in the United States. Given these programs’ demonstrated success in other countries, policy influencers such as politicians, psychiatrists, community leaders, and celebrities should make an effort to introduce these types of programs in American communities as soon as possible.

CONCLUSION

A survey of the American mental health system reveals an ever-evolving mosaic of social policy, law, and public attitudes. There are currently 42.5 million American adults suffering from mental illness.²¹⁸ As Amanda Bynes’ very public experience with bipolar disorder illustrates, mental illness can strike anyone at any time. It does not differentiate based on wealth, age, intelligence, race, sexual orientation, or social status. Thus, it is in everyone’s best interest to have a mental health system that delivers quality, reasonably accessible care. The system is not “broken,” as some observers suggest,²¹⁹ and it has certainly evolved in a positive way since the days of mass institutionalization. However, there is still a lot of room for improvement, particularly in regards to reducing the stigma of mental illness.

214. *Id.*

215. *Id.*

216. *Id.*

217. *Id.*

218. Victoria Bekiempis, *Nearly 1 in 5 Americans Suffers from Mental Illness Each Year*, NEWSWEEK (Feb. 28, 2014), <http://www.newsweek.com/nearly-1-5-americans-suffer-mental-illness-each-year-230608>.

219. See Lloyd I. Sederer & Steven S. Sharfstein, *Fixing the Broken Mental Health System*, HUFFINGTON POST (Oct. 13, 2014), http://www.huffingtonpost.com/lloyd-i-sederer-md/fixing-the-broken-mental-_b_5973106.html.