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## From Sentencing to Stability: A Solution to High Recidivism Rates for the Mentally Ill in Indiana

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# FROM SENTENCING TO STABILITY: A SOLUTION TO HIGH RECIDIVISM RATES FOR THE MENTALLY ILL IN INDIANA

## I. INTRODUCTION

Montgomery Jones is homeless.<sup>1</sup> He lives in an alley behind a restaurant where he digs for scraps left over from the diners' meals. Montgomery does not have any family or close friends and has been unemployed for five years. Additionally, Montgomery suffers from paranoid schizophrenia with paranoid delusions and bipolar disorder. He often hears voices in his head and thinks the government is watching his every move. Sometimes, Montgomery's delusions take control and he begins to think that random passersby are part of the government trying to kill him.

Because of such delusions, Montgomery has been arrested on multiple occasions, his charges usually consisting of petty theft or trespassing. Each time Montgomery is released from prison, he is placed back on the street and is not provided with any resources or medication to control his paranoid schizophrenia or his bipolar disorder. Montgomery was back on the street for thirteen days after his last arrest when he began having a severe episode of his mental illness. He was in the alley, where he spends most of his time, when the garbage man came to empty the trash cans and dumpster. Due to his mental disorders, Montgomery was convinced that the garbage man was from the government and came to kill him. Montgomery grabbed the knife he kept tucked in his waistband and stabbed the garbage man five times in the chest. Consequently, Montgomery was arrested and charged with murder. He was sentenced to twenty-five years in prison.

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<sup>1</sup> The following is the author's own hypothetical loosely based on *Best v. Bell*, No. 13 Civ. 0163, 2014 WL 1216773, at \*1-3 (S.D.N.Y. Mar. 28, 2014). Sean Best was taken into custody by the New York City Police Department. *Id.* at \*1. While preparing for his court appearance, an officer told him that he would likely be released. *Id.* Best told the officer that he needed to visit discharge planning for medication for his mental illness. *Id.* Best suffers from severe mood disorder, schizoaffective disorder, and bipolar disorder. *Id.* Despite telling many officers of his illnesses, he was subsequently released without medication and without a home. *Id.* Two months later, a manic phase set in, and Best started hearing voices and became paranoid. *Best*, 2014 WL 1216773 at \*2. A week later, he ran from a cop car thinking the officers were going to kill him. *Id.* The cops stopped him and struck him with their batons. *Id.* Best explained that he needed medication. *Id.* He received no medication during his two days in custody, and again, he was released without medication. *Id.* Two days later, he assaulted a stranger because he thought the stranger was trying to kill him with a knife. *Id.* Best was sentenced to eight years in prison. *Id.* at \*4.

Montgomery's story is a similar situation to what many mentally ill individuals experience.<sup>2</sup> Lack of resources, especially medication, lead the mentally ill to commit crimes.<sup>3</sup> Mentally ill individuals' first arrest is not usually their last because they face a slew of problems when transitioning back into society.<sup>4</sup> They tend to lack housing, employment, transportation, and mental health treatment.<sup>5</sup>

Prisons are now a substitute for mental health hospitals.<sup>6</sup> In Indiana, over twenty percent of offenders are diagnosed with a mental illness.<sup>7</sup> After release, many mentally ill offenders return to the criminal justice system.<sup>8</sup> This cycle adversely impacts both individuals and the State.<sup>9</sup> However, Indiana currently has minimal statutes addressing mentally ill offenders' reentry back into society.<sup>10</sup>

Indiana should implement the new statutory language proposed in this Note, which creates a comprehensive reentry program for mentally ill

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<sup>2</sup> See *infra* Part II.B (explaining the obstacles facing mentally ill offenders upon release from prison).

<sup>3</sup> See Michael Vitiello, *Addressing the Special Problems of Mentally Ill Prisoners: A Small Piece of the Solution to Our Nation's Prison Crisis*, 88 DENV. U. L. REV. 57, 63 (2010) (emphasizing that a lack of housing for the mentally ill leads to homelessness and that offenders remained homeless after they were released from prison).

<sup>4</sup> See *infra* Part II.B (discussing the high recidivism rates of mentally ill offenders and the problems that mentally ill offenders face that contribute to their high recidivism rates).

<sup>5</sup> See *Mentally Ill Persons in Corrections*, NAT'L INST. OF CORR., <http://nicic.gov/mentalillness> [<https://perma.cc/GSZ5-AMRP>] (stating that mentally ill offenders have a difficult time finding employment after being released from prison). See also Christy Visser et al., *Employment after Prison: A Longitudinal Study of Releasees in Three States*, URBAN INST. (Oct. 2008), <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/411778-Employment-after-Prison-A-Longitudinal-Study-of-Releasees-in-Three-States.PDF> [<https://perma.cc/7SE4-LA9Z>] (illustrating that mental health conditions in inmates served as a good predictor for lower percentages of employment time since their release from a correctional facility); Doris J. James & Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates*, U.S. DEPT. OF JUST. (2006), <https://www.bjs.gov/content/pub/pdf/mhppji.pdf> [<https://perma.cc/6ECF-W6P6>] (reporting that seventy percent of mentally ill offenders compared to seventy-six percent of non-mentally ill offenders were employed the month prior to being arrested).

<sup>6</sup> See *infra* Part II.A (focusing on the influx of mentally ill individuals in the criminal justice system).

<sup>7</sup> See Marisa Kwiatkowski & Kristine Guerra, *Indiana to Provide Treatment to Mentally Ill Prisoners under Settlement*, INDY STAR (Jan. 28, 2016), <http://www.indystar.com/story/news/politics/2016/01/28/indiana-provide-treatment-mentally-ill-prisoners-under-settlement/79085674/> [<https://perma.cc/8NER-35VJ>] (identifying what portion of the Indiana prison population has a mental illness).

<sup>8</sup> See *infra* Part II.B (providing insight into the recidivism of mentally ill offenders).

<sup>9</sup> See *infra* Part II.B (explaining that having a high number of mentally ill inmates creates a financial burden).

<sup>10</sup> See *infra* Part II.C (describing Indiana's statutes and programs concerning the release of mentally ill offenders).

offenders' transition back into society.<sup>11</sup> This Note analyzes Indiana's existing statutes and programs for diversion or release from the criminal justice system.<sup>12</sup> First, Part II of this Note discusses problems associated with the high rates of recidivism and incarceration of the mentally ill, as well as some causes of these high rates.<sup>13</sup> Then, Part III of this Note identifies the pitfalls of the statutes and programs that are currently in place in Indiana.<sup>14</sup> Next, Part IV proposes a statute creating and codifying a new reentry program for the mentally ill.<sup>15</sup> Finally, Part V provides the conclusion that both Indiana and mentally ill offenders will benefit from implementing the proposed reentry statute.<sup>16</sup>

## II. BACKGROUND

Given the alarmingly high number of mentally ill offenders in prison, like Montgomery, the current laws and programs do not provide the adequate assistance for mentally ill offenders' successful transition back into society.<sup>17</sup> Indiana offers a few programs to reduce recidivism in the mentally ill population, but many of them do not address all the contributors to high recidivism rates specifically among mentally ill individuals.<sup>18</sup> First, Part II.A reveals the high number of mentally ill individuals in state and federal prisons and causes of this recent increase.<sup>19</sup> Then, Part II.B discusses the high recidivism rates of mentally ill offenders

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<sup>11</sup> See *infra* Part IV (proposing a solution to high recidivism rates in the mentally ill population).

<sup>12</sup> See *infra* Part III (analyzing the inadequate rehabilitative programs for mentally ill offenders).

<sup>13</sup> See *infra* Part II (providing the background regarding the pervasiveness of mentally ill inmates, high recidivism among mentally ill offenders, and what different factors contribute to these high rates of the mentally ill being involved in the criminal justice system).

<sup>14</sup> See *infra* Part III (displaying the shortcomings of current Indiana programs and statutes aimed at reducing recidivism).

<sup>15</sup> See *infra* Part IV (making a proposition to introduce a codified comprehensive reentry program).

<sup>16</sup> See *infra* Part V (concluding on why Indiana should adopt a comprehensive reentry plan).

<sup>17</sup> See *infra* Part II.B (discussing the different programs and statutes that have been implemented in Indiana to reduce recidivism in the mentally ill). See also Sarah Knopf-Amelung, *Incarceration & Homelessness: A Revolving Door of Risk*, 2 A Q. RES. REV. OF THE NAT'L HCH COUNCIL 1, 1 (Nov. 2013) (indicating the high rates of incarcerated mentally ill offenders).

<sup>18</sup> See *infra* Part II.A (explaining the high recidivism rates in mentally ill offenders and what factors contribute to these high rates).

<sup>19</sup> See *infra* Part II.A (noting that there are high rates of mentally ill offenders in prisons and that deinstitutionalization has been a contributing factor).

and what contributes to these high rates.<sup>20</sup> Finally, Part II.C explains and describes the current Indiana statutes and programs designed to reduce recidivism in mentally ill offenders.<sup>21</sup>

A. *The Increased Level of Mentally Ill Inmates and Its Causes*

Throughout the past ten years, there has been an influx of mentally ill persons in the criminal justice system.<sup>22</sup> According to a 2006 report by the Bureau of Justice Statistics, over half of the inmates in United States federal

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<sup>20</sup> See *infra* Part II.B (discussing high rates at which individuals with mental illnesses are rearrested or reincarcerated).

<sup>21</sup> See *infra* Part II.C (talking about the different programs and laws that have been implemented to address the high rates of the mentally ill in prison and their high rates of recidivism).

<sup>22</sup> See U.S.: *Number of Mentally Ill in Prisons Quadrupled*, HUM. RIGHTS WATCH (Sept. 5, 2006), <https://www.hrw.org/news/2006/09/05/us-number-mentally-ill-prisons-quadrupled> [<https://perma.cc/97EM-XUUW>] [hereinafter *U.S.: Mentally Ill*] (comparing the results of the 1998 Bureau of Justice Statistic's survey to its 2006 survey about mentally ill offenders, stating that the number of mentally ill inmates grew from 283,000 to 1.25 million). See also *Risk and Mentally Disordered Offenders*, PUB. SAFETY CAN. (July 2013), <https://www.publicsafety.gc.ca/cnt/rsrscs/pblctns/rsk-mntl-ffndr/rsk-mntl-ffndr-eng.pdf> [<https://perma.cc/QYG6-A2SN>] (showing that Canada has also experienced a rise in the number of mentally ill offenders); Jillian Peterson & Kevin Heinz, *Understanding Offenders with Serious Mental Illness in the Criminal Justice System*, 42 MITCHELL HAMLINE L. REV. 537, 538 (2016) (discussing the mentally ill's relationship with the criminal justice system); *IDOC Addressing the Next Great Challenge to Corrections: Offenders with Special Needs*, IND.GOV (Mar. 11, 2014), [https://www.in.gov/idoc/files/Mental\\_Health\\_News\\_Release.pdf](https://www.in.gov/idoc/files/Mental_Health_News_Release.pdf) [<https://perma.cc/GS47-GX2Y>] (giving statistics for mentally ill in Indiana prisons).

jails and prisons have a mental health problem.<sup>23</sup> However, most mentally ill inmates are confined in state prisons.<sup>24</sup>

There has also been an increase in offenders who have severe mental illnesses.<sup>25</sup> A mental illness is severe if it greatly impacts the individual's daily activities.<sup>26</sup> Conditions that qualify as severe mental illness typically

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<sup>23</sup> See James & Glaze, *supra* note 5 (providing statistics about the mentally ill prison population). The information in this report was gathered via personal interviews with inmates from federal, state, and local facilities. *Id.* Mental health problems were defined by a recent history or symptoms occurring within twelve months before the interview. *Id.* Jails are locally operated facilities where offenders are held for a short period of time, pending arraignment, trial, conviction, or sentencing, whereas prisons, both state and federal, hold offenders that are convicted and must serve more than a year. *Id.* There are gender differences between mentally ill inmates. *Id.* Mental illness is more common in female inmates. *Id.* In state prisons, about seventy-three percent of females have mental illness, whereas only fifty-five percent of males have mental illness. *Id.* Sixty-one percent of females and forty-four percent of males in federal prisons have mental illness. *Id.* Also, almost three times more women than men in state and local facilities reported being diagnosed by a mental health professional. *Id.* There have also been differences in race among mentally ill inmates. *Id.* Non-Hispanic Caucasians have the highest rates of mental illness in the corrections system. *Id.* In the mentally ill inmate population, approximately sixty-two percent of inmates in state prison, fifty percent in federal prison, and seventy-one percent in local jails are Caucasian. *Id.* See also *The New Asylums: Some Frequently Asked Questions*, PBS FRONTLINE (May 10, 2005), <http://www.pbs.org/wgbh/pages/frontline/shows/asylums/etc/faqs.html> [<https://perma.cc/332R-GRY7>] [hereinafter *The New Asylums: FAQs*] (laying out the racial demographics of the mentally ill in prison); Dean Aufderheide, *Mental Illness in America's Jails and Prisons: Toward A Public Safety/Public Health Model*, HEALTH AFFAIRS BLOG (Apr. 1, 2012), <http://healthaffairs.org/blog/2014/04/01/mental-illness-in-americas-jails-and-prisons-toward-a-public-safety-public-health-model/> [<https://perma.cc/PV3T-HCQE>] (revealing the higher rates of female mentally ill inmates compared to male mentally ill inmates).

<sup>24</sup> See James & Glaze, *supra* note 5 (reporting that there are 705,600 mentally ill inmates serving their sentence in state prisons). See also Olga Khazan, *Most Prisoners Are Mentally Ill*, ATLANTIC (Apr. 7, 2015), <https://www.theatlantic.com/health/archive/2015/04/more-than-half-of-prisoners-are-mentally-ill/389682/> [<https://perma.cc/NA7J-HSN8>] (reporting that over half of inmates in state prisons have a mental health problem).

<sup>25</sup> See Aufderheide, *supra* note 23 (explaining that there are currently higher rates of severe mental illness in prison than in the past). “[A]ccording to the American Psychiatric Association, on any given day, between 2.3 and 3.9 percent of inmates in state prisons are estimated to have schizophrenia or other psychotic disorder; between 13.1 and 18.6 percent have major depression; and between 2.1 and 4.3 percent suffer from bipolar disorder.” *Id.* See also *The New Asylums: FAQs*, *supra* note 23 (stating that sixteen percent of inmates are considered to have severe mental illness).

<sup>26</sup> See *Behind the Term: Serious Mental Illness*, SAMHSA (2016), [http://www.nrepp.samhsa.gov/Docs%5CLiteratures%5CBehind\\_the\\_Term\\_Serious%20%20Mental%20Illness.pdf](http://www.nrepp.samhsa.gov/Docs%5CLiteratures%5CBehind_the_Term_Serious%20%20Mental%20Illness.pdf) [<https://perma.cc/Y2WF-E3WA>] [hereinafter *Behind the Term*] (listing the mental disorders that typically meet the criteria for serious mental illness). See also Marilyn Odendahl, *Treatment of Mentally Ill Prisoners Changing*, IND. LAW. (Feb. 10, 2016), <http://www.theindianalawyer.com/treatment-of-mentally-ill-prisoners-changing/PARAMS/article/39432?page=> [<https://perma.cc/FFR9-UDKE>] (defining seriously mentally ill in a settlement agreement as “those having a diagnosis or recent history of a

include schizophrenia, bipolar disorder, major depressive disorder, psychotic disorders, and schizoaffective disorder.<sup>27</sup> Individuals with severe mental illnesses are more likely to serve time in a correctional facility than be housed in a mental health facility.<sup>28</sup> Specifically in Indiana, mentally ill offenders account for approximately twenty-one percent of the prison population.<sup>29</sup>

Scholars blame deinstitutionalization for the increase in mentally ill offenders in prison.<sup>30</sup> Deinstitutionalization is the process by which state governments began to close state mental health hospitals in the 1960s.<sup>31</sup> With deinstitutionalization, the states aimed to reduce state spending and liberate individuals held in mental hospitals.<sup>32</sup> However, critics deem

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major mental illness such as schizophrenia, psychotic disorder, major depression or bipolar disorder who are suicidal”).

<sup>27</sup> See *Behind the Term*, *supra* note 26 (explaining what qualifies as a serious mental illness). The legal definitions of severe mental illness are inconsistent. *Id.* The federal government has its own definition of the term and state definitions tend to vary. *Id.* See also *The New Asylums: FAQs*, *supra* note 23 (reiterating that schizophrenia, major depression, and bipolar disorder qualify as severe mental illnesses).

<sup>28</sup> See Aufderheide, *supra* note 23 (emphasizing that mental health services are scarce in the community, resulting in large numbers of the mentally ill population being imprisoned). See also *We're More Likely to Jail the Mentally Ill Than Get Them Help*, PATHEOS (Feb. 21, 2017), <http://www.patheos.com/blogs/catholicnews/2017/02/were-more-likely-to-jail-the-mentally-ill-than-get-them-help/> [<https://perma.cc/CKV5-LY63>] (revealing that the number of state hospital beds for persons with severe mental illness went from 337 per 100,000 persons to 11.7 per 100,000 persons from 1955 to 2016).

