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MENTALLY ILL OFFENDER TREATMENT AND CRIME REDUCTION ACT OF 2003

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIME, TERRORISM, AND HOMELAND SECURITY

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

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CONTENTS

JUNE 22, 2004

OPENING STATEMENT

Page

The Honorable Howard Coble, a Representative in Congress From the State of North Carolina, and Chairman, Subcommittee on Crime, Terrorism, and Homeland Security 1

The Honorable Robert C. Scott, a Representative in Congress From the State of Virginia, and Ranking Member, Subcommittee on Crime, Terrorism, and Homeland Security 2

WITNESSES

Ms. Cheri Nolan, Deputy Assistant Attorney General, Office of Justice Programs, U.S. Department of Justice

Oral Testimony 4

Prepared Statement 6

Mr. Ted Sexton, Sheriff, Tuscaloosa County Sheriff's Office, Tuscaloosa, Alabama

Oral Testimony 9

Prepared Statement 11

Professor John Monahan, Ph.D., Henry and Grace Doherty Professor of Law, University of Virginia, and Director, MacArthur Research Network on Mandated Community Treatment

Oral Testimony 12

Prepared Statement 14

Mrs. June P. Poe, Past President, National Alliance for the Mentally Ill of Roanoke Valley, Roanoke, VA, on behalf of the National Alliance for the Mentally Ill

Oral Testimony 17

Prepared Statement 19

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

Prepared Statement of the Honorable Ted Strickland, a Representative in Congress From the State of Ohio 30

Prepared Statement of the Honorable Ms. Sheila Jackson Lee, a Representative in Congress From the State of Texas 33

Prepared Statement of the Honorable William D. Delahunt, a Representative in Congress From the State of Massachusetts 38

Letter from Jamie Fellner, Director of Human Rights Watch 41

Letter from Larry E. Naale, Executive Director of the National Association of Counties 43

MENTALLY ILL OFFENDER TREATMENT AND CRIME REDUCTION ACT OF 2003

TUESDAY, JUNE 22, 2004

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CRIME, TERRORISM,
AND HOMELAND SECURITY
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 3:03 p.m., in Room 2141, Rayburn House Office Building, Hon. Howard Coble (Chair of the Subcommittee) presiding.

Mr. COBLE. Good afternoon, ladies and gentlemen. The Judiciary Subcommittee on Homeland Security, Terrorism, and Crime will come to order.

Before I begin, I am told, Ms. Nolan, you need to depart at 4:15 today, so we will try to accommodate you to that end.

The Bureau of Justice Statistics estimated in 1999 that 16 percent of State prison inmates, seven percent of Federal inmates, and 16 percent of those in local jails who are on probation reported either a mental condition or an overnight stay in a mental hospital. According to BJS, white inmates or Caucasian inmates were more likely than blacks or Hispanics to report a mental illness, and offender mental illness was highest for those between the ages of 45 and 54.

According to this study and others, homelessness and unemployment are more prevalent among the mentally ill. Additional statistics show that six in ten mentally ill State inmates were under the influence of alcohol or drugs at the time of the offense, and a third of all mentally ill offenders were alcohol dependent.

BJS also found that six in ten of the mentally ill received treatment while incarcerated. These statistics show the importance of mental health treatment as well as additional assistance for the mentally ill non-violent offenders who end up in the criminal justice system. The statistics also reveal the importance of treatment of not only the drug or alcohol abuse issues, but also the underlying mental illness.

This hearing will examine the prevalence of mental illness in the criminal justice system and explore methods of addressing this problem. Currently, the Department of Justice administers a Mental Health Court grant program in some States. This legislation, which we will review today, S. 1194, the "Mentally Ill Offender Treatment and Crime Reduction Act of 2003," would create a grant program to encourage more States to address this issue.

Now, I have discussed this bill in detail with Senator DeWine, and he is enthusiastically supportive, as am I, but I have some second thoughts about the authorized cost. We can talk about that another day or perhaps today.

But I look forward to hearing from our witnesses today to shed some light on this important issue, and I am now pleased to recognize the distinguished gentleman from Virginia, Mr. Bobby Scott, the Ranking Member.

Mr. SCOTT. Thank you, Mr. Chairman. I am pleased that you have scheduled this hearing on the "Mentally Ill Offender Treatment and Crime Reduction Act of 2003." This bill, which passed the Senate by unanimous consent on October 27, 2003, is sponsored by Senators DeWine and Leahy. It is essentially the same as H.R. 2387, sponsored by Representative Strickland, except for the provisions to include substance abuse programs among those with which there is required collaboration under the bill.

This legislation represents phase two of an effort that started in the 106th Congress when Congressman Strickland and Senator DeWine led a successful effort in getting, quote, "Americans Law Enforcement and Mental Health Project Act" passed. That bill created a Department of Justice grant program which helped State and local governments establish Mental Health Courts. These courts provide specialized dockets which bring mental health professionals, social workers, public defenders, and prosecutors together to divert mentally ill offenders into a treatment plan.

The indication is that the pilot Mental Health Courts projects that we authorized have been proven successful. We will hear the details from our witnesses, but it is clear that a significant number of Mental Health Courts and other diversion programs have sprung up since the law was passed. It is also clear that they have successfully diverted individuals with mental health problems from the criminal justice system into treatment, restoring individuals to healthy, productive lives, and saving money, comparing the lower cost of treatment to incarceration.

S. 1194 will build on the Law Enforcement and Mental Health Project Act's success by providing additional resources for communities that wish to create Mental Health Courts. The bill will make a significant commitment to addressing the needs of both the criminal justice system and the mentally ill offender population. It offers grants to communities to develop diversion programs, mental health treatments in jails and prisons, and transition and aftercare services to facilitate reentry into the community. The bill also requires collaboration between criminal justice, mental health treatment, and substance abuse and other agencies at the local level in collaboration with the Federal level through creation of an interagency task force.

This is clearly necessary, appropriate, and helpful legislation to address a serious problem in the criminal justice and mental health treatment administration. I look forward to the testimony of our witnesses and working with you and our colleagues, Mr. Chairman, in getting this bill signed into law.

Mr. COBLE. I thank the gentleman, and I am pleased to welcome, as well, the distinguished gentleman from Florida, Mr. Feeney, and the distinguished gentleman from Virginia, Mr. Goodlatte.

Mr. GOODLATTE. Mr. Chairman?

Mr. COBLE. The gentleman from Virginia?

Mr. GOODLATTE. Mr. Chairman, I would ask unanimous consent that a statement from Representative Strickland from Ohio be entered into the record.

Mr. COBLE. Without objection, it will be received.

[The prepared statement of Mr. Strickland follows in the Appendix]

Mr. COBLE. Our first witness today is Ms. Cheri Nolan. Ms. Nolan was appointed as Deputy Assistant Attorney General for the Office of Justice Programs in July of 2001. She has served four Attorneys General and three Presidents. Prior to her service at OJP, Ms. Nolan worked for the television show "America's Most Wanted," known to all of us, as well as serving in the White House staff of President Ronald Reagan and in various cabinet agencies, including the Departments of Commerce, Energy, and Treasury.

Our second witness is Mr. Ted Sexton. Mr. Sexton has been the Sheriff of Tuscaloosa County since January 1991 and is currently serving in his fourth term. As Sheriff, Mr. Sexton served eight courts and has law enforcement jurisdiction over 1,340 square miles within Tuscaloosa County. He is currently Vice President of the National Sheriffs Association and will be President of the Association in 2005. Mr. Sexton earned his Bachelor of Arts degree at the University of Alabama and is a graduate of the FBI National Academy. And Mr. Sexton—pardon my immodesty, I am a fairly decent geographer—I assume Tuscaloosa County is in Alabama. I didn't know that was certain, but I figured that. [Laughter.]

Next, we have Dr. John Monahan. Dr. Monahan is a psychologist and holds the Doherty Chair of Law at the University of Virginia, where he is a professor of psychology and psychiatric medicine. Dr. Monahan has been appointed to the Committee on Law and Justice of the National Research Council. His work has been cited in numerous court decisions, and he has received distinguished awards for two of his books, The Clinical Prediction of Violent Behavior and Rethinking Risk Assessment.

Finally, we welcome Mrs. June Poe. Mrs. Poe, I believe you are a constituent of Congressman Goodlatte, and he has requested the honor of introducing you.

Mr. GOODLATTE. Mr. Chairman, thank you very much. Thank you for holding this hearing on what is clearly a very important issue that needs to be carefully examined because I don't think we are giving our courts and our prison system, frankly, the kind of flexibility they need to have treatment and punishment fit the circumstances of the individuals who present themselves to them.

We have somebody here with us today who can speak from personal experience. She is speaking on behalf of the National Alliance for the Mentally Ill, but she has five children. She is a widow, and I know that that has been a challenge for her because one of her children does have a mental illness and has had some problems with our criminal justice system as a result.

So I very much welcome her and am delighted to have the opportunity. I thank you, Mr. Chairman, for inviting her to testify today.

Mr. COBLE. I thank the gentleman from Virginia.

Representative Strickland, the gentleman from Ohio, I know you have been very interested in this legislation, and even though you don't sit as a Member of this Subcommittee, we would be happy to have you join us up here. You would not be able, however, to participate and question the witness. If you would like to come up and sit with us, you would be welcome to do so.

Mr. STRICKLAND. Thank you, Mr. Chairman.

Mr. COBLE. Ladies and gentlemen, it has become the practice of the Subcommittee to administer the oath to our witnesses appearing before us, so if you all would please stand and raise your right hands.

Do each of you solemnly swear that the testimony you are about to give this Subcommittee shall be the truth, the whole truth, and nothing but the truth, so help you, God?

Ms. NOLAN. I do.

Mr. SEXTON. I do.

Mr. MONAHAN. I do.

Mrs. POE. I do.

Mr. COBLE. Let the record show that each of the witnesses has answered in the affirmative and you may be seated.

Again, I welcome you all. Folks, so you will be familiar with the drill, we operate under the 5-minute rule here. When you see that red light illuminate in your eye, that is your warning that the 5 minutes have elapsed, and if you don't cease and desist I am going to order Sheriff Sexton to take you—— [Laughter.]

Mr. Scott and I are not that hard-hearted, but in view of Mrs. Poe's schedule, as well, we do try to do the 5-minute rule. Your testimony has been examined. The amber light will appear first and the amber light will tell you that the ice is becoming thin, then the red light, the 5 minutes have expired.

Ms. Nolan, if you will commence.

TESTIMONY OF CHERI NOLAN, DEPUTY ASSISTANT ATTORNEY GENERAL, OFFICE OF JUSTICE PROGRAMS, U.S. DEPARTMENT OF JUSTICE

Ms. NOLAN. Thank you, Mr. Chairman. Mr. Chairman, Mr. Scott, and Members of the Subcommittee, I am Cheri Nolan, Deputy Assistant Attorney General of the Office of Justice Programs. I am pleased to be here on behalf of the United States Department of Justice, especially the Office of Justice Programs, to discuss how the criminal justice system responds to individuals with mental illness who are involved with the system.

This is an issue that cuts across Federal, State, and local boundaries, with mentally ill individuals being held everywhere from city lockups to Federal prison facilities. For example, OJP's Bureau of Justice Statistics reported that in the year 2000, 13 percent of State prisoners were receiving some mental health therapy and nearly 10 percent were receiving psychotropic medications. Those figures translate to 143,000 prisoners receiving mental health therapy and 110,000 on medications.

Another BJS report found that 16 percent of correctional detainees self-reported that they had a mental illness. This increasing number of people with mental illness in the criminal justice system has become one of the most pressing problems facing law enforce-

ment in corrections today and it is an issue with both major public safety and fiscal implications.

However, we need to be clear at the outset that individuals who are found guilty of committing crimes must be held accountable. If they commit a serious crime, then they need to be incarcerated whether or not they are mentally ill. We will not absolve someone of responsibility for committing a crime simply because he or she has a mental illness.

At the same time, we hear from police, prosecutors, judges, and correctional administrators that they are frustrated with existing responses to people with mental illness who commit less serious non-violent crimes. On the one hand, when these individuals are not incarcerated and remain in the community, they continue to tax public safety resources and can be a threat to public safety. On the other hand, even when those with mental illness do spend time in jail, the criminal justice system is a revolving door with extremely high recidivism rates for persons with mental illness.

