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THE CRIMINAL JUSTICE SYSTEM AND MENTALLY ILL OFFENDERS

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BEFORE THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

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THE CRIMINAL JUSTICE SYSTEM AND MENTALLY ILL OFFENDERS

TUESDAY, JUNE 11, 2002

UNITED STATES SENATE,
COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The committee met, pursuant to notice, at 10:05 a.m., in Room SD–226, Dirksen Senate Office Building, Hon. Patrick J. Leahy, Chairman of the Committee, presiding.

Present: Senator Leahy.

OPENING STATEMENT OF HON. PATRICK J. LEAHY, A U.S. SENATOR FROM THE STATE OF VERMONT

Chairman LEAHY. Good morning. Today, this committee is going to consider an important but, I am afraid, often overlooked criminal justice issue—the impact of mentally ill offenders on our justice system. The consideration of the committee will be aided by the release of a comprehensive report on that topic by the Council of State Governments. We are also going to hear from a number of criminal justice and mental health experts, who will explain why the issue of mentally ill offenders has presented such problems for State and local governments. I hope this hearing will raise awareness of the role of mental illness in causing crime and help Congress valuate what role the Federal Government can play in helping State and local governments address this issue.

Now, we are all too familiar with the role that drug abuse plays in promoting crime—from drug trafficking itself, to property crimes committed by addicts or those seeking money to buy drugs, even to the tragedy of murders committed by dealers seeking to gain or maintain control over what have become lucrative drug markets. We are also well acquainted with the occasional notorious crime committed by mentally ill individuals—the assassination attempt, for example, against President Reagan. But today we will focus on the persistent problem of people with mental illness who repeatedly rotate between the criminal justice system and the outside world, committing a series of minor offenses that occupy the time of law enforcement officers and actually divert them from their more urgent responsibilities. Now, some mentally ill offenders also abuse drugs and/or alcohol, and that further complicates matters.

We will hear today from witnesses who have expertise in this area from varying perspectives, including law enforcement, corrections, State mental health systems, and local government.

I must admit—and I hope people won't believe I am being parochial, but I want to give a particular welcome to Gary Margolis,

who is the Chief of Police Services at the University of Vermont. I worked with Chief Margolis on a whole number of issues over the years, and not only have I but my staff has relied on his very good judgment. And I appreciate Representative Ted Strickland coming over from the other side of the Hill. He has personal experiences with mentally ill offenders. He served as—and tell me, Congressman, if I am right on this—a consulting psychologist at the Southern Ohio Correctional Facility before coming to Congress. I mention that because of how fortunate we are when people who have all these different backgrounds come into Congress, and both the House and the Senate have benefited from Congressman Strickland's expertise.

The Council of State Governments' report was developed by nearly 100 criminal justice and mental health policymakers—Republicans and Democrats—who wanted a non-partisan report on how to improve the criminal justice system and how it handles people with mental illness. They had sheriffs, chiefs of police, prosecutors, judges, corrections directors, parole board chairmen, mental health professionals. That is pretty extensive. The Police Executive Research Forum and the Association of State Correctional Administrators worked with the Council of State Governments and the Bazelon Center for Mental Health Law.

The evidence shows the severity of the problem. It found that more than 16 percent of those incarcerated in jails and prisons have a mental illness. The Office of Juvenile Justice and Delinquency Prevention reports that more than 20 percent of the youth in the juvenile justice system have serious mental health problems. The Los Angeles County jail often holds more people with mental illness—the Los Angeles County jail—than any State hospital or mental health institution in the United States. Every State witnesses examples of this.

Last December, Robert Woodward, a mentally ill man, interrupted services at All Souls Church in West Brattleboro, threatened first to kill himself, then armed with a knife, charged three officers who had responded to the scene. They fired back in defense. Mr. Woodward died later that day. This is tragic all the way, the tragedy of the effect on the officers, the effect on Mr. Woodward, and those who were in the church. And so we have to look at these things.

We should all agree that it makes sense to help State and local governments improve the availability of mental health services, to train their law enforcement personnel to recognize the signs of mental illness, but then to give prosecutors more tools in dealing with them.

Helping people with mental illness is the right thing to do. It would improve the safety of all Americans, but we also have to give the tools to those we ask to protect all Americans. I have worked with Senator Hatch and others to increase funding for drug treatment. We want to reduce crime, but we should also be interested in this issue. I have proposed including a study on the ability of mentally ill offenders to reintegrate into society after their release.

[The prepared statement of Senator Leahy appears as a submission for the record.]

Chairman LEAHY. If I might, I would call on Congressman Strickland to come forward.

To give you an idea, as I said, about the background of people who come here and absolutely improve the Congress with their background, Congressman Strickland represents the 6th District of Ohio. He has a master's of divinity degree from Asbury Theological Seminary, a doctorate in counseling psychology for the University of Kentucky. He served as a minister, college professor, and a psychologist. Actually, all three are probably necessary just to serve with the rest of us up here.

[Laughter.]

Chairman LEAHY. At least speaking for myself. So, Congressman, I am delighted to have you here. Please go ahead, sir.

STATEMENT OF HON. TED STRICKLAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Representative STRICKLAND. Thank you, Mr. Chairman, for your graciousness in having me here and giving me the opportunity to testify today about the solutions to the problems of the mentally ill in the criminal justice system. As a psychologist and as someone who has worked in a maximum security prison and as a Member of Congress who has worked through legislation to try to solve some of these problems, I hope that I can provide some helpful insights to you and the committee.

The striking statistic which you have just shared with us, Mr. Chairman, and that we will probably hear multiple times today is that, according to the Bureau of Justice Statistics, over 16 percent of adults in our jails and prisons have a mental illness, and the Office of Juvenile Justice and Delinquency Prevention tells us that over 20 percent of the youth who are in juvenile justice systems have serious mental health problems.

In 1963, Health, Education and Welfare Secretary Anthony Celebrezze said, "The facts regarding mental illness and mental retardation reveal national health problems of tragic proportions compounded by years of neglect." He said that large State mental hospitals were primarily institutions for quarantining the mentally ill, not for treating them, and that "all levels of government, as well as private individuals and groups, must share the responsibilities of a 20th century approach to this outstanding national health problem."

Well, Congress responded to this "outstanding mental health problem" by passing the Community Mental Health Centers Act, which sought to move as many of the mentally ill as possible out of prolonged confinement in overcrowded State custodial institutions into voluntary treatment at community mental health centers. On October 31, 1963, President Kennedy signed the Community Mental Health Centers Act into law. Unfortunately, Congress failed to keep the Act's promise by failing to fund it, and the money States needed to build adequate community mental health infrastructures flowed to other priorities.

Although the reforms were well intended and had the purpose of protecting the mentally ill, they resulted in many of the most severely ill going without treatment and, in too many cases, becoming homeless, incarcerated, suicidal, and victimized. Ironically,

these efforts are euphemistically referred to as "the deinstitutionalization movement." But, in my opinion, the huge numbers of mentally ill individuals in jails, prisons, homeless shelters, and flop houses demand that we call this movement what it has become: transinstitutionalization.

I believe there are two ways we must address this problem.

First, we must require that health plans stop discriminating against mental health treatment. There is no scientific justification for treating mental health benefits differently from other benefits. S. 543, which has been introduced by Senator Domenici, and H.R. 4066, which has been introduced by Representative Roukema and of which I am a proud cosponsor, would guarantee that health plans offer equal coverage of mental health and physical health.

Second, and most important for the topic at hand today, is that we must give the criminal justice system that resources it needs to divert and treat the mentally ill.

Senator DeWine and I worked together in the 106th Congress to begin to address some of these issues by creating a demonstration program to encourage the creation of mental health courts, which are courts with dedicated dockets with a dedicated judge where defendants may receive court-supervised treatment rather than jail terms. In most instances, the existence of the court allows a community to leverage additional mental health treatment resources because the base of support covers all parts of the criminal justice system, including law enforcement and court systems.

However successful, the mental health court initiative is but a small piece in what is needed to address the problem of the mentally ill at all stages of the criminal justice system. I am glad to be working with Senator DeWine and with you, Chairman Leahy, to build on the mental health court initiative. We are working to craft a bill that comprehensively addresses the problem of the mentally ill in the criminal justice system by encouraging law enforcement and criminal justice systems within communities to collaborate with treatment providers to ensure that individuals with mental illness receive all the services they need to live healthy, productive lives.

The bill under consideration will provide funds for States and localities to create diversion programs within the criminal and juvenile justice programs; provide training fund and materials so that police and correctional officers can recognize the symptoms of mental illness and create appropriate plans of action when a mental illness is recognized; and ensure that treatment and services, including housing, education and training, and health care are available when an individual with a mental illness is released from prison.

The bill will allow States and communities the flexibility to design a treatment program that meets their individual needs, but it will also require collaboration on the part of the agencies providing these services.

For example, a significant percentage of adults with serious mental illness in the criminal justice system were homeless upon arrest, and a lack of housing is a contributor to their difficulties in accessing treatment and other services or holding a job.

The bill we will introduce will seek to address this problem by requiring that communities receiving grants coordinate with the

Department of Housing and Urban Development and ensure that they have a plan of action for the housing needs of individuals with serious mental disorders, including those who are released from prison or jail. If this collaboration is successful, fewer individuals with serious mental disorders will commit another crime. I truly believe that based on my experience.

Collaboration between education and training as well as employment agencies must also occur. The bill will address both the juvenile and adult mentally ill populations by ensuring that communities receiving grants meet the unique needs of both adults and youth. In addition, the bill will have an evaluation component to ensure that the communities that receive funds are using them for programs that are effective. This will also ensure that extremely successful programs are recognized and can be replicated in other communities.

I believe this sort of collaboration is the best way to create a legislative mechanisms that will bridge the gap between the mental health and the criminal justice systems. It is through this gap that so many mentally ill defendants currently fall. Both Senator DeWine and I are working hard on this bill, and I am hopeful that it will be ready to be introduced very soon.

In conclusion, Mr. Chairman, I want to thank this committee for looking closely at a problem which too many of us have turned away from. I believe there is a consensus among a broad spectrum of stakeholders and political ideologies that lead us to the practical steps we can take to stop the criminal justice system from being this country's primary caretaker of the seriously mentally ill. I am so pleased and proud to be a part of this effort, and I thank you, Mr. Chairman, for this opportunity to speak to you this morning.

Chairman LEAHY. Well, thank you, Congressman Strickland. And I directed my staff to continue working with yours and Senator DeWine's on this legislation, introducing it soon. Again, just on a personal note, I appreciate your leadership in this. You come as well qualified as anybody I have served with in the Congress to give that kind of leadership.

I have no questions. I also know you are supposed to be at about five other things in the House right now, so, of course, you are excused. But I appreciate you coming over.

Let's have our staffs work on the final part, and you and I can see what we can get passed.

Representative STRICKLAND. Thank you very much.

Chairman LEAHY. Thank you.

[The prepared statement of Mr. Strickland appears as a submission for the record.]

Chairman LEAHY. We are going to set up for the next panel, which will be: Chief Gary Margolis, University of Vermont, Director of Police Services; Marylou Sudders, the Commissioner of Mental Health, Commonwealth of Massachusetts; Kenneth Mayfield, the President–Elect of the National Association of Counties, also a Commissioner of Dallas County, Dallas, Texas; and Captain John Caceci—how close did I come?

Mr. CACECI. "Caceci."

Chairman LEAHY. I am sorry. I should know that. Captain Caceci and I were talking about our Italian heritage earlier. My late moth-

er, whose family came here from Italy, would probably have a word with me if she heard me mispronounce a name like that.

Please, why don't you all come forward and take your places at the table.

Again, I thank you for taking the time to come here. I should note that Chief Margolis is the chief and Director of Police Services at the University of Vermont. He is testifying on behalf of the Police Executive Research Forum and the Council of State Governments. He has a doctorate in educational leadership and policy studies. He served on the committee that produced the Council of State Governments Criminal Justice/Mental Health report.

Ms. Sudders has served as Commissioner of Mental Health for Massachusetts since 1996. To put that in perspective, she oversees a mental health system that will deliver services to more than 24,500 Massachusetts residents. She previously served as New Hampshire's commissioner and is testifying on behalf of the National Association of State Mental Health Program Directors.

I mentioned Mr. Mayfield is the Commissioner of Dallas County, and I enjoyed talking about mutual friends with him, but he is also, more importantly right now, the President–Elect of the National Association of Counties.

The captain has worked in law enforcement for nearly 20 years and supervises all uniform personnel at the Monroe County, New York, jail where, I am sorry to say, he has had extensive experience with mentally ill offenders, and I must say I am glad to have you here because your experience is not in the abstract. I think that would be safe to say.

We will begin with Chief Margolis.

STATEMENT OF GARY MARGOLIS, DIRECTOR OF POLICE SERVICES, UNIVERSITY OF VERMONT, BURLINGTON, VERMONT

Chief MARGOLIS. Good morning. Thank you, Senator. This is indeed an honor to be here before you today.

My name is Gary Margolis, and I am the Chief of Police for the University of Vermont. As Senator Leahy knows, Vermont is struggling like other States across this Nation to improve how we respond to people with mental illness in the criminal justice system, and I applaud you and this committee for taking on this difficult issue.

Today I am representing the Police Executive Research Forum and the Criminal Justice/Mental Health Consensus Project, a 2-year initiative coordinated by the Council of State Governments. Together with numerous criminal justice professionals and mental health professionals along with victims' advocates and consumers, we have developed concrete recommendations for providing appropriate responses to people with mental illnesses at risk of criminal justice involvement. In my testimony today, I will describe traditional responses and the problem at hand, while suggesting steps this committee can take to help us.

So many police encounters involve people who essentially are displaying symptoms of untreated mental illness, and let me be clear at this point and from the start that any person who commits serious crime should be arrested, prosecuted, and appropriately sen-

tenced, including the mentally ill. But as I will illustrate, when it comes to the police response to people with mental illnesses who commit less serious crimes, we can serve them and our communities better by a collaborative police-mental health approach.

Many police encounters involve persons acting in a disorderly or disturbing manner, and the examples are plentiful. It could be the person urinating on a street corner or directing traffic in the middle of Main Street. In other cases, a family member called because their loved one with a history of mental illness needs immediate help and they don't know where to turn. They may be frightened for their own safety, or they can no longer take the stress.

In these scenarios, we all agree that treatment is needed. Often the police are the only resources available 24 hours a day, 7 days a week, and we simply do not possess the diagnostic expertise of mental health professionals. In many rural areas, we may be the only resource available within a 45-minutes or more drive. In communities without effective partnerships, the police have three options: first is to do nothing, and we must accept the fact that in some communities with severely inadequate treatment services this approach continues to be a reality.

The second is to link the person with appropriate mental health services. But, unfortunately, as in the first, in many communities such services are simply inaccessible.

The third and by far most common option is to arrest if a minor crime has been committed. When arrested, minor offenders with mental illnesses land in a criminal justice system ill-equipped to meet their needs, where they often deteriorate further. They then re-enter the community far worse and the cycle repeats.