<sup>29</sup> See Kwiatkowski & Guerra, *supra* note 7 (estimating that about 20.6 percent of the total Indiana prison population is represented by the mentally ill). See also Russ McQuaid, *Lawsuit Settlement Makes Indiana Leader in Inmate Mental Health Treatment*, FOX 59 (Jan. 28, 2016), <http://fox59.com/2016/01/28/lawsuit-settlement-makes-indiana-leader-in-inmate-mental-health-treatment/> [<https://perma.cc/59VB-C477>] (reiterating that at least twenty percent of Indiana inmates have a serious mental illness).

<sup>30</sup> See Kasey Mahoney, *Addressing Criminalization of the Mentally Ill: The Importance of Jail Diversion and Stigma Reduction*, 17 MICH. ST. U. J. MED. & L. 327, 331 (2013) (pointing out that deinstitutionalization has been criticized for putting the mentally ill on the streets without access to proper treatment). See also Aufderheide, *supra* note 23 (theorizing that the deinstitutionalization of state mental health facilities has contributed to the increase of mentally ill offenders in state, local, and federal prisons).

<sup>31</sup> See Karen A. Kugler & Jessica Plotz, *A Prosecutor's Comment on Mental Health Court – Realizing the Goal of Long-Term Public Safety*, 42 MITCHELL HAMLINE L. REV. 523, 526 (2016) (explaining that deinstitutionalization was the closing of the state mental hospitals). See also Aufderheide, *supra* note 23 (expressing that the process of deinstitutionalization involved the closing of state-owned mental health facilities).

<sup>32</sup> See Kugler & Plotz, *supra* note 31, at 526 (noting that the civil rights advocates pushing to liberate the mentally ill from state-run mental health hospitals and the need to cut costs were the propelling factors that led to the deinstitutionalization of America). See also Kimberly Amadeo, *Deinstitutionalization: How Does it Affect You Today?*, BALANCE (Dec. 5, 2016), <https://www.thebalance.com/deinstitutionalization-3306067> [<https://perma.cc/ZDH9-Z4S5>] (describing deinstitutionalization and the affect it had on society).

deinstitutionalization as a failed social experiment.<sup>33</sup> States began to decrease their spending on mental health hospitals without any increase in spending for community-based programs.<sup>34</sup> The mentally ill community then faced hardships because of deinstitutionalization, such as release from the hospitals without access to treatment or housing.<sup>35</sup> Due to the unavailability of medication or housing, mentally ill individuals began committing crimes, getting arrested, and then subsequently committing crimes upon release.<sup>36</sup> This cycle is still pervasive today, leading to high rates of recidivism in mentally ill individuals.<sup>37</sup> Closing mental health hospitals along with neglecting to

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<sup>33</sup> See Mahoney, *supra* note 30, at 331 (referring to deinstitutionalization as a failed social experiment). See also David A. Zaheer, *Expanding California's Coerced Treatment for the Mentally Ill: Is the Promise of Caring Treatment in the Community of Lost Hope?*, 10 S. CAL. INTERDISC. L.J. 385, 393 (2001) (noting that E. Fuller Torrey calls deinstitutionalization a failed social experiment because it has led to homelessness and premature deaths in the mentally ill population).

<sup>34</sup> See Aufderheide, *supra* note 23 (criticizing the government for clearing out the state mental health institutions without providing additional funding to community services for the mentally ill). See also Sheela Nimishakavi, *Through Deinstitutionalization, Massachusetts Mental Health Crisis Deepens*, NPQ (Sept. 2, 2016), <https://nonprofitquarterly.org/2016/09/06/through-deinstitutionalization-massachusetts-mental-health-crisis-deepens/> [<https://perma.cc/SX89-QZJ2>] (establishing that many states did not have community-based mental health services readily available to the mentally ill during deinstitutionalization).

<sup>35</sup> See Zaheer, *supra* note 33, at 393 (blaming deinstitutionalization for the poor circumstances that face the mentally ill because there is a shortage of resources for the mentally ill). See also Stephen P. Kiewer et al., *Deinstitutionalization: Its Impact on Community Mental Health Centers and Seriously Mentally Ill*, 35 ALA. COUNSELING ASS'N. J. 40, 41 (2009) (providing that mentally ill individuals were unsupported, had trouble integrating into the community, were homeless, and were likely to be arrested as a result of deinstitutionalization); Mahoney, *supra* note 30, at 330-31 (explaining that there was a lack of services available for the mentally ill after they were released from the state mental institutions in the 1960s); *Deinstitutionalization of the Mentally Ill Was a Bad Decision. Bring it Back*, CNN IREPORT (Dec. 16, 2012), <http://ireport.cnn.com/docs/DOC-897277> [<https://perma.cc/N63K-2XUH>] (reiterating that many individuals with mental illness were left homeless and without care after deinstitutionalization).

<sup>36</sup> See Mahoney, *supra* note 30, at 332 (indicating the cycle that the mentally ill went through after mental health hospitals were closed). See also *Deinstitutionalization*, ENCYCL. OF MENTAL DISORDERS (2017), <http://www.minddisorders.com/Br-Del/Deinstitutionalization.html> [<https://perma.cc/3W5Q-5HLZ>] (giving the history and effects of deinstitutionalization).

<sup>37</sup> See Mahoney, *supra* note 30, at 337 (emphasizing that a lack of resources has led to high recidivism rates in the mentally ill). See also *Incarceration and Mental Health*, CTR. FOR PRISON HEALTH AND HUM. RTS, <http://www.prisonerhealth.org/educational-resources/factsheets-2/incarceration-and-mental-health/> [<https://perma.cc/49C4-YK2K>] (attributing the increase in mentally ill inmates to deinstitutionalization).



provide community resources for the mentally ill is directly related to the increased recidivism rates in the mentally ill population.<sup>38</sup>

*B. High Rates of Recidivism in Mentally Ill Offenders*

Not only is there a high mentally ill inmate population, but there are high recidivism rates for mentally ill offenders.<sup>39</sup> Recidivism is defined as any re-arrest, regardless if an offender was previously sentenced or convicted.<sup>40</sup> In federal prisons, the recidivism rate for mentally ill offenders is higher than non-mentally ill offenders.<sup>41</sup> Similarly, twenty-five percent of mentally ill inmates in state prisons have been in prison

<sup>38</sup> See Aufderheide, *supra* note 23 (indicating that deinstitutionalization was the closing of state-owned mental health facilities). See also Jennifer L. Skeem et al., *Offenders with Mental Illness Have Criminogenic Needs, Too: Toward Recidivism Reduction*, 38 L. & HUM. BEHAV. 212, 217 (2014) (revealing that research shows that persons with mental illness are more likely to return to custody than persons without mental illness).

<sup>39</sup> See James & Glaze, *supra* note 5 (providing statistics for the recidivism of the mentally ill). See also Mahoney, *supra* note 30, at 337 (explaining that the mentally ill have high rates of recidivism); Susan K. Gauvey & Katerina M. Georgiev, *Reform in Ex-Offender Reentry: Building Bridges and Shattering Silos*, 44 MD. B.J. 14, 15 (Dec. 2011) (explaining the association between recidivism rates in the mentally ill); Robert Rigg, *Are There No Prisons? Mental Health and the Criminal Justice System in the United States*, 4 U. DENV. CRIM. L. REV. 103, 107 (2014) (discussing the negative interactions between the mentally ill and criminal justice system); Jennifer L. Skeem et al., *supra* note 38, at 213 (listing the factors working against mentally ill offenders upon release from prison).

<sup>40</sup> See *Recidivism*, BLACK'S LAW DICTIONARY (10th ed. 2014) ("A tendency to relapse into a habit of criminal activity or behavior"). See also *Recidivism*, NAT'L INST. OF JUSTICE (June 17, 2014), <http://www.nij.gov/topics/corrections/recidivism/pages/welcome.aspx> [<https://perma.cc/B3XA-9LEB>] (defining recidivism as "a person's relapse into criminal behavior . . . measured by criminal acts that resulted in re-arrest, reconviction or return to prison with or without a new sentence during a three-year period following the prisoner's release"); Samantha Hoke, *Mental Illness and Prisoners: Concerns for Communities and Healthcare Providers*, ONLINE J. OF NURSING ISSUES (Jan. 2015), <http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-20-2015/No1-Jan-2015/Mental-Illness-and-Prisoners.html> [<https://perma.cc/YYD5-75UU>] (labeling recidivism as a repeat arrest or incarceration).

<sup>41</sup> See James & Glaze, *supra* note 5 (providing a statistical depiction regarding the fact that mentally ill offenders are in more need of reentry assistance than regular offenders). See also Gregory L. Acquaviva, *Mental Health Courts: No Longer Experimental*, 36 SETON HALL L. REV. 971, 975 (2006) (providing statistics for the number of mentally ill persons in correctional facilities). The author notes a use of mental health courts as an alternative to traditional courts:

[T]he innovation that we're seeing now (the rise of problem-solving courts) is a result of judges processing cases like a vegetable factory. Instead of cans of peas, you've got cases. You just move 'em, move 'em, move 'em. One of my colleagues on the bench said: "You know, I feel like I work for McJustice: we sure aren't good for you, but we are fast."

*Id.* at 981-82 (internal citation omitted).

three or more times.<sup>42</sup> The constant cycling of the mentally ill in and out of prison is known as the “revolving door” effect.<sup>43</sup> The “revolving door” effect is “the process by which an individual with a severe mental illness commits a crime . . . and for a variety of reasons is released back onto the streets without support or supervision and then commits another crime.”<sup>44</sup>

There are many factors that contribute to mentally ill individuals’ return to prison, including no access to employment, housing, or medication.<sup>45</sup> Homelessness is very common among mentally ill

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<sup>42</sup> See James & Glaze, *supra* note 5 (discussing recidivism among mentally ill offenders). See also Brad Ray, *Addressing Mental Illness in the Central Indiana Criminal Justice System*, IND. UNIV. PUB. POL’Y INST. (Sept. 28, 2016), [https://policyinstitute.iu.edu/Uploads/PublicationFiles/MentalHealthBrief\\_Final20031516.pdf](https://policyinstitute.iu.edu/Uploads/PublicationFiles/MentalHealthBrief_Final20031516.pdf) [<https://perma.cc/ZS2M-YAMH>] (noting that the average number of prior bookings for the participants in the Marion County Mental Health Alternative Court was eight); William J. Rich, *The Path of Mentally Ill Offenders*, 36 FORDHAM URB. L.J. 89, 112–13 (2009) (explaining the cycle of the mentally ill in prison); Clayton E. Cramer, *Madness, Deinstitutionalization & Murder*, 13 ENGAGE: J. FEDERALIST SOC’Y PRAC. GROUPS 37, 41 (2012) (explaining the relationship between mental illness and crime).

<sup>43</sup> See Vitiello, *supra* note 3, at 63 (describing that a lack of access to housing and mental health services led to mentally ill inmates returning to prison). See, e.g., *Best v. Bell*, No. 13 Civ. 0163, 2014 WL 1216773, at \*12 (S.D.N.Y. Mar. 28, 2014) (holding that Best had a claim against the city for not providing him with medication, but the complaint was not made within the statute of limitations). See also *Higgins v. Indiana*, 601 N.E.2d 342, 343 (Ind. 1992) (holding that jail sentence for an individual who is guilty but mentally ill and a habitual offender was not cruel and unusual punishment).

<sup>44</sup> Katherine B. Cook, *Revising Assisted Outpatient Treatment Statutes in Indiana: Providing Mental Health Treatment for those in Need*, 9 IND. HEALTH L. REV. 661, 668 (2012). See also *The New Asylums: Introduction*, PBS FRONTLINE (May 10, 2005), <http://www.pbs.org/wgbh/pages/frontline/shows/asylums/etc/synopsis.html> [<https://perma.cc/5DRV-2EGM>] (recounting the story of a paranoid schizophrenic who was arrested for robbery after six days of being released on parole); Katherine A. Brown, *Assertive Community Treatment: A Reentry Model for Seriously Mentally Ill Offenders*, 32 CAP. U. L. REV. 1057, 1057–58 (2004) (explaining assertive community treatment, another attempted solution for reducing recidivism in the mentally ill).

<sup>45</sup> See Bonnie Sultan, *The Insanity of Incarceration and the Maddening Reentry Process: A Call for Change and Justice for Males with Mental Illness in United States Prisons*, 13 GEO. J. ON POVERTY L. & POL’Y 357, 364 (2006) (identifying the factors contributing to mentally ill recidivism). The following discusses factors affecting successful reentry for mentally ill offenders:

Many persons living with mental illness may not be able to obtain employment or maintain housing, may cease taking their prescribed medications, or may become volatile due to their untreated or unmonitored disorders. Untreated mental illness can lead to property offenses, trespassing, substance abuse, and violence in the community. These offenses lead mental health consumers into the criminal justice system . . . .

*Id.* See also *Mental Illness, Human Rights, and U.S. Prisons*, HUM. RTS WATCH (Sept. 27, 2016) <https://www.hrw.org/news/2009/09/22/mental-illness-human-rights-and-us-prisons> [<https://perma.cc/MYK4-2KSR>] [hereinafter *Mental Illness, Rights*] (stating that the mentally

offenders.<sup>46</sup> Mentally ill offenders are twice as likely than non-mentally ill offenders to have been homeless in the year prior to their incarceration.<sup>47</sup> However, a study from Washington state found that homelessness and crime among mentally ill offenders were reduced when provided with housing support.<sup>48</sup>

In addition to housing difficulties, mentally ill offenders also struggle with finding and maintaining employment.<sup>49</sup> A 2006 report revealed low rates of employment in mentally ill offenders prior to their incarceration.<sup>50</sup>

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ill need support for housing, employment, appropriate treatment, and access to public assistance); Sidney D. Watson, *Discharges to the Streets: Hospitals and Homelessness*, 19 ST. LOUIS U. PUB. L. REV. 357, 363 (2000) (explaining that when those who are mentally ill leave a facility, they often do so without anywhere to go or anyone to turn to); Arthur J. Lurigio et al., *The Effects of Serious Mental Illness on Offender Reentry*, 68 FED. PROB. 45, 46 (2004) (examining the factors that led to increased mentally ill in prison); Skeem et al., *supra* note 38, at 213 (2014) (listing the factors working against mentally ill offenders upon release from prison).

<sup>46</sup> See Vitiello, *supra* note 3, at 63 (illustrating that a lack of housing for the mentally ill led to homelessness and that offenders remained homeless after they were released from prison). See also E. Fuller Torrey, *250,000 Mentally Ill are Homeless. 140,000 Seriously Mentally Ill are Homeless*, MENTAL ILLNESS POL'Y ORG., <http://mentalillnesspolicy.org/consequences/homeless-mentally-ill.html> [<https://perma.cc/UKZ9-P9AK>] (stating that approximately 250,000 individuals with mental illness are homeless).

<sup>47</sup> See James & Glaze, *supra* note 5 (describing the high rates of homelessness in mentally ill inmates). See also Rick Jervis, *Mental Disorders Keep Thousands of Homeless on the Streets*, USA TODAY, <http://www.usatoday.com/story/news/nation/2014/08/27/mental-health-homeless-series/14255283/> [<https://perma.cc/SC4M-6DVH>] (stating that lack of medication and mental health counseling leads to homelessness in mentally ill individuals).

<sup>48</sup> See *Impacts of Housing Supports: Persons with Mental Illness and Ex-Offenders*, WASH. ST. INST. FOR PUB. POL'Y (Nov. 2009), [http://www.wsipp.wa.gov/ReportFile/1055/Wsipp\\_Impacts-of-Housing-Supports-Persons-with-Mental-Illness-and-Ex-Offenders\\_Full-Report.pdf](http://www.wsipp.wa.gov/ReportFile/1055/Wsipp_Impacts-of-Housing-Supports-Persons-with-Mental-Illness-and-Ex-Offenders_Full-Report.pdf) [<https://perma.cc/7LZD-LRD5>] (concluding that housing support services contribute to a decrease in homelessness and crime among individuals with mental illness). See also Merrill Rotter & W. Armor Carr, *Reducing Criminal Recidivism for Justice-Involved Persons with Mental Illness: Risk/Needs/Responsivity and Cognitive-Behavioral Interventions*, SAMHSA'S GAINS CTR. FOR BEHAV. HEALTH AND JUSTICE TRANSFORMATION (Oct. 2013) (establishing that interventions to reduce recidivism in mentally ill offenders must be implemented in such a way to get maximal responsiveness of the offenders).

<sup>49</sup> See *Mentally Ill Persons in Corrections*, *supra* note 5 (stating that mentally ill offenders have a difficult time with employment after being released from prison). See also Visher et al., *supra* note 5 (illustrating that mental health conditions in inmates served as a good predictor for lower percentages of employment time since their release from a correctional facility).

<sup>50</sup> See James & Glaze, *supra* note 5 (reporting that seventy percent of mentally ill offenders compared to seventy-six percent of non-mentally ill offenders were employed the month prior to being arrested). See also *3.1 Million Adults with Mental Illness Were Unemployed*, SAMHSA (Mar. 25, 2014), <https://www.samhsa.gov/data/sites/default/files/spot116-unemployment-mental-illness-2014.pdf> [<https://perma.cc/8SY3-VRRC>] (indicating that data gathered from 2008 and 2012 shows that 3.1 million adults with mental illness in the United States are unemployed).

