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COMMENTS

THE DRUG COURT MODEL AS A RESPONSE TO “BROKEN WINDOWS” CRIMINAL JUSTICE FOR THE HOMELESS MENTALLY ILL

JENNIFER HODULIK*

INTRODUCTION

This Comment examines the current trend toward criminalization of homeless people and its impact on the mentally ill among them, and argues that drug treatment courts provide the best model for striking a balance between the “Giuliani approach” to the homeless mentally ill and opposing civil rights arguments. New York City, as governed by former Mayor Rudolph Giuliani’s administration, illustrates the effects of criminalization as an ill-fitting solution to the city’s homelessness crisis. The general academic consensus is that this approach is merely a band-aid solution to the more complex social and economic issues that force increasing numbers of Americans into the streets.¹ But despite almost universal condemnation of criminalization, no consensus exists as to the best alternative means to address homelessness.

The extreme diversity of the homeless community presents inherent difficulties in addressing its problems. Although there are commonalities, such as high percentages of mental illness and drug addiction, this community requires a broad range of

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¹ Maria Foscarinis, Kelly Cunningham-Bowers & Kristen E. Brown, *Out of Sight—Out of Mind?: The Continuing Trend Toward the Criminalization of Homelessness*, 6 *GEO. J. ON POVERTY L. & POL’Y* 145, 159 (1999).

social services.² Criminalization as a solution to homelessness has resulted in high incarceration rates of people who commit petty crimes associated with homelessness, such as sleeping in a park or begging in the subway.³ At the same time, criminalization and incarceration of the homeless has failed to provide this diverse community with the comprehensive social services that it so desperately requires.⁴

Among those opposed to the Giuliani model are civil rights advocates who believe that the Constitution protects the rights to live on the streets and not to be institutionalized or detained.⁵ These critics contend that short-term solutions, such as temporary shelters and involuntary confinement, detract funds from long-term projects addressing the needs of the homeless.⁶ They argue that people have a basic, even constitutional, right to remain on the streets until social policy evolves to meet their needs.⁷ Additionally, many of these advocates argue that the visible presence of homeless people in major cities will engender sympathy and foster public sentiment in favor of changing social policy.⁸

Civil rights-based criticisms are valid in response to forced detention of people who have not committed crimes or are being treated abusively in confinement. Humanitarian efforts facilitated, to a certain extent, the release in the 1950s of patients from mental institutions into communities, many of whom are now homeless.⁹ However, civil rights advocates or civil libertarians impermissibly failed to provide tangible solutions by focusing "far more heavily on obtaining liberty for patients than on seeking services for them."¹⁰ Their advocacy has resulted in

² Lorne Sossin, *The Criminalization and Administration of the Homeless: Notes on Possibilities and Limits of Bureaucratic Engagement*, 22 N.Y.U. REV. L. & SOC. CHANGE 623, 627 (1996).

³ Foscarinis, *supra* note 1, at 147.

⁴ T. Howard Stone, *Therapeutic Implications of Incarceration for Persons with Severe Mental Disorders: Searching for Rational Health Policy*, 24 AM. J. CRIM. L. 283, 299 (1997) (describing the maladjustment to prison by the mentally ill and high suicide rates).

⁵ Peter A. Barta, Note, *Giuliani, Broken Windows, and the Right to Beg*, 6 GEO. J. ON POVERTY L. & POL'Y 165, 165 (1999).

⁶ Foscarinis, *supra* note 1, at 147 (see generally).

⁷ Barta, *supra* note 5, at 193.

⁸ *Id.*

⁹ Nancy K. Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness and Libertarian Theory*, 31 EMORY L. J. 375, 380 (1982).

¹⁰ *Id.* at 377.

what essentially amounts to a right to starve on the streets and to be effectively cut off from any form of treatment or assistance.¹¹ Although certain criticisms of institutionalization of the mentally ill as it existed prior to the 1950s were justifiable, anticipated relief upon their release into communities was woefully inadequate.¹²

This Comment argues that a middle ground exists between the extreme positions of criminalization of homelessness and complete freedom for the mentally ill among the homeless. Over-zealous protection of civil rights for the mentally ill is unjustified. However, funneling this group in and out of jails or prisons is equally deplorable and ineffective. Instead, this Comment looks to the emerging drug treatment courts as a viable model for involving the criminal justice system at a more therapeutic and individualized level of administering to the homeless mentally ill population. The appropriate and realistic goal is to find a means within an imperfect system for humane and individualized treatment for the homeless mentally ill.

Part I of this Comment discusses the trend in New York City to criminalize homelessness under the Giuliani administration, which supports its policies with a "Broken Windows" theory of crime deterrence. Part II considers the validity of crime deterrence and other reasons advanced in support of cities' policies that criminalize homelessness. Part III examines the complexities of the homeless community, which is composed in large part of former mental health patients released into the community following deinstitutionalization, and how jails and prisons have come to replace mental institutions in recent times. Part IV describes the role of civil libertarians in bringing about deinstitutionalization and argues that their efforts have not provided a better solution than institutionalization. Part V argues that in the wake of deinstitutionalization and resulting incarceration of former mental patients, a balance can be struck between jail and complete freedom, by involving the criminal justice system in a more therapeutic way. Finally, Parts VI and VII discuss the emergence of the drug treatment courts and argue that this apparently successful model could be useful in assisting the homeless mentally ill.

¹¹ *Id.* at 381 (describing the release of residents from mental institutions with "a quart jar of valium and a shopping bag").

¹² *Id.* at 399.

I. THE GIULIANI MODEL OF CRIMINAL JUSTICE IN NEW YORK CITY:
A CASE IN POINT

The election of Rudolph Giuliani as mayor of New York City in 1993 ushered in a new era in law enforcement policy, and brought with it a forty percent drop in the city's crime rate.¹³ Many of the mayor's supporters, who have witnessed dramatic changes in New York City's landscape in the last decade, are quick to attribute the decrease in large part to the city's adoption of "a zero tolerance approach to seemingly minor crimes such as littering, panhandling and defacing property."¹⁴ They marvel at how safe, or at least uncluttered, New York's streets have become as they stroll to the theaters around Times Square. Others are more skeptical in contemplating the current whereabouts of the city's transient community.

In adopting this policy, Giuliani cited the "Broken Windows" approach to policing proposed in a 1982 *Atlantic Monthly* article by James Q. Wilson and George Kelling.¹⁵ Wilson and Kelling argue that allowing indications of disorder, such as a broken window, to remain unaddressed demonstrates a loss of public order and control in the neighborhood, and thus breeds more serious criminal activity.¹⁶ According to the theory, crime feeds on disorder, so the deterioration of "subways, schools or neighborhoods give[s] the impression that anything goes [and] that nobody cares," encouraging the criminally inclined to believe that they can get away with committing more serious offenses.¹⁷

Perhaps no group has been hit harder by such quality of life initiatives than the New York homeless population. A key part of the Broken Windows policy is to keep the homeless out of sight, generally by sweeping large homeless populations and arrest violators of ordinances which prohibit "begging, sleeping or 'camping,' sitting, lying down, loitering, or obstructing pedestrian traffic in public places," or imposing restrictions "on being in particular public places during certain hours."¹⁸

¹³ Barta, *supra* note 5, at 194 n.1.

