# Reforming Colorado Mental Health Law

[This is a preliminary draft of an Independence Institute issue paper, by Prof. Clayton Cramer.]

## Executive Summary


- About 10% of all murders and other violent felonies are perpetrated by persons suffering from severe mental illness.
- This rate has increased very significantly since the mass deinstitutionalizations of the 1960s and 1970s.
- One-third of the current state-to-state variation in murder rates can be explained by differences in the strictness of involuntary commitment laws, with easier commitment correlating with lower murder rates.
- Evidence indicates that James Holmes had disclosed to his psychiatrist his intention to murder people. However, because the threat was not "imminent" at the time of disclosure, nothing could be done under Colorado law.
- A 1999 civil commitment law adopted by Wisconsin expands the scope of lawful civil commitment, and includes mentally ill persons in long-term danger of further physical or mental deterioration. The law should be considered as a possible model for Colorado.
- The Wisconsin statute has been upheld against challenges under the U.S. and state constitutions.
- An involuntary commitment of three months or more has the legal effect of putting the person's name on the FBI's prohibited persons list, so that he cannot pass the National Instant Criminal Background Check System for gun purchasers.
- Further, the person's mere possession of a firearm or ammunition becomes a federal felony.
- Even without considering the Aurora crimes, there about a dozen murders in Colorado perpetrated each year by the severely mentally ill. Using earlier intervention to preventing just half of them would save Colorado every year about $106 million in new long term incarceration costs—or over a billion dollars a decade.
- Many tens of millions of dollars of additional criminal justice system savings would result from prevention of some of the rapes and felony assaults (about 10% of all such crimes) perpetrated by the severely mentally ill.
- The final edition of this Issue Paper will detail the necessary additional spending required for Colorado's mental health systems.

# I. The Problem

## A. Murder and Mental Illness

The recent tragedy in an Aurora movie theater riveted the nation's attention on Colorado. While more dramatic than many similar mass murders that have taken place in recent years, it was not fundamentally different. Untreated, severely mentally ill persons are disproportionately the offender not just in the spectacular mass murders, but about 10% of all murders, and a roughly similar number of other violent felonies.[1]

This is a modern development; studies in New York and Connecticut from the 1920s through the 1940s showed a much lower arrest rate for crimes allegedly committed by the mentally ill than the general population.[2] It is significant that Marietta and Rowe's detailed study of murder cases in Pennsylvania in the years 1682-1800 finds only five murderers out of 513 surviving accusations whose actions appeared to be driven by depression or delusions—or less than 1% of all murders. Nor were the courts of the period unaware or unprepared to consider insanity as a factor in murder. Pennsylvania's first verdict of not guilty by reason of insanity was in 1743.[3] Similarly, Sarah Frazier of Connecticut, who killed an Indian woman with an ax, was found not guilty by reason of "distraction" in 1724.[4] Also in Connecticut, one Roger Humphry, who "while a soldier in the army in the year 1757, become delirious and distracted and in his distraction killed his mother…." At trial in Hartford, he "was found not guilty altogether on the account of his distraction…."[5]

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[1] Arthur Zitrin, Anne S. Hardesty, Eugene I. Burdock & Ann K. Drossman, *Crime and Violence Among Mental Patients*, 133 AM. J. PSYCHIATRY 142-9 (1976); Larry Sosowsky, *Crime and Violence Among Mental Patients Reconsidered in View of the New Legal Relationship Between the State and the Mentally Ill*, 135 Am. J. PSYCHIATRY 33-42 (1978); Larry Sosowsky, *Explaining the Increased Arrest Rate Among Mental Patients: A Cautionary Note*, 137 Am. J. Psychiatry 1602-5 (1980); H. Richard Lamb & Linda E. Weinberger, *Persons with Severe Mental Illness in Jails and Prisons: A Review*, 49 PSYCHIATRIC SERVICES 483-92 (1998); Jeanne Y. Choe, Linda A. Teplin & Karen M. Abram, *Perpetration of Violence, Violent Victimization, and Severe Mental Illness: Balancing Public Health Concerns*, 59 PSYCHIATRIC SERVICES 153-164 (Feb. 2008); Eric B. Elbogen & Sally C. Johnson, *The Intricate Link Between Violence and Mental Disorder: Results From the National Epidemiologic Survey on Alcohol and Related Conditions*, 66 ARCHIVES OF GENERAL PSYCHIATRY 152-161 (2009).