Without connections to treatment, support services, and housing, mentally ill individuals will continue to re-offend and jeopardize public safety. That is why pre-release planning and cross-agency collaboration are vital to the successful reentry of these individuals into the community.

Today, however, this collaboration is the exception, not the rule, but we believe that OJP can be a valuable resource to State and local governments in these efforts. We can promote promising practices, provide technical assistance, and conduct research that will stimulate the development and replication of programs and policies that will increase public safety and make the justice system more efficient.

For example, OJP's Bureau of Justice Assistance has published a monograph which is the first in-depth examination of Mental Health Courts and will be a guide to communities in developing their own courts. BJA has also provided grants totaling approximately $5.5 million to 37 jurisdictions in 29 different States to fund Mental Health Courts. These 2-year grants, totaling about $150,000 per site, have helped some existing courts add key components to their programs and have helped other courts launch their operations.

BJA sponsored the first ever national meeting of mental health court practitioners in Cincinnati, Ohio, this past January, which was part of OJP's overall goal of providing information and technical assistance to the field. We will also publish guides for implementing and operating Mental Health Courts later this year.

Through these activities and through our own interagency collaboration with the Department of Health and Human Services, as well as with the Council of State Governments, we are able to demonstrate to State and local governments that the collaboration between mental health and criminal justice agencies is not only possible, but extremely valuable.

My experience over the years and most recently at OJP tells me that no one sector or one agency alone can resolve the issues surrounding the involvement of mentally ill individuals in the criminal justice system. However, together, we can come closer to an out-

come that will both provide necessary treatment and preserve public safety.

I thank you for your interest in this critical issue and I will be pleased to answer any questions that you might have.

Mr. COBLE. Thank you, Ms. Nolan.

[The prepared statement of Ms. Nolan follows:]

PREPARED STATEMENT OF CHERI NOLAN

Mr. Chairman, Mr. Scott, and Members of the Subcommittee, I am Cheri Nolan, Deputy Assistant Attorney General of the Office of Justice Programs. I am pleased to be here this afternoon on behalf of the U.S. Department of Justice (DOJ) and especially the Office of Justice Programs to discuss how the criminal justice system responds to individuals with mental illness who are involved with the system.

This is an issue that cuts across federal, state, and local boundaries, with mentally ill individuals being held everywhere from city lockups to federal prison facilities.

It is becoming clear that the increasing number of people with mental illness in the criminal justice system is one of the most pressing problems facing law enforcement and corrections today. This issue has both major public safety and fiscal implications.

To understand the policy implications facing us, I would like to highlight some data about what prisons and jails are doing, and what has become a more and more common profile among offenders. According to a special report by the Office of Justice Programs' Bureau of Justice Statistics (BJS), in 2000, nearly all (95 percent) state adult confinement facilities screened inmates for mental health problems. Of the nation's 1,558 state public and private adult correctional facilities, 1,394 reported they provided mental health services to their inmates. Nearly 70 percent of facilities housing state prison inmates reported that as a matter of policy they screened inmates at intake, 13 percent of state prisoners were receiving some mental health therapy or counseling services at midyear 2000, and nearly 10 percent of state prisoners were receiving psychotropic medications. BJS's report was based on the "2000 Census of State and Federal Adult Correctional Facilities," which included—for the first time—items related to facility policies on mental health screening and treatment.

Another BJS report found that 16 percent of correctional detainees self-reported they had a mental illness. We all recognize that the accuracy of this estimate depended on the ability and willingness of inmates to report such problems, which makes a strong argument for using uniform, proven assessment and screening tools. However, if this prevalence rate of mental illnesses among correctional detainees were used as the actual rate for program planning, there would be approximately 2 million individuals with serious mental illnesses admitted to U.S. jails and prisons each year.

I'm sure that we agree that all individuals who are found guilty of committing crimes must be held accountable. If the crime is serious, incarceration is the appropriate response, regardless of whether the perpetrator has a mental illness. Our policy is clear: we will not absolve someone of any responsibility for committing a crime simply because he or she has a mental illness.

At the same time, police, prosecutors, judges, and corrections administrators regularly voice their frustrations about existing responses to people with mental illness who commit low-level, less-serious crimes. When incarceration is not the answer, individuals with mental illness often are returned to the community, where, without access to appropriate housing and comprehensive mental health care and support services, they are more likely to be picked up for low level crimes once again in a costly and repetitive cycle.

Yet, even for those with mental illness who spend time in jail, the criminal justice system is a "revolving door." Recidivism rates for individuals with mental illness are extremely high. Let me cite two examples: first, according to an October 1998 article in *Psychiatric Services,* more than 70 percent of inmates with mental illness released from the Lucas County, Ohio jail were re-arrested over the course of 3 years, and second, according to the Los Angeles County Board of Supervisors' Task Force on Incarcerated Mentally Ill, about 90 percent of Los Angeles County jail inmates with mental illness are repeat offenders, and almost one-third of the inmates have been incarcerated 10 or more times.

These figures are a testament to the difficulty of ensuring that people with mental illness leaving correctional facilities are connected to needed treatment, support

services, and housing. Without those connections, these individuals will continue to re-offend and public safety will continue to be jeopardized.

The involvement of people with mental illness in the justice system also is extremely expensive. County jails are forced to use huge portions of their pharmacy budgets for mental health treatment. According to Oregon's Lane County Sheriff's Office and Tennessee's Benjamin Harrington/Knox County Mental Health Association, respectively, in the past year, 58 percent of the pharmacy budget in Lane County and 80 percent in Knox County were spent on psychotropic medications. Many inmates with serious mental illness require 24-hour suicide watch. The New York Monroe County Sheriff's Office, which houses just over 1,000 inmates in its jail, spent $315,000 in 1 year alone on overtime for officers assigned to this responsibility.

Managing individuals with mental illness in prison is no less costly. The Pennsylvania Department of Corrections estimates that an inmate with serious mental illness costs $140 per day to incarcerate, nearly twice as much as an inmate without serious mental illness.

In response to the need to address the combined problems of offender management and increasing costs, state and local governments across the country are developing programs and policies unique to their jurisdiction's criminal justice systems that aim to improve the response to people with mental illness from the initial contact with law enforcement through the offender's re-entry to the community from prison.

For example, state and local governments have encouraged police departments to form crisis intervention teams, developed pretrial screening for defendants with mental illness, established mental health courts, specialized caseloads for probation officers, introduced new instruments to screen newly admitted inmates for mental illness, implemented therapeutic communities in jails and prisons for offenders with co-occurring substance abuse and mental health disorders, and formed multidisciplinary teams to work on inmates' re-entry planning.

At the heart of each of these emerging strategies is collaboration between the criminal justice and mental health systems, the crucial involvement of substance abuse treatment providers and other social service providers, and the need for affordable housing and employment. As we have demonstrated in the cross-agency Serious and Violent Offender Re-entry Initiative in which DOJ has partnered with the Department of Labor and the Department of Health and Human Services, no one sector or agency can solve this problem working alone. Together, they can make a difference.

Today, however, this collaboration is the exception, not the rule. As we have learned, even those leaders in the criminal justice and mental health systems who are interested in working together are unsure of what they can do, and, despite the possibility of generating significant savings to the state and county, the limited budgets in most jurisdictions make it very difficult to experiment with new ideas.

Yet, I believe that OJP can be a valuable resource to state and local governments. By promoting promising practices, providing technical assistance, and working with other DOJ agencies as well as with both the Substance Abuse and Mental Health Services Administration ("SAMHSA") (in the Department of Health and Human Services) and NIMH to conduct research, we can stimulate the development and replication of programs and policies that will increase public safety and make the justice system more efficient.

For instance, the Bureau of Justice Assistance (BJA) has supported the investigation and implementation of mental health courts. In 2000, BJA published the first in-depth examination of mental health courts, "Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload." This monograph described the organization and operation of four of the earliest mental health courts and has helped guide communities in developing their own mental health courts.

In the Fiscal Year 2003 appropriation, BJA received funding for mental health courts, which we have administered according to the parameters established in P.L. 106–515, "America's Law Enforcement and Mental Health Project." BJA has provided grants totaling approximately $5.5 million to 37 jurisdictions in 29 different states. These two-year grants, totaling approximately $150,000 per site, have helped some existing mental health courts add key components to their program and helped other courts in the planning stages launch their operations.

Beyond direct grant funding, it is our responsibility to the field to provide information and technical assistance grounded in research and representing sound criminal justice practice, regardless of whether the project receives OJP funding. That is why, in addition to the grant funding, OJP promotes technical assistance. Through this technical assistance, BJA sponsored the first-ever national meeting of mental health court practitioners in Cincinnati, Ohio this past January. In addition,

grantee courts are receiving guidance on issues such as connecting court clients to housing, responding to the particular needs of women, and gathering outcome data.

Later this year, BJA will publish guides for implementing and operating mental health courts. As with all of our programs, we are working with the field to collect outcome data, which will further inform our policy decisions in this area. OJP's National Institute of Justice (NIJ), is one of BJA's partners in these endeavors. NIJ plans to publish the results of its examination of the referral and decision-making processes of seven BJA-funded mental health courts.

While mental health courts can be a component of addressing the problems associated with offenders with mental illness, other approaches are needed as well. That is why BJA has supported the Criminal Justice/Mental Health Consensus Project, which is coordinated by the Council of State Governments. The landmark Consensus Project Report provides hundreds of recommendations that policymakers and practitioners agree will improve the response to people with mental illness who come in contact with the criminal justice system.

In recent months, we have taken several steps at BJA to help state and local governments think about this issue from arrest through re-entry.

First, the Director of BJA has appointed a senior policy advisor for criminal justice and mental health issues. This is the first time the agency has had such a position. It demonstrates our recognition that the involvement of people with mental illness in the justice system is becoming one of the most important issues facing local and state criminal justice agencies and that BJA must be responsive to their needs.

Second, some grantees are using Serious and Violent Offender Re-Entry Initiative funds, better known as "re-entry," to improve the transition that people with mental illness make from prison to the community.

Third, BJA is currently developing a strategic plan to support the efforts of law enforcement, corrections, and courts in dealing with individuals with mental illness. In fact, earlier this month, a group of court and mental health experts met to develop recommendations to BJA on what activities we and our federal partners could undertake to support court-based efforts to better address defendants with mental illness.

Increasing collaboration between criminal justice and mental health agencies is essential at the state and local levels, as well as at the federal level. We are coordinating our efforts with SAMHSA, particularly with regard to their Targeted Capacity Expansion (TCE) Grants for Jail Diversion Programs. While the programs are similar in nature, SAMHSA is providing grants for pre- and post-booking diversions that do not involve continuous judicial oversight, treatment, and case disposition. BJA is funding models that provide continuous judicial oversight and intensive case management, ensuring that offenders remain accountable throughout the process. Our cooperative efforts with SAMHSA will also help ensure that the federal government does not fund overlapping grant programs.

In addition, the technical assistance providers for both agencies' programs, the Council of State Governments and the TAPA Center for Jail Diversion (part of the GAINS Center funded by DOJ and SAMHSA), are working closely to coordinate their efforts. These organizations meet quarterly and are working together on a number of key issues, including promoting judicial leadership and better understanding the fiscal impact of mental illness in the justice system.

This coordination helps us maximize the value of each agency's grant program. Furthermore, this collaboration enables us to leverage each agency's resources, expertise, and credibility with our respective constituencies in state and local governments. Most important, it allows us to demonstrate to state and local governments that the collaboration between mental health and criminal justice agencies is not only possible, but extremely valuable.

And, BJA is working with SAMHSA to implement the policies identified in the July 2003 report of the President's New Freedom Commission on Mental Health to maximize the utility of existing resources, improve coordination of treatments and services, and promote successful community integration for adults with a serious mental illness.

Mr. Chairman, from my work at OJP I have come to believe that the increasing number of people with mental illness in the criminal justice system is one of the most pressing issues facing our police departments, jails, prisons, and courts. State and county governments have demonstrated that thoughtful policies and programs can be developed to address this problem. The federal partners are committed to doing all we can to support practitioners through our grant programs and technical assistance.

We very much appreciate the interest you and your colleagues have shown in this critical issue. I welcome the opportunity to answer any questions that you may have.

Mr. COBLE. Sheriff Sexton.