¹⁴ *Id.* at 166.

¹⁵ *Id.*

¹⁶ James Q. Wilson & George L. Kelling, *Broken Windows*, ATLANTIC MONTHLY, March 1982, at 29.

¹⁷ Barta, *supra* note 5, at 167.

¹⁸ Focarinis, *supra* note 1, at 147-48.

One of the central aims of New York City's policy was to eliminate panhandling in the subway system. To achieve this objective, the Metropolitan Transit Authority ("MTA") and the New York City Transit Authority ("TA") employed a regulation that prohibited "solicitation for charitable, religious or political causes" in and around the subway.¹⁹ For example, the ban extended to subway cars, areas not generally open to the public, areas within twenty-five feet of a token booth, and areas near subway escalators and elevators.²⁰ In addition, the TA launched a public relations campaign designed to discourage giving to beggars on the subway.²¹

Detractors of this approach have questioned its legitimacy as a means to deter crime. They challenge that New York City's lowered crime rate can be attributed to various alternative factors, such as a nationally decreasing crime rate (irrespective of enforcement policy), an improved economy and increased police force.²² However, "Broken Windows" author George Kelling has maintained that New York's lowered crime rates should be attributed to the new governance.²³ In a 1998 article, Kelling described "in your face panhandlers who terrorized passengers and TA employees," and asserted that "'homelessness' was frightening passengers and causing them to abandon the subway in droves."²⁴

As the debate continues, the City's criminalization policies have been subject to legal challenge by the homeless community and its advocates.²⁵ Two important lawsuits have attacked the subway policy on constitutional grounds. In *Young v. New York City Transit Authority*, the Legal Action Center of the Homeless brought a class action lawsuit on behalf of two homeless men alleging that "the prohibition of begging and panhandling in the subway contravene[d] the rights to free speech, due process and equal protection of the law."²⁶ The Second Circuit up-

¹⁹ *Young v. New York City Transit Auth.*, 903 F.2d 146, 148 (2d Cir. 1990) (quoting N.Y. COMP. R. & REGS. tit. 21, §§ 1050.6(b)(2), 1050.6(c)(1)-(3)).

²⁰ *Id.*

²¹ Barta, *supra* note 1, at 172.

²² *Id.* at 194 nn.19-23.

²³ George Kelling & William Bratton, *Declining Crime Rates: Insiders' Views of the New York City Story*, 88 J. CRIM. L. & CRIMINOLOGY 1217, 1220 (1998).

²⁴ *Id.* at 1221.

²⁵ Barta, *supra* note 5, at 165.

²⁶ *Young v. New York City Transit Auth.*, 903 F.2d 146, 148 (2d Cir. 1990).

held the constitutionality of the statute, finding that “begging is much more ‘conduct than it is speech’ and panhandling f[alls] far outside the scope of protected speech under the First Amendment.”²⁷ Three years later, in *Loper v. New York City Police Dep’t*, an additional class action challenged the constitutionality of a New York anti-loitering law that made it illegal to loiter, remain or wander about in a public place for the purpose of begging.²⁸ This time, the Second Circuit found that the statute was neither content-neutral nor narrowly tailored, thus “over-broad,” in that it aimed to curtail a certain kind of speech—begging—and therefore violated the First Amendment.²⁹

II. THE CRIMINALIZATION OF HOMELESSNESS: ARGUMENTS FOR AND AGAINST

Despite this Comment’s rejection of the means employed by New York City to sweep the homeless off the streets, it supports the general aim of removing people from the street. However, assistance or positive intervention on behalf of the homeless mentally ill can be accomplished through an alternative use of the criminal justice system, similar to the experimental drug treatment courts.³⁰ Although this solution necessarily involves some civil liberty costs to the extent that coercive treatment is advocated,³¹ these costs are not as great as an outright denial of liberty through incarceration.

In addition to crime-deterrence arguments illustrated by the New York model and the Broken Windows theory, several other justifications for cracking down on petty “offenses” and homelessness have been proposed.³² City officials have argued that health and safety concerns on the part of the general public and homeless people justify criminalizing homelessness.³³

However, some opponents of criminalization respond that unsightliness aside, homeless people do not pose a threat to health or safety, and such policies “are often counterproductive, creating artificial barriers for people on the path toward self-

²⁷ *Id.* at 153-56.

²⁸ *Loper v. New York City Police Dep’t*, 802 F.Supp. 1029 (S.D.N.Y. 1992).

²⁹ *Loper v. New York City*, 999 F.2d 699, 701-706 (2d Cir. 1993).

³⁰ See discussion *infra* Part VI.

³¹ See discussion *infra* Part V.

³² Foscarinis, *supra* note 1, at 151.

³³ *Id.* at 152.

sufficiency and undermining individual efforts to escape poverty.³⁴ This response is short-sighted because it assumes that the "choice" to live on the street has been made with some degree of competency. Homeless individuals' mental health conditions render many of them incapable of getting "on the path toward self-sufficiency" without intervention.³⁵

Nonetheless, advocates of criminalization "cite the need to preserve the economic vitality of urban business districts and the promotion of tourism as justifications for anti-homeless policies."³⁶ Their detractors respond that homelessness is not the cause, but the effect of economic decline.³⁷ Related aesthetic and quality of life concerns are also cited as explanations for the criminalization of homelessness. Improving the aesthetic quality of public places is a worthy goal, but "[t]he adoption of laws and policies that attack the homeless rather than attacking the social economic issues at the root of homelessness is an ineffective strategy" that imposes "punishment on people for something they cannot reasonably avoid."³⁸ In reality, both of these reasons explain why leaving the homeless on the streets is unpleasant and problematic, but neither of these reasons justifies criminal punishments.

Although criminalization of homelessness is presented as economically sound, increased fringe costs associated with its administration undermine the soundness of economic arguments. Irrespective of the success or failure of constitutional challenges, cities must expend money in defending themselves, which detracts from funding available for treatment programs.³⁹ In addition, any cost-benefit analysis of a "Broken Windows" regime must consider the cost of allocating police officers to the task and maintaining the prisons that will increasingly house the homeless.⁴⁰

However, different economic models present conflicting data, despite general agreement regarding the shortage of

³⁴ *Id.*

³⁵ See Rhoden, *supra* note 9, at 393 (describing lack of organization following deinstitutionalization that prevents former mental patients who are incapable of negotiating bureaucratic hurdles from obtaining necessary services).

³⁶ Foscarinis, *supra* note 1, at 154.

³⁷ *Id.*

³⁸ *Id.* at 155-56.

³⁹ Foscarinis, *supra* note 1, at 153.