Even if offenders have housing, they likely have little access to computers and internet, which are essential in a job search.<sup>51</sup> Evidence shows that mentally ill individuals involved in employment support programs have higher rates of employment than those who are not.<sup>52</sup>

Furthermore, mentally ill offenders do not have adequate access to transportation.<sup>53</sup> Difficulties with transportation also contribute to difficulties with employment since they cannot get to their jobs.<sup>54</sup> Lack of transportation also creates barriers to obtaining treatment, contributing to the general struggle mentally ill offenders face in securing treatment.<sup>55</sup> Lack of resources available in the community for mentally ill offenders also impedes mentally ill offenders' access to medication.<sup>56</sup>

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<sup>51</sup> See *Employment & Public Libraries*, PUB. LIB. & THE INTERNET, <http://www.plinternet.survey.org/analysis/public-libraries-and-employment> [<https://perma.cc/CK7U-DG8W>] (demonstrating the pervasive need for internet when searching for employment using services in public libraries). Over seventy-five percent of the public libraries help people create resumes and help people apply for jobs. *Id.* People often go to public libraries to look for jobs, write resumes and cover letters, and fill out job applications. *Id.*

<sup>52</sup> See Sita Diehl et al., *Road to Recovery: Employment and Mental Illness*, NAT'L ALLIANCE ON MENTAL ILLNESS (July 2014), <https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/RoadtoRecovery.pdf> [<https://perma.cc/ZZC9-FYV7>] (identifying a few employment programs that successfully assist mentally ill individuals in obtaining employment). See also Heather Stuart, *Mental Illness and Employment Discrimination* 19 *CURRENT OPINION IN PSYCHIATRY* 522, 522 (2006) (distinguishing that sixty-one percent of mentally ill individuals are unemployed from the twenty percent of individuals without mental illness).

<sup>53</sup> See Fred McLaren, *Getting In, Out and Around: Overcoming Transportation Barriers to Community Integration*, TEMPLE UNIV. COLLABORATIVE (Mar. 2011), [http://tucollaborative.org/pdfs/Transportation\\_Monograph.pdf](http://tucollaborative.org/pdfs/Transportation_Monograph.pdf) [<https://perma.cc/7K5X-7JD4>] (describing the struggle of those with psychiatric disabilities in community integration because of limited access to transportation).

<sup>54</sup> See *Getting There: Helping People with Mental Illnesses Access Transportation*, U.S. DEPT. OF HEALTH AND HUM. SERV. (2004), <https://store.samhsa.gov/shin/content/SMA04-3948/SMA04-3948.pdf> [<https://perma.cc/73EB-LU35>] [hereinafter *Getting There*] (establishing the difficulties the mentally ill population has in obtaining access to transportation).

<sup>55</sup> See Samina Syed et al., *Traveling Towards Disease: Transportation Barriers to Health Care Access* 38 *J. COMMUNITY MENTAL HEALTH* 976, 976 (2013) (noting that lack of access transportation contributes to difficulties obtaining mental health treatment). See also Sultan, *supra* note 45, at 364 (addressing the concern that an "[u]ntreated mental illness can lead to property offenses, trespassing, substance abuse, and violence in the community . . . lead[ing] mental health consumers into the criminal justice system").

<sup>56</sup> See Nora Hertel, *Mentally Ill Ex-Inmates Lack Treatment, Meds*, WIS. WATCH (Nov. 10, 2013), <http://wisconsinwatch.org/2013/11/mentally-ill-ex-inmates-lack-treatment-meds/> [<https://perma.cc/2X32-75K9>] (explaining that mentally ill offenders have significant difficulties obtaining medication after they have been released). Bonnie Richardson is a fifty-two-year-old woman who is diagnosed with anxiety disorder, attention deficit disorder, and bipolar disorder. *Id.* Richardson has been incarcerated in prison on multiple occasions and has difficulties staying out of trouble without her medications. *Id.* However, Richardson and other mentally ill offenders must face the harsh realities regarding access to medication.

Treating and housing mentally ill offenders strains the state's economy.<sup>57</sup> First, mentally ill offenders are expensive to care for while they are incarcerated.<sup>58</sup> In a single county in Indiana, the treatment of

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*Id.* In Wisconsin, an inmate released from a state prison is typically provided with only two weeks' worth of medication and a prescription for four weeks' worth of medication. *Id.* Drug and alcohol use is also considered to contribute to recidivism because many mentally ill individuals abuse substances. *Id.* See also *Untreated Mental Illness and Substance Abuse Among Inmates Increases Recidivism Rate*, MENTAL HEALTH TREATMENT (2017), <http://mentalhealthtreatment.net/blog/untreated-mental-illness-and-substance-abuse-among-inmates-increases-recidivism-rate/> [<https://perma.cc/YUS3-9A7N>] (reporting from a study published in the *International Journal of Law and Psychiatry* that sixty-eight percent of offenders with mental illness and history of substance abuse returned to prison); James & Glaze, *supra* note 5 (revealing that the highest rate of substance abuse in mentally ill offenders can be found in local jails). According to the Bureau of Justice statistics, seventy-six percent of inmates with mental health problems in local jails nationwide abuse or are dependent on drugs or alcohol; these numbers are higher than in any other type of correctional facility. *Id.* See also Anasseril E. Daniel, *Care of Mentally Ill in Prisons: Challenges and Solutions*, 35 J. OF AMER. ACAD. OF PSYCHIATRY AND THE L. 406, 406-10 (Dec. 2007), <http://jaapl.org/content/35/4/406> [<https://perma.cc/6S67-Y9UV>] (indicating that seventy percent of mentally ill inmates in Western countries had a comorbid substance abuse disorder). The next highest rate can be found in State prisons at seventy-four percent. See also James & Glaze, *supra* note 5 (providing the statistics for mentally ill offenders in state prisons that have a substance abuse problem); Christine M. Sarteschi, *Mentally Ill Offenders Involved with the U.S. Criminal Justice System: A Synthesis*, SAGE OPEN (2013), <http://journals.sagepub.com/doi/pdf/10.1177/2158244013497029> [<https://perma.cc/ZM3U-QAUR>] (stating that a survey of correctional facilities nationwide reveal that mentally ill offenders have high rates of substance abuse). Last, in federal prisons sixty-four percent of inmates have substance abuse issues. See James & Glaze, *supra* note 5 (showing that federal prisoners with mental illness have the lowest rates of substance abuse when compared to their state and local counterparts). See also *The Mentally Ill Offender Treatment and Crime Reduction Act*, JUST. CTR. COUNCIL OF ST. GOV'TS (Feb. 2016), [https://csgjusticecenter.org/wp-content/uploads/2014/08/MIOTCRA\\_Fact\\_Sheet.pdf](https://csgjusticecenter.org/wp-content/uploads/2014/08/MIOTCRA_Fact_Sheet.pdf) [<https://perma.cc/8UGT-5L6E>] (reiterating that there are high rates of mental illness coupled with substance abuse in inmates). A comparison to inmates without mental illness shows that fifty-six percent of inmates in state prisons, forty-nine percent of inmates in federal prisons, and fifty-three percent of inmates in local jails were dependent on or abused alcohol or drugs. See James & Glaze, *supra* note 5 (making a comparison between the prevalence of substance abuse problems in offenders with mental illness and those who do not have a mental illness).

<sup>57</sup> See Hoke, *supra* note 42 (noting that high rates of recidivism in the mentally ill put a strain on the prison budget). See also *Study: Mentally Ill Inmates Stay Longer in Central Ohio Jail*, WLWT (May 17, 2015), <http://www.wlwt.com/article/study-mentally-ill-inmates-stay-longer-in-central-ohio-jail/3554320> [<https://perma.cc/UU29-HVTQ>] (stating that an Ohio county could save \$5 million to \$12 million each year if it reduced the number of mentally ill offenders in jail).

<sup>58</sup> See *Report: Cost to Incarcerate Mentally Ill Prisoners 20 Times Greater Than Treatment*, TIMES RECORD (June 19, 2015), <http://www.swtimes.com/news/state-news/report-cost-incarcerate-mentally-ill-prisoners-20-times-greater-treatment> [<https://perma.cc/UNV3-FL4N>] (explaining that the cost for treating mentally ill offenders in jail is twenty times as high than if they were to be treated in the community). See also, e.g., *How Many Individuals with Serious Mental Illness Are in Jails and Prisons?*, TREATMENT ADVOC. CTR. (Nov. 2014), <http://www.treatmentadvocacycenter.org/storage/documents/backgrounders/how%20>

mentally ill inmates costs \$7.7 million in government money each year.<sup>59</sup> According to the behavioral health medical director at an Indiana hospital, “[m]edication for the mentally ill costs about \$800 to \$1,500 per dose per person . . . That means one mentally ill inmate can cost a jail up to \$3,000 a month in medication alone.”<sup>60</sup>

Mentally ill inmates are also more costly because they stay in jail longer.<sup>61</sup> Mentally ill inmates usually spend more time in prison because their conditions cause behavioral issues and an inability to understand the rules, resulting in rule violations.<sup>62</sup> Because each offender is entitled to his or her right to due process, the state also spends money during the judicial process each time a mentally ill offender is arrested or rearrested.<sup>63</sup> For

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many%20individuals%20with%20serious%20mental%20illness%20are%20in%20jails%20and%20prisons%20final.pdf [https://perma.cc/39S9-LJC9] [hereinafter *How Many Individuals*] (revealing that, in Texas, an inmate without mental illness costs approximately \$22,000 per year, whereas a mentally ill inmate can cost up to \$50,000 per year).

<sup>59</sup> See Guerra, *supra* note 7 (explaining that in Marion County, Indiana, mentally ill inmates consume approximately \$7.7 million of the sheriff’s budget each year). See also Ray, *supra* note 42 (demonstrating that mentally ill offenders are very costly to treat while they are incarcerated).

<sup>60</sup> See Guerra, *supra* note 59. See also Ade Ilesanmi, *The Costs of Correctional Mental Health*, INSIGHT BULL. (Jan. 28, 2015), <http://insightbulletin.com/the-costs-of-correctional-mental-health/> [https://perma.cc/RP4K-VWNN] (establishing that Ohio spent \$67 million on treatment for mentally ill inmates in 2005).

<sup>61</sup> See Cook, *supra* note 44, at 675 (noting that mentally ill offenders tend to serve longer prison sentences than those without a mental illness). See also Mahoney, *supra* note 30, at 336 (mentioning that mentally ill offenders stay in prison longer than the other inmates); Lori A. Marschke, *Proving Deliberate Indifference: Next to Impossible for Mentally Ill Inmates*, 39 VAL. U. L. REV. 487, 497 (2004) (highlighting that mentally ill offenders are confined a year longer than non-mentally ill offenders); McQuaid, *supra* note 29 (expressing the difficult time mentally ill offenders have following prison policies and procedures).

<sup>62</sup> See James & Glaze, *supra* note 5 (providing the prevalence of rule violations among mentally ill inmates). Fifty-eight percent of mentally ill offenders were charged with violating the facility rules, compared to forty-three percent without a mental illness. *Id.* See also Jamie Fellner, *A Corrections Quandary: Mental Illness and Prison Rules*, 41 HARV. C.R.-C.L. L. REV. 391, 396 (2006) (discussing that while mentally ill offenders account for 18.7 percent of the Washington state prison population, they also commit 41 percent of prison infractions); *U.S.: Mentally Ill*, *supra* note 22 (explaining that mentally ill inmates violate rules more than inmates without mental illness); Cook, *supra* note 44, at 675 (reiterating that one of the reasons mentally ill inmates cost more is because they often spend longer time in jail from violating jail rules); Fellner, *supra* note 62, at 295 (listing some mental health symptoms that lead to rule-breaking behavior as hallucinations, aggression, altered perception of reality, and memory problems).

<sup>63</sup> See *Overview of the Criminal Court Process*, IN.GOV (Sept. 27, 2016), <http://www.in.gov/judiciary/2725.htm> [https://perma.cc/E72W-KEAM] (explaining the steps in the judicial process for a charged and convicted offender in Indiana). There are many steps to the criminal justice system and each step has numerous subparts. *Id.* For example, the trial is one step but within the trial lies jury selection, opening statements, presentation of evidence, etc. *Id.* See also Cait Clarke & James Neuhard, “From Day One”: *Who’s in Control as Problem Solving and Client-Centered Sentencing Takes Center Stage?* 29 N.Y.U. REV. L. & SOC.

example, judges, prosecutors, and clerks must be paid for the work they do on each case.<sup>64</sup> Thus, in an attempt to keep down these ancillary costs, transition programs have been created to keep mentally ill offenders from returning to the criminal justice system.<sup>65</sup>

### C. Indiana Programs Aimed at Reducing Recidivism

Indiana has created statutes and programs to help mentally ill offenders transition back into society.<sup>66</sup> Part II.C.1 discusses the basic resources and assistance the Indiana Department of Corrections (IDOC) is required to provide a mentally ill offender upon release.<sup>67</sup> Next, Part II.C.2 examines Indiana's forensic diversion statutes.<sup>68</sup> Then, Part II.C.3 highlights the parts of the Recovery Works programs.<sup>69</sup> After, Part II.C.4

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CHANGE 11, 26 (2004) (indicating that the high number of criminal court cases overwhelm the court system); Allyson Blair, *Most Oahu Arrests Involve Those with Drug Addictions, Mental Illness*, HAW. NEWS NOW (Nov. 15, 2016), <http://www.hawaiinewsnow.com/story/33719849/majority-of-oahu-arrests-involve-those-with-mental-illness-drug-addiction> [<https://perma.cc/2EKD-WCBZ>] (establishing that sixty-one percent of the arrests in Oahu in 2015 had severe mental illness or a drug problem); Lisa S. Meyer, *Taking the "Complexity" Out of Complex Litigation: Preserving the Constitutional Right to a Civil Jury Trial*, 28 VAL. U. L. REV. 337, 340 (1993) (agreeing that the right to a fair trial is part of an offender's due process rights).

<sup>64</sup> See *Prosecutor Salary in Indianapolis Indiana*, SALARY GENIUS (Sept. 27, 2016), <http://salarygenius.com/in/indianapolis/salary/prosecutor-salary> [<https://perma.cc/XRE8-VMU2>] [hereinafter *Prosecutor Salary*] (providing the average salary of a prosecuting attorney in Indianapolis, Indiana). Indianapolis prosecutors make an average of \$71,422 per year. *Id.* See, e.g., *Survey of Judicial Salaries*, NAT'L CTR. FOR ST. CTS. (Sept. 28, 2016), <http://www.ncsc.org/FlashMicrosites/JudicialSalaryReview/2015/resources/CurrentJudicialSalaries.pdf> [<https://perma.cc/5XY8-FG6K>] (revealing that the average salary for a trial court judge in Indiana is approximately \$140,000).

<sup>65</sup> See *infra* Part II.C (describing the statutes and programs that Indiana uses to attempt to reduce the mentally ill inmate population). See also Elizabeth Depompei, *New Program in Indiana Aims to Get Criminal Offenders Treatment*, NEWS AND TRIB. (Nov. 16, 2015), [http://www.newsandtribune.com/news/new-program-in-indiana-aims-to-get-criminal-offenders-treatment/article\\_f3f09698-8be7-11e5-bdd6-1779f83b39d1.html](http://www.newsandtribune.com/news/new-program-in-indiana-aims-to-get-criminal-offenders-treatment/article_f3f09698-8be7-11e5-bdd6-1779f83b39d1.html) [<https://perma.cc/Z54Q-SGLA>] (reporting that Recovery Works is a new forensic diversion program that has been created from Indiana House Enrolled Act 1006); *Report: 17 States Reduce Recidivism, Save Billions By Reinvesting Wisely*, PRISON LEGAL NEWS (Aug. 23, 2016), <https://www.prisonallegalnews.org/news/2016/aug/23/report-17-states-reduce-recidivism-save-billions-reinvesting-wisely/> [<https://perma.cc/93Z2-7UMR>] [hereinafter *17 States Reduce Recidivism*] (revealing that Kentucky will likely save \$422 million by investing \$30 million in community-based treatment programs and other programs).

<sup>66</sup> See *infra* Part II.C.3-II.C.5 (describing the components of Indiana's general release statutes, forensic diversion statutes, a forensic diversion program, mental health alternative courts, and an assisted outpatient treatment program).

<sup>67</sup> See *infra* Part II.C.1 (laying of Indiana's general release statutes for the mentally ill).

<sup>68</sup> See *infra* Part II.C.2 (describing forensic diversion programs and Indiana's forensic diversion statutes).