Only the relatively rare police call involves a person with mental illness exhibiting threatening behavior and brandishing a weapon. These tragic incidents perpetuate the myth that people with mental illnesses are more violent than the general population, and this is what becomes our front-page news.

I am going to reiterate a story the Senator began with, that on Sunday, December 2, 2001, Robert Woodward interrupted service at the All Souls Church in West Brattleboro, Vermont. He held a three-and-a-half-inch blade to his right eye while threatening to kill himself if folks left the service. Mr. Woodward refused to comply with repeated requests from the police to drop his weapon, and when he advanced towards the officers, he was shot. He died only hours later.

In a statement to a rescue squad member, Mr. Woodward said, "Please tell the officer I assaulted that I did not want to hurt him. I would not have harmed him. I just wanted him to shoot me." The Vermont Attorney General concluded that the shooting death of Robert Woodward, "although tragic, was legally justified."

There are far too many examples like this in every jurisdiction. Too often, we had been there before, we had known of the problem, but the underlying mental health issues were never fully addressed. We respond time after time to the same locations of individuals, spending considerable resources in a helpless cycle, particularly in a time when Federal authorities are relying on local police to help in our war on terrorism. And on behalf of my colleagues, I am here to state that we are frustrated.

The reality is that police response is dictated by agency resources and community support. We must work collaboratively to develop solutions. The Consensus Project identified several best practices to serve as models. We know that effective police response to people with mental illness depends on extensive collaborations with the mental health community. Funding for the Consensus Project is an excellent example of this at the Federal level. The Department of Justice Office of Justice Programs and the Department of Health and Human Services Substance Abuse and Mental Health Services Administration each made extensive contributions. They promoted efforts by the State and local governments——

Chairman LEAHY. If you could hold up, somebody has a very important phone call. I don't want them to miss it.

In fact, if he would like to step outside and take it, he is more than welcome to.

Go ahead, chief.

Chief MARGOLIS. Thank you, sir. We know that effective police responses to people with mental illness depend on extensive collaboration with the mental health community. Funding for this Consensus Project is an excellent example of this at the Federal level. The Department of Justice Office of Justice Programs and the Department of Health and Human Services Substance Abuse and Mental Health Services Administration each made extensive contributions. They promoted efforts by the State and local governments to develop the solutions rather than imposing a one-size-fits-all Federal mandate.

Another important step was the enactment of America's Law Enforcement and Mental Health Project, the law that Senator DeWine and other committee members originally sponsored. We need your help and today's hearing marks an exciting step. I respectfully request the committee consider the following:

First, we need the Federal Government's help in determining what works.

Second, resources from the Federal Government are essential to seed new programs and facilitate coordination between criminal justice and mental health organizations.

In closing, in these difficult times it is easy to dismiss the issue we raise today. I implore you to think otherwise. Our important efforts to combat terrorism cannot impede our progress on other fronts. There are solutions described in the Consensus Project report which we can implement with your help. The bottom line is we can do better. We owe it to the people with mental illness who need our help. We owe it to their families and loved ones, to the victims and to the communities who trust us, the police, to respond effectively to their calls for help.

Thank you, Senator.

[The prepared statement of Chief Margolis appears as a submission for the record.]

Chairman LEAHY. Thank you very much.

Commissioner?

STATEMENT OF MARYLOU SUDDERS, COMMISSIONER OF MENTAL HEALTH, COMMONWEALTH OF MASSACHUSETTS, BOSTON, MASSACHUSETTS

Ms. SUDDERS. Good morning, Mr. Chairman. Thank you for the invitation to testify about the interrelationship between criminal justice and mental health. Addressing this very serious matter requires true leadership and true partnership between mental health and criminal justice at all levels.

I am here in two capacities. First, it is my great honor to serve as Commissioner of Mental Health for the great Commonwealth of Massachusetts. The mission of the department is to improve the quality of life for adults with serious and persistent mental illness and children with severe emotional disturbance. As you noted, I serve on any given day 24,000 individuals in Massachusetts. I am also here as a member of the Board of the National Association of State Mental Health Program Directors, which represents the $20 billion public mental health system in the 50 States and the District of Columbia. I am authorized to speak on behalf of all State mental health authorities and to present a national perspective regarding the urgency this issue creates for States in both our criminal justice and mental health systems.

I should note that NASHMHPD, in fact, has formed a task force devoted to this very topic. Others here this morning will focus on the burden on the criminal justice system. I will focus on the challenges in the public mental health system, as well as specific action that may be taken by Federal, State, and local governments.

Let me begin by applauding the committee for convening this hearing and bringing together what some might consider the strangest of bedfellows. As you will hear, however, this collaboration—between those responsible for criminal justice and mental health systems—is essential and, in some cases, long overdue. And we all know the tragedies. Where the seeds of that collaboration have been planted, significant outcomes have been achieved. But these achievements have been sporadic at best. Federal leadership and support at this time is critically needed.

Public mental health systems know much about how to provide services for people with mental illness who are at risk of criminal justice involvement, but we face significant challenges in translating all that we know into practice. We must overcome the conflicts and inconsistencies inherent in fragmented funding strategies at national, State, and local levels.

Our efforts must involve a two-pronged approach. First, we must prevent criminal justice involvement of people with mental illness by diverting them into community treatment. And, second, we must meet the needs of people with mental illness who are returning to the community from jail or prison. And, of course, it is essential to ensure that a mentally ill person receives good treatment while incarcerated. This involves forging links with jails and prisons to develop effective pre-release planning, including reinstatement of benefits for those who are eligible and identification of suitable housing.

Any systems approach must include the integration of substance abuse and addictions treatment with mental health interventions. Co-occurring illnesses must be seen as the expectation and not the

exception. We know from research that when substance abuse coexists with mental illness, the risk of violence significantly increases.

The Council of State Governments' Criminal Justice/Mental Health Consensus Project provides a superb template for action. Its report reflects the concept that early intervention yields best outcomes. In criminal justice terms, this means fewer police encounters for people with mental illness, fewer people with mental illness on court dockets or in jail holding cells, less time spent behind bars, and a drop in recidivism rates. For mental health, this means greater opportunity for productive lives and meaningful community members and to reduce the stigma associated with mental illness.

We recognize that people with mental illness will continue to come into contact with the criminal justice system. Therefore, we need to collaborate with law enforcement on training such as that embodied in the Memphis, Tennessee, Crisis Intervention Team model and others. In Massachusetts, the department provides court clinic services to all juvenile and district courts. These clinics function essentially as emergency services programs to the district court, performing evaluations for competency, criminal responsibilities, and for civil commitment. Persons who are a danger to self or others by reason of mental illness or by reason of substance abuse can be civilly committed from the court after an evaluation by a designated clinician, and a hearing, of course. Counsel in these commitment hearings are all specially trained in mental health law.

A model for pre-release planning is our Forensic Transition Team. The team engages with the individual while incarcerated, provides service coordination, continuity, and monitoring. The key to success has been strong interagency collaboration with criminal justice, cross-training, and very flexible services. And there are many other models across the country that have proven to be effective.

There are two final points I would like to offer. The CSG report references that mental health systems are either too overwhelmed or too frustrated to help some of these individuals. Mental health systems have been overwhelmed, in part, due to historic underfunding and erosion of base resources. We have never realized President Kennedy's dream that was envisioned in the Community Mental Health Centers Act of 1963 that was represented earlier. And given that more than 40 States are experiencing significant budget shortfalls, this situation is only exacerbated for public mental health systems.

Some of the solutions are reasonably obvious and not controversial. There is no need to invent some new technology. The lack of service response is due to funding. Then there are a set of issues that may appear to provide the ready solution, but the effects of which are largely unproven. And that is one of the reasons we need your help. With these new strategies, I would urge the thoughtful approach for innovation through pilots and rigorous evaluation prior to rolling out in prime time. The Substance Abuse Mental Health Services Administration under the leadership of Charles Curie is to be commended for following such a process through the targeted capacity expansion rants for jail diversion programs.

The Criminal Justice/Mental Health Consensus Project provides a model for effective collaboration. We are eager to work with partners in law enforcement, the courts, and corrections to ensure better outcomes for people with mental health at risk of or with histories of criminal justice involvement. At the same time, we welcome the advocacy of our partners in the project in seeking improved services and funding and consistent policies to support them.

Thank you.

[The prepared statement of Ms. Sudders appears as a submission for the record.]

Chairman LEAHY. Thank you very, very much.

Commissioner, go ahead.

STATEMENT OF KENNETH MAYFIELD, PRESIDENT–ELECT, NATIONAL ASSOCIATION OF COUNTIES, AND COMMISSIONER, DALLAS COUNTY, DALLAS, TEXAS

Mr. MAYFIELD. Chairman Leahy, thank you for inviting me to testify this morning on an issue of major importance to county governments—the diversion of non-violent mentally ill offenders from county jails and juvenile detention facilities.

My name is Kenneth Mayfield, and I am an elected county commissioner from Dallas County, Texas. I currently also serve as president-elect of the National Association of Counties.

From 1980 until 1988, I worked as an assistant district attorney for Dallas County, Texas, and eventually became chief of its Juvenile Division.

It was during this period as the county's chief juvenile prosecutor that I witnessed firsthand the growing number of juveniles that were inappropriately housed in county detention centers by virtue of their mental illness. After studying the matter, it became apparent that the majority of persons with mental illness—be they juveniles or adults—are serving time for minor offenses and were usually not taking medication at the time of their arrest. It was also clear that many persons with a mental disability also suffered from a co-occurring disorder, such as substance abuse or homelessness, and did not have caregivers to oversee their daily care.

Over a year ago, I organized a community-based task force in Dallas County to put together a comprehensive program to divert the mentally ill who commit minor offenses. The key focuses of the task force are: funding, housing, treatment eligibility criteria, communications, education/training, and law enforcement.

Mr. Chairman, I have been gratified to receive the full support of every law enforcement agency in Dallas County. I have also met with a number of foundations and agencies interested in this program. We are presently in the process of submitting grant proposals to fund a full continuum of services. At the core of the system is a triage unit that ties together intake and assessment, health care, emergency, transitional, and permanent housing, among other services.

The task force has already completed the production of its first video to provide education and training for law enforcement at every point of contact with the adult criminal justice system for persons with mental illness, mental retardation, and co-occurring

substance abuse disorders. Videos to follow will target judges, prosecutors, defense attorneys, family members, paramedics, emergency room staff, and the community in general.

Mr. Chairman, the mentally ill in jail and juvenile detention are not a problem unique to Dallas County. Of the 10 million admissions to county jails each year, it is estimated that 16 percent are individuals suffering from mental illness. Most of these individuals have committed only minor infractions, more often the manifestation of their illness than the result of criminal intent. In 1999, the Bureau of Justice Statistics released a study on the Mentally Ill in Jail. The study confirmed that too often mentally ill inmates tend to follow a revolving door, from homelessness to incarceration and then back to the streets. Too many of these individuals do not get adequate treatment and end up being arrested again.

The study underscores the importance of adequate assessments. In Los Angeles County, for example, teams of mental health workers and community police officers divert the mentally ill from the scene of an incident, but not before they make a preliminary assessment. In the vast majority of cases, the diversion is to a health unit.

Mr. Chairman, what the public needs to understand about this population is not just that they will significantly benefit from a system of comprehensive services, including housing, health and human services, but also that it would be less expensive and more effective in the long term. For minor offenders, community-based mental health care is far less expensive than maintaining them in jail.

By keeping the mentally ill within the health and human services system, we are also better able to monitor their condition, provide treatment, and to dispense medication if needed.

Jail has the opposite effect. It traumatizes the mentally ill and makes them worse. For the county health department psychiatrist, it often means working twice as hard to get them back to where they were when they entered the jail. For the sheriff, it may mean assigning a deputy to carefully monitor the individual in jail.

Mr. Chairman, the confinement of the non-violent mentally ill in county jails also represents a major liability problem for county governments. In addition, it is a financial drain on county budgets since Federal and State funding streams usually shut down when a mentally ill individual enters the jail. Even the person's own insurance policy may contain an exclusion for jail confinement.

Multnomah County, Oregon, found that the mentally ill defendants stay in jail one-third longer than those who are not mentally ill. Lengthy incarcerations not only worsen their condition, they almost guarantee difficulties after their release.

For example, in many States, even a short stay in the county jail is enough to disenroll a mentally ill person from such entitlements as Social Security, Medicaid and/or Medicare. Once an individual is released from jail, he or she is eligible to receive such benefits, but it may take weeks or months for the programs to be restored.

The need for collaboration between criminal justice and health and human service agencies at the local level in dealing with the mentally ill cannot be overemphasized. The challenge is to create a seamless web of comprehensive services.

King County, Washington, has successfully created integrated service systems for people with mental illness and other co-occurring disorders. The goal is to share clients, share information, share planning, and share resources across agency lines. In the words of one former county administrator, the experience in King County has demonstrated that the major challenge is creating a new system. "It is a matter of joint planning, pooling resources, and more effectively managing existing resources toward new goals."

In conclusion, Mr. Chairman, the National Association of Counties has been working with a coalition of more than 30 national organizations on a proposal for Federal assistance to foster community collaborations between criminal justice and health and human service agencies. The proposal provides counties with considerable flexibility to design creative solutions and to stimulate partnership programs between State and county governments.

Thank you.

[The prepared statement of Mr. Mayfield appears as a submission for the record.]

Chairman LEAHY. Thank you very much, Commissioner, and you have raised some very interesting points, including the one about the insurance stopping when they are incarcerated.

Captain?

STATEMENT OF JOHN CACECI, CAPTAIN, MONROE COUNTY JAIL, ROCHESTER, NEW YORK

Captain CACECI. I would also like to thank Representative Mayfield. I appreciate those words regarding corrections.

Good morning. My name is John Caceci, and I am captain at the Monroe County Jail in Rochester, New York. Thank you, Chairman Leahy and Ranking Member Hatch, for inviting me to testify. I also want to thank my Senator, Chuck Schumer. I am particularly grateful to my sheriff, Patrick O'Flynn, for allowing me to represent our jail.

Speaking for corrections officers across the country, I can tell you that identifying inmates with mental illness and treating, managing, and preparing them for release is one of the greatest, if not the single greatest challenges we face in overcrowded jails and prisons.

I also want to acknowledge the value of the Consensus Project report. Although I did not participate in the effort, I know that the corrections community was represented extensively. The recommendations in that document are exactly on point.

On any given day, there are about 1,400 inmates in our jail. Like any jail, the average length of stay for inmates in our facility is short. Over the course of a year, over 17,000 inmates will be booked into our facility.

Like every county in the country, our jail has experienced explosive growth over the last two decades. Our facility also resembles most jails in that it is the county's largest mental health facility. No other institution in Monroe County holds nearly as many people with mental illness, and that is just not right.