TESTIMONY OF TED SEXTON, SHERIFF, TUSCALOOSA COUNTY SHERIFF'S OFFICE, TUSCALOOSA, AL

Mr. SEXTON. Mr. Chairman, my name is Ted Sexton and I am the Sheriff of Tuscaloosa County. I serve on the Executive Committee and Board of Directors of the National Sheriffs Association. I appreciate the opportunity to share with you some thoughts from NSA and the larger enforcement community on the need for S. 1994, the "Mentally Ill Offender Treatment and Crime Reduction Act" now under consideration by this Committee. Before I begin, let me say that we strongly supported S. 1194, which passed the United States Senate unanimously and welcome these hearings in the House.

Most of the people suffering mental illness with whom law enforcement officers interact are non-violent, low-level offenders who are demonstrating signs of untreated mental illness in public. For the most part, these individuals pose a low risk of harming others, but act inappropriately enough to cause members of their community to be concerned. Many of the calls my office receives are actually placed by family members who are seeking law enforcement help to control behavior of someone who is off their medication.

It is clear that without proper training on how to respond to these individuals, law enforcement may not be able to appropriately handle the situation. These contacts have a great potential for rapid escalation of both threat and force. Minor situations can easily escalate into a violent confrontation that jeopardizes the safety of both officers and the individual.

In many circumstances, arresting the mentally ill individual is an inappropriate response, even if the officer believes that arresting the individual for a criminal charge is appropriate under the circumstances. County jails are not equipped to house a large number of mentally ill offenders. Jails are jails. They are not treatment facilities nor are they hospitals. Jails ought not to be the treatment option of first resort, but sadly, they have become just that because there is nothing else readily available.

In my own community, we have seen a steady rise in the number of calls related to mentally ill individuals. This rise in calls for response has largely corresponded to the decline in population of large institutions within my community that have traditionally provided services to the mentally ill. As these individuals have been moved from an institutional setting to community based programs, we have seen a rise in the number of contacts that officers have with them.

In response to the increased frequency in calls for service relating to this particular population of our community, my senior staff and I set out to develop a program within our office that trains officers to more effectively deal with mentally ill individuals. The training program provides officers with a better understanding of mental health issues and provides a number of suggested options other than arrest.

The training is not limited to patrol officers who are most likely to come in contact with mentally ill individuals, but also includes dispatch officers who field the calls for service. In addition, we pro-

vide the training to other law enforcement agencies, fire/rescue squads, EMTs, and our volunteer fire departments. Last year, the training program was presented to more than 100 officers from various agencies, and currently there are more than 180 officers scheduled to receive the training. The Alabama Peace Officers Standards and Training Commission has recently established this program as a pilot for eventual State-wide implementation.

Providing this training to law enforcement officers is a critically important element of providing service to the mentally ill in our community, but it is only one of the elements. Providing meaningful alternatives to incarceration is another equally critical component. As things stand now, the officer in the field is often left to choose between the unappealing alternatives of locking up the mentally ill individual or leaving them on the scene. Right now, there is very little middle ground and no real other options.

The problems with these choices are obvious. Simply leaving the individual at the scene is unacceptable and serves neither the sick individual nor the public. Taking these individuals to jail, however, is often just as problematic. County jails are not equipped to handle mentally ill individuals. There is limited space in which to house these individuals apart from the general population at the jail.

Of course, they are in jail because they were causing problems outside. Their offensive behavior does not magically improve in the jail setting. In fact, behavior often deteriorates in jail. Conflicts with other detainees or the inability to follow the rules of the facility often escalate into situations that threaten the safety of an officer or the individual.

Providing medical care for these individuals in a jail setting is a tremendous concern, as well. Tuscaloosa County houses approximately 600 inmates. At any given time, roughly 10 percent of the jail population is on some sort of psychotropic medication. The vast majority of those are on multiple medications. In the final quarter of last year, the cost of those medications cost my office and the taxpayers of Tuscaloosa almost $75,000. Additional costs are incurred because the staff of the jail has to be extra vigilant in monitoring mentally ill individuals. Frequently, they are on suicide watch, which requires additional detention officers to monitor them, thus increasing manpower needs.

A mentally ill person in jail receives very basic and limited mental health assistance. I would hesitate to call it treatment. The fact is, they receive far less mental health care than they need and are subsequently released back into society without either a safety net or a system in place to ensure compliance with a treatment plan. Frequently, the cycle is repeated over and over again. The mentally ill are being arrested after they have failed to keep up the prescribed medication regime.

The still unresolved problem for us, as for virtually all sheriffs' offices across the country, is finding an alternative placement for those individuals for whom jail is not appropriate. As I said earlier, the jail is not designed nor equipped to provide treatment for mentally ill. Jails are designed for holding those individuals awaiting trial or incarceration of those serving sentences and should not be viewed as an alternative treatment facility for mentally ill. For

those who do require incarceration, placing them in the appropriate setting will help minimize the time that they actually spend in custody.

Additionally, a system for monitoring these individuals once they are released from jail is also needed to ensure that we can break the cycle I have outlined. It is a disservice to everyone involved if we cannot arrange some more appropriate treatment than locking up the mentally ill in jail.

For our part in Tuscaloosa, we are partnering with mental health professionals within our community to try to address these issues and we believe that H.R. 2387 will provide the resources and guidance we need to develop and implement creative solutions. Thank you.

Mr. COBLE. Thank you, Sheriff.

[The prepared statement of Mr. Sexton follows:]

PREPARED STATEMENT OF SHERIFF TED SEXTON

Mr. Chairman, my name is Ted Sexton, and I am the Sheriff of Tuscaloosa County, Alabama. I serve on the Executive Committee and Board of Directors of the National Sheriffs' Association where I am the incoming First Vice President. I appreciate the opportunity to share with you some thoughts from NSA and the larger law enforcement community on the need for S. 1194, the Mentally Ill Offender Treatment and Crime Reduction Act now under consideration by this committee. Before I begin, let me say that we strongly support S. 1194, which passed the U.S. Senate unanimously and welcome these hearings in the House.

Most of the people suffering mental illnesses with whom law enforcement officers interact are non-violent, low-level offenders who are demonstrating signs of untreated mental illness in public. For the most part, these individuals pose a low risk of harming others, but act inappropriately enough to cause members of the community to be concerned. Many of the calls my office receives are actually placed by family members who are seeking law enforcement help to control the behavior of someone who is "off their medication."

It is clear that without proper training on how to respond to these individuals, law enforcement officers may not be able to appropriately handle the situation. These contacts have a great potential for rapid escalation of both threat and force. Minor situations can easily escalate into a violent confrontation that jeopardizes the safety of both the officers and the individual.

In many circumstances, arresting the mentally ill individual is an inappropriate response. Even if the officer believes that arresting the individual for a criminal charge is appropriate under the circumstances, county jails are not equipped to house a large number of mentally ill offenders. Jails are jails; they are not treatment facilities nor are they hospitals. Jails ought not be the treatment option of first resort, but sadly they have become just that because there is nothing else readily available.

In my own community, we have seen a steady rise in the number of calls related to mentally ill individuals. This rise in the calls for response has largely corresponded to the decline in the population of large institutions within my community that have traditionally provided services to the mentally ill. As these individuals have been moved from an institutional setting to community-based programs, we have seen a rise in the number of contacts that officers have with them.

In response to the increased frequency in calls for service relating to this particular population of our community, my senior staff and I set out to develop a program within our office that trains officers to more effectively deal with mentally ill individuals. The training program provides officers with a better understanding of mental health issues, and provides a number of suggested options other than arrest. The training is not limited to patrol officers who are most likely to come in contact with mentally ill individuals, but also includes our dispatch officers who field the calls for service. In addition, we provide the training to other law enforcement agencies, fire/rescue squads, EMTs, and our volunteer fire departments. Last year, the training program was presented to more than 100 officers from the various agencies last year and currently, there are more than 180 officers scheduled to receive the training. The Alabama Peace Officers Standards and Training Commission has re-

cently established this program as a pilot program for eventual statewide implementation.

Providing this training to law enforcement officers is a critically important element of providing service to the mentally ill in our community; but it is only one of the elements. Providing meaningful alternatives to incarceration is another, equally critical component. As things stand now, the officer in the field is often left to choose between the unappealing alternatives of locking up a mentally ill individual or leaving them on the scene. Right now, there is very little middle ground and no real other options.

The problems with these choices are obvious. Simply leaving the individual at the scene is unacceptable and serves neither the sick individual nor the public. Taking these individuals to jail, however, is often just as problematic. County jails are not equipped to handle mentally ill individuals. There is limited space in which to house these individuals apart from the general population at the jail. Of course, they are in jail because they were causing problems on the outside. Their offensive behavior doesn't magically improve in the jail setting. In fact, behavior often deteriorates in jail. Conflicts with other detainees or the inability to follow the rules of the facility often escalate into situations that threaten the safety of an officer or the individual.

Providing medical care for these individuals in a jail setting is a tremendous concern as well. The Tuscaloosa County Jail houses approximately 600 inmates. At any given time, roughly 10 per cent of the jail population is on some type of psychotropic medication. The vast majority of those are on multiple medications. In the final quarter of last year, the cost of those medications cost my office and the taxpayers of Tuscaloosa almost $75,000. Additional costs are incurred because the staff at the jail has to be extra vigilant in monitoring mentally ill individuals. Frequently they are on suicide watch, which requires additional detention officers to monitor them, thus increasing manpower needs and costs.

A mentally ill person in jail receives very basic and limited mental health "assistance". I would hesitate to call it treatment. The fact is that they receive far less mental health care than they need and are subsequently released back into society without either a safety net or a system in place to ensure compliance with a treatment plan. Frequently, the cycle is simply repeated over and over again with the mentally ill being arrested after they have failed to keep up with their prescribed medication regimen.

The still unresolved problem for us, as for virtually all Sheriff(s Offices across the country, is finding an alternative placement for those individuals for whom jail is not appropriate. As I said earlier, the jail is not designed nor equipped to provide treatment for the mentally ill. Jails are designed for the holding of individuals awaiting trial or incarceration of those serving sentences and should not be viewed as an alternative treatment facility for the mentally ill. For those who do require incarceration, placing them in an appropriate setting will help minimize the time that they actually spend in custody. Additionally, a system for monitoring these individuals once they are released from jail is also needed to ensure that we can break the cycle I've outlined. It is a disservice to everyone involved if we cannot arrange some more appropriate treatment than locking up the mentally ill in jail.

For our part in Tuscaloosa, we are partnering with mental health professionals within our community to try to address these issues, and we believe that HR 2387 will provide the resources and guidance we need to develop and implement creative solutions to this chronic problem.

Mr. Chairman, I am ready to take your questions and I look forward to working with you to address this issue in a way that is helpful to the mentally ill and provides them with the treatment and services that they need.

Mr. COBLE. I failed to mention earlier, folks, your entire statements will be made a part of the record.

Dr. Monahan.

TESTIMONY OF JOHN MONAHAN, Ph.D., HENRY AND GRACE DOHERTY PROFESSOR OF LAW, UNIVERSITY OF VIRGINIA, AND DIRECTOR, MACARTHUR RESEARCH NETWORK ON MANDATED COMMUNITY TREATMENT

Mr. MONAHAN. Thank you, Chairman Coble, Congressman Scott, and Members of the Subcommittee for inviting me here this afternoon. In addition to my day job at the University of Virginia School of Law, I direct the Research Network on Mandated Community

Treatment for the MacArthur Foundation. The network is now engaged in a partnership with the National Institute of Justice to evaluate seven of the Mental Health Courts funded by Congress 2 years ago that Mr. Scott mentioned.

I will begin with the bottom line. The "Mentally Ill Offender Treatment and Crime Reduction Act" is the most evidence-based piece of Federal legislation on mentally ill offenders that I have seen in my 30 years as a researcher in this field.

I say this for five reasons. First, the evidence is that the number of people this Act will affect is staggering. As you mentioned early on, Mr. Chair, 16 percent of adults in contact with the justice system are estimated to be mentally ill. This means that on any given day in the United States, there are over 200,000 prison inmates, 100,000 jail detainees, and 700,000 people under the supervision of community corrections—over one million people in all—with a serious mental illness. Three-quarters of these mentally ill people also have a co-occurring substance abuse disorder.

Women in the justice system have nearly twice the rate of mental illness as the male, but only one-third of the men and one-quarter of the women with a mental illness in jail report receiving any treatment for that mental illness while they were in jail.