[2] PHIL BROWN, THE TRANSFER OF CARE: PSYCHIATRIC DEINSTITUTIONALIZATION AND ITS AFTERMATH 133-7 (1985); Thomas M. Arvanites, *The Mental Health and Criminal Justice Systems: Complementary Forms of Coercive Control*, in SOCIAL THREAT AND SOCIAL CONTROL 138-41 (Allen A. Liska ed., 1992).

[3] JACK D. MARIETTA AND G.S. ROWE, TROUBLED EXPERIMENT: CRIME AND JUSTICE IN PENNSYLVANIA, 1682-1800 112-14, 35, 164 (2006).

[4] JOSHUA HEMPSTEAD, DIARY OF JOSHUA HEMPSTEAD OF NEW LONDON, CONNECTICUT 139, 141-2 (1901).

[5] PUBLIC RECORDS OF THE COLONY OF CONNECTICUT, 11:318.

## B. Involuntary Commitment

While there is reason to suspect that mental illness rates has dramatically risen since the Colonial period,[6] there is a simpler explanation for the relatively low rates of murder by mentally ill offenders back then, and as late as the 1940s: the looser standards for involuntary commitment (both short-term and long-term). Into the beginning of the nineteenth century, anyone could arrest the "furiously insane" and the sheriff would hold them until a court could make a decision.[7] Because of this, those who were obviously mentally ill stood a good chance of being diverted into the mental health system before they put themselves or others at risk. At least in part, this diversion was built not on prejudice against the mentally ill, but experience. As an example, the opening of state mental hospitals in Vermont in 1836 and New Hampshire in 1840 reduced family murder rates. Early commitment of those with serious mental illness problems prevented murders.[8]

Unsurprisingly, concerns (sometimes legitimate concerns) about abuse of power led to increasingly formalization of the commitment process, especially for long-term commitment. Ohio was one of the early such examples, in 1824.[9] By the latter half of the nineteenth century, while the exact mechanisms varied from state to state, the laws required something recognizably like due process. Some states required a jury trial, some relied on panels of experts ("commissions of lunacy"), but a person could not simply be locked up for more than a short time without some legal process that was supposed to protect the rights of a person believed to be mentally ill.[10]

On the eve of deinstitutionalization in the early 1970s, most states relied on emergency commitment procedures as a mechanism for hospitalizing

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[6] CLAYTON E. CRAMER MY BROTHER RON: A PERSONAL AND SOCIAL HISTORY OF THE DEINSTITUTIONALIZATION OF THE MENTALLY ILL 27-28 (2012) (summarizing evidence for and against rising schizophrenia rates).

[7] ALBERT DEUTSCH, THE MENTALLY ILL IN AMERICA: A HISTORY OF THEIR CARE AND TREATMENT FROM COLONIAL TIMES, 2nd ed. 419-20 (1949).

[8] Randolph A. Roth, *Spousal Murder in Northern New England, 1776-1865*, in OVER THE THRESHOLD: INTIMATE VIOLENCE IN EARLY AMERICA 72 (Christine Daniels & Michael V. Kennedy eds., 1999).

[9] 29 ACTS OF A GENERAL NATURE, ENACTED, REVISED AND ORDERED TO BE REPRINTED, AT THE FIRST SESSION OF THE TWENTY-NINTH GENERAL ASSEMBLY OF THE STATE OF OHIO 224 (1831) (1824 session law authorizing justices of the peace to accept applications by relatives or any overseer of the poor for commitment, with an inquest of seven jurors to return a verdict).