<sup>69</sup> See *infra* Part II.C.3 (identifying a forensic diversion program in Indiana).

explains mental health courts generally and one specific to Indiana.<sup>70</sup> Finally, Part II.C.5 discusses Indiana's assisted outpatient treatment statutes.<sup>71</sup>

### 1. Indiana's General Release Statutes for the Mentally Ill

Indiana has minimal statutes in place dealing with mentally ill offenders' transition back into society.<sup>72</sup> One statute requires the IDOC to provide services to those labeled as committed offenders.<sup>73</sup> The IDOC must secure treatment through Medicaid when the individual is either released on parole, assigned to a community transition program, discharged from the department, or required to receive inpatient psychiatric services while incarcerated.<sup>74</sup> The IDOC must also begin the process of obtaining treatment for offenders within a sufficient amount of time so that mentally ill offenders can obtain their treatment as soon as they are released, discharged, or put in a community program.<sup>75</sup>

Additionally, the IDOC must provide the offenders with internet access and employment counseling at least ninety days prior to their release from prison.<sup>76</sup> The IDOC is also required to transport to the

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<sup>70</sup> See *infra* Part II.C.4 (overviewing mental health courts and one specific to Marion County, Indiana).

<sup>71</sup> See *infra* Part II.C.5 (explaining components of Indiana's assisted outpatient treatment statutes).

<sup>72</sup> See IND. CODE § 11-10-12-5.7 (2015) (discussing general release procedures for mentally ill offenders). See also *id.* § 11-12-3.7-4-12 (2015) (stating the Indiana's forensic diversion statutes).

<sup>73</sup> See IND. CODE § 11-10-12-5.7 (2015) (establishing basic procedures for committed offenders concerning their release from a correctional facility). See also *Your Rights as an Adult Receiving Treatment in a Mental Health Facility in Indiana*, IND. PROTECTION AND ADVOC. SERV. (Feb. 2013), [http://in.gov/idr/files/0482-1036\\_IPAS-RightsBooklet02-13LASER.pdf](http://in.gov/idr/files/0482-1036_IPAS-RightsBooklet02-13LASER.pdf) [<https://perma.cc/D7GN-74SJ>] (identifying the United States Code provisions that require certain conditions upon release for the mentally ill).

<sup>74</sup> See IND. CODE § 11-10-12-5.7(a) (2015) (stating the requirement for securing treatment for mentally ill offenders upon their release from prison). See also Brandon Smith, *Indiana Department of Correction Enrolls 12k Release Offenders In HIP 2.0, Medicaid*, WFYI (May 16, 2016), <http://www.wfyi.org/news/articles/indiana-department-of-correction-enrolls-12k-released-offenders-in-hip-20> [<https://perma.cc/Q2JZ-TRLU>] (reporting that the IDOC has been successful in registering released offenders with Medicaid).

<sup>75</sup> See IND. CODE § 11-10-12-5.7(a) (2015) (explaining that the Department of Corrections is responsible for ensuring that mentally ill offenders will be able to access the treatment that was obtained for them at the time that they are released from the IDOC). Cf. MINN. STAT. § 244.054 sub. 1 (2016) (providing that the Minnesota Department of Corrections must offer mentally ill offenders discharge plans that link them to community-based services).

<sup>76</sup> See IND. CODE § 11-10-12-6 (2015) (imposing a requirement on the IDOC to provide offenders anticipating release with internet access and employment counseling at least ninety days before they will be released). Cf. MINN. STAT. § 244.054 sub. 2 (4)-(5) (2016)



released offenders to either their designated place of residence, an Indiana city or town nearest their designated place of residence, or to a place chosen by the commissioner.<sup>77</sup> However, the statutes do not require the IDOC to find housing for mentally ill offenders upon their release.<sup>78</sup> Along with Indiana's general release statutes, Indiana has made other attempts at reducing recidivism, such as forensic diversion programs.<sup>79</sup>

## 2. Forensic Diversion Programs Generally and in Indiana

Forensic diversion programs have been implemented as another way of reducing recidivism.<sup>80</sup> Diversion programs purposefully steer mentally ill offenders from the criminal justice system to treatment within the community.<sup>81</sup> The goal of a diversion program is to reduce the time mentally ill offenders spend in prison or to keep them out altogether.<sup>82</sup>

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(giving mentally ill inmates the opportunity to receive employment counseling from the corrections department).

<sup>77</sup> See IND. CODE § 11-10-12-2 (2015) (requiring that the IDOC provide released offenders with transportation to where they will likely be residing post-release). See generally *id.* § 11-10-12-5.7 (identifying what the Department of Corrections is required to do when it releases a mentally ill offender from prison).

<sup>78</sup> See *id.* § 11-10-12-2 (illustrating that the IDOC is not required to take any further steps than securing treatment for mentally ill offenders upon their release back into society). See also Reed Karaim, *Housing First: A Special Report*, NPR (2002), <http://www.npr.org/news/specials/housingfirst/whoneeds/mentallyill.html> [<https://perma.cc/5G5R-AVX7>] (reiterating the need of housing for the successful integration of mentally ill offenders).

<sup>79</sup> See *infra* Part II.C.2 (discussing what a forensic diversion program is and the forensic diversion statutes that Indiana has codified).

<sup>80</sup> See IND. CODE § 11-12-3.7-4 (2015) (providing a definition for a forensic diversion program); *id.* § 11-12-3.7-6 (defining a violent offense under the forensic diversion statute); *id.* § 11-12-3.7-7 (listing what may be included in a forensic diversion plan); *id.* § 11-12-3.7-8 (explaining how an offender can enter a forensic diversion program); *id.* § 11-12-3.7-11 (stating the eligibility to participate in a pre-conviction forensic diversion program); *id.* § 11-12-3.7-12 (stating the eligibility to participate in a post-conviction forensic diversion). See also FLA. STAT. § 916.185 (2016) (creating a forensic hospital diversion program in the state of Florida). The Forensic Hospital Diversion Pilot Program was created because the legislature recognized the need for a program that prevented mentally ill inmates from returning to prison. *Id.* To participate in the program, an individual must be at least eighteen years old, be charged with a second or third degree felony, not have a significant history of violent criminal offenses, be considered incompetent to proceed to trial or not guilty by reason of insanity, meet public safety and treatment standards, and otherwise would be admitted to a state mental health institution. *Id.* This program and statute is also similar to Indiana's forensic diversion statutes because it does not require implementation of forensic diversion program. *Id.*

<sup>81</sup> See Mahoney, *supra* note 30, at 338 (2013) (providing an explanation for the basic function of a jail diversion program).

<sup>82</sup> See Mahoney, *supra* note 30, at 338 (stating the goal of jail diversion programs). See also *A National Survey of Criminal Justice Diversion Programs and Initiatives*, CTR. FOR HEALTH AND JUST. (Dec. 2013), <http://www2.centerforhealthandjustice.org/sites/www2.centerforhealthandjustice.org/files/publications/CHJ%20Diversion%20Report%20Appendices.pdf>

In 2015, the Indiana legislature passed a House Enrolled Act (HEA) that allocated more of the state budget to develop better programs for mentally ill offenders.<sup>83</sup> The Indiana Code defines a forensic diversion program as:

a program designed to provide an adult who has an intellectual disability, an autism spectrum disorder, a mental illness, an addictive disorder, or a combination of those conditions; and who has been charged with a crime that is not a violent offense; an opportunity to receive community treatment addressing mental health and addiction and other services instead of or in addition to incarceration.<sup>84</sup>

There are over twenty crimes that disqualify an offender from participating in a forensic diversion program, such as violent offenses.<sup>85</sup>

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[<https://perma.cc/2TUX-AC4F>] (aiming to reduce crowding in jail and court costs in Arizona).

<sup>83</sup> See IND. CODE § 11-12-2-1 (2015) (allocating \$11 million of the state corrections budget to establish and operate community corrections programs and court supervised recidivism reduction programs). See also Kwiatkowski & Guerra, *supra* note 7 (describing the settlement reached in the civil dispute between the IDOC and the Indiana ACLU); Odendahl, *supra* note 26 (explaining the complaint filed against the IDOC that led to improvements in the treatment of mentally ill in prison). In late 2008, the American Civil Liberties Union of Indiana and the Indiana Protection & Advocacy Services Commission filed a complaint against the IDOC for violating the Eighth Amendment. *Id.* The claims were brought as a result of mentally ill inmates being put in solitary confinement without treatment. *Id.* This often led to the exacerbation of their symptoms. *Id.* The case revealed that those in solitary confinement remained in their cells as long as twenty-two hours and forty-five minutes a day. *Id.* In 2011, U.S. District Court Judge Tanya Walton Pratt ruled that solitary confinement for the mentally ill was cruel and unusual punishment under the Eighth Amendment. *Id.* On January 27, 2016, the parties came to a settlement. *Id.* Some of the proposed changes include individualized treatment plans, ten hours of therapeutic programming per week, and that mentally ill prisoners cannot be placed in solitary confinement. *Id.* See also *Indiana Protection & Advocacy Services Announce Settlement With Department of Corrections: Agreement with DOC Marks Fundamental, Systemic Change in the Treatment of Seriously Mentally Ill Prisoners*, ACLU OF IND. (Jan. 27, 2016), <http://www.aclu-in.org/news/36-news-with-photos/387-aclu-of-indiana-indiana-protection-advocacy-services-announce-settlement-with-department-of-correction> [<https://perma.cc/4F2P-3XLM>] (announcing the settlement agreement between the IDOC and the ACLU of Indiana in a case regarding Eighth Amendment violations); Second Chance Act of 2007, Pub. L. No. 110-199, 122 Stat 657 (2008) (providing for federal funding via grants for reentry programs).

<sup>84</sup> IND. CODE § 11-12-3.7-4 (2015). See also *id.* § 11-12-3.7-6 (2015) (providing all crimes that qualify as a violent offense).

<sup>85</sup> See *id.* § 11-12-3.7-6 (2015) (providing all crimes that are classified as a violent offense and thus, disqualify a mentally ill offender from participating in a forensic diversion program). Some offenses that disqualify an offender from a forensic diversion program include: murder, attempted murder, voluntary manslaughter, involuntary manslaughter,

Not only does this violent-offense-convictions ban apply to the current offense, but it also applies to any convictions from the past ten years.<sup>86</sup> The disqualifications further limit offenders' ability to participate in a forensic diversion program by prohibiting all individuals with drug dealing offenses.<sup>87</sup>

A forensic diversion program under the statutes may be a pre-conviction or a post-conviction program.<sup>88</sup> Offenders may participate in a forensic diversion program either after a granted request by a court or after a court-ordered evaluation.<sup>89</sup> Though these statutes exist, they caution that the existence of these forensic diversion statutes do not require their implementation.<sup>90</sup> Although forensic diversion statutes do not require the implementation of a forensic diversion program, at least one program, Recovery Works, has been created from the statutes.<sup>91</sup>

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reckless homicide, aggravated battery, battery, kidnapping, rape, child molestation, child exploitation, possession of child pornography, vicarious sexual gratification, fondling in the presence of a minor, child solicitation, child seduction, sexual battery, sexual misconduct with a minor, incest, robbery, burglary, assisting a criminal escape, trafficking with an inmate, causing death when operating a vehicle, criminal confinement, arson, possession of a weapon of mass destruction, terroristic mischief, hijacking/disrupting an aircraft, domestic battery, and any other crimes evidencing a propensity or history of violence. *Id.*

<sup>86</sup> See *id.* § 11-12-3.7-11 (2015) (prohibiting offenders from participating in a pre-conviction diversion program if they have been convicted of any violent offenses in the previous ten years). See also *id.* § 11-12-3.7-12 (preventing an offender from participating in a post-conviction diversion program if he has been convicted of any violent offenses in the previous ten years).

<sup>87</sup> See IND. CODE § 11-12-3.7-11 (2015) (disqualifying drug offenders from the forensic diversion program); *id.* § 11-12-3.7-12 (2015) (forbidding those with drug charges to participate in a forensic diversion program). See also *Morales v. State*, 991 N.E.2d 619, 621 (Ind. Ct. App. 2013) (holding that the appellant's petition for judicial review was not proper because he never put in an application to the forensic diversion program so he was never formally rejected from the program). On February 15, 2012, Morales petitioned the trial court to be placed into the Vanderburgh County Forensic Diversion Program. *Id.* Morales has been convicted of three counts of sexual misconduct of a minor and was sentenced to eighteen years in prison. *Id.* His argument was that the Vanderburgh County Forensic Diversion Program exceeded its statutory authority by having more rigid acceptance standards than those laid out in Ind. Code § 11-12-3.7-12. *Id.*

<sup>88</sup> See *id.* § 11-12-3.7-7 (2015) (providing examples of the types of forensic diversion programs). A forensic diversion program in Indiana can consist of any combination of pre- or post-conviction diversion and adults with mental illness, addictive disorders, developmental disabilities, intellectual disabilities and an autism spectrum disorder. *Id.*

<sup>89</sup> See *id.* § 11-12-3.7-8 (2015) (describing the procedure by which a mentally ill offender can become part of a forensic diversion program).

<sup>90</sup> See IND. CODE § 11-12-3.7-7(d) (2015) (cautioning that the statutes that set the law for establishing a forensic diversion program do not require the implementation of such a program).

<sup>91</sup> See *infra* Part II.C.3 (discussing the components of Recovery Works, an Indiana forensic diversion program).

### 3. Recovery Works: An Indiana Forensic Diversion Program

Recovery Works, created November 1, 2015, is a program funded by the grants in HEA 1006.<sup>92</sup> The program consists of both pre- and post-incarceration services that serve not only mentally ill offenders, but also offenders with substance abuse problems.<sup>93</sup> Its goal is to link low-level offenders with community services rather than incarcerate them, and to create a twenty-five percent reduction in recidivism.<sup>94</sup>

Recovery Works functions on a voucher system.<sup>95</sup> The program forms relationships with certain service providers in the community from whom offenders can obtain services.<sup>96</sup> The offender presents their voucher at the time services are rendered.<sup>97</sup> Then, the community service provider turns the vouchers into the government and is reimbursed for the services

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<sup>92</sup> See *About Recovery Works*, IN.GOV (Sept. 27, 2016), <http://www.in.gov/fssa/dmha/2940.htm> [<https://perma.cc/9GPQ-Q3SK>] (communicating the purpose and goals of the Recovery Works Program). See also *Indiana Launches Voucher-Based Behavioral Health Program for Uninsured Offenders with Mental Illness or Addiction Disorder*, OPEN MINDS (Dec. 20, 2015), <https://www.openminds.com/market-intelligence/news/indiana-launches-voucher-based-behavioral-health-program-for-uninsured-offenders-with-mental-illness-or-addiction-disorder/> [<https://perma.cc/DZK4-KT7L>] (providing the date that the Recovery Works Program was launched in the state of Indiana).

<sup>93</sup> See *Recovery Works: Policies and Procedures Manual*, IN.GOV (Sept. 28, 2016), [http://www.in.gov/fssa/dmha/files/Recovery\\_Works\\_Policies\\_and\\_Procedures\\_Manual.pdf](http://www.in.gov/fssa/dmha/files/Recovery_Works_Policies_and_Procedures_Manual.pdf) [<https://perma.cc/Q423-YLEN>] (listing the services provided by the Recovery Works Program). Services include alcohol/other drug screening, case management, comprehensive mental health/substance abuse assessment, health care coordination, housing assistance, inpatient detoxification, intensive outpatient treatment, medication assisted treatment, medication for treatment of mental health, medication training/support, mental health counseling (individual, family, and group), peer recovery support, psychiatric evaluation, substance abuse disorder counseling (individual, family, and group), supported employment services, and transportation. *Id.*

<sup>94</sup> See *About Recovery Works*, *supra* note 92 (providing the mission and goals of the Recovery Works program to divert mentally ill offenders from the criminal justice system and to reduce recidivism). See also *Diversion Services*, OR. HEALTH AUTHORITY, <https://www.oregon.gov/oha/amh/Pages/ds.aspx?View=%7Bde094f89-dae5-4490-b1ae-299c8779a2bd%7D&SortField=Link&SortDir=Asc> [<https://perma.cc/D2BX-PLEN>] (stating that diversion programs in Oregon connect the offenders to services in the community).

<sup>95</sup> See *About Recovery Works*, *supra* note 92 (explaining how the Recovery Works program pays for the services provided to mentally ill offenders). See also *Recovery Works: Policies and Procedures Manual*, *supra* note 93 (indicating how the voucher system works).

<sup>96</sup> See *Recovery Works: Policies and Procedures Manual*, *supra* note 93 (indicating that a designated service provider for the Recovery Works program may include a licensed professional, a qualified behavioral health professional, or other behavioral health professional).

<sup>97</sup> See *id.* (explaining that Recovery Works is provided with vouchers to give the participants to redeem for services).

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provided to the offender.<sup>98</sup> Despite Recovery Works's efforts, many offenders are excluded and do not have services readily available to them.<sup>99</sup>

#### 4. Mental Health Alternative Courts in Indiana

States have also implemented mental health courts in an effort to reduce recidivism.<sup>100</sup> The first mental health court was established in the United States in the 1990s.<sup>101</sup> Mental health courts are considered problem-solving courts.<sup>102</sup> Problem-solving courts, also referred to as

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<sup>98</sup> See *id.* (explaining the process by which the government pays for the services that are provided to the mentally ill offenders). See also Rick Callahan, *Indiana Program to Get Offenders Treatment, Not Prison Cell*, WISH-TV (Nov. 8, 2015), <http://wishtv.com/2015/11/08/indiana-program-to-get-offenders-treatment-not-prison-cell/> [<https://perma.cc/3P89-W793>] (establishing that offenders will receive a maximum of \$2,500 in vouchers to use for mental health and addiction treatment and screenings, as well as for transportation).