Another piece of evidence about the magnitude of this problem is the large number of communities that have taken it upon themselves to do something about people with mental illness in the justice system. The number of Mental Health Courts in the United States has mushroomed from one in 1997, to a dozen in 2002, to close to 100 this month.

By the most recent count, there are almost 300 jail diversion programs now operating in the United States. This means that 7 percent of all counties have a police or a court-based program to divert defendants with a mental illness from jail. This also means that 93 percent of all counties are without any program to keep non-violent defendants with a mental illness from crowding their jails and from committing more crime.

Second, the evidence is that we can make a difference. Offenders with a mental illness can, in fact, be dealt with in ways that can reduce crime, save taxpayers money, or both.

In terms of crime reduction, consider the MacArthur Violence Risk Assessment Study of over 1,000 people who have been hospitalized for mental illness, about half of whom had a prior contact with the criminal justice system. Now, the people who received no medication or therapy in the community after they get out of the hospital, 14 percent soon committed a violent act. Of the people who received an inadequate amount of treatment, about one treatment session a month, the violence rate was reduced from 14 percent to about 9 percent. But of the people who received the amount of treatment that they needed, about one session a week, the violence rate went from 14 percent to less than 3 percent. Amazingly enough, the people with mental illness who were receiving adequate treatment in the community were actually less violent than their neighbors who were not mental illness at all.

In terms of saving taxpayer money, consider the pioneering Broward County, Florida, Mental Health Court. Compared to a nearby county without a Mental Health Court, the Broward de-

fendants are twice as likely to actually receive service for their mental illness and are no more likely to commit a new crime, despite the fact that the number of days they spent in jail is reduced by 75 percent, at enormous savings to the public.

Third, the evidence is that one size does not fit all in terms of effectively dealing with mentally ill offenders. This Act is remarkably adaptable to local conditions in the pragmatic approach it takes to mentally ill offenders. Funded programs may include pretrial diversion in one jurisdiction, a Mental Health Court in another, a reentry program from jail or prison in a third, and some combination of these options in a fourth jurisdiction.

Fourth, the evidence is that collaboration is essential to get anything accomplished having to do with mentally ill offenders. As the Council on State Government's Criminal Justice/Mental Health Consensus Project concluded after 5 years of intensive study, and as Ms. Nolan just noted, neither mental health nor criminal justice can do the job alone. This Act creates powerful incentives for cooperation between the Department of Justice and the Department of Health and Human Services and among agencies at the Federal, State, and local levels. Crime and mental illness deeply affect all of our communities, and perhaps for this reason, the turf battles that doom many reform efforts seem to have been carefully avoided in drafting this Act.

Finally, the evidence is that we need more evidence. We know a lot about how to deal with mentally ill offenders, vastly more than we knew even 5 years ago. But by no means do we know all we need to state with confidence what the best practices are for dealing with different kinds of mentally ill offenders in different kinds of American communities. By imposing strict requirements for objective assessments of the measurable outcomes of the programs that are implemented with its funds, the Act will generate a self-correcting body of knowledge that uses findings about the effectiveness of past practice to shape improvements in future practice.

As Sheriff Sexton noted, the Act was born of the frustration of criminal justice officials in seeing ever more people with mental illness further crowd the already overcrowded jails, rarely receive the mental health treatment that they so plainly need, and continue to appear before them for the commission of yet another crime. The Act before you can set State and local governments on a course to put a stop to this revolving door.

The evidence is there. I urge you to pass the "Mentally Ill Offender Treatment and Crime Reduction Act".

Mr. COBLE. Thank you, Doctor.

[The prepared statement of Mr. Monahan follows:]

PREPARED STATEMENT OF JOHN MONAHAN

Thank you, Chairman Coble and Congressman Scott, for inviting me to testify before you today. I am Dr. John Monahan, a psychologist, and I hold the Doherty Chair in Law at the University of Virginia, where I am also a Professor of Psychology and of Psychiatry. I have been involved in Federally-funded research on mentally ill offenders since the publication of my first book, *Community Mental Health and the Criminal Justice System,* in 1976. I currently direct the Research Network on Mandated Community Treatment for the John D. and Catherine T. MacArthur Foundation, which is concerned with how the criminal justice system can be used as "leverage" to get offenders with a mental disorder to accept treat-

ment for their illness.[1] The Network is now engaged in a productive partnership with the National Institute of Justice to evaluate seven of the mental health courts funded by Congress as part of the 2000 America's Law Enforcement and Mental Health Project Act.[2]

I will begin with the bottom line: the Mentally Ill Offender Treatment and Crime Reduction Act of 2003 is the most evidence-based piece of federal legislation on mentally ill offenders that I have seen in 30 years as a researcher in this field. I say this for five reasons.

FIRST, THE EVIDENCE IS THAT THE NUMBER OF PEOPLE THIS ACT WILL AFFECT IS STAGGERING.

In its initial finding, the Act notes that the Bureau of Justice Statistics, using a broad definition of mental illness, concludes that over 16 percent of adults in contact with the justice system are mentally ill. This means that on any given day in the United States, there would be over 200,000 prison inmates, 100,000 jail detainees, and 700,000 people under the supervision of community corrections—over one million people in all—with a serious mental illness. Three-quarters of these mentally ill people also have a co-occurring substance abuse disorder.[3] Women in the justice system have nearly twice the rate of mental illness as men.[4] But only one-third of the men and one-quarter of the women with a mental illness in jail report receiving any treatment while they were detained.[5]

Another piece of evidence about the magnitude of the problem that the Act addresses is the large number of communities that have taken it upon themselves to do something about people with mental illness in the justice system. The number of mental health courts in the United States has mushroomed from one in 1997, to a dozen in 2002, to close to 100 this month.[6] By the most recent count, there are almost 300 jail diversion programs now operating in the United States.[7] This means that 7 percent of all counties have a police or court-based program to divert defendants with a mental illness from jail.[8] This also means that 93 percent of all counties are without any program to keep non-violent defendants with a mental illness from crowding their jails and committing more crime.

SECOND, THE EVIDENCE IS THAT WE CAN MAKE A DIFFERENCE: OFFENDERS WITH A MENTAL ILLNESS CAN IN FACT BE DEALT WITH IN WAYS THAT REDUCE CRIME, SAVE TAXPAYERS' MONEY, OR BOTH.

In terms of crime reduction, consider the MacArthur Violence Risk Assessment Study of over 1,000 people who had been hospitalized for mental illness, about half of whom had a prior contact with the criminal justice system.[9] Of the people who received no medication or therapy in the community after they got out of the hospital, 14 percent soon committed a violent act. Of the people who received an inadequate amount of treatment—about one treatment session a month—the violence rate was reduced from 14 percent to about 9 percent. But of the people who received the amount of treatment that they needed—about one session a week—the violence rate went from 14 percent to less than 3 percent. Amazingly enough, the people with a mental illness who were receiving adequate treatment were actually less violent than their neighbors in the community who were not mental ill.

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[1] A list of Network publications can be found at *http://macarthur.virginia.edu*

[2] Redlich, A., Steadman, H., Monahan, J., Petrila, J., & Griffin, P. (in press). The second generation of mental health courts. Psychology, Public Policy, and Law.

[3] Abram, K., & Teplin, L. (1991). Co-occurring disorders among mentally ill jail detainees. *American Psychologist, 46,* 1036–1045.

[4] National GAINS Center. (2002). *The prevalence of co-occurring mental illness and substance abuse disorders in the justice system.*Delmar, NY: GAINS Center.

[5] Massaro, J. (2004). *Working with people with mental illness involved in the criminal justice system: What mental health service providers need to know* (2nd ed.). Delmar, NY: TAPA Center for Jail Diversion.

[6] Survey of Mental Health Courts. (2004). Available at *http://www.mentalhealthcourtsurvey.com*

[7] TAPA Center for Jail Diversion. (2004). *What can we say about the effectiveness of jail diversion programs for persons with co-occurring disorders?* Available at *http://www.gainsctr.com/pdfs/tapa/WhatCanWeSay.pdf*

[8] Steadman, H. (2004). A national perspective on diversion and linkage to community-based services. Available at *http://www.gainsctr.com/ppt/NationalPerspectiveon DiversionanLinkage.ppt*

[9] Monahan, J., Steadman, H., Silver, E., Appelbaum, P., Robbins, P., Mulvey, E., Roth, L., Grisso, T., & Banks, S. (2001). *Rethinking risk assessment: The MacArthur study of mental disorder and violence.* New York: Oxford University Press.

In terms of saving taxpayers' money, consider the pioneering Broward County (Ft. Lauderdale), Florida, Mental Health Court, whose rigorous evaluation is also being supported by the MacArthur Foundation. This court presents mentally ill misdemeanor defendants with the choice of accepting mental health treatment in the community, or having their cases processed in the business-as-usual way, which may well mean jail time. Perhaps not surprisingly, 95 percent of the defendants given this option choose treatment. Compared to a nearby county without a mental health court, the Broward defendants are twice as likely to actually receive services for their mental illness [10] and are no more likely to commit a new crime, despite the fact that the number of days they spend in jail for the current offense is reduced by 75 percent, at enormous savings to the public.[11] While the NIJ/MacArthur-funded evaluation of mental health courts receiving federal grants is still in progress, the Broward study demonstrates that courts have a central role to play in responding to people with mental illness in the justice system.

THIRD, THE EVIDENCE IS THAT ONE SIZE DOES NOT FIT ALL IN TERMS OF EFFECTIVELY DEALING WITH MENTALLY ILL OFFENDERS.

"First and foremost," leading researchers have concluded, "it must be clear that there is no one best way to organize a program [of diverting mentally ill offenders from jail]. An approach that works in one community may not be practical somewhere else." [12]

The Act is remarkably adaptable to local conditions in the programmatic approach it takes to mentally ill offenders. Funded programs may include pre-trial diversion in one jurisdiction, a mental health court in another, a re-entry program from jail or prison in a third, or some combination of these options in a fourth.

What Justice Brandeis wrote in 1932 and the Supreme Court has quoted on three dozen subsequent occasions is true today. "It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel . . . experiments without risk to the rest of the country." This Act is one of those happy incidents.

FOURTH, THE EVIDENCE IS THAT COLLABORATION IS ESSENTIAL TO GET ANYTHING ACCOMPLISHED HAVING TO DO WITH MENTALLY ILL OFFENDERS.

Neither mental health nor criminal justice can do the job alone. This Act incentivizes cooperation between the Department of Justice and the Department of Health and Human Services, and among agencies at the federal, state, and local levels. Crime and mental illness deeply affect all of our communities, and perhaps for this reason the turf battles and the narrow single-issue concerns that doom many reform efforts seem to have been carefully avoided in drafting this Act.

As the Council of State Government's *Criminal Justice/Mental Health Consensus Project* concluded after five years of intensive study: [13]

The single most significant common denominator shared among communities that have successfully improved the criminal justice and mental health systems' response to people with mental illness is that each started with some degree of cooperation between at least two key stakeholders—one from the criminal justice system and the other from the mental health system (p. xx).

FINALLY, THE EVIDENCE IS THAT WE NEED MORE EVIDENCE.

We know a lot about how to deal effectively with mentally ill offenders—vastly more than we knew even five years ago. But by no means do we know all we need to state with confidence what the "best practices" are for dealing with different kinds of adult and juvenile mentally ill offenders in different kinds of American communities. By imposing strict requirements for objective assessments of the measurable outcomes of the programs that are implemented with its funds, the Act will generate a self-correcting body of knowledge that uses findings about the effectiveness of past practice to shape improvements in future practice. In mandating

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[10] Boothroyd, R., Poythress, N., McGaha, A., & Petrila, J. (2003). The Broward Mental Health Court: Process, outcomes, and service utilization. *International Journal of Law and Psychiatry, 26,* 55–71.

[11] Cristy, A., Poythress, N., Boothroyd, R., Petrila, J., & Mehra, S. (submitted for publication). Evaluating the efficiency and community safety goals of the Broward County Mental Health Court.

[12] Morris, S. & Steadman, H.J. (1994). Keys to successfully diverting mentally ill jail detainees. *American Jails,* July/August, 47–49.

[13] Council of State Governments. (2002). *Criminal Justice/Mental Health Consensus Project.* Available at *www.consensusproject.org*

empirical evidence of program performance, the Act avoids simply throwing money at a problem. Instead, it assigns accountability and it demands results.