We work in a jail and our job is to incarcerate offenders, not hospitalize sick people. With my testimony today, I would like to re-

view several points. First I want to give you an idea of the types of people who have mental illness who land in our jail. Second, I would like to explain the services we attempt to provide these inmates. Third, I will describe the impact the current situation has on the operation of our jail. And, finally, I would like to recommend some steps that this committee could take to help corrections administrators and line staff address this overwhelming problem.

Between 15 and 20 percent of the inmates in our jail have a mental illness, which is consistent with most jails in the country. I want to be clear that we incarcerate many offenders who have committed serious, violent crimes, and some of those people have a mental illness. Like was said earlier, they need to be punished and they need to be in jail. There are no two ways about that.

But the majority of people we see with mental illness in our jail aren't murderers or sex offenders, or even criminals with a history of violence. They are people who have been in and out of our jail on countless occasions, charged with committing low-level offenses.

We don't blame law enforcement officers for taking these people to our jail. They often don't have any other option. Take, for example, the young man whom police recently brought to us. He had a history of mental illness and was on several mental health medications. He had been giving his mother an extremely hard time. He had threatened her, and one evening he was particularly menacing. The mother was frightened, so she called 911. The police knew the emergency room would not provide prolonged care, so they brought him to jail. We placed him in a single cell on a 24-hour suicide watch.

In regard to screening, in New York State we are unique in that each jail uses the same screening process. Our protocols are extremely effective. Jail suicides have dropped by 70 percent over the last decade in our State. At some point, we hope to establish a system in which the mental health community can inform us when someone with mental illness whom they have served is in our jail.

Good release planning is paramount. I know we have talked about it earlier. I can't say enough about it. We know an effective discharge plan includes appointments with community-based treatment providers, a short supply of medications, health coverage, and linkage to supportive housing. Meeting all of these objectives is difficult, but it is nearly impossible with pre-trial detainees. Staff often receive less than 2 hours advance notice of these inmates' departure.

Inmates will mental illness sometimes act out and violate rules, which means we have to reassign them to high-security cells, typically reserved for dangerous inmates. Other inmates with mental illness are vulnerable to predatory inmates. Other inmates with mental illness refuse medication or become manipulative. We try to discourage our staff from using a restraint chair, but sometimes it can't be avoided. I worry that as staff try to restrain the inmate, someone will get injured.

I also have in the back of my mind stories I hear from colleagues in other facilities across the country that things get out of control as the officers try to subdue an inmate, inadvertently asphyxiating him or her.

This is one of many reasons for providing extensive training. We are fortunate that Sheriff O'Flynn commits extensive time and resources to our annual training.

We would like to increase mental health coverage in our facility 24 hours a day. We are very reluctant, however, to advocate for extensive mental health services in our jail. As it is, we receive too many people with mental illness. A first-rate psychiatric unit in our jail would simply draw more people with mental illness into our facility and discourage building and facilitating better mental health treatment options in our communities.

For this reason, we would prefer that the community's capacity to support people with mental illness improve. We would welcome community mental health providers into our facilities.

If we are going to make meaningful change around this issue, we will need the leadership of this committee and the Federal Government. First, corrections needs to be included in any Federal effort or grant program designed to target offenders.

Second, the Federal Government is in a unique position to promote collaborative efforts between corrections and the mental health community.

And, third, the importance of training correctional staff on mental health issues cannot be overstated. In this regard, the National Institute of Corrections is an invaluable resource.

In conclusion, local jails should not be in the business of running hospital emergency rooms for people with mental illness. When it comes to people with mental illness, we in corrections have been handed an incredibly complex problem which has to be addressed. We are returning people with mental illness to the community many times in no better shape than when we received them. We are doing everything we can to make sure these people don't hurt themselves and their health doesn't deteriorate further. This makes it very difficult for us to focus on protecting staff and inmates and the community. That is supposed to be our primary mission. Please help us fulfill it.

Thank you very much.

[The prepared statement of Captain Caceci appears as a submission for the record.]

Chairman LEAHY. Thank you very much, Captain.

I have a statement by Senator DeWine which will be included in the record at the opening of this and a statement—written testimony, rather, by Reginald Wilkinson, the Director of the Ohio Department of Rehabilitation and Corrections. That can be included in the record.

Let me ask, Chief Margolis—and this is a question that actually several members on this committee have. What about when you get to a rural State, like Vermont, or rural areas of a larger State, with the unique problems in a rural area?

Chief MARGOLIS. Well, certainly, Senator, the problems are in any jurisdiction, but in rural jurisdictions, they can be exacerbated. Let me answer that question, sir, with a short story.

Sheriff Don Edson of the Washington County Sheriff's Office relayed to me just several days ago that 2 weeks ago his deputies had taken into custody a person who had committed a crime. This person had mental illness.

Now, Washington County, as you well know, sir, is 790 square miles with 53,000 residents. That is approximately 67 people for every square mile. That is fairly rural.

The individual was brought to the court. The judge, the defense, the prosecution all agreed that a mental health assessment was needed, and the deputies had to wait for over 2 and a half hours with that person for someone to come and screen. Now, that is 2 and a half hours that those deputies were taken away from the community to serve other calls for service.

So this is very common, and it is frustrating, and other sheriffs and other police chiefs in our State of Vermont in the rural areas echoed this frustration.

Chairman LEAHY. That was about Washington County. I grew up there, and I have known Sheriff Edson from the time he was a child. I know the situation you talk about.

The Council of State Governments report has a lot of proposals and recommendations. If there are key areas that the Federal Government should work on, what are those?

Chief MARGOLIS. Well, the models that were underscored and found, Senator, include areas like crisis intervention teams and comprehensive advance response where officers are specially trained. They work with mental health responders. In some jurisdictions, mental health professionals either respond as special units or as mobile crisis teams.

We have looked at dispatch protocols, how calls are handled, and examined the kinds of questions that are asked by the dispatcher at the initial intake; on-scene assessment skills, how are officers trained to recognize those issues; what training topics should be included in police academies and in in-service training to help in these areas; information gathering and how do we evaluate the success of our response; and then, last, and certainly not least, is the collaborative areas that we can work with our colleagues in mental health and in corrections and in the county governments to begin to develop new tools to respond more effectively.

Chairman LEAHY. There have been some places in the country where there have been experiments with mental health courts. Do you have any experience with that?

Chief MARGOLIS. Sir, my experience with mental health courts is limited. My understanding is that there are a number of areas and a number of ways that our criminal justice professionals are seeking to address that issue.

In speaking with members of our Vermont judiciary, what I learned was that we have commitment hearings that we use, but not very much done in the area of mental health courts per se.

Chairman LEAHY. Captain, I am back to your testimony. I think we can all agree that if people commit a crime, then there are consequences for criminal conduct. I spent 8 years in law enforcement before I was here, and I certainly have no question about that.

Nobody wants to see mental illness used as an excuse to avoid such consequences, and we have seen cases where somebody has tried to use that as an excuse when it is not applicable.

So how do you do this? You have got somebody who comes in. How do you determine whether they should be staying in jail or they should be transferred to mental health services?

Captain CACECI. In Monroe County, we have a wonderful collaborative effort with our mental health staff. The socio-legal clinic for the county handles all of our mental health situations.

One of the things we have done is, on a daily basis, we meet with medical, mental health, and security commanders in the facilities, and we sit down on a daily basis Monday through Friday at 11 o'clock, and we go over each case of people with serious mental illness who is in custody, all of the cases of individuals who may be on suicide watch, and we discuss them and we try to figure out who needs to maybe go to a facility that has more extensive mental health coverage or could we approach one of the judges with mental health, psychiatry, and those types of people to see if we can get those people placed in some supportive housing or other living situation.

So we work in a collaborative effort to try to move certain people out of the facility.

Chairman LEAHY. But you are welcoming the mental health professionals into the jail. You make this kind of determination. Is there a general willingness, do you think, among law enforcement to do that? I mean, are you unique? Or are you seeing this more and more around with other law enforcement?

Captain CACECI. Senator, I recently have gone to the American Jail Association's convention in Milwaukee, and I see from across the country colleagues such as myself that are really trying to move in this direction, are trying to have more collaborative efforts with their local mental health people, and really trying to move to get those kinds of people with serious mental illness out of their facilities, because it is a tremendous drain on their resources, staffing, and what have you to really watch these people closely. And they don't want to see people deteriorate while they are in the facility.

So I think it is across the country that we are seeing this movement.

Chairman LEAHY. Would it be an overstatement to say you want to be involved in law enforcement and you want people who should be in a mental health situation to be dealt with by people who trained to do mental health matters?

Captain CACECI. Yes, sir.

Chairman LEAHY. Commissioner Sudders, what is your experience about how law enforcement and mental health agencies work together at the State level to address this? And the reason I ask, I am just trying to think about what kind of a model we have to talk about at the Federal level between the Department of Justice and Health and Human Services, and I am just curious. What has been your experience at the State level?

Ms. SUDDERS. In Massachusetts, I am lucky and honored to have actually a very strong relationship with the commissioner of corrections. And so, in fact, the relationship between mental health and corrections at the State level is very strong. I actually have sort of quality control over the mental health services provided in the correctional system in Massachusetts to someone who is mentally ill in the prison system. They can also in the jails in Massachusetts transfer from jails to the public mental health system for inpatient

care of there is a mentally ill offender who needs—who is really acutely ill, they can transfer.

So the State level in Massachusetts, probably because both Commissioner Maloney and I believe very strongly about collaboration, we have a strong partnership. And so, in fact, on re-entry programs, my staff go into the prisons to start working with people who are mentally ill offenders to help, to engage with them so that when they are leaving the prison we can connect them with benefits and get them into the mental health system rather than sort of back on to the streets and into crime.

But that is because of our relationship, I would say, and not because of some systems approach, if you would. And I think one of the things that I would point out from the CSJ report is that there is no one size to fit each State. Massachusetts is not a county-based system, for example, so you would not want to craft legislation that said it would all be county-based, because in Massachusetts that wouldn't be terribly helpful.

But one of the things the CSJ report talks about in collaborations, and anything that the Senate would consider I would strongly urge that would require the collaboration and true partnership between mental health and criminal justice, and then allow States and counties and providers to sort of determine what makes the most sense given how we have sort of figured out our systems, if you would, but that you would require in any legislation, in any funding, true collaboration between mental health and criminal justice that you have to demonstrate in whatever kinds of applications come forward. We all know you can sign a letter saying, yes, you know, we sat down and talked, but really true collaborations is the key.

The other thing I would say that the jails—I think sheriffs are doing everything they can to respond out of necessity. I think the quality in jails is dependent, again, upon who the sheriff is and how many mentally ill people are in their jails and whether they want to provide treatment or really just have the mental health system take care of them. But for me, sir, I would say that what the mental health system needs to do with criminal justice is to divert people, particularly the low-incidence crimes, you know, the nuisance crimes, that our responsibility is to really divert them so that they never get into jails. And that is what we need to do, and I would urge you, as you ask the question of the chief, really looking at the diversion programs, mobile crisis intervention teams, assessments, working closely police with mental health experts, so that we divert people from ever entering into the system to begin within.

Chairman LEAHY. Well, Commissioner, when you mention that, it makes me think, Commissioner Mayfield, if I am correct in the briefing material I was reading, you helped initiate a diversion program in Dallas. I was thinking on the practicality of it, because I happen to agree with Commissioner Sudders on this. How do you determine who should be diverted to mental health services and who, because of either themselves or the nature of what they have done, is going to have to be held right there in jail?

Mr. MAYFIELD. Well, that is a very tricky assessment, Senator, but every police department in Dallas County—and right now they

are gathering statistics for me on the number that they think they would divert on a weekly basis to this type of program. But every—I met with all of the police chiefs in Dallas County, and there are 26 cities within the county. And every one—I thought there might be a problem in—we are trying to open up a mental health triage that is open 24 hours for these individuals who are minor offenders, basically victimless crimes that they happen to be arrested and taken to the city's holdover and then transferred down to the counties because of their behavior, which is usually related to their mental health condition. And I thought there might be a problem in having them transport these individuals to this location, which we would like to locate somewhere close to the county jail in some proximity because that is where they used to come in. Now, it didn't matter where it is located, where the city is located In Dallas County, how far it is. They are willing to bring these individuals down to this location so that they can get the help they need rather than putting them in their own facilities or the county's facilities where they know their condition is just going to worsen.

We have produced a video. We are looking at all of the training that they get in their academies. We are making recommendations on perhaps some longer training, some in-depth scenarios, and we have done this with mentally ill and mentally retarded individuals, and police officers in a video to show what is the most common encounter that you would have with someone who suffers from a mental illness or mental retardation, and then how you respond to that.

Of course, each department has to come up with criteria of—we hope it will be uniform, and we think it will be—of individuals that they would divert to this system. They have to be comfortable that when they bring them down there that they are going to be taken care of, they are going to be assessed, we are going to find out where they have been getting services, if they are homeless. And, by the way, I can't emphasize enough permanent housing is the key to this revolving door, because you can divert——

Chairman LEAHY. I see a lot of heads shaking yes.

Mr. MAYFIELD. You can divert all you want, but if they don't—if there is not some sort of supervised living condition for these people, who are often homeless, have no friends, have no family, or if they do have friends and family, they are not engaged with them to monitor them on a casual basis at the least, to see what they are doing, they are taking the medication that they should be taking at the time that they should be taking it, and keeping them out of situations where they come into contact with law enforcement.

So that is a real key, and that is what we are really working on. We are working with HUD on vouchers and trying to set up not just triage mental health location but emergency and transitional housing and then permanent housing for these individuals so we can truly keep them out of the jails.

Chairman LEAHY. What is the population of Dallas County?

Mr. MAYFIELD. It is 2.2 million people.

Chairman LEAHY. Like the Commonwealth of Massachusetts, we have counties, but we don't really have a county form of government. But these models are transferable easy enough to whatever——

Mr. MAYFIELD. Yes.

Chairman LEAHY. Whether you have a State system or a Commonwealth system.

Am I correct that the National Association of Counties has put this issue of mentally ill offenders right up near the top?

Mr. MAYFIELD. It is at the top. I am the incoming president, Senator. It is one of my two initiatives. The other is early childhood development. This is diverting the mentally ill from county jails. So this is the top priority that NACo has—one of the two top priorities.

Chairman LEAHY. Kind of nice to be the boss, isn't it?

[Laughter.]

Mr. MAYFIELD. Yes, sir.

Chairman LEAHY. I was going to say, it is something like being a committee chairman. You can set the priorities.

I want to thank you all for this. We had asked you—you know, you are going to get the transcript back of this hearing and all. If you get some other ideas, things that I forgot to ask or thoughts you have, don't hesitate to add it. We want to learn from this, as Congressman Strickland was saying when he came in here. Or if you get some ideas and you just want to send them to me, just send them directly to me and I will look at it. We want a good piece of legislation. We don't want to pass something just for the heck of passing something.