<sup>99</sup> See *Recovery Works: Policies and Procedures Manual*, *supra* note 93 (showing that mentally ill offenders must travel to receive treatment).

<sup>100</sup> See Lauren Almquist & Elizabeth Dodd, *Mental Health Courts: A Guide to Research-Informed Policy and Practice*, COUNCIL OF ST. GOV'TS JUST. CTR. (2009), [https://www.bja.gov/Publications/CSG\\_MHC\\_Research.pdf](https://www.bja.gov/Publications/CSG_MHC_Research.pdf) [<https://perma.cc/9WEY-E9FY>] (stating the common goals of mental health courts). Common goals of mental health courts are as follows: "to improve public safety by reducing criminal recidivism; to improve the quality of life of people with mental illnesses and increase their participation in effective treatment; and to reduce court- and corrections-related costs through administrative efficiencies and often by providing an alternative to incarceration." *Id.* See also 6A ILL. PRAC., § 28:115 (providing definitions for different types of mental health courts, including pre-adjudicatory, post-adjudicatory, and combination mental health court programs).

<sup>101</sup> See *Long-Awaited Marion County Mental Health Court Up and Running*, WISHTV (Mar. 16, 2016), <http://wishtv.com/2016/03/16/long-awaited-marion-county-mental-health-court-up-and-running/> [<https://perma.cc/4TD3-LSEE>] [hereinafter *Long-Awaited*] (providing an example of a mental health court). See also Evan M. Lowder et al., *Recidivism Following Mental Health Court Exit: Between and Within-Group Comparisons* 40 L. & HUM. BEHAV. 118, 118 (2015) (establishing that mental health courts were developed in the mid-1990s because of the rise in mentally ill offenders).

<sup>102</sup> See Acquaviva, *supra* note 41, at 985 (discussing mental health courts). See also Kugler & Plotz, *supra* note 31, at 528 (explaining that the drug courts' inadequacies in helping those who also had mental illness led to the development of mental health courts); Georgia L. Sims, *The Criminalization of Mental Illness: How Theoretical Failures Create Real Problems in the Criminal Justice System*, 62 VAND. L. REV. 1053, 1077 (2009) (defining a mental health court). The following is a typical definition and explanation of mental health courts:

Mental health courts already are present in today's adult criminal justice system. These courts divert individuals with mental disorders away from the traditional criminal justice system and provide more rehabilitative services. A mental health court is an example of a "problem-solving court." Unlike traditional state courts, problem-solving courts "seek to broaden the focus of legal proceedings, from simply adjudicating past facts and legal issues to changing the future behavior of litigants and ensuring the well-being of communities." The focus on individuals and communities rather than crimes and legal

specialty courts, differ from traditional criminal courts because they focus on addressing the individual offender's needs, rather than punishing the offenders, and have a separate docket than a traditional criminal court.<sup>103</sup> Like forensic diversion programs, mental health courts divert mentally ill offenders from the criminal justice system, usually after pleading guilty to the charged crime.<sup>104</sup> Mental health courts use therapeutic jurisprudence.<sup>105</sup> "Therapeutic jurisprudence is an interdisciplinary legal approach emphasizing the creation of beneficial consequences via legal actors, rules, and procedures."<sup>106</sup> In mental health courts, offenders are connected with community resources to aid in reducing or eliminating the factors causing the criminal behavior.<sup>107</sup>

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issues is an embodiment of the rehabilitative principles most commonly found in the juvenile justice system.

*Id.* (internal citations omitted); *What are Drug Courts?: The Most Effective Justice Strategy Addressing the Drug-Addicted and Mentally Ill*, NAT'L ASS'N. OF DRUG CT. PROFESSIONALS, <http://www.nadcp.org/learn/what-are-drug-courts> (explaining how drug courts work). In drug courts, offenders are supervised closely. *Id.* They are to provide intensive treatment and services to help offenders get clean and sober. *Id.* The offenders are held accountable by the presiding judge to make sure they are fulfilling their obligation. *Id.* They are required to appear in court on a regular basis and get rewarded for doing well or punished for not doing well. *Id.*

<sup>103</sup> See *Problem-Solving Courts*, IRESEARCHNET, <http://criminal-justice.iresearchnet.com/system/problem-solving-courts/9/> [<https://perma.cc/R5NV-P7BB>] (providing the difference between problem-solving courts and traditional courts). Problem-solving courts also differ because the courts utilize social service to assist the offender and monitor the offenders' behavior to keep offenders accountable. *Id.* See also Acquaviva, *supra* note 41, at 971 (reporting the elements of mental health court).

<sup>104</sup> See Acquaviva, *supra* note 41, at 971 (describing the function of a mental health court). See also 6 *Mental Health Courts Pros and Cons*, VGA VIRGINIA (Dec. 27, 2015), <http://vgavirginia.org/6-mental-health-courts-pros-and-cons> [<https://perma.cc/U26A-CK6S>] (listing three cons of mental health courts as: (1) unavailability of mental health services; (2) longer than necessary mandated treatment; and (3) a requirement that the mentally ill offender must plead guilty to participate in the program).

<sup>105</sup> See Acquaviva, *supra* note 41, at 971 (stating the method used in mental health courts).

<sup>106</sup> *Id.* at 986–87. See also Brianna Chesser, *Therapeutic Jurisprudence*, OXFORD BIBLIOGRAPHIES (July 27, 2016), <http://www.oxfordbibliographies.com/view/document/obo-9780195396607/obo-9780195396607-0203.xml> [<https://perma.cc/W7A9-ATMU>] (providing a history of therapeutic jurisprudence). The term therapeutic jurisprudence was coined by two law professors, David Wexler and Bruce Winick, in 1990. *Id.*

<sup>107</sup> See Indiana Network, *Marion County Gets Approval for Mental Health Court*, IND. PUB. MEDIA (Mar. 16, 2016), <http://indianapublicmedia.org/news/marion-county-approval-mental-health-court-95495/> [<https://perma.cc/9V3S-PMEA>] (describing how the mental health court aids its participants). See also Lowder, *supra* note 101, at 118 (indicating that the goal of mental health courts is to link mentally ill offenders with treatment resources in the community); Ray, *supra* note 42 (overviewing the general steps of court proceedings). Individuals involved in this program include the "court judge, court coordinator, recovery coaches, probation officers/community corrections case managers, public defender, and prosecutor." *Id.*

In January 2015, Marion County, Indiana introduced a post-conviction mental health court.<sup>108</sup> However, the Marion County mental health court did not become a fully integrated part of the criminal justice system until March 2016.<sup>109</sup> The program is “designed, specifically to address the mental health needs of moderate to high risk individuals in the criminal justice system whom have been convicted of certain offenses and have a mental health illness.”<sup>110</sup> The Marion County Mental Health Alternative Court (MHAC) has a four-phase program.<sup>111</sup> Each phase of the program generally requires mentally ill offenders to be present for progress meetings, to comply with medication, to attend life-skills training, and to show that progress is being made.<sup>112</sup> From December 2014 to February 1, 2016, the Marion County MHAC has only admitted twenty-five offenders into the program.<sup>113</sup>

##### 5. Assisted Outpatient Treatment Statutes

Finally, Indiana utilizes assisted outpatient treatment programs to keep mentally ill offenders from re-entering the criminal justice system.<sup>114</sup>

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<sup>108</sup> See *Long-Awaited*, *supra* note 101 (reporting the commencement of the Marion County Mental Health Alternative Court in January 2015). See also *Indiana Network*, *supra* note 107 (indicating that the mental health court was created fourteen months before it became permanent).

<sup>109</sup> See *Long-awaited*, *supra* note 101 (declaring that the Marion County Mental Health Court became an official part of the criminal justice system). See also *Indiana Network*, *supra* note 107 (getting approval to become a permanent mental health court in Indiana).

<sup>110</sup> Ray, *supra* note 42.

<sup>111</sup> See Ray, *supra* note 42 (illustrating the four-phase structure of the Marion County Mental Health Alternative Court). The first phase of the program is geared towards getting the offenders acclimated with the program. *Id.* Participants must appear in court once a week, meet with probation officers regularly, and be drug tested. *Id.* The participants cannot get arrested again and must continue taking their medication. *Id.* The second phase is focused on keeping the offender compliant with their medication. *Id.* This phase usually lasts about three months. *Id.* The third phase requires court visits every three weeks, compliance with medication, life-skills training, and a showing of progress in areas such as employment. *Id.* Finally, the fourth phase of the program, which ends in a graduation if completed successfully, focuses on continuing to make progress and complying with medication, court appearances, pro-social activity, etc. *Id.* The court must see the participants making positive changes in their lives. *Id.* During the entire program, the participants are required to attend any of their scheduled appointments for treatment or appointments to visit the doctor. *Id.*

<sup>112</sup> See *id.* (giving a general overview of the requirements an offender must follow as part of the mental health court).

<sup>113</sup> See Ray, *supra* note 42 (comparing the number of referrals to the mental health court at sixty-five to the twenty-five participants that were admitted). The mental health alternative court does plan on opening up the program to more participants. *Id.* The goal is to admit at least fifty new participants per year in the future. *Id.*

<sup>114</sup> See generally IND. CODE §§ 12-26-14-1-10 (providing the statutory language of Indiana’s assisted outpatient treatment program). See also ARIZ. REV. STAT. §§ 36-533-36-544 (2016)

Along with Indiana, many other states have adopted some form of assisted outpatient treatment statutes.<sup>115</sup> Assisted outpatient treatment has been defined and described as “court-ordered treatment (including medication) for individuals who have a history of medication noncompliance, as a condition of remaining in the community.”<sup>116</sup> Some data evidence from states using assisted outpatient treatment programs suggests that the programs have been effective in reducing problems with the mentally ill population such as homelessness, arrests and incarcerations, and violent episodes.<sup>117</sup> Assisted outpatient treatment programs have also been shown to increase both long-term and short-term compliance with treatment while reducing caregiver stress.<sup>118</sup>

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(stating Arizona’s assistant outpatient treatment statute); Cook, *supra* note 44, at 684 (explaining Indiana’s assisted outpatient treatment program).

<sup>115</sup> See *Promoting Assisted Outpatient Treatment*, TREATMENT ADVOC. CTR. (2017), <http://www.treatmentadvocacycenter.org/fixing-the-system/promoting-assisted-outpatient-treatment> [https://perma.cc/3G4U-5DZB] (revealing that Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming, and the District of Columbia have laws implementing assisted outpatient treatment programs). See also McKinney’s Mental Hygiene Law § 9.60 (2015) (discussing the assisted outpatient treatment program in New York). Assisted outpatient treatment program is defined as “a system to arrange for and coordinate the provision of assisted outpatient treatment, to monitor treatment compliance by assisted outpatients, to evaluate the condition or needs of assisted outpatients, to take appropriate steps to address the needs of such individuals, and to ensure compliance with court orders.” *Id.* The criteria to participate the New York’s assisted outpatient treatment program include: being over the age of eighteen, having a mental illness, unlikely to function safely in the community without supervision, a history of not complying with treatment for their mental illness, being unlikely volunteer to participate in the program, needing of prevention from deterioration or relapse to serious harm, and being likely to benefit from the assisted outpatient treatment. *Id.*

<sup>116</sup> Cook, *supra* note 44, at 664 (internal citations omitted). See also *Guide to How Assisted Outpatient Treatment (AOT – Involuntary Commitment to Outpatient Treatment) Works*, MENTAL ILLNESS POL’Y, <http://mentallillnesspolicy.org/aot/assisted-outpatient-treatment-guide.html> [https://perma.cc/KTP2-2N62] (outlining the typical eligibility requirements for assisted outpatient treatment programs).

<sup>117</sup> See Cook, *supra* note 44, at 664 (revealing evidence that assisted outpatient treatment programs have been successful). See also Stephanie Mencimer, *There Are 10 Times More Mentally Ill People Behind Bars than in State Hospitals*, MOTHER JONES (Apr. 8, 2014), <http://www.motherjones.com/mojo/2014/04/record-numbers-mentally-ill-prisons-and-jails> [https://perma.cc/D95R-W6K5] (showing that a North Carolina assisted outpatient treatment program reduced arrests from forty-five to twelve percent).

<sup>118</sup> See Cook, *supra* note 44, at 664 (describing assisted outpatient treatment’s effect on medication compliance). See also Rosanna Esposito et al., *A Guide for Implementing Assisted Outpatient Treatment* (June 2012), <http://www.treatmentadvocacycenter.org/storage/documents/aot-implementation-guide.pdf> [https://perma.cc/X249-RSBR] (emphasizing



Under the Indiana assisted outpatient treatment statutes, an individual must have a mental illness and must be deemed dangerous or gravely disabled to participate in the program.<sup>119</sup> An individual must also be one who would likely benefit from the program, which is designed to decrease the dangerousness or disability of the individual.<sup>120</sup> The court must determine that the likeliness of the individual being dangerous or gravely disabled will substantially decrease with participation in the assisted outpatient program.<sup>121</sup> Last, the assisted outpatient treatment program must be recommended by the individual's examining physician for the individual to participate in the program.<sup>122</sup>

While Indiana has attempted to implement the aforementioned programs to reduce recidivism, none of the programs address every factor that leads to high recidivism rates in the mentally ill population.<sup>123</sup> Thus, Part III of this Note analyzes problems associated with high rates of mentally ill offenders and discusses mentally ill reentry statutes and

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that assisted outpatient treatment programs increase both short-term and long-term compliance in mentally ill individuals).

<sup>119</sup> See IND. CODE § 12-26-14-1(1) (2015) (providing the first qualification to participate in the assisted outpatient treatment program). See also Cook, *supra* note 44, at 684 (reiterating that a mentally ill individual must be dangerous or gravely disabled to participate in the program).

<sup>120</sup> See IND. CODE § 12-26-14-1(2) (2015) (stating the second qualification to participate in the assisted outpatient treatment program). See also Cook, *supra* note 44, at 684 (reinforcing that a mentally ill individual must be likely to benefit from the services provided in the program to participate in the program).

<sup>121</sup> See IND. CODE § 12-26-14-1(3) (2015) (establishing the third qualification to participate in the assisted outpatient treatment program). See also Cook, *supra* note 44, at 684 (repeating that a mentally ill individual must be likely to recover from the dangerous behavior or grave disability to be able become a participant in the assisted outpatient treatment program). *But see* N.Y. MENTAL HYGIENE LAW § 9.60 (McKinney 2016) (lacking a standard of dangerousness, and instead, imposing a standard of "unlikely to survive in the community without supervision").

<sup>122</sup> See IND. CODE § 12-26-14-1(4) (2015) (providing the fourth qualification to participate in the assisted outpatient treatment program). See also Cook, *supra* note 44, at 684 (reiterating that a mentally ill individual must be dangerous or gravely disabled to participate in the program). Indiana assisted outpatient treatment statutes are rarely used for any type of involuntary treatment. *Id.* See also DJ Jaffe, *Involuntary Treatment Saves Lives*, FORBES (Mar. 7, 2010), <https://www.forbes.com/2010/03/07/mental-illness-schizophrenia-laws-opinions-contributors-dj-jaffe.html> [<https://perma.cc/UM33-9USB>] (asserting that Washington state rarely takes advantage of its assisted outpatient treatment statutes). The critics have identified the following weaknesses in assisted outpatient treatment: using improper language, having no standard of proof, lacking any opportunity for a third party to petition for an individual to be placed in the program, lacking a mandated time for treatment, lacking definitions of statutory terms, and lacking guarantees of placement. *Id.* See also *infra* Part III.B.5 (discerning the problems with the Indiana assisted outpatient treatment statutes).

<sup>123</sup> See *infra* Part III (identifying the shortcomings of Indiana's programs and legislation attempting to reduce recidivism in mentally ill offenders).

programs.<sup>124</sup> An examination of the negative impact of high recidivism rates and the shortcomings of the current statutes and programs reveals the need for a codified comprehensive program that combats all factors that lead to high recidivism.<sup>125</sup>

### III. ANALYSIS

The high rates of mentally ill offenders in prison and the high recidivism rates in the mentally ill population suggest that mentally ill offenders are not functioning well in society and are not transitioning well back into society after incarceration.<sup>126</sup> While there are statutes and programs currently in place to help this problem, such statutes and programs do not completely solve the problem.<sup>127</sup> Therefore, a more comprehensive program must be codified to meet all the needs of mentally ill offenders such as housing, employment, transportation, and treatment needs.<sup>128</sup> Part III analyzes the negative impact of high recidivism rates among mentally ill individuals and the inadequacies of Indiana's reentry programs for mentally ill offenders.<sup>129</sup> First, Part III.A describes the increasing economic burden resulting from high rates of mentally ill offenders in prison and high recidivism rates in the mentally ill population.<sup>130</sup> Then, Part III.B discusses how the current statutes and programs in Indiana aimed at improving reentry for mentally ill offenders are inadequate in addressing all of the problems mentally ill offenders face upon reentry.<sup>131</sup>

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<sup>124</sup> See *infra* Part III (indicating the negative impact of high recidivism in mentally ill offenders and the downfalls in Indiana's efforts to solve the problem).