The Act was born of the frustration of criminal justice officials in seeing ever more people with mental illness further crowd their already over-crowded jails, rarely receive the mental health treatment that they so plainly need, and continue to appear before them for the commission of yet another crime. The Act before you can set state and local governments on a course to put a stop to this revolving door.

The evidence is there. I urge you to pass Mentally Ill Offender Treatment and Crime Reduction Act of 2003.

Mr. COBLE. Mrs. Poe.

TESTIMONY OF JUNE P. POE, PAST PRESIDENT, NATIONAL ALLIANCE FOR THE MENTALLY ILL OF ROANOKE VALLEY, ROANOKE, VA, ON BEHALF OF THE NATIONAL ALLIANCE FOR THE MENTALLY ILL

Mrs. POE. Thank you, Chairman Coble, Representative Scott, and other distinguished Members of the Committee for this opportunity to speak to you on the importance of S. 1194. I also thank my representative, Congressman Goodlatte, for being here, and also thank Congressman Strickland for his leadership on the issues that we are discussing today.

I am June Poe from Roanoke, Virginia, and I have one of my five children who suffers from severe mental illness. I have worked in the field of psychiatry as a Licensed Clinical Social Worker and my husband was a physician. My family has experienced the heartbreaking lack of vital services needed to help prevent unnecessary contacts of people with mental illnesses with the criminal justice system.

I am also pleased to be here today to testify on behalf of NAMI, the National Alliance for the Mentally Ill, and at the outset, I would also like to recognize the support of the Campaign for Mental Health Reform, representing the broad mental health community for S. 1194.

You have heard these distinguished witnesses. Now, my son and I want to put a human face on this bill. In 1974, John, a brilliant student and athlete, suffered his first psychotic break as an 18-year-old freshman at Wake Forest University. He was diagnosed with paranoid schizophrenia. For the next 12 years, he struggled courageously to try to continue his education and employment as he dealt with the pain of his chronic severe mental illness. He was hospitalized nine times and received some community mental health services, but in those days, the 1970's and 1980's, psychiatric treatment and services for people with severe mental illness was still in the dark ages.

In 1987, unfortunately, he stopped taking his medication and we finally had to call the police because we did not feel safe due to his psychotic behavior. He was arrested and jailed for breaking and entering our home, destroying property. My husband and I were very well educated about medicine and the mental health system. We sought help from every possible source. Despite this, John had to suffer the horrible experience of being locked up in jail and treated as a criminal. He was becoming sicker without treatment.

The darkest day in my memory was that day when I realized that the court did not have the ability to provide him the help he desperately needed. A felony conviction was the worst thing that

could have happened to him. Physicians take an oath of "do no harm." Lawyers should take the same oath. The judge sent him back to jail with no other than an admonition to take his medication. John was not able to comply because of his mental illness. When John was psychotic, he did not know he was sick.

The horrendous manner in which my son's case was handled demonstrates the profound need for education and cross-training of criminal justice and mental health personnel. Most of the individuals involved in my son's case at that time had no knowledge about schizophrenia, its symptoms, and its treatments, and there was no system in place for coordinating services between the criminal justice and mental health.

The story gets worse. While in jail, John's condition continued to deteriorate. After his release from jail, the mental health professionals could not make him take his medications. He was jailed two more times. Having to call the police about your own child and then visiting him in jail is an agony that I pray no one in this room will ever have to endure.

John's incarcerations only made his psychiatric symptoms worse and we could do nothing to help him. The services he needed to recover were not available.

Finally, in 1990, a gifted probation officer and mental health professional helped my son begin a tortuous journey back to recovery. The road has not been smooth. John was hospitalized on three more occasions and even attempted to commit suicide. Throughout the 1990's, John had periods when he was able to maintain a degree of independence and periods when he was very ill and symptomatic.

In 2001, John again stopped taking his medication and became psychotic. He had a paranoid delusion that neighbors were harming their dogs, so he opened the gate and let them escape from being hurt by their owners and the owners wanted to call the police and have him arrested. This time the Assertive Community Treatment, the PACT team, intervened and prevented his arrest and incarceration. With this excellent, intensive community care he is now back on medication, has an understanding of his illness, and is stabilized. Unfortunately, these high-quality mental health services and supports are not available to most people.

I am excited about the purpose of S. 1194, to foster local collaborations. In our Roanoke Valley, we have developed collaborations for providing better services for people like John who need treatment, not punishment. The only thing lacking are resources to implement our ideas and our plans. S. 1194, if enacted, will provide the needed resources.

In conclusion, I strongly urge passage of S. 1194, a bill that will greatly benefit both people with serious mental illnesses and entire communities. In 1974, John, a brilliant young freshman at Wake Forest University, suffered paranoid schizophrenia. In 1987, he was cast away by the criminal justice system. Today, at age 48, John, instead of being incarcerated as a criminal, is living independently in the community. He is truly a courageous survivor.

I have asked permission to read a very short statement that he asked me to read to you. "Thank you for this opportunity to testify why I support S. 1194. I am John Poe, June Poe's son. I am men-

tally ill and have been sent to jail on two misdemeanors and one felony, non-violent and non-drug abuse crimes. If the Mental Health Court and the PACT team had been in effect at that time, it would have made my life more comfortable. Jail is a very bad place for people with mental health. People with mental health cannot get proper treatment in jail. I urge you to vote for this bill. Signed, John Poe."

Thank you for giving me the opportunity to testify.

Mr. COBLE. Thank you, Ms. Poe. You indicated John was a courageous young man. I think his mom is a pretty courageous person in her own right.

Mrs. POE. And I have three of my children back here who are courageous, too.

Mr. COBLE. It is good to have all of you in the audience with us today.

[The prepared statement of Mrs. Poe follows:]

PREPARED STATEMENT OF JUNE P. POE

Thank you, Chairman Coble, Representative Scott and other distinguished members of the Committee for this opportunity to speak to you on the importance of S. 1994, a bill that would foster collaborations to ensure that resources are effectively and efficiently used to develop alternatives to incarceration for individuals with mental illnesses charged with non-violent crimes.

I am June P. Poe from Roanoke, Virginia, a widow with 5 children, one of whom suffers from severe mental illness. I have worked in the field of psychiatry as a Licensed Clinical Social Worker and my husband was a physician. My family has experienced the heartbreaking lack of vital services needed to help prevent unnecessary contacts of people with mental illnesses with the criminal justice system. My husband, until his death in 1994, and I have continued to fight for my son, John, and many others who fall between the cracks.

I am pleased to be here today to testify on behalf of NAMI (the National Alliance for the Mentally Ill). At the outset, I would also like to recognize the support of the Campaign for Mental Health Reform for S. 1194. It is very important to note that the mental health community as a whole stands behind this bill.

You will hear from the other distinguished witnesses how critical the problems are and what is needed to alleviate them. My son John and I want to put a human face on this bill. John has given me permission to tell this story. This is our story but we are not alone. I am speaking for many many families who have similar stories. In most cases, these stories would have been far happier had the services envisioned in S. 1194 been available to people like my son.

In 1974, John, a member of the High School National Honor Society, former Captain of his High School Track team (voted most valuable member of that team), artist, and a brilliant freshman at Wake Forest University suffered his first psychotic break. He was diagnosed with paranoid schizophrenia. For the next 12 years he struggled courageously to try to continue his education, and employment as he dealt with the pain of his chronic severe mental illness. He was hospitalized nine times and received some community mental health services but these services were not adequate to keep him stabilized. He struggled with the side effects of the old medications. In those days (1970s and 1980s) psychiatric treatment and services for people with severe mental illnesses were still in the dark ages. Our family has continued to give him love and support through it all.

In 1987 unfortunately he stopped taking his medications and we finally had to call the police because we did not feel safe due to behaviors that were the product of his deteriorating psychiatric state. He was eventually arrested and jailed for breaking and entering our home at 5:30 AM and destroying property. John said "I just wanted to get some sleep." The Commonwealth's attorney recommended a felony charge, explaining that this was the only way to get John treatment. My husband and I were very well educated about medicine and the mental health system. We had sought help from every possible source—judges, lawyers, and many mental health programs and mental health professionals. John had to suffer the horrible experience of being locked up in a jail and treated as a criminal. We suffered the painful agony and grief of visiting our son in jail. He was becoming sicker without

medication and treatment. The Commonwealth's attorney and his assistant and even our own attorney (my cousin) did not know what to do.

The darkest day in my memory was that day in court when I realized that the court did not have the ability to provide him the help he desperately needed. We had been advised that pleading guilty to a felony was the only way to get John treatment. In actuality, a felony conviction was the worst thing that could have happened to him. The judge sent him back to jail, with no treatment whatsoever, other than an admonition to take his medication. When the judge told my son to take his medication, he was not able to comply because of his mental illness. When John was psychotic he did not know he was sick.[1]

The horrendous manner in which my son's case was handled demonstrates the profound need for education and cross training of criminal justice and mental health personnel. Most of the individuals involved in my son's case at the time had no knowledge about schizophrenia, its symptoms, and its treatments. And there was no system in place for coordinating services between criminal justice and mental health. I am very gratified that S. 1194 will allow communities to use available funds to provide the training necessary to ensure that those responding to individuals like my son in the future will be better prepared to do so in a humane and effective way.

The story gets worse. While in jail, John's condition continued to deteriorate.

For the next 3 years my son and the rest of our family went through hell. After his release from jail, the mental health professionals could not make him take or stay on his medications. The services he needed to recover, such as assertive community treatment, were not available.[2]

We had to call the police again. Having to call the police about your own child, and then visiting him in jail is an agony that I pray no one in this room will ever have to endure. Research proves that people with severe mental illnesses get sicker when they do not get necessary medical treatment. We saw our son get sicker and could do nothing to help him. His incarcerations only made his psychiatric symptoms worse.

Finally, in 1990, a gifted probation officer who is also a gifted mental health professional, helped my son get released from jail and begin his tortuous journey back to recovery. This is not to say that the road was smooth. John was hospitalized on several occasions and even attempted to commit suicide. Schizophrenia is a disease known to be episodic in nature. Throughout the 1990's, John had periods when he did quite well, and periods when he was very ill and symptomatic.

In 2001 John again became psychotic when he stopped taking his medication. He had a paranoid delusion that neighbors were harming their dogs so he opened the gate and let them "escape from being hurt by their owners". After he had done this the third time the neighbors called the police and brought charges to have him arrested. This time his Assertive Community Treatment (PACT) team intervened and prevented his arrest and incarceration. With this excellent intensive community care he is now back on medication, has an understanding of his illness and need for medication and is stabilized. He has received excellent acute care at Catawba Hospital (our regional state psychiatric hospital) and excellent services through Blue Ridge Behavioral HealthCare (our regional community mental health services). I am grateful that mental health care is now available to prevent a repeat of the horror of those 3 years when he was in jail. Unfortunately, these high quality mental health services and supports are not available to most people.

I am excited that the purpose of S. 1194 is to "foster local collaborations" which will ensure that resources are effectively and efficiently used to reduce the unnecessary incarceration of non-violent offenders with mental illnesses. In the Roanoke Valley, we have numerous examples of such collaborations. For example, in 2001, under the leadership of Police Chief Ray Lavender of Roanoke County, the County established a police Crisis Intervention Team (CIT) program, the first of its kind in the Commonwealth of Virginia. The Mental Health Association of Roanoke Valley and NAMI-Roanoke Valley worked closely with Chief Lavender in creating this important new program.

In 2002, I, representing NAMI-Roanoke Valley, helped to establish a Task Force to better address the needs of people with mental illnesses who come into contact with the criminal justice system in the Valley. Its mission is to "identify those issues

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[1] Amador, Xavier, "I'm Not Sick, I Don't Need Help", Vida Press, revised 2004.

[2] Assertive community treatment programs are characterized by intensive, outreach-oriented services, available on a 24 hour, seven day a week basis, for people with severe and persistent mental illnesses who are at risk of hospitalizations. These programs have proven effectiveness in reducing involvement with criminal justice systems, homelessness and other adverse consequences of lack of treatment.

inhibiting the effective delivery of services for offender populations with a mental illness and encourage the development and implementation of a continuum of community based care for persons with mental illness that will reduce the prevalence and incidence of offenders with mental illness within the criminal justice system." The Task Force members represent state and federal criminal justice professionals, (judges and probation officers in the 23 Judicial Circuit and District Courts and US Federal Court) public mental health professionals (the Medical Director of Catawba Hospital, Blue Ridge Behavioral Health staff) and advocates (NAMI-Roanoke Valley and the Mental Health Association of Roanoke Valley).