I think it is a major problem. I thought it was a problem back when I was a prosecutor, but it has gotten much, much worse. You are talking about the homeless situation and all, and I want law enforcement to be able to do law enforcement. And I want the ability to help those who have mental problems that they be helped. Chief Margolis referred to this situation we had in Brattleboro. It was a terrible situation. The Attorney General's office rules the actions appropriate on the part of the police officers. But I am sure for the police officers, this is nothing that gave them any great joy to be put in a situation like that, and they shouldn't have to be.

So I thank you. I commend you for what you are doing. I think all four of you have extraordinarily difficult jobs. And maybe people should realize that those who take a career in public service keep this country going, and I applaud all of you.

We will stand in recess.

Mr. MAYFIELD. Senator, let me just add, let me just say if there is any help that NACo as an organization can give to the success of this legislation, and certainly in looking at it and helping with comments, but I personally can give—in testifying before any committee or lobbying any of my colleagues on the Hill, rest assured that we will do it.

Chairman LEAHY. Thank you. I appreciate that. Thank you all.

[Whereupon, at 11:07 a.m., the committee was adjourned.]

[Submission for the record follow.]

June 10, 2002

The Honorable Patrick J. Leahy
Chairman
Senate Committee on the Judiciary
SD 224 Dirksen Senate Office Bldg.
Washington, D.C. 20510-6275

Dear Senator:

The undersigned organizations are all deeply concerned about the high numbers of adults and juveniles with mental disorders in the criminal and juvenile justice systems. We believe that programs are urgently needed to ensure that, when appropriate, individuals are referred to treatment and that localities have the resources to provide the essential services that can prevent people becoming caught up in the criminal justice again.

There has been a rapid rise in the numbers of individuals with mental disorders arrested and incarcerated in recent years. This has caused great concern among those who work in law enforcement, courts and corrections systems. The diversion of resources (human and fiscal) from activities more in line with criminal justice agencies' core mission is a very serious problem. Moreover, correctional systems are ill-equipped to handle these individuals needs appropriately. Criminal justice professionals believe that the current system also has high costs for those with mental illness, and that we can do better.

We understand that you are developing a proposal for federal assistance to states and localities who are struggling with these issues. This would be of immediate and direct help to those on the front line. We commend you for taking the lead in bringing this important issue to the attention of your colleagues. Legislation to support development of a range of alternative programs focused specifically on this population would be an excellent and appropriate next step, following the enactment last year of legislation to foster the development of mental health courts.

Our organizations represent a cross section of concerned interests: law enforcement, courts and others concerned with the criminal justice system, mental health administrators, providers and advocates and local and state government. We have been urging the Congress to examine this pressing issue. We all look forward to reviewing the details of your bill and to working with you

to improve the function of both the criminal justice and the mental health systems in ways that provide more appropriate opportunities to individuals with serious mental illness so they may avoid future contacts with the criminal justice system.

ON BEHALF OF:

American Correctional Association
American Jails Association
American Psychiatric Association
Bazelon Center for Mental Health Law
Center for Behavioral Health, Justice and Public Policy
Center for Community Corrections
Children's Defense Fund
Children & Adults with Attention Deficit/Hyperactivity Disorder
Council of State Government
Federation of Families for Children's Mental Health
International Association of Psychosocial Rehabilitation Services
International Community Corrections Association
National Alliance for the Mentally Ill
National Association of Counties
National Association of County Behavioral Health Directors
National Association of Mental Health Planning and Advisory Councils
National Association of Protection and Advocacy Systems
National Association of State Mental Health Program Directors
National Coalition for the Homeless
National Health Care for the Homeless Council
National Council for Community Behavioral Healthcare
National Law Center on Homelessness and Poverty
National League of Cities
National Legal Aid and Defender Association
National Mental Health Association
National Network for Youth
Police Executive Research Forum
Pretrial Services Resource Center
The Sentencing Project

For further information contact: Chris Koyanagi, Bazelon Center for Mental Health Law (202/467-5730, ext.118)

6-442

Testimony by

Captain John Caceci

Before the

Senate Judiciary Committee

on

"The Criminal Justice System

and Mentally Ill Offenders"

Submitted by

Captain John Caceci

Monroe County Jail, Rochester, New York

June 11, 2002

Monroe County Jail / 130 South Plymouth / Rochester, NY 14614
t. (716) 428-3142 / f. (716) 428-4089

Good morning. My name is John Caceci and I am a captain at the Monroe County Jail in Rochester, New York. Thank you Chairman Leahy and Ranking Member Hatch for inviting me to testify and for looking at the issue of people with mental illness in the criminal justice system. I also want to thank my senator, Chuck Schumer, for his commitment to corrections officers across New York State. I am particularly grateful to our sheriff, Patrick O'Flynn, for allowing me to represent our jail and to tell you about some of the promising programs we have developed under his leadership.

Speaking for corrections officers across the country, I can tell you that identifying inmates with mental illness and treating, managing, and preparing them for release is one of the greatest – if not the single greatest – challenges we face in our overcrowded jails and prisons. For this reason, I want to underscore how grateful I am that you have asked someone on the front lines of our country's corrections facilities to testify.

I also want to acknowledge the value of the *Criminal Justice / Mental Health Consensus Project Report.* Although I did not participate in the effort, I know that the corrections community was represented extensively, and for that I thank the Association of State Corrections Administrators, the National Association of County Officials, the National Sheriffs Association, and other corrections organizations. The recommendations in that document are exactly on point, and I am eager to see them implemented in my community.

MONROE COUNTY JAIL

In Monroe County (in which Rochester is the biggest city), there are about 750,000 people. On any given day, there are about 1,400 inmates in our jail. Around 400 of these inmates are serving sentences of one year or less; the remaining 1,000 inmates

are pretrial detainees. Like any jail, the average of length of stay for inmates in our facility is relatively short; over the course of a year, over 17,000 inmates are booked into our jail. Nationally, 10 million people are booked into US jails each year.

Like every county in the country, our jail has experienced explosive growth over the last two decades. When I started working in the jail in 1984, there were about 325 inmates. The population has grown on average by about 100 inmates a year. In 15 years, the population has grown nearly 500 percent. During this time, our jail has almost always been overcrowded, operating at about 120 percent of capacity.

Our facility also resembles most jails in that it is the county's largest mental health facility. No other institution in Monroe County holds nearly as many people with mental illness as does our county jail. As you may know, Riker's Island, the New York City Jail, is the largest mental health facility in New York State. After the Los Angeles County Jail, it is the largest mental health institution in the United States.

That's just not right. We work in a jail and our job is to incarcerate offenders, not hospitalize sick people. With my testimony today, I would like to review several points. First, I want to give you an idea of the types of people who have mental illness who land in our jail. Second, I will explain the services we attempt to provide these inmates. Third, I will describe the impact the current situation has on the operation of our jail. Fourth, I will suggest some ways in which we could improve the response to people with mental illness in our facility. Finally, I would like to recommend some steps that this Committee could take to help corrections administrators and line staff address this overwhelming problem.

WHO IS IN OUR JAIL?

Between 15 and 20 percent of the inmates in our jail have a mental illness, which is consistent with most jails in the country. I want to be clear that we incarcerate many offenders who have committed serious, violent crimes, and some of those people have a mental illness. They need to be punished and locked up. There are no two ways about that.

But the majority of people we see with mental illness in our jail aren't murderers or sex offenders—or even criminals with a history of violence. They are people who have been in and out of our jail on countless occasions, charged with (or convicted of) committing low level offenses, like trespassing, harassment, and vehicle and traffic violations. They can't make bond, and, when they're sentenced, it's for time served.

We don't blame police officers for taking these people to our jail. They often don't have any other option. Take, for example, the young man whom police recently brought to us. He had a history of mental illness, and he had recently been giving his mother a hard time. He'd threatened her, and one evening he was particularly menacing. The mother was frightened, so she called 911. The police arrived and they knew the son wasn't so sick that the psychiatric ward would accept him, and there wasn't another mental health center in the community that would accept him, no questions asked. They have to do something, though, and they are justifiably concerned about liability if they just walk away, so they brought the kid to us. Now we have him in a single cell on 24-hour suicide watch.

Another recent example is of a 19-year old girl who is seriously mentally ill and was receiving services at a center for mental health services in Rochester. She was a

behavioral problem there. One day, she pulled the fire alarm—a false alarm, which is a crime. She was brought to the jail and we had to place her on "constant observation" watch. Because she was hearing impaired, we had to bring interpreters from the community mental health center to the jail. They came three or four times a day. The staff from the community mental health center told us that she was not getting better in the jail, and that they wished they had reacted differently when she pulled the fire alarm. What she really needed was intensive mental health services and supportive housing in the community. But there aren't enough of those kinds of supports in Rochester.

MENTAL HEALTH SERVICES WE PROVIDE

Screening

It is hard to compare the percentage of inmates with mental illness in each facility, because each jail uses a different process (if they have one at all) to identify inmates with mental illness admitted to the institution. New York State is unique in that each jail uses the same screening process and the same definitions of mental illness.

At our jail, we screen everyone who is admitted to the jail for mental illness. The state Office of Mental Health developed one form in particular which is nationally recognized, the suicide prevention screening guideline form. In addition, in our jail, we use two additional forms for medical and mental health screening by booking officers. Security command officers have a regularly scheduled daily meeting with medical and mental health to discuss inmates with serious mental health issues or who are at risk of committing suicide. This screening process used in our jail and other jails in New York State has caused suicides to drop by 70 percent over the last decade. Although I am

proud that the rate of suicide in our jail is low, we lost one inmate last year to suicide, and that is still one too many.

Information that community-based providers submit to us regarding people with mental illness whom they have served is extremely helpful. At some point, we hope to establish a system in which the mental health community can inform us when someone with mental illness whom they have served is in our jail.

Release Planning

We try to prepare inmates for their return to the community by developing a discharge plan that includes appointments with community-based treatment providers, a short supply of medications, and some type of health coverage. We have better success meeting these objectives with our sentenced population because we know in advance the date of their release. We have very limited success with non-sentenced pretrial detainees because we don't know when they will be released.

Often, we have little more than a couple of hours advance notice before the inmate's release. In these instances, it is nearly impossible to connect the inmate to treatment, housing, and benefits before they leave the jail.

As I mentioned earlier, one of our biggest frustrations is seeing the same offenders over and over again. When we release people with mental illness without a community-based treatment plan and linkage to a community-based provider, we know the odds are good that he or she will be back soon. Without health coverage, it is nearly impossible for most of these people to receive care or obtain medications. Although many are eligible for Medicaid, few are actually enrolled in the benefits program. It would be an improvement to the system in general if Medicaid benefits were suspended

rather than terminated to ensure that the inmate has health coverage is reinstated when he or she is back on the streets. The absence of safe and adequate housing in the community also reduces the likelihood of an inmate's successful return to the community.

IMPACT OF THE SITUATION ON LIVES, FACILTY OPERATIONS

It's important to explain the impact that the incarceration of the type of people I just described has on their lives and the operation of our facility.

Inmates with mental illness sometimes act out and violate rules, which means we have to reassign them to segregation or high security cells, which we typically reserve for really dangerous inmates. Inmates with mental illness are also vulnerable to predatory inmates, so we often have to protect them in cells we typically reserve for inmates who are in protective custody.

Other times inmates with mental illness refuse medication or become manipulative. We try to discourage our staff from using the restraint chair, but sometimes it can't be avoided. Still, I always have in the back of my mind the stories I hear from my colleagues in other facilities: as staff try to restrain the inmate, a violent struggle ensues, and staff get injured. I also worry about things getting out of control as the officers try to subdue the inmate, inadvertently asphyxiating him or her.

Extensive training is essential to avoid such scenarios, and we are fortunate that Sheriff O'Flynn commits extensive time and resources to our training academy for basic and annual in-service training. Officers receive training regarding suicide prevention, understanding mental illness and responding to emotionally disturbed persons, interpersonal transaction skills, cell extractions.

The biggest portion of a correctional facility's operational budget is, by far, personnel. Every day, one of our lieutenants or I meet with mental health staff to review the status of those inmates who have mental illness and we are watching closely because we are concerned they may attempt suicide. On a given day, there are about 30 such inmates in our jail.

That may not sound like much, but making sure someone is *always* watching these inmates 24 hours a day, 7 days a week in a high security area is extremely staff-intensive and therefore expensive. Nevertheless, this degree of supervision is necessary to ensure a safe environment.

IMPROVING THE DELIVERY OF CARE

We can and should improve the availability of mental health treatment in our jail. For example, mental health professionals are on site in our facility only on weekdays during business hours; we need 24-hour coverage. Currently, when an inmate needs acute care at night or on the weekends, which is a relatively common occurrence, I need to assign one or two escort officers to take the inmate to a local psychiatric emergency room or some other facility where a doctor may be available to see the inmate.

I am very reluctant, however, to advocate for extensive mental health services in our jail. As it is, we receive too many people with mental illness. I have no doubt that a first-rate psychiatric unit in our jail would simply draw more people with mental illness into our facility and discourage building and facilitating better mental health treatment options in our communities.

For this reason, I would prefer to see the community's capacity to support people with mental illness improved. We would welcome community mental health providers

into our facility. In fact, we are eager to facilitate their access to the institution to help us. They know the inmates' treatment history in the community prior to their incarceration, and they are the ones who will need to care for them after their release.

In Monroe County we have the benefit of Project Link, an innovative program that takes referrals from the police, the jail, the court, and emergency rooms. They provide intensive treatment, case management, and support, and they report impressive results. In fact, the American Psychiatric Association recently awarded the program the "gold achievement award" for 1999.

RECOMMENDATIONS FOR THE COMMITTEE

We can develop many programs at the local level, and in partnership with our state, but, in the end, if we are going to make meaningful change around this issue, we will need the leadership of this committee and the federal government. To that end, I have several recommendations.

First, as you continue to consider mental health and substance abuse issues among offenders, keep in mind that corrections facilities represent one of the largest health care delivery systems in the country. We should be included in any federal effort or grant program designed to target offenders. Research that the federal government sponsors to evaluate new programs should be expanded to include jail and prison-based initiatives.

Second, the federal government is in a unique position to promote collaborative efforts between corrections and the mental health community. As I mentioned earlier, I believe that building a comprehensive mental health care delivery system behind the walls of our jail will exacerbate the current problem. Instead, we want the mental health

community to see us a partner whom they can help. County and state budgets are strapped. Federal funding will help us to initiate—or strengthen—these relationships.

Third, the importance of training correctional staff on mental health issues cannot be overstated. The National Institute of Corrections is an invaluable resource for us in corrections; I urge you to increase its capacity to train corrections staff around mental health issues.

CONCLUSION

Our job is to detain people who commit crimes and watch them once they are in the jail. Local jails should not be in the business of running hospital emergency rooms for people with mental illness. When it comes to people with mental illness, we in corrections have been handed an incredibly complex problem. And sometimes it feels like we're only making the situation worse because we are the only viable alternative for local law enforcement officers.