⁴⁰ *Id.*

money assisting the homeless community with its underlying problems. According to United States Department of Housing & Urban Development figures, the cost of providing housing, food, transportation, and counseling to homeless people would be less expensive on a daily basis than detaining that person in jail.⁴¹ In contrast to the federal figures, Milwaukee County Sheriff Lev Brown stated that public policy criminalizes mental illness to save money.⁴² He commented that "warehousing the mentally ill in jail" costs \$60 a day while the cost of treating them at Milwaukee Mental Health Complex is \$527 a day.⁴³

Despite the previously mentioned justifications for criminalizing homelessness, the underlying reason is that criminalization is the last resort.⁴⁴ This is particularly true in the case of the homeless mentally ill population, many of whom have been released into communities without adequate funding to accommodate them.⁴⁵ According to Nancy K. Rhoden, Ohio State law professor and former consultant to the Coalition for the Homeless, "[t]he reason deinstitutionalization has failed is simple: adequate community facilities have not been created."⁴⁶ The fact that many members of this community might not be competent to comply with their treatment programs due to mental illness complicates matters further.⁴⁷

The only viable explanation for criminalizing homelessness among those cited above is out of necessity and lack of community resources. More and better treatment options for mental illness in the community is the optimal solution. But as public policy apparently opposes this ideal,⁴⁸ the current choice between life on the streets or in prison should be modified to prevent the injustices associated with criminalization.

⁴¹ *Id.* at 155.

⁴² Meg Kissinger, *Broken Promises 25 Years After We Unlocked the Mentally Ill: Trading One Locked Door for Another*, MILW. J. SENTINAL, Sept. 10, 2000, at 4A.

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ Rhoden, *supra* note 9, at 376.

⁴⁶ *Id.*

⁴⁷ See discussion *infra* Part V.

⁴⁸ See discussion *infra* Parts I and II.

III. THE HOMELESS MENTALLY ILL AS A SPECIAL SUBSET WITH DIFFERING NEEDS

The actual number of homeless people in America today is difficult to quantify with precision. Estimates have ranged between 300,000 to 3,000,000 nationwide.⁴⁹ In New York City, the ranks of the homeless ballooned by an estimated 350% during the 1980s.⁵⁰

However, the term "homeless" encompasses a broad spectrum of groups that are not homogeneous and do not require the same types of assistance to address their needs.⁵¹ For example, forty percent of the homeless are estimated to suffer from alcoholism, though more homeless men than women tend to suffer from alcoholism.⁵² In addition, recent studies have indicated that eighty percent of male residents in general population shelters in New York City and twenty-nine percent of the adults in the family shelters had tested positive for drug. Furthermore, approximately one-third of the homeless are veterans at the national level.⁵³ Most important for purposes of this Comment, an estimated one-third of the homeless—some studies indicate more⁵⁴—suffer from untreated or under-treated mental illness.⁵⁵ Among homeless women this percentage leaps to ninety percent.⁵⁶

The large percentage of mentally ill individuals among the homeless population is due in large part to the deinstitutionalization of the mentally ill beginning in the 1950s.⁵⁷ At that time, new drugs, such as Thorazine, were developed that allowed schizophrenics and other institutionalized patients to function better in the community.⁵⁸ In 1975, the Supreme Court deci-

⁴⁹ Sossin, *supra* note 2, at 634.

⁵⁰ *Id.* at 635.

⁵¹ *Id.*

⁵² *Id.* at 635-36.

⁵³ *Id.* at 636.

⁵⁴ Raymond B. Martin, *Homelessness: A Community and a Bibliography*, 4 J. CONTEMP. HEALTH L. & POL'Y 203, 208 (1988) (citing a fifty percent figure as reported by the National Institutes of Mental Health in a 1985 presentation before the House Committee on Government Operations).

⁵⁵ Sossin, *supra* note 2, at 635.

⁵⁶ *Id.*

⁵⁷ Melanie B. Abbott, *Homelessness and Substance Abuse: Is Mandatory Treatment the Solution?*, 22 FORDHAM URB. L. J. 1, 74-76 (1994).

⁵⁸ Edmond V. Ludwig, *The Mentally Ill Homeless: Evolving Involuntary Commitment Issues*, 36 VILL. L. REV. 1085, 1086-97 (1991).

sion in *O'Conner v. Donaldson*⁵⁹ compelled state hospitals to release patients who were not "dangerous" and who could survive in the care of family and friends.⁶⁰ These factors, coupled with a rising civil liberties movement,⁶¹ have contributed to a decline in the population of state mental hospitals from approximately 500,000 in the 1950s to less than 100,000 today, with further reductions planned.⁶²

Although civil libertarian advocacy on behalf of the mentally ill community clearly contributed to deinstitutionalization, some scholars have argued that economic factors are a better explanation.⁶³ The deinstitutionalization cause became an ideal social reform policy and resulted in an odd marriage between liberals seeking to "free" mental patients and fiscal conservatives seeking to save millions of dollars spent on funding mental institutions.⁶⁴ In addition, other federal programs, most prominently Medicaid and Medicare, aided the deinstitutionalization movement and forced many poor former mental health patients into the streets.⁶⁵ Medicaid, which assists states in providing health services to the poor, does not cover treatment for mental illness in a state mental hospital for persons between the ages of twenty-one and sixty-five, and Medicare, which funds treatment for the elderly, will pay for only 190 days of care in a psychiatric hospital over the course of a lifetime (despite the fact that there is no similar restriction for physical illness).⁶⁶

Deinstitutionalization turned jails into a modern dumping ground for the mentally ill.⁶⁷ As civil commitment criteria became more stringent, the type of criminal observation provisions employed by the Guiliani administration became prevalent and arrests of the mentally ill for minor offenses soared.⁶⁸ To a certain extent, arrests for minor "offenses" committed by men-

⁵⁹ 422 U.S. 563 (1975).

⁶⁰ Ludwig, *supra* note 58, at 1086-97.

⁶¹ See discussion *infra* Part IV.

⁶² Ludwig, *supra* note 58, at 1086.

⁶³ Rhoden, *supra* note 9, at 382.

⁶⁴ *Id.*

⁶⁵ *Id.* at 383.

⁶⁶ *Id.* at 384.

⁶⁷ Darold Treffert, *Editorial: It Took Awhile*, WISCONSIN PSYCHIATRIST, Vol. 41 No. 1 at 7 (Winter 2000) (citing San Diego newspaper article describing "the L.A. County Jail [as] the nation's largest treatment facility for the severely mentally ill").

⁶⁸ Darold Treffert, *The MacArthur Coercion Studies: A Wisconsin Perspective*, 82 MARQ. L. REV. 759, 766 (1999).

tally ill persons were an admitted effort on the part of law enforcement officials to get needy persons into a safe environment and into treatment.⁶⁹ Ironically, the criminalization of the mentally ill has come at a time when alcoholism and drug abuse have been decriminalized to a certain extent⁷⁰ and is apparently a regression to the pre-institutional era that jailed the mentally ill (until the mid-1800s).⁷¹ Unfortunately, modern jails have proven equally inadequate in meeting the needs of this group as their Nineteenth Century counterparts.⁷²

Illustrative of this phenomenon are the following separate accounts from two New York City judges:

There is a crisis in our nation's jails. Mentally ill offenders are not receiving adequate treatment while incarcerated. The cycle of mental illness, crime and homelessness is thus never ending.