[10] HENRY F. BUSWELL, THE LAW OF INSANITY IN ITS APPLICATION TO THE CIVIL RIGHTS AND CAPACITIES AND CRIMINAL RESPONSIBILITY OF THE CITIZEN 25-36 (Boston: Little, Brown & Co., 1885). Spot checking of the stupefyingly complete collection of state laws in *George Leib Harrison, Legislation on Insanity: A Collection of All the Lunacy Laws of the States and Territories of the United States to the Year 1883, Inclusive…* (1884), confirms Buswell's claim. See also Isham G. Harris, *Commitment of the Insane, Past and Present, in the State of New York,* 7 NEW YORK STATE JOURNAL OF MEDICINE 12 [December, 1907] 487-91, for a detailed account of the increasing formalization of the commitment procedure in that state.

those believed to be either a danger to themselves or others, or in need of treatment before the situation became perhaps irretrievably bad. The justification for allowing hospitalization based only on a determination made by a doctor or police officer was that the risk of leaving such a person unrestrained exceeded the loss of the patient's liberty, especially because this emergency commitment was supposed to be short term. But some state laws provided for extensions without due process, and a few, such as Maine, had no time limit for such an emergency commitment.[11]

Some emergency commitment procedures were too easy back then. A variety of movements and concerns came together in the 1960s and 1970s to destroy the old way of caring for the mentally ill.[12] Today, however, the situation has gone too far the other way—and this is not simply arguing from one or two tragic examples, such as the Virginia Tech mass murder, or what happened in the theater at Aurora. Longitudinal studies at both national and state level demonstrate a statistically significant relationship between the total institutionalization rate (the rate of prisoners plus mental hospital inmates), and murder rates; as the TIR rises, murder rates fall.[13]

As states emptied out their mental hospitals, and made it increasingly difficult to commit those who were mentally in the 1970s, murder rates rose. (There were, of course, other factors in this.) Much of the reduction in murder rates in the 1990s was not just because states were giving longer sentences to criminals, but because many mentally ill offenders were now going to prison, instead of mental hospitals. Unfortunately, they were often going to prison *after* they had committed a violent felony against someone else. One-third of the current state-to-state variation in murder rates can be explained by differences in the strictness of involuntary commitment laws, with easier commitment correlating with lower murder rates. This state-to-state difference associated with strictness of commitment laws is more important that the availability of psychiatric in-patient beds and the quality of mental health care systems.[14]

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[11] ALEXANDER D. BROOKS, LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM 751-2 (1974).

[12] Generally, see chs. 7, 9, 13-15 of CRAMER, MY BROTHER RON, for a discussion of the various movements that came together, sometimes unwittingly.

[13] Bernard E. Harcourt, *From the Asylum to the Prison: Rethinking the Incarceration Revolution*, 84 TEX. L. REV. 1751, 1766-75 (2006); Bernard E. Harcourt, *From the Asylum to the Prison: Rethinking the Incarceration Revolution—Part II: State Level Analysis* (University of Chicago Law & Economics, Olin Working Paper No. 335, Public Law Working Paper No. 155, March 2007), available athttp://ssrn.com/abstract=970341.

[14] Steven P. Segal, *Civil Commitment Law, Mental Health Services, and US Homicide Rates,* SOCIAL PSYCHIATRY AND PSYCHIATRIC EPIDEMIOLOGY, Nov. 10, 2011, available http://kendras-law.org/national-studies/commitmenthomiciderates.pdf.

## II. Solutions for Colorado

Mass murders are very atypical crimes in America, and in Colorado. The vast majority of murders are "little" incidents, with one, sometimes two people dead. Unless they involve someone famous, they are seldom considered worthy of news coverage outside the community in which they take place. The tragedy in Aurora is a distinct outlier from the average murder in Colorado—but actions taken to deal with a tragedy like this carries over to the tens of murders and hundreds of other violent felonies committed each year in Colorado by mentally ill offenders. It is therefore worth considering what part of Colorado's mental health laws failed its citizens at that midnight showing.