In sum, many of you may assume that as long as there is space for each inmate in our corrections facilities, the problem regarding people with mental illness in our jails is a problem that is not particularly pressing. Nothing could be further from the truth. We're returning people with mental illness to the community many times in no better shape than when we received them. We're doing everything we can to make sure these people don't hurt themselves and that their health doesn't deteriorate further. This makes it difficult for us to focus on protecting staff and inmates and the community. That is supposed to be our primary mission. Please help us fulfill it. Thank you.

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HEARING STATEMENT
MENTAL HEALTH COURTS
SENATE COMMITTEE ON THE JUDICIARY
U.S. SENATOR MIKE DEWINE
JUNE 11, 2002

Mr. Chairman, thank you for holding this very important hearing today. As you know, the mentally ill population poses a particularly difficult challenge for our criminal justice system. People afflicted with mental illness are incarcerated at significantly higher rates than the general population. According to Bureau of Justice statistics, while only about five percent of the American population has a mental illness, about 16 percent of the state prison population has such a mental illness. The Los Angeles County Jail, for example, typically has more mentally ill inmates than any hospital in the country.

Unfortunately, however, the reality of our criminal justice system is that jails and prisons do not provide a therapeutic environment for the mentally ill, and are unlikely to do so any time soon. Indeed, mentally ill inmates often are preyed upon by other inmates or becomes even more sick in jail. Once released from jail or prison, many mentally ill people frequently end up on the streets. With limited personal resources and little or no ability to handle their illness alone, they often commit further offenses resulting in their re-arrest and re-incarceration. This "revolving door" is costly and disruptive for all involved -- it's bad for the mentally ill population and bad for our criminal justice system.

Although these problems tend to manifest themselves primarily within the prison system, the root cause of our current situation is found in the mental health system and its failure to provide sufficient community-based treatment solutions. Accordingly, the solution will necessarily involve collaboration between the mental health system and criminal justice system. In fact, it also will require greater collaboration between the substance abuse treatment and mental health treatment communities, because many mentally ill offenders have a drug or alcohol problem in addition to their mental illness.

For these reasons, I believe that mental health courts can and should be part of the solution. These courts enable the criminal justice system to provide an individualized treatment solution for a mentally ill offender, while also requiring accountability of the offender. Two years ago, Congressman Strickland and I introduced legislation to support the establishment of more mental health courts across the country. That measure recently became law. We are continuing to work with the mental health courts that were established prior to the enactment of that legislation, and we are pleased with the early results.

While the establishment of mental health courts was an important step forward, I believe that we can and should do more. I intend to introduce further legislation this year, with Senator Leahy and Representative Strickland, to authorize more funding for treatment and other services for mentally ill people who come into contact with the criminal justice system. Our goal is to establish, within the criminal justice system and the mental health system, a network of diagnostic, preventive and treatment services that will target the mentally ill early, and effectively -- so that mental health services are provided as soon as possible and as efficiently and effectively as possible. That should help us curb the incidence of repeat offenders and help the mentally ill to live more productive lives.

I look forward to hearing from our witnesses and working with them to introduce this legislation in the near future.

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U.S. SENATOR PATRICK LEAHY

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Statement of Senator Patrick Leahy,
Chairman, Senate Judiciary Committee
Hearing on "The Criminal Justice System and Mentally Ill Offenders"
June 11, 2002

Today this Committee will consider an important but often overlooked criminal justice issue – the impact of mentally ill offenders on our justice system. The Committee's consideration will be aided by today's release of a comprehensive report on that topic by the Council of State Governments. We will also hear from a number of criminal justice and mental health experts, who will explain why the issue of mentally ill offenders has presented such problems for State and local governments. I hope this hearing will raise awareness of the role of mental illness in causing crime, and help Congress evaluate what role the Federal government can play in helping State and local governments address this issue.

We are all too familiar with the role that drug abuse plays in promoting crime – from drug trafficking itself, to property crimes committed by addicts, to murders committed by dealers seeking to gain or maintain control over lucrative drug markets. We are also well-acquainted with the occasional notorious crime committed by mentally ill individuals, such as the assassination attempt against President Reagan. But today we will focus on the persistent problem of people with mental illness who repeatedly rotate between the criminal justice system and the outside world, committing a series of minor offenses that occupy the time of law enforcement officers, diverting them from their more urgent responsibilities. Some mentally ill offenders also abuse drugs and/or alcohol, further complicating matters for law enforcement.

We will hear today from witnesses who have expertise in this area from varying perspectives – including law enforcement, corrections, state mental health systems, and local government. I would like to give a particular welcome to Gary Margolis, the Chief of Police Services at the University of Vermont. We will also hear from Representative Ted Strickland, who has personal experiences with mentally ill offenders, having served as a consulting psychologist at the Southern Ohio Correctional Facility before coming to Congress.

The Council of State Governments' ("CSG") report was developed by nearly 100 criminal justice and mental health policymakers – Republicans and Democrats – who want to improve how the criminal justice system handles people with mental illness. The committee included sheriffs, chiefs of police, prosecutors, judges, corrections directors, and parole board chairmen, along with mental health professionals, showing that interest in this issue is quite far-reaching. Indeed, the

Police Executive Research Forum and the Association of State Correctional Administrators worked with the Council of State Governments, the Bazelon Center for Mental Health Law, and other excellent groups to produce this report. This is a law enforcement problem, as our witnesses today will make clear.

The evidence shows the severity of this problem. The Bureau of Justice Statistics has found that more than 16 percent of those incarcerated in jails and prisons have a mental illness. The Office of Juvenile Justice and Delinquency Prevention reports that more than 20 percent of the youth in the juvenile justice system have serious mental health problems. As the CSG report discusses, individuals who are booked into U.S. jails are three to four times more likely to have serious mental illnesses than the general population. To provide a more specific and rather shocking example, the Los Angeles County Jail often holds more people with mental illness than any state hospital or mental health institution in the United States.

Vermont, like every State, has witnessed wrenching examples of the effects of mental illness. Last December, Robert Woodward, a mentally ill man, interrupted services at All Souls Church in West Brattleboro, Vermont, threatened to kill himself, and, armed with a knife, charged three Brattleboro Police officers who had responded to calls from the scene. The officers were forced to shoot Mr. Woodward – who died later that day – to protect themselves and the others in the church. (Vermont's Attorney General has cleared the officers of any charges of wrongdoing.) The effect of this tragic incident on those officers, the witnesses who simply set out to spend a Sunday morning in church, and the family of Mr. Woodward defies words, and it would behoove us to do what we can to prevent such situations before they occur.

The Council's report provides a roadmap for our consideration. Although there may be recommendations in the report with which some members of this Committee disagree, I think we should all agree that it makes sense to help State and local governments improve the availability of mental health services, train their law enforcement personnel to recognize the signs of mental illness in offenders, and give prosecutors more tools to deal appropriately with mentally ill offenders.

This issue matters to me, both because helping people with mental illness is the right thing to do, and because doing so could improve the safety of all Americans. I have worked with Senator Hatch and others to increase funding for drug treatment out of a similar desire to reduce crime, and we should be equally interested in this issue. I have already proposed including a study on the ability of mentally ill offenders to reintegrate into society after their release in the DOJ authorization legislation that is in conference, and I look forward to considering additional legislative proposals on this issue.

I hope that this hearing prompts a larger discussion of these issues and a concerted and bipartisan effort to find solutions, and I look forward to hearing from our witnesses.

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POLICE EXECUTIVE
RESEARCH FORUM

Testimony by
Chief Gary Margolis
On behalf of the Police Executive Research Forum
and the *Criminal Justice/Mental Health Consensus Project* (The Council of State Governments)

Before the
Senate Judiciary Committee
on
"The Criminal Justice System
and Mentally Ill Offenders"

Submitted by
Chief Gary Margolis
University of Vermont Police Department
June 11, 2002

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Good morning and thank you for allowing me to appear before you today. My name is Gary Margolis and I am the Chief of Police for the University of Vermont. As Senator Leahy knows, Vermont is struggling like other states across this nation to determine how we in the criminal justice system can improve our response to people with mental illness.

The importance of addressing the issue of people with mental illness in contact with the criminal justice system cannot be overstated. This issue is difficult and complex; I applaud you for taking it on. I am at once struck by the enormity of the problem and by the creativity and drive in the police community to significantly address the problem if given the proper support, resources and leadership.

Today I am here representing the Police Executive Research Forum (PERF), which is a membership organization of progressive police chief professionals dedicated to advancing policing services to all members of our communities. PERF general members collectively serve more than half the nation's population and see the indignities, the tremendous resources expended without positive result, and human costs our current system generally imposes on the response to people with mental illnesses who come into contact with police.

I am also here representing the *Criminal Justice / Mental Health Consensus Project.* The Council of State Governments, a nonprofit organization serving all elected and appointed state government officials, has coordinated this two-year initiative. Together with municipal police chiefs, sheriffs, officers, mental health professionals and criminal justice representatives that included prosecutors, defense attorneys, judges, jail and prison administrators and so many others, we worked to develop concrete recommendations for dealing with some of the greatest obstacles to providing appropriate responses to people with mental illnesses who are at risk of criminal justice involvement. We worked with victim advocates, consumers and other stakeholders in an unprecedented project with tremendous result: hundreds of recommendations that explain how to improve the criminal justice system's response to people with mental illness.

I want to provide you with a brief context in which to consider law enforcement's recommendations in the Consensus Project. It really comes down to how we want to use our police resources. The grim reality is that police will need to focus more attention on terrorism and even assume a potentially greater role in activities traditionally conducted by the FBI—all without the infusion of much greater numbers of police personnel and other resources. More

routine police duties must be honed to be efficient and effective. The question is how to do this in an area that has always generated significant repeat calls for police service and for which police alone cannot address the underlying causes of those requests for assistance.

In my testimony, I will describe existing traditional responses to people with mental illness in Vermont and communities across the country that have failed to address a problem of crisis proportions. In the second part of my testimony, I will review the elements of programs and policies that both the law enforcement and mental health community agree would improve these responses. I will also provide some examples of how communities across the country have successfully implemented these programs and policies. Finally, I would like to suggest steps that you and your committee can take to help the law enforcement community address this problem.

Calls for Police Service In Which Mental Illness Is a Factor

Given the limits of this testimony, I will discuss the types of situations police encounter that take up most of our time and generate the greatest concern. Most of these encounters involve people who, essentially, are displaying the symptoms of untreated mental illness. I want to be clear from the start that I'm not suggesting that people with mental illness who commit serious crimes should not be arrested. Any person who commits a serious crime should be arrested, prosecuted and appropriately sentenced. But as the examples I am about to provide you illustrate, when it comes to our response to people with mental illness who commit less serious crimes, we can serve them and our communities better with collaborative police–mental health approaches.

Please "Do Something"

Many police encounters involve a person who is acting in a disorderly or disturbing manner—whether or not a crime has been committed. This may include a man muttering to himself in front of a store, or urinating on a street corner yelling obscenities at people passing by. Or a person standing in the middle of Main Street attempting to direct traffic. Or a person apparently homeless, passed out in the park. Many times concerned citizens place these calls requesting police assistance, though in some cases, business owners or others simply want the police to take the person from the area.

In other cases, a mother, son, or other family member calls us: a loved one with a history of mental illness needs immediate help and they do not know where to turn. Sometimes, the family may be frightened for their safety or for that of their loved one in crisis, or they simply can't take the stress any longer and want help and relief.

In these scenarios, some people want to see the person with mental illnesses receive needed treatment, while others are simply disturbed by the behaviors and want immediate interventions that will get the individual away from them. And because often we're the only resource available 24 hours a day, 7 days a week, they call us. In fact, in many rural areas, like in Vermont, Utah, or Alabama, we may be the only resource available within a 45-minute drive.

Officers who arrive on the scene aren't mental health professionals, and we don't expect them to be diagnosticians. Oftentimes, they can't know whether the person has a physical problem (e.g., seizures), is intoxicated or drugged, mentally ill, or some combination of these. So, in most communities without appropriate programs, the police have three options. The first option is to do nothing, or simply to encourage the person to move along. While this is certainly not encouraged, we need to accept the reality that in some communities, particularly those in which there are severely inadequate treatment services for which an individual qualifies, it continues to be a reality.

The second option, which we do promote, is to link the person with appropriate mental health services and supports. Unfortunately, in many communities, such services do not exist or are unknown to the officer, particularly where no innovative collaborative programs have been implemented. In many cases, the only option available to the officer is to take the person to an emergency room, where the officer may wait hours before the individual is evaluated. Without insurance or circumstances serious enough to warrant commitment, the person is often quickly released into the community, where the officer will invariably encounter the person again behaving in a way that originally prompted someone to call the police.

The third option available to the responding officer is to arrest the individual. After all, some minor crime typically has been committed: disturbing the peace, trespassing, loitering, lewd behavior, vandalism, or another quality-of-life offense. This option becomes especially attractive to officers who have tried unsuccessfully to link individuals with mental health services. It is not uncommon for police to exercise this option. Police are frustrated by the lack

of community-based mental health resources, especially for those with co-occurring disorders like alcohol or drug abuse. With nowhere else to turn, law enforcement officers often arrest these minor offenders who end up in a criminal justice system that is ill-equipped to meet their needs, and will often exacerbate them. There, they decompensate further. They re-enter the community often far worse than when they entered. Then the cycle begins again.

Immediate Threat to Self, Police or Public

Another type of call for police service involving a person with mental illness is the relatively rare call involving a person who has a weapon and who is behaving in an irrational and threatening manner. I am reluctant to talk about these stories because, as compelling as they may be, they perpetuate this myth that people with mental illnesses are more violent than the general population. Although the public tends to associate violence with mental illness, experts have conducted extensive studies, and they have found that in the absence of substance abuse, that the correlation between mental illness and violence is no greater than in the general population (Steadman et al. 1998).

Still, these are the situations that become front-page news stories in every state and are the calls that every officer dreads. Vermont is no exception. On December 2, 2001, a Sunday morning, Robert Woodward interrupted services at All Souls Church in West Brattleboro. He held a folding knife with a 3.5-inch blade to his right eye while threatening to kill himself if people left the service. Brattleboro police units were dispatched to the church. Mr. Woodward refused to comply with repeated police requests to drop the knife, and when he advanced towards the police with the knife in his hand, he was shot seven times. He died a few hours later. In a statement to a rescue squad member, Mr. Woodward said, "Please tell the officer I assaulted that I did not want to hurt him. I would not have harmed him. I just wanted him to shoot me." The State Attorney General conducted an extensive investigation of the incident and concluded that the shooting death of Robert Woodward "although tragic, was legally justified."

Cops know that we must intervene in ways that minimize the chances for such tragedies to occur. An encounter in which de-escalation techniques are unsuccessful, or never appropriately applied, can increase the likelihood that lethal force is used and people are hurt. There are far too many stories, in every jurisdiction I have talked to about this, in which the

person with mental illness is injured or killed or that person lashes out at an officer or bystander. And too often, police had been there before, had a previous contact with the individual or known of the problem, but the underlying mental health issues were never fully addressed. I want to provide some suggestions as to how to prevent the loss of life or serious injury. Before I do that, however, I want to explain the impact of tragedies like the one that occurred in the Brattleboro church. At the same time, I want to underscore that the encounters that our officers have on a much more regular basis with people with mental illness have their own tragic outcomes.