With the ever deepening cuts in funding for the mentally ill, society is now feeling the effects of the ill-conceived closures of state mental facilities. Jails have become the dumping ground for the mentally ill; indeed, jails are now the only places some of these individuals can get treatment.

As a judge, I have seen firsthand the difficulty in finding treatment programs for the mentally ill offender. It is far easier to find treatment programs for those with substance abuse problems such as drug or alcohol addiction than it is to place those with mental illness.⁷³

Another New York judge described a similar experience:

Our jails have become modern mental institutions—albeit institutions neither designed nor able to provide the required care these thousands that were cut loose during the deinstitutionalization of our state mental hospitals need Urban forces spend millions annually interfacing with the homeless. Similarly our urban jail holding tanks contain many homeless persons charged with misdemeanors including failure to

⁶⁹ *Id.*

⁷⁰ *Id.* at 767.

⁷¹ Treffert, *supra* note 68, at 759.

⁷² Kissinger, *supra* note 42, at 4A.

⁷³ Hon. Abraham G. Gerges, *The Faceless Mentally Ill in Our Jails*, 71 N.Y. St. B.J. 52, 52 (March 1999).

appear on an infraction, such as spitting on the sidewalk or tossing a cigarette.⁷⁴

As these experiences demonstrate, judges and courts are overburdened with the problems associated with criminalizing mental illness or homelessness and express frustration with the inadequacy of the criminal justice system to provide effective placement and/or treatment for this group in the wake of deinstitutionalization.

IV. THE CIVIL LIBERTARIAN APPROACH

While advocates for the mentally ill worked to limit forced confinement of the mentally ill during the period of deinstitutionalization, this sentiment also played a role in recent legal battles over criminalization policy toward the homeless.⁷⁵ Despite what appears to be the clear failure of deinstitutionalization, the social movement continues to attract dedicated advocates.⁷⁶

The *Loper* and *Young* cases illustrate current libertarian efforts in this area. Proponents argued that begging should be considered speech, or at least conduct protected by the First Amendment, because it conveys a message. According to one scholar, "[t]his humble plea [begging], articulated in the simplest of gestures, can convey a sense of destitution 'worth a volume of logic,' [and] the plight of an individual homeless person can carry with it a powerful statement about our failure as a society to take care of its own."⁷⁷ The same scholar concluded that "[w]e must fulfill the fundamental promise of the First Amendment—that all Americans, regardless of their wealth or social status, will be allowed a voice in the political discourse."⁷⁸

Critics of the civil libertarian movement contend that the price paid for this "voice in the political discourse" by living and starving in the streets is unjustifiably high.⁷⁹ Rael Isaac and Virginia Armat argue in their article, *Madness on the Streets*, that the

⁷⁴ Robert C. Coates, *Legal Rights of Homeless Americans*, 24 U.S.F. L. REV. 297, 343-44 (1990).

⁷⁵ Barta, *supra* note 5, at 165.

⁷⁶ See generally *id.*

⁷⁷ *Id.* at 181 (citing Wayne Barrett & Eileen Markey, *50 Reasons to Loathe Your Mayor*, VILLAGE VOICE, Nov. 4, 1997 (available in WL 11417426)).

⁷⁸ *Id.* at 194.

⁷⁹ Sossin, *supra* note 2, at 654.

rise of what they term a “mental health bar” and its support of the right of mentally ill homeless people to refuse confinement and treatment have significantly contributed to the homelessness crisis.⁸⁰ Lorne Sossin of the University of Toronto summarizes their argument as follows:

[H]omeless individuals cannot be hospitalized against their will unless they are shown to be a danger to themselves or others. Motivated by a basic distrust of psychiatry and a belief that the central threat to the homeless was the possibility of involuntary state confinement, the mental health bar argued for the civil rights of the homeless to be placed ahead of other concerns, such as these individuals' families interests in seeing them hospitalized [F]amilies of the homeless mentally ill discovered their loved ones had the “right to refuse treatment,” even if it amounted to little more than a “right to freeze.”⁸¹

Unfortunately, the modern reality has proven that once the “threat” of involuntary commitment dissipated, it was replaced by a potentially worse encroachment upon the “right to freeze,” that of incarceration.

In addition, a rights-based approach emphasizes an individual's right to refuse treatment regardless of the resulting effect on her health.⁸² Some scholars have criticized this approach for “encouraging mentally disabled adults to ‘die with their rights on.’”⁸³ According to Professor Rhoden, lawyers have over-emphasized liberty and ignored the needs of severely ill patients unable to recognize their need for treatment in doing so:

[c]ivil libertarians have argued that ‘the right to eat garbage or to be a shopping bag lady is still a very important right,’ and they are correct, if this sort of lifestyle is chosen with some degree of competency. But the notion of a competent choice is complex, and not all of the homeless mentally disturbed have completely chosen to forego treatment.⁸⁴

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² Sharon Flower, *Resolving Voluntary Mental Health Treatment Disputes in the Community Setting: Benefits of and Barriers to Effective Mediation*, 14 OHIO ST. J. ON DISP. RESOL. 881, 889 (1999).

⁸³ *Id.*

⁸⁴ *Id.* at 405-06.

V. FINDING A PROPER BALANCE

The past century in America has seen the rise and fall of institutionalization of the mentally ill and corresponding social reform movements.⁸⁵ Irrespective of the positive intentions of reformers in this area, one set of bars has effectively replaced another in modern practice.⁸⁶ The preceding era was characterized by strict *parens patriae* state intervention on behalf of the mentally ill, which relied on a "best interest approach" that placed primary emphasis on the patient's medical treatment needs.⁸⁷ In contrast with the preceding era, deinstitutionalization caused the pendulum to swing in favor of the civil rights approach and its current strict requirements for involuntary commitment.⁸⁸

Ironically, the transition toward a civil rights approach cuts against recent advancements in psychiatric treatment.

[A]t a time when definitive treatment for major mental illness did not exist—from the 1850s to the 1950s—the authority to intervene was then too broad, the standards too liberal, and statutes constitutionally too vague. Yet beginning in the 1950s, after prompt, safe, and effective treatments became available for many forms of major mental illness, mental health statutes too stringent and too cumbersome prevented, or unsuccessfully delayed, such treatment.⁸⁹

The result is that "the right to refuse treatment cancels out the right to receive treatment in many instances."⁹⁰ This tension between an individual's need for medical treatment and her constitutional right to refuse such treatment leaves many community mental health treatment providers with few options when patients refuse to comply with treatment.⁹¹

A combination of factors, including the failure of deinstitutionalization, compliance problems specific to mental illness, and advances in treatment programs make it less problematic from a civil libertarian standpoint to intervene on behalf of someone who is not competent to evaluate her need for treat-

⁸⁵ Treffert, *supra* note 68, at 768-69.

⁸⁶ Kissinger, *supra* note 42, at 4A.

⁸⁷ Flower, *supra* note 82, at 889.

⁸⁸ Treffert, *supra* note 68, at 768.