<sup>125</sup> See *infra* Part IV (proposing statutory language that establishes a comprehensive reentry plan). See also *infra* Part III (outlining the negative impact of the high recidivism rates for mentally ill offenders and Indiana's current programs that attempt to reduce recidivism in mentally ill offenders).

<sup>126</sup> See *supra* Part II.B (illustrating the high rates of mentally ill inmates and the high rates of recidivism in the mentally ill population).

<sup>127</sup> See *infra* Part III (criticizing the current programs and legislation in place for mentally ill reentry from prison in Indiana).

<sup>128</sup> See *infra* Part IV (discussing a proposal regarding a statute that can annihilate the criminogenic factors that cause high recidivism rates).

<sup>129</sup> See *infra* Part III (examining the need for a reform in reentry programs and services for the mentally ill prison population).

<sup>130</sup> See *infra* Part III.A (evaluating the high costs associated with treating mentally ill offenders and associated with high recidivism rates in the mentally ill population). See also Guerra, *supra* note 59 (addressing the high costs of treating the mentally ill while they are incarcerated).

<sup>131</sup> See 2015 Ind. Legis. Serv. P.L. 179-2015 (2015) (allocating a portion of the corrections budget to reentry and diversion programs for the mentally ill); IND. CODE § 11-12-3.7-4 (2015) (giving a definition for forensic diversion program); *id.* § 11-12-3.7-6 (defining a violent offense under the forensic diversion statute); *id.* § 11-12-3.7-7 (listing what may be included

A. *Negative Impact of Elevated Rates of Mentally Ill Inmates*

High numbers of mentally ill inmates in Indiana prisons are a direct result of inadequate legislation and are a burden on the state's economy because it is very expensive to house and treat the mentally ill population in prison.<sup>132</sup> Due to these inadequacies, treatment for mentally ill inmates consumes a significant amount of the budget for corrections each year.<sup>133</sup> However, treatment is not the only type of cost that the government must pay when a mentally ill offender is cycling in and out of prison.<sup>134</sup> The problem of high costs may be solved by better reentry programs.<sup>135</sup> Also, because mentally ill offenders are likely to remain incarcerated in a jail or prison longer than an offender without mental illness, they will have to be treated longer, which costs the IDOC more money.<sup>136</sup> Having a plan narrowly tailored to reduce recidivism can prevent the mentally ill from returning to prison, thus reducing the costs of treating mentally ill inmates.<sup>137</sup> Therefore, the less mentally ill offenders there are returning to

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in a forensic diversion plan); *id.* § 11-12-3.7-8 (explaining how an offender can enter into a forensic diversion program); *id.* § 11-12-3.7-11 (stating the eligibility to participate in a pre-conviction forensic diversion program); *id.* § 11-12-3.7-12 (giving the eligibility to participate in a post-conviction forensic diversion).

<sup>132</sup> See *supra* Part II.B (examining how the high costs of treatment for mentally ill offenders imposes a substantial burden on the state's economy). See Guerra, *supra* note 59 (discussing the cost of medication per month for each mentally ill inmate).

<sup>133</sup> See Guerra, *supra* note 59 (explaining that in Marion County, Indiana, mentally ill inmates consume approximately \$7.7 million of the sheriff's budget each year). See also Kwiatkowski & Guerra, *supra* note 7 (estimating that about 20.6 percent of the total Indiana prison population is represented by the mentally ill).

<sup>134</sup> See, e.g., *Survey of Judicial Salaries*, *supra* note 64 (revealing that the average salary for a trial court judge in Indiana is approximately \$140,000).

<sup>135</sup> See *infra* Part IV (proposing legislation establishing a comprehensive reentry program for mentally ill offenders). See also Beth A. Colgan, *Teaching a Prisoner to Fish: Getting Tough on Crime by Preparing Prisoners to Reenter Society*, 5 SEATTLE J. FOR SOC. JUST. 293, 298 (2006) (discussing the circumstances that contribute to a mentally ill offender's return to the criminal justice system).

<sup>136</sup> See *infra* Part II (describing the high cost of the mentally ill's presence in correctional facilities and in the court system). See also James & Glaze, *supra* note 5 (establishing that mentally ill offenders tend to serve longer prison sentences than those without mental illness because mentally ill offenders are more likely to violate the prison rules); Guerra, *supra* note 59 (discussing that the cost of medication per month for each mentally ill inmate can be as high as \$3,000).

<sup>137</sup> See Vitiello, *supra* note 3, at 62–63 (describing the "revolving door" effect on the mentally ill in prison). Many state-run mental hospitals have closed leading to an influx in the mentally ill in the criminal justice system. *Id.* After the hospitals' closings, many mentally ill were left homeless. *Id.* Police began arresting these individuals for petty crimes and drug use. *Id.* at 67. Upon release, mentally ill inmates cannot find housing and treatment, resulting in their return to prison. *Id.* See also *Best v. Bell*, No. 13 Civ. 0163, 2014 WL 1216773 (S.D.N.Y. Mar. 28, 2014) (recounting a mentally ill offender's cycle in and out of the criminal justice system due to the jail's refusal to give him medication and his lack of

prison, the lower the treatment costs will be. Unfortunately, the excess use of government money from high recidivism is not limited to inside the prison.<sup>138</sup>

Beyond the cost of treating and housing mentally ill inmates, there is also an economic impact in terms of court costs.<sup>139</sup> Each time mentally ill offenders are arrested, they are entitled to their due process rights and must go through the judicial system.<sup>140</sup> The excessive number of arrested mentally ill offenders is an inefficient use of judicial resources, especially if mentally ill offenders can be kept out of jail altogether with a comprehensive reentry program.<sup>141</sup> Since the current legislation is not adequately addressing the problems facing the mentally ill population upon release from a correctional facility, a comprehensive reentry plan that combats the housing, employment, and medication issues affecting mentally ill offenders upon release will reduce costs for the treatment in prison by reducing recidivism.<sup>142</sup>

#### *B. Inadequate Legislation and Programs in Indiana*

Indiana's current statutes and programs regarding release and reentry procedures for mentally ill offenders are inadequate because they do not properly address the factors that lead to high recidivism rates in the mentally ill population.<sup>143</sup> Although many of the programs do address some issues leading to recidivism, none of the programs or statutes are comprehensive.<sup>144</sup> Part III.B.1 criticizes Indiana's general release procedures that detail what the IDOC must provide mentally ill offenders upon their release back into society.<sup>145</sup> Part III.B.2 analyzes the forensic

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access to housing); *Higgins v. State*, 601 N.E.2d 342, 342 (Ind. 1992) (providing another account of a habitual offender with mental illness).

<sup>138</sup> See *infra* Part III.A (criticizing the economic impact of mentally ill offenders continually going through the court system).

<sup>139</sup> See, e.g., *Survey of Judicial Salaries*, *supra* note 64 (revealing the average salary for a trial court judge in Indiana).

<sup>140</sup> See *Prosecutor Salary*, *supra* note 64 (providing that, on average, a prosecuting attorney in Indianapolis, Indiana makes \$71,422 per year).

<sup>141</sup> See Blair, *supra* note 63 (giving evidence of how many mentally ill offenders overload the criminal justice system).

<sup>142</sup> See *supra* Part II.B (establishing that high rates of recidivism in mentally ill offenders is due to lack of access to housing, medication, and employment).

<sup>143</sup> See *infra* Part III.B (explaining the current deficiencies in Indiana statutes addressing the reentry of mentally ill offenders).

<sup>144</sup> See *infra* Part IV (describing a plan in comprehensive and the advantages associated with a comprehensive reentry plan for mentally ill offenders).

<sup>145</sup> See *About Recovery Works*, *supra* note 92 (explaining Indiana's current reentry program for addicts and the mentally ill); *Recovery Works: Policies and Procedures*, *supra* note 93 (explaining the policies and procedures of the Recovery Works program).

diversion statutes in place in Indiana.<sup>146</sup> Part III.B.3 shows that the current forensic diversion program, Recovery Works, in place in the state of Indiana is inadequate.<sup>147</sup> Part III.B.4 explains that Indiana's Mental Health Alternative Courts fall short when attempting to reduce recidivism.<sup>148</sup> Last, Part III.B.5 of this Note describes the inefficiencies of Indiana's assisted outpatient treatment program in addressing the high recidivism rates for mentally ill offenders.<sup>149</sup>

### 1. The Shortcomings of Indiana's General Release Statutes

Indiana's minimal statutes in place regarding any requirements for the IDOC when releasing committed offenders from prison is inadequate because it neglects factors that lead to high rates of recidivism in the mentally ill prison population.<sup>150</sup> Although the statutes establishing release procedures for offenders provide some assistance to the mentally ill upon their release from prison, such as employment counseling, the statute does not address other factors that contribute to the high recidivism rates of mentally ill offenders.<sup>151</sup> The Indiana release statutes do not address the issue of homelessness in the mentally ill population, which contributes to high recidivism. Failing to address housing issues for mentally ill offenders makes the job search pointless.<sup>152</sup> If the offender does not have a place to sleep or shower before an interview or beginning employment, then an offender will likely be unsuccessful in obtaining and maintaining employment.<sup>153</sup>

Further, by providing transportation to only the offenders' homes or the nearest city, the offender may not have transportation to get to and

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<sup>146</sup> See *infra* Part III.B.2 (demonstrating how the forensic diversion statutes in Indiana do not fully address the problem of high rates of mentally ill offenders).

<sup>147</sup> See *infra* Part III.B.3 (identifying the pitfalls of the Recovery Works program, which resulted from HEA 1006).

<sup>148</sup> See *infra* Part III.B.3 (analyzing the downfalls of mental health courts).

<sup>149</sup> See *infra* Part III.B.4 (addressing the many concerns associated with the Indiana assisted outpatient treatment program). See also *About Recovery Works*, *supra* note 92 (providing a general description of the goals and purpose of the Recovery Works program).

<sup>150</sup> See *infra* Part III.B.1 (noting the requirements imposed on the IDOC to handle the release of offenders from prison). See also IND. CODE § 11-10-12-5.7 (2015) (listing some requirements the IDOC must meet when releasing a mentally ill offender from prison).

<sup>151</sup> See *Criminal Justice, Homelessness & Health*, NAT'L HEALTH CARE FOR THE HOMELESS COUNCIL (Sept. 28, 2016), <http://www.nhchc.org/wp-content/uploads/2011/09/Criminal-Justice-2012.pdf> [<https://perma.cc/S76M-8CTQ>] (revealing the social and economic factors contributing to high recidivism rates in mentally ill offenders).

<sup>152</sup> See Christine Schanes, *Homelessness Myth #1: "Get a Job!"*, HUFFINGTON POST (Nov. 17, 2011), [http://www.huffingtonpost.com/christine-schanes/homelessness-myth-1-get-a\\_b\\_339500.html](http://www.huffingtonpost.com/christine-schanes/homelessness-myth-1-get-a_b_339500.html) [<https://perma.cc/VW2F-5PAJ>] (describing the difficulties the homeless population faces to be clean, one of the basic requirements of a job).

<sup>153</sup> See *id.* (reiterating that homeless people have difficulty finding employment).

from a job or job interview.<sup>154</sup> Transportation assistance is vital because individuals with mental illness face several barriers to transportation including affordability, accessibility, applicability, availability, and awareness.<sup>155</sup> Although access to the internet and employment counseling is available for at least ninety days prior to release, this internet access and counseling is not unlimited.<sup>156</sup> The statute also fails to identify a minimum number of hours that must be available to offenders for this purpose.<sup>157</sup> Given that it is recommended that an individual spend at least twenty-five hours a week on a job search and offenders get little time out of their cells, an inmate is likely not given much time to find a job.<sup>158</sup> A comprehensive reentry program that has employment resources readily available to offenders assists them in obtaining and maintaining employment, which will help become contributing members of society and decrease the likelihood they will return to prison.<sup>159</sup> Other Indiana programs specifically targeted at reducing recidivism of mentally ill offenders, such as forensic diversion statutes, are also inadequate because they are not comprehensive.<sup>160</sup>

## 2. Indiana's Forensic Diversion Statutes and Their Inadequacies

Indiana's forensic diversion statutes do not address all the reentry problems facing the mentally ill upon their release from prison.<sup>161</sup> The fact that the statutory language does not require the state to adopt or implement any forensic diversion program is a concern because it merely provides an opportunity to help but does not demand assistance for

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<sup>154</sup> See McLaren, *supra* note 53 (explaining the struggle of those with psychiatric disabilities regarding community integration because of limited access to transportation).

<sup>155</sup> See *Getting There*, *supra* note 54 (discussing the many barriers that mentally ill individuals face in gaining access to transportation).

<sup>156</sup> See, e.g., *The Development and Delivery of Education and Recreation Library Services*, IND. DEPT. OF CORR. (May 1, 2008), [https://www.in.gov/idoc/dys/files/01-01-102\\_5-01-08.pdf](https://www.in.gov/idoc/dys/files/01-01-102_5-01-08.pdf) [<https://perma.cc/Y923-Y6A9>] (stating that the library should be available to offenders on a daily basis and that these services must be divided among all offenders in a fair and equitable manner).

<sup>157</sup> See IND. CODE § 11-10-12-2-6 (showing that the statute imposing a minimum number of hours for job search or counseling).

<sup>158</sup> See, e.g., Alison Doyle, *How Much Time to Spend on a Job Search*, BALANCE (Aug. 6, 2016), <https://www.thebalance.com/how-much-time-to-spend-on-a-job-search-2062204> [<https://perma.cc/DA7A-KSYQ>] (recommending that an individual spend at least twenty-five hours per week searching for employment opportunities).

<sup>159</sup> See Sultan, *supra* note 45, at 364 (identifying the factors that lead to high recidivism rates).

<sup>160</sup> See *infra* Part III.C.2 (analyzing Indiana's forensic diversion statutes, which fail to explicitly state what services a forensic diversion program is required to provide).

<sup>161</sup> See Ind. H.B. 1006 (2014) (presenting a bill was enacted in response to a lawsuit filed against the IDOC by the American Civil Liberties Union of Indiana).

mentally ill offenders.<sup>162</sup> If there does not need to be a forensic diversion program in place then the government always has the option to not fund a diversion program, leaving mentally ill offenders without access to housing, treatment, or employment resources other than what is provided by general statutes concerning the release procedures and requirements.<sup>163</sup>

Also, forensic diversion statutes cause many mentally ill offenders to fall through the cracks by automatically excluding certain groups from the forensic diversion programs.<sup>164</sup> The statute specifically disqualifies any offender who has committed a violent crime, such as domestic battery, assisting in a crime, or murder.<sup>165</sup> Violent offenders should not be singled out based on the classification of their crime because their “violence” may have been the result of their mental illness.<sup>166</sup> The violent-offense limitation would automatically exclude Montgomery, who stabbed a man, but is desperately in need of assistance.<sup>167</sup> The statute creates a much too simplistic, binary approach—violent offender versus non-violent offender—for determining who is eligible to participate in a forensic diversion program.<sup>168</sup> Leaving violent offenders without an opportunity

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<sup>162</sup> See IND. CODE § 11-12-3-7-7(d) (2015) (failing to impose a requirement that the IDOC must implement a forensic diversion program).

<sup>163</sup> See *supra* Part II.C.2 (showing that the forensic diversion statutes in Indiana do not mandate the formation or implementation of forensic diversion programs).

<sup>164</sup> See *supra* Part II.C.2 (describing the limitations of eligibility for a forensic diversion program under Indiana statutory law).

<sup>165</sup> See *supra* Part II.C.2 (noting that only offenders who have not been convicted of a violent crime in the past ten years are eligible to participate in a forensic diversion program in Indiana).

<sup>166</sup> See *supra* Part II.C.2 (providing the eligibility requirements for a forensic diversion program that disqualify individuals for participation based on the fact that they have committed a violent crime). See also Harv. Med. Sch., *Mental Illness and Violence*, HARV. HEALTH PUBLICATIONS (Jan. 2011), [http://www.health.harvard.edu/newsletter\\_article/mental-illness-and-violence](http://www.health.harvard.edu/newsletter_article/mental-illness-and-violence) [https://perma.cc/8H7T-KHAY] (explaining the relationship between violent acts and mental disorders). Eighteen percent of people with psychiatric disorders commit at least one act of violence per year. *Id.* This statistic is increased to thirty-one percent when the mental disorder is paired with a substance abuse problem. *Id.* However, a new study suggests that violence in persons with mental disorders may be the result of other factors such as issues concerning their family, stress, and socioeconomic situation. *Id.*; see Cook, *supra* note 48, at 669 (establishing that there is a link between violence and severe mental illness). There are an estimated 1000 homicides per year that have been committed by a person with a severe mental illness. *Id.* at 669–70. One study revealed that about twenty-seven percent of individuals released from psychiatric hospitals reported that they had committed a violent act within an average of four months following their release from the facility. *Id.* at 670.

<sup>167</sup> See *supra* Part I (providing an original hypothetical about Montgomery, a man with severe mental illness who cycles in and out of the criminal justice system).