First of all, as is typical with other mass murderers,[15] the killer had given clear signs of serious mental illness problems to acquaintances—serious enough for Mr. Holmes' psychiatrist at the medical school to alert police. While the details of exactly who said what to whom and when are likely to be locked up in understandable efforts to protect individuals and institutions from civil suits, what is clear is that Dr. Lynne Fenton's efforts would indicate that she perceived Holmes to be at least at level 4 of the Behavioral Evaluation and Threat Assessment (BETA) matrix: "High Risk."[16]

Because Dr. Fenton broke doctor/patient confidentiality, it is reasonable to assume that she did so under the only condition under which she legally could in Colorado: "required by law."[17] The almost inescapable inference is that Holmes had communicated to Dr. Fenton that he desired, intended, or planned to kill or injure others. Mandatory disclosure under such circumstances is known as "the Tarasoff rule."[18] Pursuant to the Tarasoff rule, psychiatrists and other mental health workers have a duty to warn threatened persons based on conversations with a patient.

In short, public safety takes precedence over doctor/patient confidentiality where there is "foreseeable danger." Subsequent decisions in other states have created something of a checkerboard of results, with some states requiring an "identifiable victim" before a therapist has a duty to warn.[19]

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[15] Laurie Goodstein and William Glaberson, *The Well-Marked Roads to Homicidal Rage*, NEW YORK TIMES, April 10, 2000.

[16] Arthur Kane, Tak Landrock, and John Ferrugia, *Did CU Officials Consider James Holmes 'High Risk' For Violence?*, CALL7, August 16, 2012, http://www.thedenverchannel.com/news/31363132/detail.html, last accessed August 19, 2012.

[17] C.R.S. § 12-43-218 (2010).

[18] The rule was announced in Tarasoff v. Regents of the University of California, 17 Cal.3d 425 (1976), and has been adopted almost everywhere in the U.S.

[19] John M. Greene, M.D., *Psychiatrist Duties: Tarasoff,* Stanford University Department of Psychiatry, http://www.stanford.edu/group/psylawseminar/Tarasoff.Greene.htm, last accessed August 19, 2012.

Nonetheless, Dr. Fenton's actions suggest that she recognized a *Tarasoff* duty to warn.

So why did Dr. Fenton's commendable concern not lead to any action? Here is where Colorado law appears to boxed itself in, and perhaps discouraged the police from taking action. Like many other states, Colorado law allows for an emergency commitment for a 72-hour observation period. As in many other states, a police officer or a variety of mental health professionals may cause police to take such a person into custody. However: the emergency commitment procedure only applies to persons who are "gravely disabled" or who present an "imminent danger to others or to himself or herself."[20]

Who is gravely disabled? Colorado law has two different definitions of "gravely disabled." One definition includes mentally ill persons at risk because they are unable or unwilling "to provide himself or herself with the essential human needs of food, clothing, shelter, and medical care" or "lacks judgment… to the extent that his or her health or safety is significantly endangered and lacks the capacity to understand that this is so."[21] This does not describe Holmes, whose actions in booby-trapping his apartment and planning the crime suggest a person of considerable intelligence and foresight.

The other definition of "gravely disabled" would fit *many* mentally ill persons, but not Holmes. It includes persons diagnosed with schizophrenia, but requires that such a person must have been hospitalized "at least twice during the last thirty-six months."[22] This means that a mentally ill person who has gone from well to severely mentally ill in a few months, as is alleged to be the case with Holmes, could not be considered gravely disabled until *at least* three years later.

In Colorado, a mentally ill person who is not "gravely disabled" can still be subject to emergency commitment if he is an "imminent danger" to self or others—but the evidence of how police responded to Dr. Fenton's inquiry suggests that Holmes was not yet "imminent." Perhaps "high threat" means that you are talking about mass murder; is "imminent threat" the situation where you are talking about mass murder, while loading magazines? The requirement for "imminent danger" excludes a mental patient who is making threats, but is not capable of immediately carrying that threat out—as appears to have been the case with not only the recent tragedy in Aurora, but many other incidents around the country.