⁸⁹ *Id.* at 769.

⁹⁰ *Id.*

⁹¹ Flower, *supra* note 82, at 888.

ment. Accordingly, “[w]hile voluntary treatment has been shown to have positive therapeutic effects for [patients], it can create significant compliance issues including, frequently, the mentally disabled individual’s refusal to comply with program medication and treatment plans.”⁹² While adherence to treatment is a critical factor, cognitive impairments and delusions might cause a patient to discontinue or refuse treatment, putting her at risk for injury as a result of psychotic behavior.⁹³

This refusal to comply does not necessarily indicate that the patient would refuse the treatment if lucid. A former president of the State Medical Society of Wisconsin, Darold Treffert, explains that “[w]hen not in a psychotic state, affected individuals may clearly and accurately perceive that a rapid treatment response to relapse is heavily in their best interests.”⁹⁴ Treffert favorably cited a recent study indicating that “[m]ore than 50 percent of the re-interviewed patients who said initially that they did not need to be hospitalized [for mental health reasons] reported that, in retrospect, the decision for their hospitalization was the correct one.”⁹⁵

In striving to achieve a proper balance between a strict rights-based approach and highly restrictive solutions of incarceration or institutionalization, the justice system should follow a more middling type of intervention. A system that prioritizes clinical interests must necessarily involve sacrificing some liberty interests based on incompetency of the mentally ill to act in their own best interest in some cases. Because a patient’s illness sometimes inhibits her willingness to comply with medication programs, the line between voluntary and involuntary care, or “coercion,” is far from clear.⁹⁶ According to Treffert’s coercion studies, “major mental illness, by its intrinsic nature and manifestations, makes the use of coerced care—rather than pure voluntary treatment—necessary in some instances.”⁹⁷ Commitment research indicates that coercion can occur with voluntary admission status as well, and on occasion the involuntarily

⁹² *Id.*

⁹³ William Spaulding et al., *Applications of Therapeutic Jurisprudence in Rehabilitation for People with Severe and Disabling Mental Illness*, 17 T.M. COOLEY L. REV. 135, 156 (2000).

⁹⁴ *Id.*

⁹⁵ Treffert, *supra* note 68, at 779.

⁹⁶ *Id.* at 759.

⁹⁷ *Id.*

committed patient may have experienced little or no coercion in spite of the "involuntary" status.⁹⁸ Complicating matters further, "[i]nvoluntarily committed patients do not invariably deny their illness and protest the hospitalization process."⁹⁹

In the modern context, as demonstrated by the Giuliani administration's approach, the "right to freeze" has been removed once again by criminalization of homelessness. But instead of placing the homeless mentally ill back into psychiatric institutions, they have been placed into jails and prisons, and have arguably paid a high price for this new "freedom." Leaving the state to its own devices seems troubling and paternalistic, but championing the civil rights of the homeless has proven limited, if not futile.¹⁰⁰ A proper balance between these inapposite and ill-fitting extremes can be struck to achieve better administration of the homeless mentally ill.

VI. THE EMERGENCE OF DRUG TREATMENT COURTS

The government's recent "war on drugs" has resulted in vigorous pursuit of drug users and traffickers by the criminal justice system.¹⁰¹ According to Department of Justice figures, "[m]ore than half of all prison inmates are illegal drug users, and each year brings additional legislation mandating long minimum sentences and other forms of harsh punishment for those who violate the drug laws."¹⁰² Partly motivated by concern about the increase in drug offenses (largely related to the crack cocaine epidemic of the 1980s)¹⁰³ in conjunction with the abandonment of a rehabilitative criminal justice system in favor of deterrence and retribution,¹⁰⁴ "drug treatment courts" have emerged as an alternative to incarceration for drug offenders. As of July 1, 1999, there were almost four-hundred drug courts

⁹⁸ *Id.* at 771 (citing an example of a patient who was grateful to have received "coerced care" after going into a catatonic state after going off of his medication).

⁹⁹ *Id.* at 778 (citing studies indicating that thirty-four percent of involuntarily committed individuals believed that they were mentally ill and almost half agreed that there was no reasonable alternative to hospitalization).

¹⁰⁰ See discussion *infra* Part IV.

¹⁰¹ Michael C. Dorf & Charles F. Sabel, *Drug Treatment Courts and Emergent Experimental Government*, 53 VAND. L. REV. 831, 831 (2000) (citing Office of Justice Programs, Annual Report 19 (Fiscal Year 1998), at <http://www.ojp.usdoj.gov/98anrpt/chap3.htm>).

¹⁰² *Id.*

¹⁰³ *Id.* at 841.

¹⁰⁴ *Id.* at 839 n.19.

for adult drug offenders in the United States and more than half of that number in the planning stages.¹⁰⁵

The basic process of the drug court allows a criminal defendant to opt out of a criminal trial for low level, drug-related offenses, with the consent of the prosecuting attorney. The premise of the drug court system rests upon the notion that nonviolent drug offenses are victimless crimes and those who commit them lack the necessary self-control to avoid violating the law, therefore, drug offenders lack culpability and do not deserve to be incarcerated.¹⁰⁶ The Brooklyn Treatment Court, for example, requires that three criteria be met before a defendant is eligible to have her case heard: "(1) [the matter] must originate within the court's geographical jurisdiction; (2) the client 'cannot have any violent felony conviction or violent charge'; and (3) the treatment court clinical staff must determine that the client is in fact a substance abuser."¹⁰⁷

Moreover, "drug courts treat addicts as clients, rather than criminals, and provide them with the incentive to rehabilitate themselves."¹⁰⁸ Through the cooperation of the judge and the prosecuting and defense attorneys, the defendant pleads guilty, or otherwise accepts responsibility for the offense charged.¹⁰⁹ These actors work together "to learn continuously and incrementally from each other rather than instructing them to institute a comprehensive remedial plan devised by the court alone or even in consultation with the parties."¹¹⁰ As "punishment," the defendant accepts placement in a court-mandated program of drug treatment, which could include residential or outpatient treatment.¹¹¹

The actual method of treatment allows the judge to monitor the defendant's progress closely and to evaluate which programs are successful.¹¹² Thus, the court will cease directing defendants to programs that appear to be ineffective, and will increase re-

¹⁰⁵ *Id.* at 846.

¹⁰⁶ Lynne M. Brennan, Note, *A New Beginning for Non-Violent Drug Afflicted Offenders—An End to Cruel and Unusual Punishment*, 22 *HAMLINE L. REV.* 355, 393 (1998).

¹⁰⁷ Dorf, *supra* note 101, at 847 n.39.

¹⁰⁸ Brennan, *supra* note 106, at 393.

¹⁰⁹ Dorf, *supra* note 101, at 832.

¹¹⁰ *Id.* at 837.