<sup>168</sup> See IND. CODE § 11-12-3-7-6 (2015) (establishing that an offender convicted of a violent crime in the past ten years is not eligible to participate in a forensic diversion program).

to be involved in a forensic diversion program that would keep them out of the criminal justice system and allow them to rehabilitate their lives creates the situation for this group to commit subsequent violent crimes.<sup>169</sup> Also, every offender with mental illness has his or her own individual needs.<sup>170</sup> The statutes do not consider the individual circumstances surrounding the mentally ill offender's criminal offense, including whether the individual's mental illness contributed to the crime.<sup>171</sup> After assessing each offender individually, the court may find that a particular offender with a violent offense is most in need of the services provided by a forensic diversion program.<sup>172</sup>

Also, for offenders to be eligible to participate in forensic diversion programs, offenders must either be court ordered to participate, or they must voluntarily apply and get court approval to participate in the program.<sup>173</sup> This requirement unnecessarily limits access to a forensic diversion program because it excludes anyone who is not court ordered and is unaware that the program may be an option for them.<sup>174</sup> In

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<sup>169</sup> See *id.* § 11-12-3.7-4 (2015) (restricting the state's forensic diversion programs to non-violent offenders). See also Colgan, *supra* note 135, at 295 (revealing that 67.5 percent of prisoners have been rearrested for new crimes after being released); Amanda Joy Peters & Indira Azizi Lex, *Improving Insanity Aftercare* 42 MITCHELL HAMLIN L. REV. 564, 564-65 (2016) (explaining an incident in which a man with a psychiatric disorder stabbed a man in a grocery store). In Texas, Martin Smith walked into a grocery store and, without speaking to or making eye contact with him, stabbed the man in front of him in the checkout line. *Id.* Smith was subsequently diagnosed with schizophrenia, bipolar disorder, and antisocial personality disorder. *Id.* He was found not guilty by reason of insanity, was put in a mental hospital, and was eventually put into outpatient treatment. *Id.* Smith committed another crime within four months of being in outpatient treatment. *Id.*

<sup>170</sup> See *Rehabilitation*, ENCYCL. OF CRIME AND JUS. (2012), <http://www.encyclopedia.com/medicine/divisions-diagnostics-and-procedures/medicine/rehabilitation> [<https://perma.cc/4TKJ-JZPA>] (indicating that people's individual differences can determine how they behave and whether they are likely to commit a crime).

<sup>171</sup> See IND. CODE § 11-12-3.7-11-12 (2015) (providing the eligibility requirements for a pre-conviction and post-conviction forensic diversion program).

<sup>172</sup> See, e.g., Nathan James, *Risk and Needs Assessment in the Criminal Justice System*, CONG. RES. SERV. (Oct. 13, 2015), <https://fas.org/sgp/crs/misc/R44087.pdf> [<https://perma.cc/Y4G6-ELL7>] (proposing that the government administer a risk-needs assessment to each offender to determine whether and in which rehabilitative program an offender should be placed).

<sup>173</sup> See IND. CODE § 11-12-3.7-8 (2015) (stating that a mentally ill offender can obtain treatment under the forensic diversion statute by either requesting it or the court ordering an evaluation of an individual).

<sup>174</sup> See Vitiello, *supra* note 3, at 71 (describing forensic diversions programs). Forensic diversion programs are designed to redirect offenders from prison to community-based treatment. *Id.*



addition, this requirement also excludes those offenders who are unaware that they have a mental illness and need treatment.<sup>175</sup>

The overarching inadequacy of a forensic diversion program is that the program merely diverts a select group of mentally ill offenders from the criminal justice system.<sup>176</sup> Mentally ill offenders will still be imprisoned if they do not qualify for the forensic diversion program and therefore, are still faced with the criminogenic factors that are working against them upon release from prison.<sup>177</sup> Indiana's forensic diversion statute does not specifically address problems with access to treatment, housing, and employment facing offenders who are not eligible for a program that diverts them from the criminal justice system upon reentry back into society.<sup>178</sup>

Housing, employment, education, and transportation are all resources that mentally ill offenders have a difficult time gaining access to, which play a large role in whether mentally ill offenders commit another crime.<sup>179</sup> Although more specific programs, like Recovery Works, have been created and implemented as a result of the forensic diversion statutes, they still do not properly solve the recidivism problems for the mentally ill prison population.<sup>180</sup>

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<sup>175</sup> See Cook, *supra* note 48, at 666–67 (indicating that many persons with psychotic disorders, such as schizophrenia and manic depressive disorder, lack the ability recognize that they have a mental illness and that they should seek treatment). See also *Assisted Outpatient Treatment—Frequently Asked Questions*, TREATMENT ADVOC. CTR. (2016), <http://www.treatmentadvocacycenter.org/component/content/article/1336> [<https://perma.cc/C3QM-LG89>] (reasoning that many individuals with mental illness go untreated because they reject or refuse treatments based on a condition called anosognosia).

<sup>176</sup> See *About Recovery Works*, *supra* note 92 (communicating the purpose and goals of the Recovery Works Program). Recovery Works was developed as a result of Indiana passing House Enrolled Act 1006. *Id.* This bill established a grant for forensic treatment services. *Id.* The grant supplied the program with \$10 million for the first year and \$20 million for the second year. *Id.*

<sup>177</sup> See Mahoney, *supra* note 30, at 337 (listing some of the criminogenic risk factors that can lead to recidivism).

<sup>178</sup> See Mahoney, *supra* note 30, at 337 (discussing some of the criminogenic factors that have been known to contribute to high rates of recidivism).

<sup>179</sup> See Skeem & Peterson, *Major Risk Factors for Recidivism Among Offenders with Mental Illness*, BERKELEY.EDU (last visited Dec. 13, 2016) [http://risk-resilience.berkeley.edu/sites/default/files/journal-articles/files/major\\_risk\\_factors\\_for\\_recidivism\\_among\\_offenders\\_with\\_mental\\_illness\\_2011.pdf](http://risk-resilience.berkeley.edu/sites/default/files/journal-articles/files/major_risk_factors_for_recidivism_among_offenders_with_mental_illness_2011.pdf) [<https://perma.cc/DW6M-LJHC>] (stating the eight main risk factors for mentally ill offenders include criminal history, antisocial personality, antisocial cognition, antisocial associates, substance abuse, employment instability, issues with family, and lack of engagement in prosocial activities).

<sup>180</sup> See *infra* Part III.C.3 (identifying the weakness of Indiana's Recovery Works program).

## 3. Recovery Works

A current forensic diversion program in place, Recovery Works, is also inadequate. Recovery Works is an Indiana program aimed at providing support services for the mentally disabled and addicts.<sup>181</sup> Despite seeming to address all of the problems associated with the reentry of mentally ill offenders, Recovery Works is not flawless.<sup>182</sup> Although this program targets both pre- and post-incarceration reentry services, it only targets low-level offenders.<sup>183</sup> Thus reiterating that forensic diversion programs, like this one, fail to reach all of those who need and may benefit from the program.<sup>184</sup> Instead, statutes should put as few limitations on participation in reentry programs as possible, so that more mentally ill offenders will be less likely to commit another crime and return to prison.<sup>185</sup>

Recovery Works also contracts out the services they provide to third-party mental health in the community.<sup>186</sup> Contracting out services is a negative aspect of the program because the mentally ill offenders in the program are required to travel to the location of the person or facility from whom they seek service, rather than have the services readily available to them.<sup>187</sup> Given the limited access to transportation in the mentally ill offender population, mentally ill offenders may not be able to attend their treatment appointments, thus defeating the rehabilitative purpose of a

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<sup>181</sup> See *About Recovery Works*, *supra* note 92 (describing that Recovery Works is focused on mental health treatment and recovery services to those who suffer from mental illness or addiction). See *Recovery Works: Policies and Procedures Manual*, *supra* note 93 (listing the categories in which Recovery Works provides assistance).

<sup>182</sup> See *supra* Part II (explaining Indiana's forensic diversion statutes and Recovery Works, an example of a forensic diversion program used in Indiana).

<sup>183</sup> See *About Recovery Works*, *supra* note 92 (communicating the purpose and goals of the Recovery Works Program). See also IND. CODE § 11-12-3.7-4 (explaining the ineligibility of violent crime offenders for a forensic diversion program).

<sup>184</sup> See Jennifer L. Skeem et al., *Correctional Policy for Offender with Mental Illness: Creating a New Paradigm for Recidivism Reduction*, 35 L. & HUM. BEHAV. 110, 110 (2011) (stating that the amount of mentally ill offenders is disproportionate to the rest of the prison population).

<sup>185</sup> See *id.* at 121 (showing that preventing the effects of criminogenic factors will likely reduce the mentally ill prison population).

<sup>186</sup> See *Recovery Works: Policies and Procedures Manual*, *supra* note 93 (providing the system by which the participants of the Recovery Works program get their treatment).

<sup>187</sup> See *Recovery Works: Policies and Procedures Manual*, *supra* note 93 (establishing how the participants receive their treatment). Recovery Works functions on a voucher system. *Id.* The vouchers are given to the participants and the participants then give the vouchers to the mental health provider as "payment." *Id.* The mental health providers then redeem those vouchers with the government and get paid for the services they provided to the participant. *Id.*

forensic diversion or reentry program.<sup>188</sup> Similar programs to forensic diversion programs fail for many of the same reasons.<sup>189</sup>

#### 4. Mental Health Alternative Courts

Some areas of Indiana have established mental health alternative courts.<sup>190</sup> Mental health courts' shortcomings are similar to those of forensic diversion programs.<sup>191</sup> Although mental health courts have allegedly had success, there are downsides.<sup>192</sup> Because mental health courts refer participants to services in the community, mentally ill offenders may have to wait for services in mental health clinics that are already overloaded.<sup>193</sup> The lack of mental health services available to mentally ill offenders defeats the purpose of the mental health alternative courts because it cannot address the mental health needs of the offenders like it promises to do.<sup>194</sup> A person with mental illness cannot be rehabilitated if they do not have access to the treatment or medication they

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<sup>188</sup> See *Getting There*, *supra* note 54 (revealing that persons with mental illness have issues obtaining transportation because of factors such as affordability, accessibility, applicability, availability, and awareness).

<sup>189</sup> See *infra* Part.III.B.3 (analyzing the Marion County Mental Health Alternative Court and mental health courts generally).

<sup>190</sup> See Ray, *supra* note 46 (demonstrating that a Mental Health Alternative Court has been implemented in Marion County, Indiana).

<sup>191</sup> See *supra* Part III.C.2 (indicating the pitfalls of Indiana's forensic diversion statutes in combating high recidivism rates in mentally ill offenders).

<sup>192</sup> See Kelly McAleer, *Mental Health Court: The Drawbacks*, PSYCH CENT. (Sept. 28, 2016), <http://blogs.psychcentral.com/forensic-focus/2010/04/mental-health-court-the-drawbacks/> [<https://perma.cc/7TWZ-4MWS>] (describing the criticisms of mental health alternative courts). See also 6 *Mental Health Courts Pros and Cons*, *supra* note 104 (including unavailability of mental health services, longer than necessary mandated treatment, and a required guilty plea to participate in the program as downsides to mental health courts).

<sup>193</sup> See McAleer, *supra* note 192 (explaining that many mental health clinics in the community already have long waiting lists that may not be able to accommodate referrals from mental health courts). See also Health News Florida Staff, *Mental-Health Crisis System Overloaded*, WUSF PUB. MEDIA (Mar. 11, 2013), <http://health.wusf.usf.edu/post/mental-health-crisis-system-overloaded#stream/0> [<https://perma.cc/AHN2-5GKN>] (noting that a crisis stabilization center is currently overcrowded); Cassandra Garcia & Kevin Johnson, *Las Vegas Mental Health Services Overloaded*, LAS VEGAS NOW (Dec. 17, 2012), <http://www.lasvegasnow.com/news/las-vegas-mental-health-services-overloaded> [<https://perma.cc/56C2-V36N>] (revealing that there is a waiting list of at least thirty days in a Las Vegas mental health facility).

<sup>194</sup> See Ray, *supra* note 46 (identifying the purpose of the design of the Marion County Mental Health Alternative Court). But see Matt Terzi, *Do We Want Prisons to Punish, Or to Rehabilitate?*, REVERB PRESS (Aug. 19, 2015), <http://reverbpress.com/justice/want-prisons-punish-rehabilitate/> [<https://perma.cc/BG4J-CMGV>] (reporting that the current trend in the prison system is to punish offenders for their criminal activity rather than rehabilitate them to be functioning members of society upon release).

need to become a functioning member of society.<sup>195</sup> Mentally ill offenders would benefit more from receiving treatment from mental health professionals that are solely dedicated to their mental well-being, rather than professionals incorporating the mentally ill offenders into their existing clientele.<sup>196</sup>

Additionally, mentally ill offenders are often required to plead guilty to a crime to participate in a rehabilitative program, further perpetuating the criminalization of the mentally ill rather than separating disordered behavior from criminal behavior.<sup>197</sup> Also, mentally ill offenders are often required to plead guilty to a crime that they would not necessarily be convicted of if they were to participate in a trial.<sup>198</sup> A criminal conviction is also a negative aspect because it can create barriers for access to housing or employment.<sup>199</sup> Because some employers will not hire individuals with criminal records, criminal convictions can prevent offenders from obtaining jobs, thus impeding them from being contributing members of society.<sup>200</sup>

Mental health alternative courts also exclude mentally ill offenders who, due to ineligibility, still serve a prison or jail sentence.<sup>201</sup> Mentally ill

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<sup>195</sup> See Shaili Jain, *Understanding Lack of Access to Mental Healthcare in the US: 3 Lessons from the Gus Deeds Story*, PLOS BLOGS (Feb. 14, 2014), <http://blogs.plos.org/mindthebrain/2014/02/06/understanding-lack-access-mental-healthcare-3-lessons-gus-deeds-story/> [<https://perma.cc/2DGD-W3UC>] (revealing the severe deficit of mental health services available in the United States).

<sup>196</sup> See *infra* Part IV.A (proposing a comprehensive release program for mentally ill offenders that includes an on-site team of mental health experts that are dedicated to the treatment and rehabilitation of the individuals participating in the program).

<sup>197</sup> See Mahoney, *supra* note 30, at 333 (defining criminalization of the mentally ill as “the idea that behaviors that were once managed by hospitalization came to have a criminal, as opposed to a psychiatric, explanation” that caused a rise in the mentally ill prison population).

<sup>198</sup> See McAleer, *supra* note 192 (stating that mentally ill offenders may not be given the most quality legal advice from their public defenders, resulting in a criminal conviction from entering a guilty plea necessary to participate in a mental health court program).

<sup>199</sup> See Kai Wright, *Boxed In: How a Criminal Record Keeps You Unemployed for Life*, THENATION.COM (Nov. 6, 2013), <https://www.thenation.com/article/boxed-how-criminal-record-keeps-you-unemployed-life/> [<https://perma.cc/W3UT-WRDU>] (indicating that persons with felony convictions are prohibited from working in over 800 occupations). See also *Second Chances: Seeking Fair Treatment for People with Criminal Records*, ACLU OF WASHINGTON ST., <https://aclu-wa.org/second-chances> [<https://perma.cc/5S7X-RXSH>] [hereinafter *Second Chances*] (confirming that persons with criminal records often get denied employment and housing because of their criminal records).

<sup>200</sup> See Wright, *supra* note 199 (disqualifying people with felony convictions from working certain jobs in the United States). See also *Second Chances*, *supra* note 199 (reiterating that a criminal record creates barriers to employment).

<sup>201</sup> See Ray, *supra* note 46 (diverting the mentally ill from incarceration and into alternative programs). The redirecting nature of the mental health alternative court results in lack of rehabilitation for mentally ill offenders that do end up in prison. *Id.*

offenders who are incarcerated and then released will have the burden of limited access to medication, housing, and employment.<sup>202</sup> Marion County automatically excludes 900 inmates suffering from mental illness that are currently in jail and did not have a chance to be admitted to the MHAC.<sup>203</sup> The Marion County MHAC also lacks a community housing aspect like the forensic diversion programs.<sup>204</sup> Because the MHAC excludes many mentally ill offenders and recidivism factors like housing, Indiana would benefit from a reentry program that addresses all recidivism factors.<sup>205</sup>

## 5. Assisted Outpatient Treatment

Assisted outpatient treatment, like the other Indiana programs, is inadequate in reducing recidivism.<sup>206</sup> First, funds are not large enough to add new treatment resources for the mentally ill, so the assisted outpatient treatment programs usually bog down the mental health services that are currently available.<sup>207</sup> The fact that offenders must demonstrate that they are dangerous or gravely disabled to participate in assisted outpatient treatment creates a high burden for offenders to meet, having to prove more than the fact that the offender has a mental illness.<sup>208</sup> The

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<sup>202</sup> See *The New Asylums: FAQs*, *supra* note 23 (indicating that lack of access to resources has led to high recidivism rates and high incarceration rates in the mentally ill population).

<sup>203</sup> See Ray, *supra* note 46 (providing the number of inmates in Marion County jails that are suffering from mental illness).

<sup>204</sup> See IND. CODE § 11-12-3.7-4 (explaining that an individual who has been charged with a violent crime is not eligible for a forensic diversion program). This does not only include the nature of the current offense but also disqualifies those who have been convicted in the last 10 years of a violent offense as defined by the statute. See *also id.* § 11-12-3.7-11 (listing the pre-conviction eligibility requirements for a forensic diversion program); *id.* § 11-12-3.7-12 (listing the post-conviction eligibility requirements for a forensic diversion program).