Despite the severe cutbacks in mental health agencies and facilities and criminal justice systems due to the state budget crisis, this Task Force, in just its first year accomplished the following:

- Established communication between the professionals (including judges) in the criminal justice system, mental health agencies, and advocates, which previously did not exist because they did not have a forum to communicate with each other;
- Identified 11 issues and challenges inhibiting the effective and efficient treatment of offenders who have mental illness within the Roanoke Valley;
- Assessed current capabilities of mental health agencies and facilities and criminal justice systems to effectively respond to offenders who have mental illness and avoid re-hospitalizations and re-incarcerations;
- Achieved some non-cost approaches to improve the efficiency and effectiveness in responding to the needs of this population;
- Developed coordination of services between jails, mental health community agencies and hospitals;
- Eliminated duplication of services in the transition of services from jail to community; and
- Provided training this past Spring, 2004, to more than 60 attorneys, judges and probation officers about mental health issues and treatment resources.

In the Roanoke Valley we are well down the path of developing more humane and cost-effective responses to individuals with mental illnesses who, due to non-violent offenses, come into contact with criminal justice systems. The only thing lacking are resources to implement our ideas. S. 1194, if enacted, will provide communities like ours with opportunities to implement services to break the endless cycle of deterioration and arrests for people like my son, who are not criminals but desperately need treatment!

In conclusion, I strongly urge passage of S. 1194, a bill that will greatly benefit both people with serious mental illnesses and entire communities. Jail diversion programs and community reentry services, coupled with comprehensive community mental health treatment such as PACT, are less expensive than a criminal justice system without treatment. The benefits are obvious. Today, my son, instead of being incarcerated as a criminal, is living independently in the community, volunteering weekly in the psychosocial rehabilitation program at Catawba Hospital, participating actively in treatment, and is well along the road to recovery. And, I once again feel safe, as do others in my family and community.

In 1974, John, a brilliant young freshman at Wake Forest University suffered a biologically based brain disorder. In 1987, he was "cast away" by the criminal justice system. Now, John is truly a courageous survivor. He wrote the following statement urging the passage of S. 1194. He asked me to read it to you.

(Written statement of John Poe, read by June P. Poe).

Thank you for this opportunity to testify why I support S. 1994.

I am John Poe, June Poe's son. I am mentally ill and have been sent to jail for two misdemeanors and one felony, non-violent and non-drug abuse crimes.

If the mental health court and PACT had been in effect at that time it would have made my life more comfortable. Jail is a very bad place for people with mental illness. People with mental illness cannot get proper treatment in jail.

I urge you to vote for this Bill.

(signed: John Poe)

Thank you for giving me the opportunity to testify before you today.

Mr. COBLE. Folks, we impose the five minute rule against us, as well, so if you all could keep your answers tersely, we would be appreciative.

Ms. Nolan, one of the criticisms of the Drug Court program is the lack of evaluation and the lack of reporting by the grantees. Is there any effort in the Mental Health Court program to require grantees to provide information for evaluations, and how is the program being evaluated? Furthermore, is there an effort to establish best practices for the grantees?

Ms. NOLAN. Yes, sir, yes, sir, and yes——

Mr. COBLE. It is a multi-faceted question. [Laughter.]

Ms. NOLAN. The quick answer to your question, sir, is yes to all the questions that you posed. The National Institute of Justice, a component of the Office of Justice Programs, is currently overseeing a process evaluation of all the currently funded sites. Following that, as was mentioned in the testimony, the MacArthur Treatment Foundation will be conducting an outcome evaluation of seven of the sites that we are funding.

In addition, each one of the grantees on a semi-annual basis is required to report to us on various performance measures, both from the client standpoint and from the community's standpoint.

Mr. COBLE. I thank you.

Sheriff, law enforcement officials must collaborate with mental health professionals to most effectively address the lack of treatment of mentally ill non-violent offenders. Have you experienced or do you anticipate any difficulties or impediments or road blocks in this collaborative effort?

Mr. SEXTON. No, sir.

Mr. COBLE. And you have had good experience with it?

Mr. SEXTON. Yes, sir.

Mr. COBLE. All right. When I said terse, I think they took me literally. [Laughter.]

Mr. COBLE. Dr. Monahan, according to your testimony, 95 percent of defendants, when faced with the option of treatment or jail time for an active sentence—they choose treatment. In your opinion, should these defendants have that option, A, and why do you believe these individuals do not seek treatment on their own without court intervention? Is this generally the first treatment these individuals will be involved with?

Mr. MONAHAN. Sir, many individuals who need mental health treatment oftentimes unfortunately don't avail themselves of it, sometimes because of the side effects of those treatments. I think that the 95 percent of the defendants in Broward who accept treatment do so in part because the criminal justice system is being used as leverage to get them into treatment. As I mentioned, they are no more likely to commit a crime if they are diverted from the criminal justice system. It saves the community 75 percent on jail days, and I think if you can either reduce the crime rate or keep the crime rate constant but drastically reduce the cost at no additional risk to the public, that sounds like a winning strategy to me.

Mr. COBLE. I thank you.

Mrs. Poe, you mentioned in your testimony that the Roanoke Valley Task Force initially identified challenges inhibiting the ef-

fective and efficient treatment of mentally ill offenders within your community. Identifying these challenges and assessing current capabilities seems essential to developing a strategy to address the issue. During this phase, did you discover deficiencies inherent within the criminal justice system or the mental health community regarding the treatment of mentally ill offenders?

Mrs. POE. Yes, sir. In the mental health system, there was a strong—there was not enough money to provide for the services that were needed. Money was one issue.

There are difficulties in the collaboration—well, there are difficulties with the criminal justice system in dealing with the issues of medication, serious problems there which we have been trying to address. The problems of having the appropriate medications that the doctor has, the psychiatrist has prescribed needs to be with that patient. They do not always get those medications in the jail. We have been working hard on trying to solve that problem.

There is also a need for greater education of the people in the criminal justice system to understand what mental illnesses are. One of our groups, one of our projects has been to have an educational program where we trained this spring with 60 of the lawyers, the judges, and probation officers to begin to understand what mental illnesses are and what the medication issues are.

Mr. COBLE. I see my red light, but before I yield to Mr. Scott, let me ask you this question, Mrs. Poe. Is it your belief that the bill before us appropriately addresses these problems?

Mrs. POE. Yes. There is in education—in the bill, there is cross-training and education that is crucial. Money for the services are very important, but the collaboration, fostering the collaboration between the systems is of major importance. It is—one of the things we found was that until we had this task force, they weren't speaking to each other. Coming together, communicating with each other, they found out what their problems were and began to work on ways of solving those problems, that when we didn't have any money, we could still be a little bit more efficient in communicating on those problems.

Mr. COBLE. I thank you, and I will say to the gentleman from Virginia, I owe you a minute and 3 seconds. [Laughter.]

Mr. SCOTT. Thank you. Thank you, Mr. Chairman.

Dr. Monahan, you went to great lengths to talk about the evaluation and research and importance in that. Is this something unusual in criminal justice legislation, to actually evaluate and study what you are doing before you do it?

Mr. MONAHAN. Well, it is certainly not unheard of, sir, but I think it is unusual to have the emphasis on evaluation be so integral a part of the bill as it is a part of this bill. I think, ideally, people will learn from what they try in the beginning. They will see what works and doesn't work. They will do less of the former and more of the latter.

Mr. SCOTT. Thank you, and I think that is something new. We don't usually do a lot of studying before we jump into it.

Ms. Nolan, what are the costs involved in setting up a program?

Ms. NOLAN. It varies, sir. Funding is available currently through the Edward Burn Memorial Justice Assistance grant programs as one of the purpose areas that States can use to help fund start-up

of Mental Health Courts. In addition, there are a number of jurisdictions that have been able to, through existing resources, been able to basically cobble together through existing resources some courts.

As far as specific numbers as to the extent to which, at the low end, what courts may cost, and at the high end, I would be happy to try to get that information for you and back to you.

Mr. SCOTT. Thank you. There are two parts of it. One is the administrative expense in setting up the court. You have got the setup costs, administrative, if you have got to hire an administrator or a computer or a desk and that kind of thing, and they are ongoing administrative expenses. Also, if it is going to work, you have to have some services available for the defendants. Do the courts that you have funded have adequate services to refer the defendants to?

Ms. NOLAN. On those that I am familiar with, yes, there are adequate funds, but again, we are funding only some demonstration projects. My understanding of what is going to be offered under the pending legislation is that there will be planning and implementation grants so that jurisdictions will be able to determine really what their needs are going to be in that particular jurisdiction, what kind of funds will be needed.

Mr. SCOTT. Because this is one of the problems. We have gone to community-based mental health rather than institutional-based mental health, and Sheriff Sexton has mentioned that some of his people run into people in the community that are not getting all of the services that they actually need. We run into this with juveniles occasionally. The only way they can get services is if you arrest them on something and then the court can provide the services.

But it is your understanding that in these courts, there are adequate services available once someone gets into the system?

Ms. NOLAN. What I would like to focus on, sir, is the importance of the collaborative efforts that are involved in each of these Mental Health Courts, that it is not just a criminal justice problem, it is not just a mental health problem, but there are various systems with their resources that can all come together to help generate the resources that are needed.

One thing that I have found under my leadership with the Serious and Violent Offender Reentry Initiative and the work with the other Federal agencies that I do, it is impossible for just one Government agency or one segment of the services that are provided to be able to do it alone. It is very important that we are able to leverage the resources that we have to be able to address the problem.

Mr. SCOTT. It has been mentioned also that a lot of the defendants have, what did you call them, co-occurring problems, not only mental health but also substance abuse. Are they dealt with in this legislation?

Ms. NOLAN. I am sorry, sir, I don't know. I am not that familiar with the specifics of the legislation.

Mr. SCOTT. Dr. Monahan, do you——

Mr. MONAHAN. They are explicitly. Defendants with a mental disorder who also have a co-occurring secondary substance abuse

disorder are indeed—can have programs for them funded under this legislation.

Mr. SCOTT. Sheriff Sexton, if you don't arrest the mentally ill, what happens to them?

Mr. SEXTON. That is a great question. Oftentimes, it depends on what the family wants to do. Normally, the family calls us in order to try to get something done. It also depends on the economic status and well-being of the family at the time. But a majority of the times, unfortunately, the only option out there is arrest, so they end up coming into the facility. In our particular community with the program that we have now, we are using the local cooperative venture that we have, the collaborative effort to bring in local mental health, to channel that person to another mechanism.

The problem comes, as Ms. Nolan mentioned, is when you have a felony, you are dealing with a felon. Virtually, there is no way to deal with the problem on the front end. It has to be dealt with at the back through a circuit judge. In those situations, we are somewhat limited, but again, the collaborative effort of this particular bill and the problem of the tennis game of batting the client back and forth between the agencies, I think everybody, at least in our community, has finally settled in to—and other communities is settling down on focusing the problem and solving it.

Mr. SCOTT. Now, can they get that kind of effort going without an arrest?

Mr. SEXTON. Yes, sir.

Mr. SCOTT. So they don't have to be arrested to get services?

Mr. SEXTON. No, sir. We have crisis intervention, suicide intervention, or get them to the local community mental health officials.

Mr. SCOTT. Do you have sufficient mental health services to address the need in your community?

Mr. SEXTON. We are the mental health capital of Alabama. [Laughter.]

Yes, sir, we have, and then we also serve several hospitals for the State. So yes, sir, we do.

Mr. SCOTT. Ms. Nolan, is $150,000 enough to get these things going? Are there things that the programs are not doing because of insufficient funding?

Ms. NOLAN. If I may be able to get back with you, sir, with specific information regarding the sites that we are going to be doing specific evaluation of and see what their needs are, I would be happy to get back to you with that specific information. I do not have that with me right now.

Mr. SCOTT. Mr. Chairman, I know Virginia doesn't spend as much for mental health as some other areas, but I am delighted to see that some don't have the funding problems that I believe we do in Virginia.

Mr. SEXTON. Mr. Scott, if I may, Alabama would be more than glad to accept grants—— [Laughter.]

Let me not shortchange the State.

Mr. SCOTT. Thank you.

Mr. COBLE. I thank the gentleman.

Folks, since only Mr. Scott and I are here and it appears we are going to be able to release Ms. Nolan by 4:15, let us do a second round.