¹¹¹ *Id.*

¹¹² *Id.* at 832.

ferrals to more effective programs.¹¹³ The court's level of involvement with the treatment process facilitates an exchange of information and a pooling of experience.¹¹⁴ Built into the treatment process is the awareness, based on new research, that the client's addiction will likely cause her to relapse during recovery. The high probability of relapse "suggested the need for a counter-intuitive combination of sanctions and forbearance in treatment. Sanctions were necessary to demonstrate palpably that relapse was costly, but forbearance was necessary to help the addict learn through experience to anticipate conditions that triggered relapse."¹¹⁵

Cessation of drug use is the ultimate goal of the drug court system, and the individual participant progresses toward that goal incrementally through steps such as showing up for required court appearances, regularly arriving at treatment sessions on time, attending and participating in treatment, cooperating with treatment staff, and submitting to regular drug testing.¹¹⁶ Each client's program is individually tailored to the level of need involved in a particular case.¹¹⁷ Benchmarks for meeting various goals of that program include ceremonies and tokens of progress, such as advancement to the next treatment phase, and reduced supervision to reward progress.¹¹⁸ Demotion to earlier program phases, and even confinement if necessary, are employed to sanction non-compliance.¹¹⁹ Finally, the court will typically expunge the conviction upon successful completion of the treatment program.¹²⁰

The recent implementation of the drug courts has generally been met with enthusiastic, if cautious, support. Stephen Balenko of the National Center on Addiction and Substance Abuse at Columbia University conducted a 1998 study to update a 1997 General Accounting Office report on the drug courts.¹²¹ He found that drug courts generate savings, at least in the short

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ *Id.* at 841-42.

¹¹⁶ *Id.* at 845-46.

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ *Id.* at 846.

¹²⁰ *Id.* at 832.

¹²¹ *Id.* at 849 n.47 (citing Steven Balenko, *Research on Drug Courts: A Critical Review*, 1 NAT'L DRUG CT. INST. REV. 1, 1 (1998)).

term, from reduced jail and prison use, reduced criminality and lower criminal justice costs, and drug courts reduce recidivism (though this was based on more limited data) for participants after they leave the program.¹²² Related studies have demonstrated that in addition to lower re-offending rates and reduced criminal justice costs, the length of time between re-arrest proved significantly longer than for other non-felony defendants.¹²³ Limited as this and other assessments might be, the experiment of the drug courts appears to be a promising alternative to serving time in prison for these same offenses.

VII. APPLICABILITY OF THE DRUG COURT MODEL TO THE HOMELESS MENTALLY ILL

A system similar to the drug courts could assist the homeless mentally ill in addressing their unique needs. The recovery process, or stabilization of mental illness, and drug addiction are not entirely dissimilar and involve many of the same relapse and compliance problems. In addition, both are essentially health problems that the criminal justice system has been forced to deal with out of necessity. Occasional coercion, as argued, seems to have positive implications in the treatment of both groups.

In addition, substance abuse and mental health treatment require similar types of "rehabilitation." Similar to substance abusers, the mentally ill must "reacquire basic personal and social skills, and the special skills required to manage their illness"¹²⁴ to become functional in society. According to Professor Elizabeth Winans of the University of Illinois at Chicago College of Pharmacy, goals of stabilization for schizophrenia, for example, include "minimizing stress experienced by the patient, preventing relapse, facilitating adaptation to life and the

¹²² *Id.* at 850.

¹²³ Brennan, *supra* note 106, at 381 (citing Peter Finn & Andrea Newlyn, *Miami Drug Court Gives Drug Defendants a Second Chance*, 77 JURIDICATURE 268 (1994), for statistics showing that participation in a drug court program totaled about \$800 per client per year, which represents the cost of incarcerating an offender for roughly nine days, and that recidivism rates for other non-felony defendant is sixty percent as compared to eleven percent for drug court participants).

¹²⁴ Spaulding et al., *supra* note 93, at 143.

community, continuing to alleviate symptoms and consolidating remission."¹²⁵

Whereas the drug courts plan for relapse as part of the recovery process, a primary objective of mental health treatment of psychotic disorders is to prevent psychotic episodes, and to minimize their impact when they cannot be prevented.¹²⁶ Because many mentally ill individuals show highly recognizable patterns of behavior at the beginning of a relapse,¹²⁷ the right treatment plan could monitor for this and implement preventive measures if necessary. Similarly, recovering substance abusers must learn to anticipate the conditions that trigger relapse.¹²⁸ In addition, "[e]arly identification leads to early treatment that can help patients and family gain a feeling of mastery over the illness."¹²⁹ However, because these relapses in the mental illness model often coincide with refusal to take medication, coercive treatment should not be ruled out under a scheme similar to the drug courts.

As further evidence of correlation in treating these problems, mental illness and drug addiction reportedly share a commonality in that "a substantial body of evidence indicates that legally mandated and coerced [drug court] clients generally perform as well as or better than others in terms of treatment retention, abstinence, and psychological functioning across a diverse range of settings."¹³⁰ Despite the controversial nature of and ethics involved in coerced treatment of both the mentally ill and drug abusers, the drug addiction treatment community strongly endorses the use of coercion.¹³¹ For example, a treatment provider from an addiction center indicated that "people don't just wake up one morning and decide today is the day I'll quit my habit. It takes a crisis, like losing a job or

¹²⁵ Elizabeth Winans, *Effective Management of Schizophrenia*, CNS NEWS SPECIAL EDITION, Vol. 2, December 2000, at 96.

¹²⁶ Spaulding et al., *supra* note 93, at 141.

¹²⁷ *Id.* at 158.

¹²⁸ See *supra* note 115 and accompanying text.

¹²⁹ Winans, *supra* note 125, at 95.

¹³⁰ Dorf, *supra* note 101, at 842 n.23 (citing, in reference to drug treatment, Douglas B. Marlowe & Kimberly C. Kirby, *Effective Use of Sanctions in Drug Courts: Lessons from Behavioral Research*, 2 NAT'L DRUG CT. INST. REV. 1 (1999); Charles W. Lidz, *Coercion in Psychiatric Care: What Have We Learned from Research?*, 26 J. AM. ACAD. PSYCHIATRY & L. 631 (1996)).

¹³¹ *Id.* at 842.

going to jail.”¹³² Similarly, another treatment provider found that “[w]hether participants sought treatment on their own or were coerced to do so, they reported that entering the program involved experiencing a crisis.”¹³³ Thus, despite the folk wisdom that a desire to recover is central to recovery, “there is an emerging consensus that mandated clients perform better than voluntary ones.”¹³⁴

Data from the previously cited coercion studies seems to indicate that the drug court model could be appropriate for working with the mentally ill. For example, the coercion studies demonstrated that:

[T]here is usually a low level of perceived coercion if persuasion and inducement are used rather than threats or force; others, including friends and family, are involved in the decision making as a form of caring; the patient believes others acted out of genuine concern; the patient believes he or she was treated respectfully and in good faith; and the patient was afforded a chance to tell his or her side of the story.¹³⁵

Similarly, some scholars have proposed mediation as an alternative to a rights-based approach to resolving voluntary treatment disputes.¹³⁶ The proposed mediation is similar to the drug court approach in that mediation allows greater flexibility than more traditional legal approaches: “[Flexibility] is particularly desirable in the resolution of mental health disputes, where individuals may not be able to abide by more rigid, court-ordered requirements. Through mediation, the parties may arrive at an agreement that is tailor-made to accommodate the needs of the [patient] while taking into account the resources of the community provider.”¹³⁷ This is exactly what the drug courts have done by providing a middle ground between rigid court-ordered formalities and involuntary treatment. Further, “recent studies have shown that mentally disabled adults can participate in their own treatment decisions and welcome the opportunity to do so.”¹³⁸

¹³² *Id.*

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ Treffert, *supra* note 68, at 779.