<sup>205</sup> See *infra* Part IV (proposing a comprehensive plan for dealing with mentally ill offenders).

<sup>206</sup> See *supra* Part III.C.1–III.C.3 (describing the downfalls of Indiana’s general release statutes, forensic diversion statutes, forensic diversion program, and mental health alternative court). See *also* Cook, *supra* note 48, at 684 (criticizing the assisted outpatient treatment programs and statutes in Indiana).

<sup>207</sup> See *On the Problem of Assisted Outpatient Treatment*, HOPEWORKSCOMMUNITY.WORDPRESS.COM (Dec. 6, 2009), <https://hopeworkscommunity.wordpress.com/2009/12/06/on-the-problem-of-assisted-outpatient-treatment/> [<https://perma.cc/K6B3-NHVG>] (praising Tennessee for not having assisted outpatient treatment programs because there is not enough funding and available services to provide adequate care to the mentally ill community).

<sup>208</sup> See IND. CODE § 12-26-14-1 (2015) (requiring that a person be dangerous or gravely disabled to be a participant in the assisted outpatient treatment program but failing to provide definition for the term “dangerous” or the term “gravely disabled”). See *also id.* § 12-7-2-96 (providing the definition for gravely disabled under Indiana’s civil commitment statute). Gravely disabled is defined as “a condition in which an individual, as a result of

consequence of having such high standards for commitment into assisted outpatient treatment is that it severely limits mentally ill offenders' access to the assisted outpatient program.<sup>209</sup> The idea should be to help mentally ill offenders, not disqualify them based on not meeting Indiana's current standard.<sup>210</sup>

In addition to a very high standard, the method for determining whether an offender is eligible for the program is unclear.<sup>211</sup> A standard of proof for dangerous or gravely disabled would provide consistency and clarity for evaluating an offender's eligibility for the program.<sup>212</sup> If all judges require that the offender shows that beyond a reasonable doubt the offender is dangerous or gravely disabled, then they would be applying the highest standard, creating lower chances that an offender will be allowed to participate in the assisted outpatient program.<sup>213</sup>

Similarly, the eligibility requirement that involves the likeliness to benefit from the treatment is a vague and arbitrary standard.<sup>214</sup> The statute does not include the criteria for someone to be likely to benefit from the treatment, making it easy for a judge to reject an offender for an outpatient assistance program.<sup>215</sup> The Indiana assisted outpatient treatment statute also requires that the offender have a recommendation from a physician.<sup>216</sup> This is also a tough standard for mentally ill offenders to meet due to the existing disadvantages they face in gaining access to

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mental illness, is in danger of coming to harm because the individual is unable to provide for that individual's food, clothing, shelter, or other essential human needs; or has a substantial impairment or an obvious deterioration of that individual's judgment, reasoning, or behavior that results in the individual's inability to function independently." *Id.*

<sup>209</sup> See Cook, *supra* note 48, at 685 (demonstrating that the standard set for being committed into an assisted outpatient treatment program is the same standard that is set for civil commitment).

<sup>210</sup> See *id.* (conveying the standard necessary for being committed into an assisted outpatient treatment program, which is the same standard that is needed for civil commitment).

<sup>211</sup> See IND. CODE § 12-26-14-1 (communicating the requirements an offender must meet to be ordered to participate in an assisted outpatient treatment program).

<sup>212</sup> See Cook, *supra* note 48, at 686 (criticizing the lack of a definition for dangerous or gravely disabled in the assisted outpatient treatment program).

<sup>213</sup> See *Evidentiary Standards and Burdens of Proof*, JUSTIA (2017), <https://www.justia.com/trials-litigation/evidentiary-standards-burdens-proof/> [<https://perma.cc/JTY6-MDR4>] (identifying the beyond a reasonable doubt standard as the highest standard of proof, mostly used in criminal proceedings).

<sup>214</sup> See IND. CODE § 12-26-14-1(2) (2015) (establishing the second requirement for eligibility for the assisted outpatient treatment program).

<sup>215</sup> See *id.* (demonstrating the lack of guidance in the assisted outpatient treatment program on how to determine if a person will likely benefit from the treatment).

<sup>216</sup> See *supra* Part II.C.5 (explaining the requirements of the assisted outpatient treatment).

mental health services.<sup>217</sup> Because high recidivism imposes an economic burden on the economy and Indiana's reentry statutes and programs do not encompass enough of the mentally ill population or fully address all of the issues facing mentally ill offenders upon release, Indiana would benefit from a more comprehensive reentry program that is codified into Indiana law.<sup>218</sup>

#### IV. CONTRIBUTION

Based on the inadequacies of the current legislation and programs concerning the reentry of mentally ill offenders, Indiana should enact a statute that requires the implementation of a comprehensive reentry program.<sup>219</sup> Indiana would benefit from the codification of this statute because it would reduce recidivism, assist mentally ill offenders in becoming functional members of society, and remove the financial burden caused by treating mentally ill offenders in prison.<sup>220</sup>

##### A. Proposed Legislation

The State should implement a statute to reduce recidivism in the mentally ill population. The statute should include a provision that extends treatment and assistance to offenders after they have been released from prison. The provision should include a requirement to provide assistance in medication, housing, and employment. The statute would appear as follows:

Purpose: The purpose of this statute is to codify a reentry program for mentally ill offenders that addresses all the needs of mentally ill offenders for successful integration back into society and reduces recidivism in mentally ill offenders.

##### (a) Definitions

(1) Mentally Ill. An individual is mentally ill if the individual has been diagnosed with a mental disorder by a licensed mental health professional.

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<sup>217</sup> See *supra* Part II.B (examining the factors that contribute to high rates of recidivism in mentally ill offenders, including limited access to mental health services).

<sup>218</sup> See *infra* Part IV (proposing a codified comprehensive reentry program for mentally ill offenders that combats all of the struggles facing the mentally ill upon release).

<sup>219</sup> See *supra* Part III.B (addressing the pitfalls of Indiana's legislations and programs targeting the reduction of recidivism in mentally ill offenders).

<sup>220</sup> See *supra* Part III.A (discussing the high costs associated with treating mentally ill offenders).

- (2) Mental health professional. A mental health professional is anyone who is properly licensed by the correct licensing board in the state of Indiana.
- (b) Eligibility. An individual is eligible for the reentry program if:
- (1) the individual is over the age of 18
  - (2) the individual is mentally ill
  - (3) the individual does not pose a health or safety risk to members or staff of the program
  - (4) must have served a sentence of any length
- (c) Intake. Each offender must participate in an intake assessment to determine the status of their mental health
- (d) Discharge Planning. The Department of Corrections is required to provide discharge planning for the offenders prior to release. The following are requirements of discharge planning.
- (1) the Department of Corrections must begin reentry planning at least 90 days prior to release from prison and completed at least 30 days prior to release
  - (2) the Department of Corrections must attempt to register every offender in Medicaid
  - (3) the Department of Corrections must determine in which community housing facility the offender will be placed, or whether the offender will live with family
  - (4) the Department of Corrections must determine the best course of treatment for the offender
- (e) Parts of the Program
- (1) Housing. The state shall provide community housing facilities for mentally ill offenders released from prison
    - (i) the facility must be equipped with the standard necessities for living
  - (2) Medication and Treatment. Within the housing facility there will be:
    - (i) access to medications necessary to treat the participants' disorders
    - (ii) counseling services as treatment for the participants
  - (3) Vocational training. The program shall provide vocational services to aid participants in finding and maintaining employment including:



- (i) access to computers
- (ii) training in gathering application materials
- (4) Transportation. The program must provide transportation to and from employment and employment opportunities.
- (f) Budget. A portion of the budget for the Department of Corrections will be dedicated to supporting this program.
- (g) Workers. All those who intend on providing treatment within the housing facility must be a mental health provider certified by the proper board within the state.<sup>221</sup>

B. Commentary

This program is designed to combat all of the factors working against mentally ill offenders when released from prison. Providing the offenders with an opportunity to gain independence and have some stability can

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<sup>221</sup> The proposed statute is the work of the author. The statute first requires a discharge plan for the mentally ill that will detail all of the resources that mentally ill offenders will have access to after their release and the best course of treatment recommended by a mental health provider. See IND. CODE § 11-10-12-5.7 (2015) (requiring that IDOC determine the best course of treatment). The discharge plan also requires the IDOC to provide access to medication, provide information about where they should obtain their medication once their supply runs out if the offender is not in the community housing, attempt to obtain Medicaid for the offender. *Id.* This is important because many offenders do not have sufficient funds to pay for their medication after release. See *id.* § 11-10-12-5.7(a) (requiring the IDOC to register the offender for Medicaid). The second part of the statute is a program that includes assistance in finding and obtaining employment, such as helping offenders write cover letters and resumes, teaching them interviewing skills, and teaching them how to efficiently and effectively search for employment. See Diehl, *supra* note 52 (showing mentally ill offender success with employment assistance). Another part of the program includes housing assistance. See Sultan, *supra* note 45 (providing factors leading to recidivism). Initially, the IDOC will be required to contact any family or close friends that the offender may live with upon release, and if the offender is unable to find residence with a family or friend, the offender will be admitted into the program's community housing. This community housing provides a safe and stable living environment for the offenders. The community housing unit must be staffed with licensed counselors and psychiatrists who will aid in the rehabilitation process for the offenders and treat the offenders. The community housing will also provide transportation to the offenders so they can get to and from their jobs. See *Getting There*, *supra* note 54 (explaining that mentally ill individuals have trouble using and accessing transportation). Depending on the distance, the transportation may include a bus operated by the housing unit or access to the public transportation system. The community housing is not designed to be a permanent living situations for these offenders. Ideally, the offenders would remain in the housing facility until they can support themselves and become full functioning members of society.

decrease the likelihood that they will return to the prison system.<sup>222</sup> By reducing recidivism in the mentally ill, there will be a reduction in the use of taxpayer money to provide long-term medical assistance for mentally ill offenders.<sup>223</sup>

The new process and program implemented by the proposed statute will also have a humanitarian effect. These individuals who are sick and cannot help that that they have these illnesses will no longer have to cycle in and out of the prison system. The mentally ill offenders will also no longer have to leave prison with nothing except the clothes on their backs.<sup>224</sup> The proposed statute provides an opportunity for mentally ill offenders to become functioning members of society.<sup>225</sup> Society also benefits from having less risk of crime that would otherwise be there due to an untreated and uncontrolled mental illness.<sup>226</sup>

Some may argue that a comprehensive reentry program for the mentally ill is going to cost the government more money rather than save the government money.<sup>227</sup> Although it is true that a comprehensive program will cost money, it will save money in the long run.<sup>228</sup> The hypothesis is that the program will reduce recidivism and the revolving-door effect for the mentally ill and therefore cut costs by not having to treat them in prison.<sup>229</sup> The proposed statute is designed to eliminate these

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<sup>222</sup> See, e.g., *High Costs of Cutting Mental Health*, NAT'L ALLIANCE ON MENTAL ILLNESS (2016) (indicating that mentally ill offenders have higher rates of recidivism without stable housing).

<sup>223</sup> See *17 States Reduce Recidivism*, *supra* note 65 (suggesting that states can reduce prisons costs by investing in reentry services).

<sup>224</sup> See *supra* Part IV.A (requiring Indiana to provide housing, transportation, treatment, and vocational training for mentally ill offenders upon release from prison).

<sup>225</sup> See *Brad H. v. City of N.Y.*, 712 N.Y.S.2d 336, 430 (N.Y. 2000) (commenting that mentally ill offenders need discharge planning to become healthy and thus, contributing members of society).

<sup>226</sup> See *Dangerous Minds: The Mental Illness of Infamous Criminals*, FORENSICS COLLEGES, <http://www.forensicscolleges.com/blog/resources/dangerous-minds-criminal-mental-illness> [<https://perma.cc/3X3W-RGX3>] (listing infamous criminals with mental health disorders, including Jeffery Dahmer, Ted Bundy, Charles Manson, and John Wayne Gacy).

<sup>227</sup> See *How Many Individuals*, *supra* note 58 (revealing the high costs associated with treating the mentally ill in prison).

<sup>228</sup> See *Reentry Programs*, DEPT. OF JUSTICE (Sept. 27, 2016), <https://www.justice.gov/usao-edva/reentry-program> [<https://perma.cc/9T4M-K4LM>] (establishing that reentry programs are specifically designed to save the government money).

<sup>229</sup> See generally *Reducing Recidivism: States Deliver Results*, THE COUNCIL OF ST. GOV'TS (Sept. 27, 2016), <https://csgjusticecenter.org/wp-content/uploads/2014/06/Reducing-Recidivism-StatesDeliverResults.pdf> [<https://perma.cc/4MNN-DKZ4>] (emphasizing the fact that both state and federal governments are focused on improving reentry programs to reduce recidivism).

individuals from the criminal justice system altogether.<sup>230</sup> As previously demonstrated in this Note, the mentally ill stay in prison longer and this will help cut down on those costs.<sup>231</sup> Others may wonder how the government will fund a program in the proposed statute. Ten million dollars has already been dedicated to the development of a forensic diversion program. Since the forensic diversion statutes are inadequate, Indiana can shift this money to fund the comprehensive reentry program under the proposed statute.<sup>232</sup>

Another concern others may have regarding the proposed statute is the lack of spaces available in the proposed program. Specifically, there could be a problem having openings in the housing units.<sup>233</sup> However, this is going to be a problem in any type of program created to help the mentally ill. There are always going to be limited resources, whether they are time, money, or workforce. Space constraints can always be combatted by a time limit on how long an offender can stay in the program and by reliable assessments to determine who would benefit most from the program.<sup>234</sup> This may be based on the severity of the mental illness or an assessment of the overall factors that contribute to recidivism.<sup>235</sup> Additionally, some participants in the program may stay with family and friends instead of in the community housing.<sup>236</sup> There is also a plan to have multiple housing facilities across the state so the program can accommodate a large number of participants. This is a positive factor

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<sup>230</sup> See *Keeping People Out of Prison: Transition Jobs as a Reentry Strategy*, THE HUFFINGTON POST (Sept. 27, 2016), [http://www.huffingtonpost.com/the-national-transitional-jobs-network/decreasing-recidivism\\_b\\_2600020.html](http://www.huffingtonpost.com/the-national-transitional-jobs-network/decreasing-recidivism_b_2600020.html) [https://perma.cc/NU89-3AB3] (reiterating that the purpose of reentry programs is to keep offenders from reentering the prison system).

<sup>231</sup> See *17 States Reduce Recidivism*, *supra* note 65 (determining that investing money into community treatment programs can save money in the long-run).

<sup>232</sup> See *supra* Part III.B.2 (describing the shortcomings of Indiana's forensic diversion statutes).

<sup>233</sup> See Michael J. McCarthy, *Give Ex-Cons and Prisons a Break*, NEWS REV. (Sept. 28, 2016), <https://www.newsreview.com/chico/give-ex-cons-prisons-a/content?oid=595072> [https://perma.cc/3LGB-3H84] (discussing how there are simply not enough beds in community corrections programs).

<sup>234</sup> See Emily B. Drake & Steven LaFrance, *Findings on Best Practices of Community Re-Entry Programs for Previously Incarcerated Persons*, LAFRANCE ASSOCS., LLC (Sept. 27, 2016), <http://www.eisenhowerfoundation.org/docs/Ex-Offender%20Best%20Practices.pdf> [https://perma.cc/9PFU-VK5H] (discussing the temporal restrictions on reentry programs). Many programs have a set completion timeline. *Id.*

<sup>235</sup> See *Ill-Equipped U.S. Prisons and Offenders with Mental Illness*, HUMAN RIGHTS WATCH (Sept. 27, 2016), <https://www.hrw.org/report/2003/10/21/ill-equipped/us-prisons-and-offenders-mental-illness> [https://perma.cc/G8G9-E27M] (explaining that there has been an increase in severity of mental illness in the prison population).

<sup>236</sup> See *supra* Part IV.A (requiring that mentally ill offenders be either placed with family or in the community housing).

because it is much different than the only twenty-five participants that the Marion County Mental Health Alternative Court held in its first full year up and running.

#### V. CONCLUSION

It is apparent that mental illness is pervasive in the criminal justice system. There are both high rates of mental illness in correctional facilities and high rates of recidivism among the mentally ill population. This shows that there is a problem and the mentally ill population does not have appropriate access to the resources they need to thrive in society. However, it is not their fault. Mentally ill inmates are denied access to shelter, employment, medication, and other essentials. These issues can have less of an impact on mentally ill offenders if the issues are addressed in a codified comprehensive reentry plan. A mandatory comprehensive reentry statute will combat and address all the obstacles concerning housing, employment, medication, and mental health treatments.

Had the proposed statute been in place, Montgomery would likely not have been in the position in which he found himself. He would have had a place to live, employment training, transportation, and medication to help him become a functioning member of society. He would have likely been rehabilitated instead of living in the alley. The garbage man's life would have been spared and Montgomery would not be in prison, depleting economic resources and drifting much further away from a normal life.

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