Why does Colorado law have this requirement for "imminent danger" or "gravely disabled" before police or mental health professionals can use emergency commitment? To a large extent, this is an outgrowth of the due

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[20] C.R.S. § 27-65-105(a)(1) (2010).
[21] C.R.S. § 27-65-102(9)(a) (2010).
[22] C.R.S. § 27-65-102(9)(b) (2010).

process expansion in mental health law in the 1970s. It is significant that Colorado appears to have substantially revised its mental health commitment laws in the mid-1970s, vacating any commitment and incompetency decrees "entered by a court of this state prior to July 1, 1975."[23] The landmark decision in the Wisconsin case *Lessard v. Schmidt* struck down existing commitment laws on the grounds that the social stigma of having been released from a mental hospital was worse than being an ex-felon.[24] The same decision also claimed that mental hospitals caused insanity, not that people were committed to mental hospitals because of mental illness.[25]

Wisconsin was a national trend-setter. The *Lessard* decision not only forced Wisconsin to adopt a much stricter due process standard for commitment, but largely ended commitment unless the patient was an *imminent* danger to himself or others. The plaintiff in this case, Alberta Lessard, who had been running through her apartment complex "shouting that the communists were taking over the country that night" and other statements that were not even that rational.[26] She was probably not an *imminent* danger to herself or others, but it takes no great imagination to foresee serious public safety risks from someone suffering such delusions. The effect of the change was that large numbers of mentally ill people in Wisconsin "died with their rights on," as Darold Treffert, a psychiatrist with the Wisconsin Mental Health Institute described it. To conform to the *Lessard* decision, many other states followed Wisconsin's example.[27]

After considerable debate, Wisconsin in 1999 expanded its involuntary commitment law to include more than imminent danger; the new law includes long-term danger of further physical or mental deterioration. This statute has been upheld by the Wisconsin Supreme Court against both due process and equal protection challenges, under both the U.S. and Wisconsin state constitutions.[28] If Colorado adopted statutory language similar to Wisconsin's 1999 law for C.R.S. § 27-65-102(9), it seems that the revised statute would be reasonably safe from the dangers of the courts overturning it.

A review of Colorado case law on the subject suggests that there is nothing to fear from existing Colorado precedents. *P.F., Jr., v. Walsh* (Colo. 1982) held that different procedures and standards for involuntary commitment for minors vs. adults violated due process and equal protection

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[23] C.R.S. § 27-65-114 (2010).
[24] Lessard v. Schmidt, 349 F.Supp. 1078, 1089, 1090 (E.D.Wisc. 1972).
[25] Lessard v. Schmidt, 349 F.Supp. 1078, 1089, 1092 fn.18 (E.D.Wisc. 1972).
[26] E. FULLER TORREY, THE INSANITY OFFENSE: HOW AMERICA'S FAILURE TO TREAT THE SERIOUSLY MENTALLY ILL ENDANGERS ITS CITIZENS 76-78 (2008).
[27] RAEL JEAN ISAAC AND VIRGINIA C. ARMAT. MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL 127 (1990).
[28] State of Wisconsin v. Dennis H., 647 NW2d 851 (Wisc. 2002); Wis. Stat. § 51.20(1)(a)2.e. (1999-2000).

rights. It did not directly address the question of whether imminent danger was required.[29] *People v. Lane* (Colo. 1978) held that "clear and convincing evidence" is required to deprive a person of his liberty because of dangerousness, the standard endorsed the following year by the U.S. Supreme Court in *Addington v. Texas* (1979).[30] The *Lane* decision recognized that psychiatric opinion *alone* was insufficient to meet this standard; there must also be "'recent overt acts, attempts or threats' constituting dangerous behavior" (as there was in the *Lane* case).[31] Dr. Fenton, we may reasonably infer, did not contact the police solely because of her own opinion; rather, she was acting because of particular statements that Holmes had made. Under the Wisconsin model, whatever statements Holmes made to Dr. Fenton would be sufficient for emergency commitment; and Colorado case law suggests that the Wisconsin model would not violate the Colorado Constitution.