Sheriff, supporters contend that this legislation will result in a huge cost savings. How will this program save local government money, A, and how about Federal programs, if you are able to comment to that?

Mr. SEXTON. Well, the taxpayers immediately would have a mechanism to deal with especially the low-level non-violent offender. As I mentioned in my statement, $75,000 was spent in the last quarter of our budget last year for psychotropic drugs. This will allow us to have other mechanisms.

One of the problems that we do have when it comes to funding is that many community-based health programs can support the psychotropic drugs under particular drug programs that are available in the Federal Government now, but as soon as that person is incarcerated, we lose the ability of having that same drug coverage. I think it is called a 207(b) program. So, therefore, we are having to pay that additional coverage. So once somebody becomes incarcerated, we have more strings that tie us up in a jail situation.

As far as the Federal programming, the ability to be able to possibly intervene in situations earlier, an earlier intervention than what we have now, would ultimately save family, save local government, State, and incarceration medical costs. And then we experienced the loss of three police officers in Birmingham last week, substance abusers and potential mental health problems. We could save the loss of life.

Mr. COBLE. I thank you.

Ms. Nolan, does the Bureau of Justice Statistics continue—I don't think we have touched on this—continue to collect data on the number of mentally ill within the system and have you seen any reduction in the number since you began the Mental Health Court grant program?

Ms. NOLAN. Yes, sir. The Bureau of Justice Statistics is continuing to collect data and the next round of data will be available in 2005. We expect in early 2005, the new data will be available.

And the next part of your question? I am sorry.

Mr. COBLE. I just discarded it.

Ms. NOLAN. Okay. [Laughter.]

Mr. COBLE. Have you seen the reduction?

Ms. NOLAN. It is too early to tell, sir, because the Mental Health Courts have been in existence for such a short period of time. It is too early to be able to tell exactly what the results are.

Mr. COBLE. I thank you.

Dr. Monahan, you indicated in your testimony that you have done research on the Mental Health Court program the Department of Justice is currently managing. How does that program differ from the program described in this bill, A, and what are the advantages and disadvantages of this approach?

Mr. MONAHAN. Yes, sir. I think that the bill envisions Mental Health Courts that could function very much as the courts that are currently funded by the Office of Justice Programs. I am involved in the evaluation of the first seven of those programs funded by the National Institute of Justice. We have a few more months of that evaluation, and then the MacArthur Foundation is going to fund

the evaluation, as Ms. Nolan said, of the actual outcomes, which will take longer.

Some of the initial results of this process evaluation, it seems like the seven Mental Health Courts, early on, Mental Health Courts accepted primarily misdemeanors. The new Mental Health Courts, many of them are accepting felonies, primarily non-violent felonies. But they are demanding that the defendant plead guilty before he or she can get in the Mental Health Court. They are not just suspending prosecution.

And indeed, early on, the Mental Health Courts were very reluctant to place people in jail if they didn't adhere to mental health treatment. The newer Mental Health Courts, if you don't go to treatment, then you do go to jail. And they are also, finally, increasing using the criminal justice system supervision, for example, probation rather than some kind of social work.

Mr. COBLE. I thank you, Doctor, and I say to my friend from Virginia, now you owe me a minute and 4 seconds. [Laughter.]

Mr. SCOTT. Thank you. Dr. Monahan, do insanity defenses get involved in these?

Mr. MONAHAN. No, sir, they do not. Insanity defense, despite many people's views to the contrary, are generally raised in about one percent of prosecutions. It fails three-quarters of the time that it is raised. So only one-quarter of 1 percent of criminal cases are disposed of by the insanity defense. Those people usually spend at least as much time in the hospital as they would have spent in jail.

Mr. SCOTT. Mrs. Poe, in your testimony, you ended up that your son ended up getting arrested. Were you able to get services for him without him being arrested?

Mrs. POE. No. No. When he became psychotic, he was off of his medication—and I could not get the help.

Mr. SCOTT. And after he was arrested, did you get the help?

Mrs. POE. No. The treatment, the help only came in 2001 when the Assertive Treatment Team became involved, and that did the trick. That is a very important part.

Mr. SCOTT. And was that a result of the criminal justice system or the mental health system?

Mrs. POE. It was a part of the mental health system and June Poe. [Laughter.]

Mr. SCOTT. Okay. Dr. Monahan, we have been talking about coordinating the service delivery system. There is a slight difference between coordinated and integrated services, that is whether you have two different services, one for drugs and one for mental health, or they are provided together. Does this bill address that situation, where they might be coordinated but not integrated?

Mr. MONAHAN. Yes, sir, I think it does. I think, Mr. Scott, exactly as you mentioned before, there are two different kinds of funding issues here. The first is either the coordination or integration, what my colleague Henry Steadman has called the boundary spinner. You need somebody to be at that boundary between mental health and criminal justice.

But then, secondly and more expensively, are the services themselves. We often talk about diversion from the criminal justice system. Well, that is important, but the more important issue is diver-

sion to what? Where are these people going? You can't divert people to services that don't exist.

So I think that on the integration versus coordination issue, in the treatment of co-occurring disorders, the research is clear. What you need is integrated, not simply coordinated, services. You can't simply bus people to mental health treatment here and the substance abuse treatment someplace over there. You have to have the same people provide treatment for both disorders. This bill certainly allows that. It doesn't mandate it.

Mr. SCOTT. That is all.

Mr. COBLE. I thank the gentleman and we thank you all. This has been a very productive hearing, I believe. Ms. Nolan, Mr. Scott and I have accommodated you with your request. You will be out of here by 4:15.

I am going to depart from our normal format and let Mrs. Poe—would you like to close out for a minute or two, Mrs. Poe, because you have been with this problem far closer than any of the others?

Mrs. POE. Thank you, sir. I want to state in a positive way that I am so grateful for the legislators at the State and the national level that are recognizing this problem. I appreciate so much working with the NAMI, National Alliance for the Mentally Ill. I am not alone. We have many families, many consumers who recognize the seriousness of this and we appreciate being heard.

We appreciate the opportunity to educate everyone working in the system, from professors and teachers in the schools to understand what serious mental illness is, or are, and also the importance of the criminal justice system involvement. This is a very, very complicated problem. The more education we can give to the public about what struggles you gentlemen are having in trying to come up with the money for this is major. We need to give you the support, as consumers of this important issue.

I have fought a long time and I appreciate what you said. If we had only had the Mental Health Courts back there in the very beginning when John needed that back in his first jail experience, it would have been a far different story. I am delighted to know of evidence-based practices going now in what I have heard.

I wish you gentlemen the very best in continuing to help us in solving this problem. And anything that we can do as family members and as consumers, let us know.

Mr. COBLE. Thank you, Mrs. Poe, Dr. Monahan, Sheriff Sexton, and Ms. Nolan. We are delighted to have you all with us. We thank you for your testimony today.

This concludes the legislative hearing on S. 1194, the "Mentally Ill Offender Treatment and Crime Reduction Act of 2003." Thank you for your cooperation, and the Subcommittee stands adjourned.

[Whereupon, at 3:59 p.m., the Subcommittee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

Congressman Ted Strickland
Submitted testimony to the House Judiciary Committee
Crime, Terrorism and Homeland Security Subcommittee:
Legislative Hearing on
S. 1194, the "Mentally Ill Offender Treatment and Crime Reduction Act of 2003"
June 22, 2004

I would like to thank Chairman Coble and Ranking Member Scott for holding today's subcommittee hearing about S. 1194, the Mentally Ill Offender Treatment and Crime Reduction Act of 2003 and for giving me the opportunity to submit testimony about the bill. As you know, I have introduced the House companion to S. 1194, H.R. 2387, which has strong bipartisan support.

S. 1194 has been introduced and shepherded through the Senate by Ohio's Senior Senator, Mike DeWine, and I would like to thank him for his leadership and friendship. Senator DeWine and I have worked together to end the criminalization of the mentally ill since the 106th Congress when we introduced and passed into law a bill that established a small demonstration program to help communities begin and operate mental health courts. 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.

As a counseling psychologist who worked in a maximum security prison, I know how important this legislation is for improving our mental health treatment system. This bill addresses one small part of the mentally ill population's complex treatment system by seeking to treat mentally ill individuals who are or who become involved in the criminal or juvenile justice systems.

According to the Bureau of Justice Statistics, over 16 percent of adults incarcerated in U.S. jails and prisons have a mental illness. In addition, the Office of Juvenile Justice and Delinquency Prevention reports that over 20 percent of youth in the juvenile justice system have serious mental health problems, and many more have co-occurring mental health and substance abuse disorders. Untreated mental illness often leads to behaviors that attract the attention of police officers. If a person with mental illness does not receive treatment, his or her condition almost definitely will worsen when he or she is in custody. Generally, the criminal justice system is not equipped to identify and ensure people with mental illness find appropriate treatment programs, either through diversion into community treatment or within a jail or prison.

I have testified several times before this committee and the Senate Judiciary Committee about the history of mental health treatment and how we have come to have so many mentally ill individuals concentrated in the criminal justice system, but with the hope that past failures will instruct solutions, I am compelled to mention again how the mental health treatment system 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 with 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.

The Mentally Ill Offender Treatment and Crime Reduction Act of 2003 seeks to attend to a small portion of the negative result of transinstitutionalization by encouraging communities to recognize and treat the mentally ill who come in contact with the criminal justice system. S 1194 and HR 2387 would build on a Department of Justice demonstration program to encourage the creation of mental health courts. Senator DeWine and I worked together to pass this demonstration program, titled America's Law Enforcement and Mental Health Project, into law (P.L. 106-515) during the 106th Congress. Mental health courts 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 all parts of the criminal justice and mental health treatment systems, including law enforcement, court systems, and mental health treatment providers, are involved in the court.

Response to the mental health courts program has been tremendous, with the Department of Justice (DOJ) receiving applications from far more communities seeking to establish mental health courts than they could fund with the small appropriation allocated for the program. So far, DOJ has provided grants totaling about $5.5 million for 37 mental health courts in 29 states. I am fortunate that two of the grants have been awarded to jurisdictions that will serve my constituents. I have personally met with the criminal justice and mental health professionals who are working collaboratively to create

these mental health courts, which will be located in Youngstown, Ohio and Athens Hocking, and Vinton counties, and I am impressed with their commitment to solving this serious problem in their communities.

The Mentally Ill Offender Treatment and Crime Reduction Act of 2003 will build on America's Law Enforcement and Mental Health Project by providing additional resources for communities that wish to create mental health courts. The bill Senator DeWine and I have introduced represents a significant commitment to addressing the needs of both the criminal justice system and the mentally ill offender population. The bill will create a grants program for communities that will provide resources for diversion programs across the spectrum of the criminal justice system, including pre-booking diversion programs like those that have been so successful in Los Angeles, California and Memphis, Tennessee. Communities will also be able to design programs that provide mental health treatment in jails and in prisons. And finally, grants will be available for transitional or aftercare programs that seek to ensure offenders are provided appropriate treatment and care when they transition from jail or prison back into the community when they have completed their sentences.

The bill is intended to give communities much flexibility to design and operate the programs they identify as most appropriate for meeting their needs. And, grant funds will be able to be used for planning, establishing a treatment structure, and funding treatment. All successful grant applicants will be required to demonstrate collaboration between the criminal justice and mental health treatment agencies in a community. Too often, mentally ill offenders fall through the cracks because the relevant systems in a community do not work together. This lack of collaboration is detrimental to both the mentally ill offender as well as the stability of the criminal justice system. Therefore, criminal justice and mental health treatment agencies will be required to apply together for the grants established by the bill, compelling the collaboration that is needed to get those who are mentally ill and coming in contact with the criminal justice system the mental health and substance abuse treatment they need. In addition, the bill requires that grant applicants ensure mentally ill offenders are linked to education, job training and placement, and housing programs.

In addition, the bill calls for an Interagency Task Force to be established at the federal level. Task Force members will include: the Attorney General; the Secretaries of Health and Human Services, Labor, Education, Veterans Affairs, and Housing and Urban Development; and the Commissioner of Social Security. The Task Force will be charged with identifying ways that federal departments can respond collaboratively to the needs of mentally ill adults and juveniles.

I strongly believe that encouraging collaboration at the federal, state, and local levels of government is essential to ensuring that people with mental illness are able to access the mental health treatment and other support programs they need.