¹³⁶ Flower, *supra* note 82, at 893.

¹³⁷ *Id.*

¹³⁸ *Id.* at 896.

Thus, the success of coercion in therapy is a unifying theme in treating both drug addicts and the mentally ill. The drug addict who does not want to stop taking drugs and is unlikely to stop absent a crisis can be compared to a mentally ill person who desires to stop taking her medication, despite her awareness of the potential risks or benefits involved. This type of mental patient might be in denial of the illness or in a period of stability that induces this misjudgment, or concerned with the stigmas associated with mental illness, or reacting to unpleasant side effects and strict regimens associated with medications.¹³⁹

The establishment of a system similar to the drug court to assist homeless mentally ill clients is a natural progression because "a significant proportion of people with severe and disabling mental illness interact with the legal/judicial system because of problems related to their illness"¹⁴⁰ as it is. To attempt to alleviate the ethical dilemma of involuntary commitment, a homeless person might opt for the legally prescribed incarceration for whatever offense triggered involvement with the criminal justice system, as opposed to mandated treatment. However, after several such convictions and upon proven clinical need, or upon voluntarily requesting treatment, the individual could be referred to a mental health treatment court designed to place respondents into an approved treatment program that would potentially include involuntary treatment or commitment based upon need. Requiring multiple infractions before resorting to this step would alleviate some civil libertarian concerns, particularly because past negative behaviors resulting from mental illness are reasonable predictors of future behavior.¹⁴¹

It is not difficult to envision other ways in which drug court models could be established for the homeless mentally ill. They might offer some type of "conditional release" similar to that employed by the drug courts to accommodate a particular individual's needs when institutionalization is not necessary. If this type of defendant could not comply with the treatment requirements, he would be faced with a choice of institutionalization or incarceration associated with the original infraction. Thus the offender would be able to choose between taking re-

¹³⁹ Winans, *supra* note 125, at 95.

¹⁴⁰ Spaulding et al., *supra* note 93, at 136.

¹⁴¹ *Id.* at 161.

sponsibility for managing his illness or revolving through the door between life in the streets and in jail.

States have previously demonstrated a willingness to resort to coercion as a means of removing the homeless mentally ill from the streets and into facilities geared toward treatment and surveillance.¹⁴² For example, former Mayor Ed Koch of New York established Project HELP, which sought to involuntarily commit mentally ill homeless people to psychiatric institutions.¹⁴³ HELP involved surveillance of homeless people on the street by social workers and psychiatrists who sought to identify individuals in need of psychiatric treatment.¹⁴⁴ However, the program was limited by involuntary commitment laws preventing forced hospitalization where a particular person did not pose a danger to herself or others.¹⁴⁵

Maryland more recently has attempted to implement aftercare in the community for mentally ill former inmates, a plan which could be greatly improved by changing its structure to a program more similar to the drug courts. Maryland's Community Criminal Justice Treatment Program "brings treatment and criminal justice providers together to screen mentally ill individuals while they are confined in local jails, prepare treatment and aftercare plans for them, and provide community follow-up after their release."¹⁴⁶

Wisconsin has come closest to implementing a system similar to the drug courts in its administration of the mentally ill, but its new policy is limited to involuntary commitment.¹⁴⁷ Wisconsin has adopted a less restrictive standard for involuntary commitment known as "the 5th Standard" for civil commitment, which has been met with some success.¹⁴⁸ The 5th Standard provides for earlier intervention in some instances on behalf of

¹⁴² Sossin, *supra* note 2, at 654-55.

¹⁴³ *Id.* The author documents the story of a woman named Billy Boggs who had lived a relatively stable life before being diagnosed as schizophrenic. Involuntarily committed as part of project HELP, she successfully sued to win her release through the New York Civil Liberties Union, but eventually went on to bounce back and forth between the street, shelters and psychiatric hospitals. *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ *Id.* at 656.

¹⁴⁶ Dorf, *supra* note 101, at 844 n.25 (citing Catherine Conly, *Coordinating Community Services for Mentally Ill Offenders: Maryland's Community Criminal Justice Treatment Program*, NAT'L INST. OF JUSTICE PROGRAM FOCUS (1999)).

¹⁴⁷ Treffert, *supra* note 68, at 780.

¹⁴⁸ *Id.*

persons with a documented history of mental illness before deterioration to physical dangerousness as required by the previous standard.¹⁴⁹ The 5th Standard includes provisions designed to account for the likelihood that the person can be treated in the community, and for whether he or she is likely to avail herself of these services.¹⁵⁰ In addition, the 5th Standard attempts to assess the patient's cognitive level regarding the advantages or disadvantages of a particular medication or treatment.¹⁵¹ Thus, "[m]edication or treatment may be administered without the consent of the person if, at or after the probable cause hearing, the court finds that there is a substantial likelihood that the person meets the standard."¹⁵² At some point prior to or at the final hearing, "the county must provide a recommended treatment plan" for goals, type of treatment, and expected providers of inpatient or community after-care upon release.¹⁵³ An ideal drug court model would be almost identical to Wisconsin's system, but would allow for a "sentence" of community treatment if the patient did not require involuntary commitment.

Civil libertarians have criticized drug treatment courts, and would likely direct similar complaints toward treatment courts for the homeless mentally ill.¹⁵⁴ Civil libertarians are concerned that the drug courts are actually worse than the standard criminal sanctions because drug courts "create incentives for extension of the criminal justice system and entrenching criminalization."¹⁵⁵ Accordingly, paternalistic officials are able to extend their reach, and allow family members to selfishly rid themselves of the burden associated with drug abuse.¹⁵⁶ However, these critics confuse criminalization with coercion, arguing that treatment inside the criminal justice system will be coercive, whereas treatment outside the criminal justice system will be non-coercive.¹⁵⁷

Wisconsin's experience with the 5th Standard has not produced the anticipated negative results—patients flooding into

¹⁴⁹ *Id.*

¹⁵⁰ *Id.*

¹⁵¹ *Id.*

¹⁵² *Id.* at 781.

¹⁵³ *Id.*

¹⁵⁴ Dorf, *supra* note 101, at 868-69.

¹⁵⁵ *Id.* at 869.

¹⁵⁶ *Id.* at 871.