There is a separate problem with Colorado's current law which requires two hospitalizations in 36 months as part of the "gravely disabled" definition: it may increase the number of schizophrenics who do not recover. Some evidence suggests that early and consistent treatment of schizophrenia with antipsychotic medications improves recovery rates and reduces the severity of disability for those who do not recover.[32] Especially because paranoid schizophrenics are unlikely to accept voluntary hospitalization, making it difficult to hospitalize persons who are just suffering their first schizophrenic episode may condemn individuals to lifelong mental illness, and our society to lifelong costs.

Emergency commitment is not the only strategy by which a mentally ill person may be committed under Colorado law. Another statute does not require *imminent* danger for a judge to order an observational hold, but it does require efforts "to secure the cooperation of the respondent" before taking him into custody.[33] For a paranoid schizophrenic, a police request may provoke more paranoia. For a mentally ill person who has already began to see zombies and government conspiracies, such a request seems like an action that might provoke violence

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[29] P.F. Jr., v. Walsh, 648 P.2d 1067, 1071 (Colo. 1982) ("We do not believe that this comports with due process standards under U.S.Const.amend. XIV or Colo.Const. art. II, sec. 25. ").

[30] Addington v. Texas, 441 U.S. 418 (1979) ("clear, unequivocal and convincing evidence" required for a civil commitment).

[31] People v. Lane, 581 P.2d 719, 723 (1978) ("The specific question before the trial court, therefore, was whether there was "clear and convincing evidence" of dangerousness sufficient to justify continued confinement for a certain period for a limited purpose.").

[32] IRWIN G. SARASON & BARBARA R. SARASON, ABNORMAL PSYCHOLOGY: THE PROBLEM OF MALADAPTIVE BEHAVIOR. 10th ed. 378 (2002); A. G. Jolley, S. R. Hirsch, E. Morrison, A. McRink, & L. Wilson, *Trial of brief intermittent neuroleptic prophylaxis for selected schizophrenic outpatients: clinical and social outcome at two years,* 837 BRITISH MEDICAL JOURNAL 1136 [October 13, 1990], http://www.bmj.com/content/301/6756/837.abstract.

[33] C.R.S. § 27-65-106 (2010).

### C. Does Commitment Accomplish Anything?

One question that might be asked is whether it accomplishes anything to hospitalize persons who are psychotic. It is true that many will leave a hospital within a few months, better, but not well. Even so, there are benefits.

In Colorado and in many other states, when person has been held for observational hold or short-term treatment (up to three months),[34] the person's name to sent to the FBI's National Instant Criminal Background Check System as having been committed against his will. As a result, the persons is prevented from buying a gun. If the person obtains a gun anyway, the person's mere possession of the gun is a felony, for which he can be prosecuted and imprisoned.

After three years, Colorado removes that person from the prohibited persons list if he has not been subject to additional commitment orders or other provisions for those for whom "further treatment will not be likely to bring about significant improvement in the person's condition."[35]

Had Mr. Holmes been hospitalized under emergency commitment, he would have not had access to firearms, ammunition, or explosives while hospitalized. Even if he was later released, because of his commitment, he would have been unable to legally purchase a firearm or ammunition until at least three years had elapsed since his last commitment order. Would this have made it absolutely impossible for him to buy a gun? No. But it would have certainly made it more difficult. A law does not have to work 100% of the time to still be helpful.

## III. The Costs

Mental hospitals cost money. So do trials of mentally ill offenders. Determining the costs of murder trials is surprisingly difficult, because so much of the published research is driven by attempts to prove that capital murder trials cost more than non-capital murder trials. Trying to just find raw data without the ideological motivations is hard.