Costs

The costs of not meeting the needs of people with mental illness cannot be computed simply in the dollars spent for police services, overtime and other investments, but in many other human and fiscal costs as well.

Lives Destroyed

Traditional criminal justice interventions for people with mental illness who commit minor crimes decimate lives. Arrests of people with mental illness who have committed relatively minor crimes set in motion a series of events that can result in incarceration, deterioration of the person's health, longer jail or prison terms, escalation in behaviors, the person losing employment (if any) or housing. Arrest or incarceration could add to the stigma associated with mental illness and preempt future employment and housing options that can then result in additional contacts with police. These lives are difficult, if not impossible, to rebuild—for them and their loved ones.

If mental health needs are inadequately addressed, symptoms may escalate and increase police contacts. With each contact comes a risk that the encounter will result in the individual with mental illness being arrested, or the individual or officer being injured. In communities with no innovative police–mental health program, there are also no long-term positive outcomes for meeting the individual's problems that prompted the call for service.

The situations in which a serious crime has been committed can devastate victims and their families. While responses to serious crimes prompt the clearest course for police action, they often have the greatest human costs. Often lives have been lost or changed forever.

Poor Officer Morale

We as police officers want to do the right thing. But when it comes to people with mental illness, we often feel like we're contributing to a hopeless cycle, and this hurts morale among line staff and undermines our credibility with the community. Police respond time after time to the same locations and individuals. They spend considerable resources responding to calls and transporting individuals to services. These efforts often are fruitless. The individual is turned away because he or she doesn't meet access criteria or the individual is back on the streets no better off a few days later.

The relatively rare incident involving a person with mental illness that includes the use of lethal force harms a community and can devastate an officer. The report from the Vermont Attorney General regarding the shooting in Brattleboro pointed to the "pain and strife" that Mr. Woodward's death "caused and continues to cause for his family and many members of the Brattleboro community... Some witnesses expressed guilt for what happened and blame themselves for not having been able to help." And let us not forget the police officers themselves. Even though the shooting is entirely justified, suicide-by-cop is a traumatic experience from which some officers never recover.

Inefficient and Ineffective Use of Resources

It is hard to talk about police resources when the human costs are so compelling, and it almost seems to denigrate their importance to discuss such practical issues as resources. We do not, in any way, want this discussion to be perceived as such. The reality is, however, that police response is and will be dictated by resources available within the agency, and the level of support or resources in the community that they can access.

My colleagues and I face tremendous challenges as we reposition local policing to respond to the latest threats to domestic security. But our efforts to combat terrorism cannot impede our progress on other fronts. We cannot abandon our efforts to prevent crime, ensure public safety and serve all our citizens with dignity and fairness. We do, however, need to be more effective and efficient in all our efforts.

Calls for police service in which mental illness is a factor make up between seven and 10 percent of all police contacts, and continue to pose significant operational problems for police (Borum, Deane, Steadman and Morrissey 1998). They also tend to take a considerable amount of the officer's time (DeCuir and Lamb 1996). The police resources currently spent in many communities across the nation are not resulting in lasting positive outcomes. Police refer individuals to agencies that cannot provide services or extended care, for a variety of reasons. They spend hours transporting individuals for treatment, assessment or commitment that may or may not be available or granted. They often spend considerable time on the scene trying to resolve issues that are best handled by mental health professionals. Too often they are simply waiting with the individual to be seen or transferred. Some of these issues have been addressed by innovative efforts to improve the police response to people with mental illnesses.

WHAT DO WE DO?

It is tempting—and would be easy—to spend the remainder of my allotted time detailing how we got to this point, the reasons why the system is broken, and the frustrations and terrible experiences police have had trying to minimize contacts by people with mental illness with the criminal justice system. But I think it is more important to focus on some basic truths: that every community has different resources, priorities and problems and that we need responses that can be tailored to the unique needs of local communities. We need to work collaboratively, across disciplines, to develop any meaningful long-term solutions related to improving the criminal justice response to people with mental illness.

These are a few of the many principles to which we adhered through the Consensus Project. Like those communities that have pioneered new programs to improve the response to people with mental illness who come into contact with the criminal justice system, we brought together all key stakeholders in the criminal justice and mental health communities.

With PERF's help, we identified four basic approaches that improve the police response to people with mental illness. These include using the following:

1) *Crisis Intervention Teams(CITs)* in which specially trained, uniformed officers respond to every call in which mental illness is a factor;

2) Individual *mental health professionals,* who either ride along with officers in special teams or respond when called by an officer after the scene has been secured;

3) *Comprehensive Advance Responses,* where the traditional police response is modified by mandating advanced, 40-hour training for all officers within the department; and

4) *Mobile Crisis Teams (MCTs),* which are county-based teams that act as secondary responders who are called out once the scene has been secured by law enforcement.

The recommendations for the law enforcement section are drawn from these models and specifically address detailed suggestions for improving training and collaboration, as well as the following:

1) *Dispatch Protocols* to determine whether mental illness is a factor in the call and relaying relevant information accurately and appropriately to officers;

2) *On-Scene Assessment* that involves recognizing signs or symptoms of mental illness; stabilizing the scene; determining whether a serious crime has been committed; consulting with personnel with mental health expertise; and determining whether the person might meet the criteria for emergency evaluation;

3) *On-Scene Response* that promotes referral to mental health services and supports, provides information to victims and families, and facilitates transportation and detention when necessary;

4) *Incident Documentation* that captures relevant data in calls for service data and reports; and

5) *Police Response Evaluation* based on consultation with service providers to

evaluate referral mechanisms and to identify individuals who come into repeat contact with the police.

There are many innovative, promising efforts around the country that illustrate the successful implementation of aspects of these recommendations. For example, in Memphis, before the implementation of their Crisis Intervention Team (CIT) model, officers spent 4-6 hours at the medical center waiting for the person to be admitted for mental health care; the wait time now averages about 15 minutes (Vickers 2000). Shortly after the Memphis CIT was implemented, injuries that individuals with mental illnesses suffered during the course of their encounter with the police decreased by nearly 40 percent. While this certainly has reduced the human costs detailed above, it would be remiss to not mention the implications for reduced liability and resources spent defending police use of force, even if deemed proper.

In Houston, the estimated time for obtaining a mental health warrant dropped from three to four hours to 15 minutes. This reduced the amount of time that a person with mental illness remained in police custody and expedited treatment.

In the San Diego Police Department, the Psychiatric Emergency Response Team (PERT) (sworn officers are partnered with mental health professionals) in its first year realized significant reductions in time required for police interventions and far fewer jail dispositions. Many more incidents were resolved on scene.

In 1999, the Albuquerque Police Department, which also employs a CIT model, reported that officers arrested, transported to jail, or otherwise took into protective custody fewer than 10 percent of those people with mental illnesses they contacted. Injuries were also reduced to just more than 1 percent of calls after their CIT model was implemented. The decrease in use of SWAT was reported at 58 percent (Bower and Pettit 2001).

The effectiveness of new programs has been measured in savings in resources and overall impact: For example, a study of three police departments that had implemented innovative solutions (Memphis, Knoxville and Birmingham) demonstrated that 34.7 percent were resolved on scene; subjects were referred to long-term mental health specialists in 13 percent of the cases; and 45.7 percent were immediately transported to a treatment facility or were admitted to a

hospital. Only 6.7 percent of the incidents from the total survey resulted in arrest (Borum et al. 1998).

Numerous other police departments, from Montgomery County, Md., to Minneapolis, Minn., to Seattle, Wash., are also in the midst of implementing similar approaches.

LOOKING TO CONGRESS

Throughout my testimony, I have attempted to underscore a key finding in our Consensus Project: Effective police responses to people with mental illness depend on extensive collaborations with the mental health community. Funding for the consensus project is an excellent example of valuable collaboration across systems at the federal level. The U.S. Department of Justice (Office of Justice Programs) and the U.S. Department of Health and Human Services (Substance Abuse and Mental Health Services Agency) each contributed extensively to the project. To their credit, they also promoted efforts by state and local governments to develop the solutions, rather than imposing a one-size-fits-all federal mandate to address this complex problem.

Indeed, federal agency support for the Consensus Project has been a wonderful first step to assist law enforcement in improving the response to people with mental illness. Another important step was the enactment of "America's Law Enforcement and Mental Health Project," the law that Sen. DeWine and other committee members originally sponsored. It recognizes the importance of training law enforcement officers regarding responses to people with mental illness. We hope that funds beyond the initial $4 million will be appropriated to that program, and that the grant program will make police departments eligible for some of this funding support.

These recent developments notwithstanding, considerable work remains. We need the help and leadership of this committee promoting the implementation of the examples in the report. Today's hearing marks an exciting step in that direction. These are the steps I respectfully request you consider taking next.

First, we need the federal government's help determining what works. The Consensus Project is complete with countless examples describing innovative efforts by communities to address the problem. For many of these models we need an evidence base. The federal government is in a unique position to fund and oversee these program evaluations.

Second, despite the extraordinary value of the innovative programs I described earlier, the budget crises in most states, counties, and cities are so severe that the flexibility to fund a new program doesn't exist—even if it will generate cost savings. Resources from the federal government—both in the form of technical assistance from national experts and direct funding support—are essential to help us overcome this hurdle.

Third, discretionary grants from the federal government can be extremely effective in facilitating coordination between criminal justice and mental health organizations. A grant assigning responsibilities to both DOJ and HHS could effect this type of collaboration. We in law enforcement would be happy to work with you to see this type of concept converted into legislation.

CONCLUSION

In these difficult times, it is easy to dismiss efforts such as those we raise today. I implore you to think otherwise. Never before has local law enforcement been more taxed to do more with less. We are at a critical crossroads in our community policing work and in our efforts to serve vulnerable populations. This is precisely the time that we must act to ensure that police resources are properly focused to ensure the greatest possible public safety and quality-of-life outcomes. Police services must have the greatest possible impact and long-term results. The accounts I have provided you today demonstrate that there are tremendous costs—in human lives, dignity, dollars and police resources—that we can no longer afford to sustain in how we respond to people with mental illnesses who come into contact with the criminal justice system.

There are also solutions to this problem, which the Consensus Project Report describes, and which we can implement with your help. The bottom line is: We can do better. We owe it to the people with mental illnesses who trust us to respond fairly; to their families and loved ones; to victims and to the communities who need to trust the police to respond effectively to their calls for service.

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Statement of

The Honorable Kenneth Mayfield
Commissioner
Dallas County, Texas

and

President Elect
National Association of Counties

on

The Mentally Ill in Jail

Before the

Committee on the Judiciary
United States Senate

June 11, 2002
Washington, DC

Chairman Leahy, Senator Hatch and Members of the Committee, thank you for inviting me to testify this morning on an issue of major importance to county governments – the diversion of non-violent mentally ill offenders from county jails and juvenile detention facilities.

My name is Kenneth Mayfield, and I am an elected county commissioner from Dallas County, Texas. I currently also serve as President Elect of the National Association of Counties (NACo)[*].

From 1980 until 1988, I worked as an Assistant District Attorney for Dallas County, Texas and eventually became the Chief of its Juvenile Division.

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[*] NACo is the only national organization representing county government in the United States. Through its membership, urban, suburban and rural counties join together to build effective, responsive county government. The goals of the organization are to: improve county government; serve as the national spokesman for county government; serve as a liaison between the nation's counties and other levels of government; achieve public understanding of the role of counties in the federal system.

It was during this period as the county's chief juvenile prosecutor that I witnessed first hand the growing number of juveniles that were inappropriately housed in county detention centers by virtue of their mental illness. After studying the matter, it became apparent that the majority of persons with mental illness – be they juveniles or adults--are serving time for minor offenses and were usually not taking medication at the time of their arrest. It was also clear that many persons with a mental disability also suffered from a co-occurring disorder, such as substance abuse or homelessness and did not have caregivers to oversee their daily care.

Over a year ago, I organized a community-based task force in Dallas County to put together a comprehensive program to divert the mentally ill who commit minor offenses. The key focuses of the task force are: funding, housing, treatment eligibility criteria, communications, education/training and law enforcement.

Mr. Chairman, I have been gratified to receive the full support of every law enforcement agency in Dallas County. I have also met with a number of foundations and agencies interested in this program. We are presently in the process of submitting grant proposals to fund a full continuum of services. At the core of the system is a "triage unit" that ties together intake and assessment, health care, emergency housing and transitional housing, among other services.

The task force has already completed the production of its first video to provide education and training for law enforcement at every point of contact with the adult criminal justice system for persons with mental illness, mental retardation, and co occurring substance abuse disorders. Videos to follow will target judges, prosecutors, defense attorneys, family members, paramedics, emergency room staff, and the community in general.

Mr. Chairman, the mentally ill in jail and juvenile detention are not a problem unique to Dallas County. The nation's local jails have increasingly become the dumping grounds for the mentally ill. Of the 10 million admissions to county jails each year, it is estimated that 16 percent are individuals suffering from mental illness. Most of these individuals have committed only minor infractions, more often the manifestation of their illness than the result of criminal intent. In 1999, the Bureau of Justice Statistics released a study on the Mentally Ill in Jail. The study confirmed that too often mentally ill inmates tend to follow a revolving door, from homelessness to incarceration and then back to the streets. Too many of these individuals do not get adequate treatment and end up being arrested again.

The study underscores the importance of adequate assessments. In Los Angeles County, for example, teams of mental health workers and community police officers divert the mentally ill from the scene of an incident (e.g. disturbing the

peace, trespassing, disorderly conduct, etc.) but not before they make a preliminary assessment. In the vast majority of cases, the diversion is to a health unit.

Mr. Chairman, what the public needs to understand about this population is not just that they will significantly benefit from a system of comprehensive services, including housing, health and human services but also that it would be less expensive and more effective in the long term. For minor offenders, community based mental health care is far less expensive than maintaining them in jail.

Implementing a community based social service system is infinitely more preferable to jail in terms of addressing the multiple issues facing this population. By keeping the mentally ill within the health and human services system, we are also better able to monitor their condition, provide treatment and to dispense medication if needed. The public safety is certainly better served.

Jail has the opposite effect. It traumatizes the mentally ill and makes them worse. For the county health department psychiatrist, it often means working twice as hard to get them back to where they were when they entered the jail. For the Sheriff, it may mean assigning a deputy to carefully monitor the individual in jail.

Mr. Chairman, the confinement of the non-violent mentally ill in county jails also represents a major liability problem for county governments. In addition, it is a financial drain on county budgets since federal and state funding streams usually shut down when a mentally ill individual enters the jail. Even the person's own insurance policy may contain an exclusion for jail confinement.

Multnomah County, Oregon found that the mentally ill defendants stay in jail one-third longer than those who are not mentally ill. Lengthy incarcerations not only worsens their condition, they almost guarantee difficulties after their release.