¹⁵⁷ *Id.* at 870.

hospitals, the shifting of funds away from community-based programs, and constitutional challenges.¹⁵⁸ Instead, the result has largely involved "a small number of persons with a documented history of major mental illness who were deteriorating . . . , largely because they went off medication which had been effective to that point and who were so ill as to be incapable of understanding the need for or advantages or disadvantages of treatment."¹⁵⁹ Because of the intervention through the involuntary commitment process, patients were prevented from having to suffer further severe mental, emotional, or physical harm before treatment intervention could occur.¹⁶⁰

Civil libertarian concerns regarding the potential for abuse of discretion in allowing state and or judicial intervention in the interest of the mentally ill are valid to the extent that they raise awareness about injustices affecting largely disenfranchised groups. However, their energies are often misdirected toward attacking the existing systems instead of fighting for treatment as effective as that which the courts provide outside of the criminal justice system.¹⁶¹ That some addicts "may prefer to submit to the supervision of drug courts rather than seek justice is an indictment of the choices that current social policy affords."¹⁶² Thus, civil libertarians should respond to the limited availability of treatment outside of the criminal justice system by striving to increase its availability rather than shutting down the drug courts.¹⁶³ The same is true with regard to the homeless mentally ill. Instead of attacking current policy, advocates for the homeless mentally ill should focus on better treatment solutions in the community.

CONCLUSION

Criminalizing homelessness, or more specifically, the homeless mentally ill, is a cruel, ill-fitting solution designed to hide the underlying lack of resources available to provide services to this community. Nonetheless, the goal of "sweeping people off the streets" is not without merit, particularly if there is a system

¹⁵⁸ Treffert, *supra* note 68, at 782.

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ Dorf, *supra* note 101, at 873.

¹⁶² *Id.*

¹⁶³ *Id.*

in place to address their needs. Although coerced treatment of the mentally ill presents ethical dilemmas, a carefully structured treatment court program would greatly benefit the homeless mentally ill despite potential infringements on civil liberties. Some intervention is necessary, even if coerced, on behalf of the homeless mentally ill because deinstitutionalization has left many mentally ill individuals in the street without adequate community resources, or worse, in jail or prison. This situation is no better, and perhaps worse, than the mental institutionalization of previous eras.

The drug court model and the ideals associated with Wisconsin's more flexible commitment standards provide hope that the current system can be reshaped to provide better treatment solutions for the homeless mentally ill. Lack of funding presents the most significant challenge to its implementation. Even if the drug court model were to be molded to meet the needs of the homeless mentally ill community, community-based programs to which courts could refer "clients" would require increased funding to provide the necessary services. In the era of deinstitutionalization, one of the central problems was that "[d]ollars that supported hospital beds did not follow the patient into the community in adequate amounts when those hospital beds closed. While it is often better to treat the seriously mentally ill in the community where feasible, it is not, if properly done, cheaper to do so."¹⁶⁴

Although the drug court solution might be met with the same funding obstacles that placing homeless mentally ill clients who might not require commitment are, there is hope that the current high cost associated with treatment of the mentally ill will diminish with the tremendous advancements in available treatments.¹⁶⁵

With the increasingly effective, well-tolerated, and safe treatments now available for major mental illness such as severe depression, manic depressive disorder, and schizophrenia—along with increasing community resources and support systems which make such treatments even more accessible—the number of patients requiring involuntary treatment is being reduced even further.¹⁶⁶

¹⁶⁴ Treffert, *supra* note 68, at 7.

¹⁶⁵ Winans, *supra* note 125, at 95.

¹⁶⁶ Treffert, *supra* note 68, at 763.

Dramatic advances in the last few decades in understanding and treating mental illness, including safer, more effective medications and new psychological therapies, lower the need for expensive involuntary commitment.¹⁶⁷

Recent advances in pharmacological treatments indicate that noncompliance could be reduced.¹⁶⁸ According to a recent study among patients treated with anti-psychotic medication, the most commonly cited reason for noncompliance was the occurrence of unpleasant side-effects (thirty-seven percent).¹⁶⁹ Similarly, patients highlighted "denial of illness" as a common reason for noncompliance, though "this reason was linked with intolerance and intense fear of the side effects of antipsychotics."¹⁷⁰ These fears were not unfounded, as treatment-emergent extrapyramidal symptoms (EPS), including muscle spasms, involuntary grimacing or chewing movements and symptoms resembling Parkinson's disease (e.g. tremor and rigidity), were commonly associated with the old anti-psychotics.¹⁷¹ Tardive dyskinesia, characterized by "chewing and sucking movements, grimacing, and jerky, purposeless movements of the limbs," is among the worst of these and can occur in as high as fifteen percent of patients on the traditional long-term anti-psychotic drug treatment.¹⁷² These disorders often result in social rejection, hindrance to rehabilitation and poor employment prospects, in addition to causing significant noncompliance and undermining the therapeutic allegiance between patient and psychiatrist.¹⁷³

In the 1990s, a new class of anti-psychotics, "atypicals," became available which have been described as "revolutionary."¹⁷⁴ Their unifying characteristic is a "reduced propensity to induce motor system disturbance" (or EPS and tardive dyskinesia), and because of their high patient acceptability these agents (such as olanzapine and risperdone) should improve compliance with

¹⁶⁷ Spaulding et al., *supra* note 93, at 135, 141.

¹⁶⁸ *Academic Highlights from Clear Vision—A Fresh Look at EPS* (conference held September 23, 1999, at the 12th European College of Neuropsychopharmacology in London, England), J. CLIN. PSYCHIATRY 61:12, December 2000, at 955.

¹⁶⁹ *Id.* at 955.

¹⁷⁰ *Id.* at 995.

¹⁷¹ *Id.*

¹⁷² Stone, *supra* note 4, at 305.

¹⁷³ *Id.*

¹⁷⁴ See *Academic Highlights*, *supra* note 168, at 956.

treatment and lower the risk of relapse.¹⁷⁵ In considering funding obstacles, “[a]lthough atypical antipsychotics generally cost more than traditional agents, recent studies indicate a favorable pharmacoeconomic impact of atypical agents because of decreased rehospitalization rates and reduced total healthcare burden.”¹⁷⁶ This data bodes well, and ongoing studies are currently examining “the effects of atypical agents on the downward economic spiral suffered by schizophrenics and the long-term impact of atypical agents on patients’ quality of life and the economic burden of the illness.”¹⁷⁷

Making uses of new treatments and applying a model similar to the drug treatment courts could achieve the goal of getting people off the streets and on the path to self-sufficiency. Hopefully, the pendulum is swinging back from civil rights advocacy that has left the homeless mentally ill community in the streets, or alternatively, incarcerated, and moving toward a middle ground. Society and treatment have progressed from the days when all social undesirables were locked up indefinitely in mental institutions. Much has changed since the era of Ken Kesey’s *Nurse Ratched*¹⁷⁸—we’ve had the Prozac Revolution, and drug treatment for the most severe disorders is showing tremendous progress and reduced side-effects. Unfortunately, the homeless mentally ill community has not felt many of these changes.

¹⁷⁵ *Id.*

¹⁷⁶ Winans, *supra* note 125, at 95.

¹⁷⁷ *Id.*

¹⁷⁸ KEN KESEY, *ONE FLEW OVER THE CUCKOO'S NEST* (Penquin 1999) (1962).