An estimate of costs in murder cases in Clark County, Nevada for the years 2009-2011 determined that public defender costs *alone* for capital murder trials averaged $229,800; for non-capital murder trials, $60,100.[36] It seems quite believable that including prosecution costs, time spent operating

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[34] C.R.S. § 27-65-107 (2010).
[35] C.R.S. § 13-9-123 (2010).
[36] Terance D. Miethe, University of Nevada, Las Vegas, *Estimates of Time Spent in Capital and Non-Capital Murder Cases: A Statistical Analysis of Survey Data from Clark County Defense Attorneys*, Feb. 21, 2012, http://www.deathpenaltyinfo.org/documents/ClarkNVCostReport.pdf.

the courts, investigating the crime, as well as the inevitable appeals, that a non-capital murder trial can easily cost the government $500,000, especially because mentally ill defendants are almost always indigent, and thus receive public defenders. A capital murder case, of course, will be substantially more expensive because ardent opponents of the death penalty litigate every point, valid or not, for decades on end.

Colorado had 120 murders in 2010.[37] If 10% of those murders were by severely mentally offenders (a reasonable guess based on the Indiana data discussed above)[38], that is $6 million spent on trials that will often be preventable.

The costs of incarceration after conviction are substantial. Colorado currently spends $32,335 per year per inmate. A mentally sane murderer who spends thirty years in prison will cost $970,060 (in 2011 dollars).[39]

However, states are required to provide mental health services for prisoners. Mentally ill inmates are more expensive for states to care for than sane inmates. Pennsylvania several years ago found that mentally ill prisoners cost $51,100/year; sane prisoners, $28,000/year.[40] If a similar cost differential applies in Colorado, a mentally ill prisoner will cost about $1.77 million over a thirty-year term of imprisonment. If just six separate Colorado homicides were prevented each year by earlier treatment, this would save Colorado from adding $106 million worth of long-term financial obligations *each year*.

Murder is not the only crime involving mentally ill offenders. Previous studies suggest that the severely mentally ill commit more than 10% of rapes and felonious assaults. For 2010, this would be more than 1,300 crimes, most of which will result in a trial and a prison term. Even at an average cost of $25,000 (an estimate pulled out of the air, because no one seems particularly interested in calculating those actual costs), this would be more than $32 million in preventable costs, plus the long-term obligations of imprisonment. Money spent trying and imprisoning mentally ill offenders could be spent on preventative mental health care.

Victim costs are not included; it seems likely that anyone in the theater in Aurora would have gladly paid more taxes to hospitalize mentally ill persons before they opened fire.

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[37] FBI, *Crime in the United States 2010*, Table 5.

[38] Jason C. Matejkowski, Sara W. Cullen, & Phyllis L. Solomon, *Characteristics of Persons With Severe Mental Illness Who Have Been Incarcerated for Murder*, JOURNAL OF THE AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW 36:1[2008]74-86, http://www.jaapl.org/cgi/reprint/36/1/74.

[39] Tom Clements, Colorado Department of Corrections, Budget Hearings, January 5, 2012, 2, http://www.state.co.us/gov_dir/leg_dir/jbc/2011-12/corhrg.pdf.

[40] Lynne Lamberg, "Efforts Grow to Keep Mentally Ill Out of Jails," *Journal of the AMA* 292:5 [August 4, 2004] 555-6.

## IV. Conclusion

The costs of waiting until a person who is severely mentally ill goes on a rampage are very high, not just in lives, but in dollars as well, and, perhaps, for those mentally ill people who might, by receiving earlier and more consistent treatment, be helped on the road to recovery. Minor corrections to Colorado's mental health law, coupled with spending money on prevention, rather than on punishment, might well turn out to be cost-neutral, or better.

The Independence Institute's *Citizens Budget* has identified a billion dollars in potential savings in the state budget. Some of these savings could be used to provide full funding for all the additional beds and treatments that are needed. The final, published version of this Issue Paper will provide a detailed analysis of the additional resources that would be required.