For example, in many states, even a short stay in the county jail is enough to disenroll a mentally ill person from such entitlements as Social Security, Medicaid and/or Medicare. Once an individual is released from jail he or she is eligible to receive such benefits but it may take weeks or months for the programs to be restored.

The need for collaboration between criminal justice and health and human service agencies at the local level in dealing with the mentally ill cannot be overemphasized. The challenge is to create a seamless web of comprehensive services.

King County, Washington has successfully created integrated service systems for people with mental illness and other co-occurring disorders. The goal is to share clients, share information, share planning and share resources across agency lines. In the words of one former county administrator, the experience in King County has demonstrated that the major challenge is creating a new system. "It is a matter of joint

planning, pooling resources and more effectively managing existing resources toward new goals."

In conclusion, Mr. Chairman, the National Association of Counties has been working with a coalition of more than 30 national organizations on a proposal for federal assistance to foster community collaborations between criminal justice and health and human service agencies. The proposal provides counties with considerable flexibility to design creative solutions and to stimulate partnership programs between state and county governments.

We are pleased to assist the committee in its investigation of this important topic and look forward to working with you on legislation that will help local governments design flexible and innovative programs.

Congressman Ted Strickland
Testimony before the Senate Judiciary Committee
Hearing: "The Criminal Justice System and Mentally Ill Offenders"
June 11, 2002

Introduction

I want to thank Chairman Leahy and Ranking Senator Hatch for giving me the opportunity to testify here today about solutions to the problem of the mentally ill in the criminal justice system. As a clinical psychologist who worked in a maximum security prison and a Member of Congress who has worked to address some of these concerns through legislation, I hope I have some helpful insights into this problem, which has such a ravaging effect on our society.

Briefly, I also would like to commend the Council of State Governments and other groups who were involved in the Consensus Project for assembling such a comprehensive "guidebook" for states to use when searching for solutions, and I'm sure their testimony will provide many helpful insights into this problem. I would also like to thank Senator DeWine for his leadership and friendship. We have

worked together on this issue since the 106th Congress when we introduced mental health courts legislation, and I continue to be impressed by his understanding and dedication to finding ways to solve the difficult and important problems you will hear about today.

The striking statistic that you will probably hear multiple times today is that, according to the Bureau of Justice Statistics, **over 16 percent of adults in our jails and prisons have a mental illness**. In addition, the Office of Juvenile Justice and Delinquency Prevention reports that **over 20 percent of youth who are in the juvenile justice system have serious mental health problems**. The over-representation of the mentally ill in jails and prisons puts a strain on the criminal justice system, which does not have the resources or expertise needed to give those with mental illness the treatment they need. This is a particular travesty when you consider that the majority of individuals with a mental or emotional disorder who are involved in the criminal or juvenile justice systems can be successfully treated for their disorder.

The result is one that our society should be ashamed of: untreated mental illness in offenders results in homelessness, high recidivism rates, and a great loss of human potential. I have personally treated individuals who will live out the rest of their lives behind bars because they have committed crimes that they most likely would not have committed had they been able to receive adequate mental health care. The problem is self-perpetuating and cyclical if not addressed through treatment: the prison environment has a devastating effect on the mentally ill and the mentally ill have a destabilizing effect on the prison environment.

Background

On September 21, 2000, I testified before the House Judiciary Subcommittee on Crime about the background of the broken criminal justice system, and I want to share this information for the record and to add perspective to today's testimony. Before we consider the effects and possible solutions of this system, we should remember how it became

broken in the first place. In 1963, Health, Education and Welfare Secretary Anthony Celebrezze said, "The facts regarding mental illness and mental retardation reveal national health problems of tragic proportions compounded by years of neglect." He said that large state mental hospitals were primarily institutions for quarantining the mentally ill, not for treating them, and that "all levels of government, as well as private individuals and groups, must share the responsibilities of a 20th century approach to this outstanding national health problem."

Congress responded to this "outstanding mental health problem" by passing the Community Mental Health Centers Act, which sought to move as many of the mentally ill as possible out of prolonged confinement in overcrowded state custodial institutions into voluntary treatment at community mental health centers. On October 31, 1963, President Kennedy signed the Community Mental Health Centers Act into law. Unfortunately, Congress failed to keep the Act's promise by failing to fund it, and the money states needed to build adequate

community mental health infrastructures flowed to other priorities. In addition, Congress imposed restrictions on Medicaid that kept Medicaid dollars from going into state mental hospitals. Thus, we set in motion a public health tragedy that resulted in thousands of mentally ill patients being dumped out of state hospitals into communities that did not have the adequate services to receive them.

Although these reform efforts were well intended and had the purpose of protecting the mentally ill, they resulted in many of the most severely ill going without needed treatment and, in too many cases, becoming homeless, incarcerated, suicidal, and victimized. Ironically, those efforts are euphemistically referred to as "the deinstitutionalization movement." In my opinion, the huge numbers of mentally ill individuals in jails, prisons, homeless shelters, and flop houses demand we call this movement what it has become: transinstitutionalization.

Solutions

I believe there are two ways that we must address the startling statistics I mentioned.

1) Mental Health Insurance Parity

First, we must require that health plans stop discriminating against mental health treatment. There is no scientific justification for treating mental health benefits differently from other benefits. S. 543, which has been introduced by Senator Domenici, and H.R. 4066, which has been introduced by Representative Roukema and of which I am a proud cosponsor, would guarantee that health plans offer equal coverage of mental health and physical health. In addition to ensuring that more people have access to the treatment they need, parity would begin to address the problem of the mentally ill in the criminal justice system by ensuring that those who have insurance and want to seek treatment have the access they need. As a result, more people will be able to live healthy lives and fewer will end up ever contacting the criminal justice system as a result of an untreated mental illness.

2) Criminal Justice System

Second, and more important for the topic at hand in today's hearing, is that we must give the criminal justice system the resources it needs to divert and treat the mentally ill. As such, we must ensure that, when appropriate, there are pre-booking diversion options, court systems that can provide supervision and direct offenders to treatment, and release systems that will ensure that the mentally ill have the housing, education, employment, and health care they need so that they don't end up back in prison because of a treatable mental illness. Integrated with these systemic needs are needs for training of law enforcement and correctional officers who on a daily basis interact with individuals struggling with mental illness: for example, a guard in a prison must be able to recognize a symptom of a mental illness instead of mistaking it for belligerence or purposeful misbehavior.

A) Mental Health Courts

Senator DeWine and I worked together in the 106th Congress to

begin to address some of these issues by creating a demonstration program to encourage the creation of mental health courts, which are courts with dedicated dockets with a dedicated judge where defendants may receive court-supervised treatment rather than a jail sentence. In most instances, the existence of the court allows a community to leverage additional mental health treatment resources because the base of support covers all parts of the criminal justice system, including law enforcement and court systems.

Mental health courts began with two communities, one in Florida and one in Washington State, who independently recognized a need and embarked on a solution. The Florida court was inspired by a case in which a boy with a brain injury became agitated in a supermarket line and pushed an elderly woman, causing her to fall and also sustain a brain injury. She later died and the boy was charged and convicted of murder. The community wasn't satisfied with this outcome, and its response was to create Judge Ginger Lerner Wren's mental health court. In

Washington State, Judge Jim Cayce's court was started after a firefighter was stabbed by a schizophrenic man. When the firefighter's family wanted a response more appropriate than jail, the Washington court began and is now named after the slain firefighter.

The legislation that Senator DeWine and I introduced and was passed into law is intended to help these mental health courts flourish in other communities. The courts themselves can be coordinated with relatively modest resources since many of the personnel are already in place, and most courts use start-up funds to facilitate conversations between local stakeholders and to hire a case manager. The original bill I introduced was very modest, asking for 25 courts at a total cost of $10 million over five years. Senator DeWine introduced an even more ambitious Senate version later on. This bill, which was eventually passed by both the House and Senate and signed into law, created 100 courts at a total authorization of $40 million per year.

The program received a $4 million appropriation for fiscal year 2002, and the Department of Justice is currently working to establish the program and obligate the funds. Although this is not much money to work with, the program will give communities who are struggling to contend with the problem of the mentally ill in the criminal justice system the initial resources they need to start a mental health court. Indicating both the scope of the problem and the excitement over the mental health court solution, my office has received countless calls from communities across the country that are interested in starting these courts. I am hopeful that the program will receive a larger appropriation this year so that it can reach more communities.

B) New Legislation: Collaboration is Key

However successful, the mental health court initiative is a small piece of what is needed to address the problem of the mentally ill at all stages in the criminal justice system. I am glad to be working with Senator DeWine and Chairman Leahy to build on the mental health court

initiative. We are working to craft a bill that comprehensively addresses the problem of the mentally ill in the criminal justice system by encouraging law enforcement and criminal justice systems within communities to collaborate with treatment providers to ensure that individuals with mental illness receive all the services they need to live healthy, productive lives. The bill will provide funds for states and localities to create diversion programs within the criminal and juvenile justice programs; provide training funds and materials so that police and correctional officers can recognize the symptoms of mental illness and create appropriate plans of action when a mental illness is recognized; and ensure that treatment and services, including housing, education and training, and health care, are available when an individual with a mental illness is released from prison. The bill will allow states and communities the flexibility to design a treatment program that meets their individual needs, but the bill will require collaboration on the part of the agencies providing these services. For example, a significant percentage of adults with serious mental illness in the criminal justice

system were homeless upon arrest, and a lack of housing is a contributor to their difficulties in accessing treatment and other services or holding a job. The bill we will introduce will seek to address this problem by requiring that communities receiving grants coordinate with the Department of Housing and Urban Development (HUD) to ensure that they have a plan of action for the housing needs of individuals with serious mental disorders, including those who are released from prison or jail. If this collaboration is successful, fewer individuals with serious mental disorders will commit another crime. Collaboration between education and training as well as employment agencies must also occur. The bill will address both the juvenile and adult mentally ill populations by ensuring that communities receiving grants meet the unique needs of both adults and children. In addition, the bill will have an evaluation component to ensure that the communities that receive funds are using it for programs that are effective. This will also ensure that extremely successful programs are recognized and can be replicated in other communities.

I believe that this sort of collaboration is the best way to create a legislative mechanism that will bridge the gap between the mental health and criminal justice systems. It is through this gap that so many mentally ill defendants currently fall. Both Senator DeWine and I are working hard on this bill and I am hopeful that it will be ready to be introduced very soon.

Conclusion

I want to thank this committee for looking closely at a problem which too many of us turn away. I believe there is a surprising consensus among a broad spectrum of stakeholders and political ideologies that lead us to the practical steps we can take to stop the criminal justice system from being this country's primary caretaker of the seriously mentally ill. I am happy to answer any questions you may have.

United States Senate
Committee on the Judiciary
Hearing Examining the Criminal Justice System and Mentally Ill Offenders

Marylou Sudders, Commissioner of Mental Health
Commonwealth of Massachusetts

June 11, 2002

Mr. Chairman and members of the Committee good morning. Thank you for the invitation to testify about the interrelationship between criminal justice and mental health. Addressing this very serious matter requires leadership and true partnership between mental health and criminal justice systems at all levels.

I am here in two capacities. First, I am the Commissioner of Mental Health for the Commonwealth of Massachusetts. The mission of the Department of Mental Health is to improve the quality of life for adults with serious and persistent mental illness and children with severe emotional disturbance. I am also here as a member of the Board of the National Association of State Mental Health Program Directors (NASMHPD), which represents the $20 billion public mental health system in the 50 states and the District of Columbia. I am authorized to speak on behalf of all state mental health authorities and to present a national perspective regarding the urgency this issue creates for states in both our criminal justice and mental health systems. It should be of interest that NASMHPD has formed a taskforce devoted to this issue. Others here this morning will focus on the burden on the criminal justice system. I will focus on the challenges in the public mental health system, as well as specific action that may be taken by the federal, state, and local government.

Let me begin by applauding the committee for convening this hearing and bringing together what some might consider the strangest of bedfellows. As you will hear, however, this collaboration – between those responsible for criminal justice and mental health systems – is essential and, in some cases, long overdue. Where the seeds of that collaboration have been planted, significant outcomes have been achieved. But these achievements have been sporadic at best. Federal leadership and support at this time is critically needed.

We know much about how to provide services for people with mental illness who are at risk of criminal justice involvement, but we face significant challenges in translating all that we know into practice. We must overcome the conflicts and inconsistencies inherent in fragmented funding strategies at national, state and local levels.

Our efforts must involve a two pronged approach. First, we must prevent criminal justice involvement of people with mental illness by diverting them into community treatment. Second, we must meet the needs of people with mental illness who are returning to the community from jail or prison. This involves forging links with jails and prisons to

develop effective pre-release planning, including reinstatement of benefits for those who are eligible and identification of suitable housing.

Any systems approach must include the integration of substance abuse and addictions treatment with mental health interventions. Co-occurring illness must be seen as the expectation, not the exception. We know from research that when substance abuse coexists with mental illness, the risk of violence significantly increases.

The Council of State Governments' (CSG) Criminal Justice/Mental Health Consensus project provides a superb template for action. Its report reflects the concept that early intervention yields better outcomes. In criminal justice terms, this means fewer police encounters for people with mental illness, fewer people with mental illness on court dockets or in jail holding cells, less time spent behind bars, and a drop in recidivism rates. In mental health terms, this means greater opportunity for productive lives and meaningful community membership and to reduce the stigma associated with mental illness.

We recognize that people with mental illness will continue to come into contact with the criminal justice system. Therefore, we need to collaborate with law enforcement on training such as that embodied in the Memphis, TN, Crisis Intervention Team model. In Massachusetts, the Department provides court clinic services to all juvenile and district (adult) courts. These clinics function essentially as emergency services to the district court, performing evaluations for competency, criminal responsibility and for civil commitment. Persons who are a danger to self or others by reason of mental illness or by reason of substance abuse can be committed from the court after an evaluation by a designated forensic clinician and a hearing. Counsel in commitment hearings are all specially trained in mental health law.

A model for pre-release planning is our Forensic Transition Team. The team engages with the individual while incarcerated, provides service coordination, continuity and monitoring. The key to success has been strong interagency collaboration, cross training and very flexible services. And, there are other models across the country that have proven to be effective.

There are two final points I would like to offer. The CSG report references that mental health systems are either too overwhelmed or too frustrated to help some of these individuals. Mental health systems have been overwhelmed, in part, due to historic underfunding and erosion of base resources. Given that more than 40 states are experiencing significant budget shortfalls, this situation is only exacerbated.

Some of the solutions are reasonably obvious and not controversial. There is no need to invent new technology; the lack of service response is due to funding. Then there are a set of issues that may appear to provide the ready solution, but the effects of which are largely unproven. With these new strategies, I would urge the thoughtful approach for innovation through pilots, and rigorous evaluation prior to rolling out into prime time. The Substance Abuse Mental Health Services Administration (SAMHSA) under the

leadership of Charles Curie is to be commended for following such a process through the targeted capacity expansion grants for jail diversion programs.

The Criminal Justice/Mental Health Consensus Project provides a model for effective collaboration. We are eager to work with partners in law enforcement, the courts, and corrections to ensure better outcomes for people with mental illness at risk of or with histories of criminal justice involvement. At the same time, we welcome the advocacy of our partners in the project in seeking improved services and consistent policies to support them.

Thank you. I look forward to answering your questions.

Written Testimony

United States Senate Judiciary Committee Hearing

on

"The Criminal Justice System and Mentally Ill Offenders"

June 11, 2002

Reginald A. Wilkinson, Ed.D.

President-Elect
The Association of State Correctional Administrators

Past President
The American Correctional Association

and

Director
The Ohio Department of Rehabilitation and Correction

It is impossible to watch a newscast or read a paper without seeing some mention of a myriad of problems that affect our nation's cities. Virtually every city faces the challenge, with limited financial resources, of what to do with the homeless and the growing substance abusing population who are also frequently mentally ill. Now think of correctional institutions as small cities and multiply those problems ten fold. This is the challenge facing corrections professionals today.

I would like to thank you for the opportunity to provide testimony to this hearing of the Senate Judiciary Committee on the subject of "The Criminal Justice System and Mentally Ill Offenders." I am Reggie Wilkinson, President-Elect of the Association of State Correctional Administrators (ASCA), Past President of the American Correctional Association (ACA), and Director of the Ohio Department of Rehabilitation and Correction (ODRC). I am honored to submit this written testimony to you for your consideration.

In my 29-year career in corrections, I have witnessed a significant growth in the percentage of inmates with a mental illness and the related management challenges associated with this population. The daily challenges that confront a correctional agency in this nation are often wide-ranging and formidable. ODRC, a very large adult state correctional system, is no exception. In addition to operating 33 prisons with a population averaging 45,000, the agency is responsible for parole supervision statewide and probation supervision in 50 of Ohio's 88 counties. One of the monumental challenges to departments of correction, however, is that of operating a comprehensive mental health service delivery system for inmates with a mental illness. In essence, corrections directors also serve as de facto mental health directors.

Funding shortfalls in public mental health systems nationally are well documented with regard to the impact on the delivery of community mental health services to adults and children. Departments of correction are universally experiencing similar budget constraints, which in turn affect the delivery of mental health services to prisoners, parolees, and probationers. The impact of these constraints on offender mental heath services, however, has received less attention. Fiscal constraints, burgeoning prison populations with multiple health and substance abuse issues, as well as legal decisions on the state's obligation to treat the seriously mentally ill have all greatly influenced correctional administration in the local, state and federal correctional systems. By 1986, 38 state prison systems were operating under court orders or consent decrees (Stewart, 1987).

The Ohio Experience, Reflective of the National Experience:

The Ohio prison system was originally created as a part of the Department of Mental Hygiene and Correction and has had a long history of working with those responsible for the state's mentally ill population. The Ohio Department of Rehabilitation and Correction became a stand-alone department in 1972, but maintained a strong working relationship with the new Ohio Department of Mental Health (ODMH). After the filing of a lawsuit Davis v. Watkins against the Lima State (psychiatric) Hospital in the 1970's, formal mental health programs were initiated in Ohio's prisons. ODMH's hospital institutional population during this era was 21,000. At the

same time, ODRC supervised about 8,000 inmates in correctional facilities.

In the 1980's, with the closing of mental hospitals, a shifting began of many mentally ill patients into the community, while mental health services in prisons began to grow. The de-institutionalization of the mentally ill reduced the ODMH population down to about 1,800 in the 1990's. At the same, ODRC's inmate population rose to over 40,000, including about five percent classified as "seriously" mentally ill. The ODRC contracted with the ODMH to provide psychiatric services within the correctional institutions.

Relationships between the two agencies were at times challenging due to the dramatic increase in the prison population and the resultant greater demands for services and staffing. Vigorous debates arose over policy issues such as confidentiality and the priority of treatment versus security. These issues were not unique to Ohio, but were a national phenomenon. As a result of these differences in philosophy, a bifurcated system existed within the prison setting, with security personnel often at odds with treatment staff. In many cases, inmate/patient care bore the brunt of this conflict.

A second major lawsuit began to impact ODRC in 1993. The Dunn v. Voinovich class-action lawsuit, filed in federal court, alleged inadequate mental health care in prisons. Rather than expend time and resources fighting the lawsuit, I elected to take the non-traditional approach of cooperation, thus avoiding court-imposed monitoring and change. A fact-finding team of experts, headed by Attorney Fred Cohen, first investigated and evaluated the state of mental health care within Ohio prisons. The team's recommendations became the basis for successful negotiations between plaintiff and ODRC attorneys. The result was a commitment by the ODRC to make radical changes in the delivery of mental health care to prisoners.

The ODRC and the ODMH, along with assistance from the Ohio Department of Alcohol and Drug Addiction Services (ODADAS), began collaborative efforts to improve the treatment of inmates with a mental illness. The directors of these three departments, along with some of their staff, formed the Governor's Select Team. This group attended the National Coalition on Mental and Substance Abuse Health Care in Criminal Justice Policy Design Academy in Aspen, Colorado in August of 1994, and jointly developed the following mission statement:

> To develop an organized approach for the continuity of holistic, quality treatment for juveniles and adults who come into contact with the criminal justice, mental health and substance abuse systems.

The Governor's Select Team recommendations, along with other factors, set the stage for the development of a comprehensive correctional mental health system of care for inmates in the Ohio prison system.

Prevalence of Mental Disorders in Prison:

There are now an alarming number of inmates with mental illness in our correctional systems.

According to the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics *Special Report* published in July of 1999, at midyear 1998 an estimated 283,800 inmates with a mental illness were incarcerated in the nation's prisons and jails. More recent surveys completed by the Bureau of Justice Statistics found that 16 percent of state prison inmates and 7 percent of federal inmates reported either a mental condition or an overnight stay in a mental hospital. In addition, about another 16 percent of probationers said they had had a mental condition or stayed overnight in a mental hospital at some point in their lifetime.

The July 2001 *Special Report* of the Bureau of Justice Statistics noted that one in every 8 state inmates was receiving some mental health therapy or counseling services at midyear 2000. Ten percent of the state inmate population was reported to be receiving psychotropic medications.

These statistics demonstrate the magnitude of the problems with which departments of correction are faced. Unlike the general public, correctional systems are *required* to provide treatment. Inmates with serious mental illnesses have a constitutional right to treatment under the Eighth Amendment. Failure to provide treatment constitutes grounds for civil lawsuits (Cohen & Dvoskin 1992; Cohen 1993). Linking inmates with mental health services while incarcerated is also less costly and disruptive, not only for the justice system, but upon the inmate's release to the community as well.

Legal Context

The U.S. Supreme Court decision in Estelle v. Gamble, 429 U.S. 97 (1976), made clear that prison inmates have a constitutional right to treatment for physical ailments. Subsequently Bowring v. Godwin (1977) asserted that there were no differences in the need for treatment of physical ills and the need to treat the symptoms of serious mental illness (Cohen & Dvoskin, 1992). In 1980 Ruiz v. Estelle, a landmark case in general prison reform and in mental health care, established six basic components for a "minimally adequate mental health treatment program" for the Texas Department of Criminal Justice.

Most of the important litigation has occurred in the federal courts, with the plaintiff bringing suit under a federal (civil rights) statute, 42 USC Sec. 1983. Defendants are shown to be acting "under the color of state law" and are alleged to have violated the claimants' constitutional rights. These court decisions set the foundation for a right-to-treatment posture in the corrections arena.

Correctional administrators who wish to avoid litigation are thus placed in the position of needing to convince legislators of the need for funding to provide mental health care to inmates with a mental illness.

Funding of Corrections:

Since "September 11th," state governments have been reeling from the impact of a slowed

economy. Consumer spending and business growth is diminished, and consequently revenue from the collection of state taxes is considerably below the projections required to balance budgets. While recent economic data suggests the economy is recovering, states are still experiencing dismal budget situations according to a fiscal survey by the National Association of State Budget Offices.

The provision of mental health care for inmates is a very expensive and staff-intensive operation for correctional administrators. Despite funding shortfalls, state prison systems are pressured to provide mandated care in the most cost efficient manner. The direct cost of such mental health services was estimated nationally to be approximately 60 million dollars in 1990. In addition to the cost for providing the appropriate ratio of treatment staff per inmates on the caseload, a significant portion of the budget is needed to cover the high costs of psychopharmacology needed for the treatment of the mentally ill.

The increases in the costs for medications in general exceed the cost of inflation. The newer psychotropic medications are especially expensive and have almost quadrupled the cost for treating the mentally ill, thus further negatively impacting an already constrained correctional budget. Yet the newer medications are considered to be evidence-based good practice for the treatment of many mental disorders. They have been shown to be more effective than the older, traditional medications in treating the symptoms of mental illness while causing fewer serious, potentially irreversible, side effects and thereby increasing medication.

Diversion:

Diversion alternatives to incarceration affect the number of persons with a mental illness entering the prison setting. Closing the front door of prisons with innovative programs to divert many mentally ill misdemeanants from incarceration, and linking them to mental health services within the community, are not only critical but also the right thing to do. Innovative programs such as mental health courts, police intervention programs such as the nationally known "Memphis Program," and more assertive case-mangement will go a long way towards not only increasing diversions but also reducing the recidivism rates for this special needs population. The recent legislation approved by Congress for funding diversion programs is testimony to the increased understanding by legislators of the need to promote programs that ensure the proper justice system attention to the mentally ill.

Offender Reentry Considerations:

Offender reentry is a justice philosophy, not merely a program. The reentry process should begin upon the felon's admission to the prison system and focuses throughout incarceration on preparing inmates to return to the community as productive citizens with the tools needed for successful reintegration. Reentry cannot be managed in a vacuum, but must include families when possible and be done in collaboration and/or partnership with community resources. This is especially true for special needs populations such as those with mental illness or those who

system were homeless upon arrest, and a lack of housing is a contributor to their difficulties in accessing treatment and other services or holding a job. The bill we will introduce will seek to address this problem by requiring that communities receiving grants coordinate with the Department of Housing and Urban Development (HUD) to ensure that they have a plan of action for the housing needs of individuals with serious mental disorders, including those who are released from prison or jail. If this collaboration is successful, fewer individuals with serious mental disorders will commit another crime. Collaboration between education and training as well as employment agencies must also occur. The bill will address both the juvenile and adult mentally ill populations by ensuring that communities receiving grants meet the unique needs of both adults and children. In addition, the bill will have an evaluation component to ensure that the communities that receive funds are using it for programs that are effective. This will also ensure that extremely successful programs are recognized and can be replicated in other communities.

prison to the community.

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Monitor and facilitate compliance with conditions of release and respond swiftly and appropriately to violations of conditions of release.

Correctional Management:

The effective supervision of the mentally ill offender is both a health concern as well as a management challenge. The following passages are excerpts from an article published in *Correctional Mental Health Report* (Wilkinson, January/February 2000):

> For years, corrections personnel have attempted to discern the difference between prisoners who are "mad" versus those who are "bad." For both security and health reasons, we need to know whether offenders are demonstrating purposeful negative behavior as opposed to those who are "acting out" because of their mental illness. Mental health professionals working closely with security professionals assist in this task.
>
> Whether the prisoner has an acute psychiatric illness or a personality disorder, correctional staff should be concerned with preventing further deterioration. Suicide, and suicide attempts, are stark examples of the consequences of unknown or unattended deterioration. Accordingly, prevention and amelioration of mental health related problems, from an administrative and clinical perspective, is a conscious, ongoing mission.
>
> Unfortunately, prisoners with a "weakness," either physical or mental, are at a disadvantage and are sometimes preyed upon by "stronger" inmates. There is, of course, a constitutional duty to protect vulnerable inmates, and the mentally ill and developmentally disabled often fall into that category. (See Farmer v. Brennan, 511 US 825 (1994), on the "duty to protect" inmates. The duty to protect often overlaps with the duty to treat, and DRC officials are aware of that fact.)
>
> Knowing inmates' physical and mental limitations allows DRC staff to most appropriately house, classify, assign jobs, and treat prisoners. Good mental health, then, includes screening and evaluations, which provide this crucial information. As is the case with 95% of all prisoners, transition to the community is inevitable. For community health and safety reasons, operating a holistic mental health service delivery program for offenders is paramount.

Summary:

Having a significant percentage of mentally ill offenders in prison creates enormous management challenges to correctional administrators and health care professionals alike, who may also be faced with staff shortages, a lack of adequate resources and frequently crowded conditions. It is clear that comprehensive mental health care for offenders yields positive results both within the prison environment and upon release. With adequate treatment within prison, offenders with mental illness are better able to cope with the prison environment and are less likely to exhibit disruptive behavior and challenge the safety and security of the institution, its staff and the other inmates. With continuity of treatment services upon release, the mentally ill offender stands a better chance of not recidivating and of making a successful transition into the community. This in turn not only benefits the offender and his family, but also helps to ensure general public safety.

It is essential that we leverage existing resources to address the challenges of meeting the needs of the mentally ill offender. Effective communication and the establishment of collaborative partnerships between those working in the mental health and criminal justice fields are critical. Such partnerships in which challenges are jointly faced and solutions are collaboratively developed are the key to success in addressing the needs of the mentally ill impacted by the criminal justice system.

Therefore, I would encourage you to consider the need for allocating resources to:

- Support training for justice and health care professionals to ensure recognition of the signs and symptoms of mental illness so that those so affected are appropriately referred for evaluation and treatment;
- Support the efforts of community justice agencies to develop programs that divert misdemeanant mentally ill offenders toward community-based treatment;
- Support adequate mental health services within the correctional system;
- Allow for open access to the newer psychotropic medications that encourage compliance and reduce the risk of litigation;
- Support community efforts to provide safe and affordable housing to help ensure successful transition from incarceration to the community;
- Support applied research regarding working with the mentally ill offender;
- Acknowledge the existence and support the treatment of criminals who have co-occurring disorders: i.e., mental illness and substance abuse, or mental illness and retardation;
- Support the development of treatment models that successfully link the released offender to community services; and,
- Support collaboration between justice agencies and mental health services providers to ensure

timely access to services upon release.

The implementation of these measures would serve as a major step toward improving the lives of the criminal who is mentally ill, increasing the safety of the prison environment for both inmates and staff, decreasing the recidivism rate of offenders with mental illness, increasing public safety, and providing an opportunity for offenders with mental illness to become productive, contributing, and law-abiding citizens.

Within the corrections field there are many issues which consume the attention of correctional administrators. Mental health concerns has risen to the top of the agenda. There are management concerns, fiscal constrains, safety considerations, and health care problems associated with the delivery of mental health care services. The problem is complicated and so is the solution. One thing do we know, however, is doing nothing, or little or nothing, is not an option. Legally it is not an option; having a less than adequate mental health system is very costly, but so is have an acceptable system. Providing good treatment to those with a diagnosed mental illness, whether or not there is a criminal conviction, is simply the "right thing to do."