I look forward to working with my colleagues here in the Judiciary Committee and in the full House to pass this bill this year. Doing so will make our communities safer for all. I thank this committee for looking closely at a problem from which too many of us turn away.

SHEILA JACKSON LEE
18TH DISTRICT, TEXAS

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REMARKS

BY

CONGRESSWOMAN SHEILA JACKSON LEE:

JUDICIARY SUBCOMMITTEE ON CRIME, TERRORISM, AND HOMELAND SECURITY

LEGISLATIVE HEARING ON – S. 1194, THE MENTALLY ILL OFFENDER TREATMENT AND CRIME REDUCTION ACT OF 2003

2141 RHOB, 3:00 P.M.

I thank Chairman Coble and Ranking Member Scott for the energy that they have put into organizing today's legislative hearing on this bi-partisan legislation, S. 1194, the "Mentally Ill Offender Treatment and Crime Reduction Act of 2003." It

promises to address the needs of those who suffer from mental illness and get entangled with the criminal justice system.

All to often, we find that mentally ill defendants are placed into criminal or juvenile corrections facilities erroneously, and the negative impact that this has on the individual is reflected in increased recidivism rates, wasted administrative costs, and unnecessary overcrowding of corrections facilities, among other things.

The Bureau of Justice reported that in 1998, over 280,000 individuals in jail or prison and almost 550,000 of those on probation had a mental impairment. The mentally ill are disproportionately represented in jails and prisons. Five percent of all Americans have a serious mental illness, but sixteen to twenty percent of incarcerated individuals have a mental impairment.

We need to focus our spending powers on resources related to this issue that are needed to provide solutions, including expanding diversion programs, community-based treatment, re-entry services, and improved treatment during incarceration. The Mentally Ill Offender Treatment and Crime Reduction Act of 2003 recognizes that true partnerships between the mental health and criminal and juvenile corrections systems are needed to meet these challenges.

Under the provisions of this legislation, grants would be authorized to:

- Require local and statewide collaborative efforts between the criminal and juvenile justice, mental health, and substance abuse systems;
- Provide mental health and, where appropriate, substance abuse treatment;
- Combine treatment with additional services such as education, housing and job placement; and
- Train criminal and juvenile justice personnel about mental illness and substance abuse disorders.

S. 1194 would authorize the grants program at $100 million a year for two years and would authorize the amounts necessary to cover the final three years. Furthermore, this bill would establish a federal "Interagency Task Force" to identify better federal-local and interdepartmental coordination of mental health services.

We in Congress have an obligation to legislate to protect the community from those who become aggressive or violent because of mental illness. In addition, we have a responsibility to see that the offender receives the proper treatment for his or her illness. Far too often, mental illness goes undiagnosed, and many in our prison system would do better in other settings more equipped to handle their particular needs.

This legislation has been advocated by the U.S. Conference of Bishops. According to its statement, S. 1194 would be "a good start towards ensuring that mentally ill offenders receive the proper

treatment they need with grants designed to create community based treatment programs and other services."

In Texas, past treatment of mentally ill offenders warrants the passage of legislation such as S. 1194. Senior U.S. District Judge William Wayne Justice, who is experienced in dealing with mentally ill prisoners in the Texas prison system ruled in 1980 that the Texas prison system is unconstitutional and placed it under Federal control for 30 years. In Judge Justice's estimation, the Texas laws that apply to the mentally ill "lack compassion and emphasize vengeance." KPFT news reported him as having said,

> We have allowed the spirit of vengeance such unrivaled sway in our dealings with those who commit crime that we have ceased to consider properly whether we have taken adequate account of the role that mental impairment may play in the determination of moral responsibility. As a result, we punish those who we cannot justly blame. Such result is not, I believe worthy of a civil society.

In addition to the problem of legislation that is uncompassionate to the mentally ill young offender, we must

address the improper prescription of drugs to these offenders. Because they are dependent on public assistance, the system mistreats these young people by allowing administrators to prescribe medication to them that produce negative side affects with impunity.

The Mentally Ill Offender Treatment and Crime Reduction Act of 2003 takes a good first step toward reforming a system that has operated under a shield for far too long. We must continue to make this legislation effective enough to save the lives of these defendants who are truly victims.

I yield back.

6

PREPARED STATEMENT OF THE HONORABLE WILLIAM D. DELAHUNT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

I would like to thank Chairman Coble and Ranking Member Scott for holding this hearing on the "Mentally Ill Offender Treatment and Crime Reduction Act" of 2003. I would also like to commend my colleague Rep. Ted Strickland for his continued leadership on this bill and other initiatives to improve our nation's mental health systems. I appreciate your courtesy in permitting me, as a former member of this subcommittee, to add my voice in support of this much-needed legislation.

As the distinguished witnesses testified, the mental health community and law enforcement are united behind this legislation. And, in a rare instance within the current session of Congress, the Senate has already moved forward and passed this bill by unanimous consent. I hope that my colleagues on the House Judiciary Com-

mittee will join me to see that the House moves this legislation quickly in the same bipartisan spirit.

As Thomas J. Conklin, M.D., Director of Health Services of the Hampden County Correctional Services of Massachusetts, has observed, "It can be safely said that American jails and prisons have become the nation's default mental health system." Our nation's jails and prisons are in a state of crisis as they struggle to provide mental health services for incarcerated individuals. Congress should proceed with haste.

It is simply wrong that families must resort to the police in order to obtain treatment for a loved one suffering from an extreme episode of mental illness. Yet, during times of extreme distress, families face no alternative because an individual experiencing symptoms like paranoia, exaggerated actions and impaired judgment may be unable to recognize a need for treatment.

It is unconscionable and, may well be, unconstitutional, that these vulnerable individuals become further marginalized once incarcerated, often denied even minimal treatment as a result of inadequate resources. Most mentally ill offenders that come into contact with the criminal justice system are charged with low-level, non-violent crimes. However, once behind bars, these individuals may face an environment that only further exacerbates symptoms of mental illness, which may otherwise be manageable with proper treatment. Then, caught in a revolving door, they may soon be back in prison as a result of insufficient and inadequate transitional services upon release. This comprehensive legislation is a step in the right direction in order to move away from laws that criminalize mental illness. Through this legislation, state and local correctional facilities will be able to create appropriate, cost-effective solutions. And low-level, nonviolent mentally ill offenders will have greater access to continuity of care.

Congress must also address an unfunded mandate that has been imposed on the states for decades. In *Estelle* v. *Gamble* (1967), the Supreme Court held that deliberate indifference to serious medical needs of inmates is unconstitutional "whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed." Further, in *Ruiz* v. *Estelle* (1980), the Supreme Court established minimum standards for mental health services in correctional settings. It is hard to imagine that more than twenty years later, state and local facilities still do not have nearly enough resources to come even close to meeting these constitutional requirements.

Congress must do its part to assist state and local governments in meeting this burden. We cannot tolerate a system that fails to meet constitutional safeguards. Further, we cannot tolerate a system that fails to dedicate resources effectively in order to ensure that people are getting help instead of jail time. And as a result of state budget cuts, communities are looking to the federal government for help.

For example, a few years ago Sheriff Michael J. Ashe of Hampden County created an innovative inpatient mental health care unit within one of his prisons, providing a resource to four counties within the state. A highly successful facility, the unit allowed inmates to be treated in a safe and structured environment, thereby reducing costly emergency calls and transfers to the state-run hospital for behavioral disorders. Unfortunately, the Sheriff was forced to shut down this program in 2001 as a result of a decision by the Commonwealth's Department of Mental Health to eliminate all funding for mental health services at correctional facilities. Now, Sheriff Ashe is struggling to provide minimum treatment to inmates, many of whom are repeatedly returning to jail as a result of the lack of diversion programs and transitional services. Across the state, other correctional facilities and members of law enforcement are battling the same problem—struggling to create innovative solutions with very limited resources.

The Massachusetts Mental Health Diversion & Integration Program (MMHDIP) is one such program that continues to advocate for new networks to facilitate the diversion of mentally ill persons. The MMHDIP seeks to promote extensive collaboration between police, health and social service providers, consumer advocates, judges, and probation officers and, in the past two years, the program has achieved many significant accomplishments. The MMHDIP has developed and provided in-service training on crisis intervention, de-escalation and risk management techniques to members of several police departments, including Boston, Worcester and Fitchburg. The program also intends to develop a "No Wrong Door" triage center to receive persons who are mentally ill and/or chemically dependant at a downtown Boston hospital. Through these types of initiatives, persons in crisis who are chargeable with non-serious crimes can be referred to community treatment in lieu of arrest. Despite significant progress, the MMHDIP faces significant hurdles to develop

and implement their goals based on the far-reaching needs of communities due to statewide funding cuts.

Consistent with the federal average, 12 to 16 percent of those incarcerated in Massachusetts are suffering from serious mental illness. Compared to the average rate of mental illness in the general population, inmates in Massachusetts are more than twice as likely to have a mental illness. And, consistent with nationwide statistics, the recidivism rates of the mentally ill are much higher than average.

Unfortunately, the situation in my state is not unique. In every state, the interaction between law enforcement and individuals suffering from mental illness continues to rise. In a very tragic situation just last week in Indiana, a law enforcement officer shot and killed one young man, John Montgomery, diagnosed with bipolar disorder. With four other sheriffs, the deputy had arrived at Mr. Montgomery's home to carry out a court order obtained by the parents of this 29-year-old as the only recourse to help him get medical treatment. Even though the deputies knew the young man was mentally ill based on previous calls to Mr. Montgomery's home, the officers resorted to deadly force when Mr. Montgomery became violent as a result of his psychotic state. Perhaps this tragic outcome could have been avoided with greater resources allocated for adequate training and education for state and local law enforcement. And Mr. Montgomery's parents would have seen their son obtain treatment rather than plan for his funeral.

Having spent over two decades as a state prosecutor, I support the goals of this bill to "foster local collaborations" between law enforcement and mental health providers. What works in one community will not necessarily work or be desired in another—solutions must take into account the existing landscape as well as the social and political dynamics within each community. Given the complexity of the issues surrounding the intersection of mental illness and the criminal justice system, no magic solution will solve the problems faced in communities across America. Accordingly, this legislation does not seek to impose a standardized model that must be adopted by all state and local jurisdictions. To the contrary, S. 1194 encourages funding for specialized programs that will most effectively address the needs of local communities.

Consistent with one of the key objectives set forth by President George W. Bush in his State of the Union Address, it is important to note that the Department of Justice has endorsed this bill. The federal government needs to provide communities with the tools to reduce recidivism among returning inmates. The statistics speak for themselves. This year alone the majority of the 600,000 prisoners who will be released will return to prison after committing another crime. Congress must continue do all that it can to ensure that state and local law enforcement can address this problem, especially given its disproportionate impact on the mentally ill.

Although I am encouraged that the Judiciary Committees in both chambers are giving this issue serious consideration, Congress must continue to address other extraordinary gaps in our current system—such as the ability of prisoners to have continued access to affordable medications, case management and affordable housing following release. Looking ahead, federal and state government must not ignore these challenges, as nearly 57% of offenders are sent back into our communities without any supervision or support.

With this legislation, Congress can join with local communities in their response to this problem. Individuals and their loved ones are struggling with countless challenges and barriers during a mental health crisis. In addition, members of state and local law enforcement need access to training and alternatives to improve safety and responsiveness. Without adequate funding, projects like those in the Commonwealth of Massachusetts will take much longer to achieve their goals due to limited staff and resources. Therefore, federal grants must be made available for innovative programs that address the challenges presented by mental illness to public safety in our communities. With this bill, Congress can provide significant support to collaborative efforts between law enforcement and mental health experts. Without unnecessary delay, I urge my colleagues on the subcommittee to move forward on their consideration of this legislation so that the House has an opportunity to consider it for final passage before the end of this current session of Congress.

HUMAN RIGHTS WATCH

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June 22, 2004

Re: Enact S. 1194, the Mentally Ill Offender Treatment and Crime Reduction Act of 2004

Dear Representative Coble:

We write to urge you to enact S. 1194, the Mentally Ill Offender Treatment and Crime Reduction Act of 2004. The Senate unanimously passed this bill, introduced by Sen. DeWine, on October 27, 2003. Enactment of this legislation followed by sufficient levels of appropriations could help catalyze important and cost-effective reforms across the country in the way the criminal justice system responds to people with mental illness.

In the United States today, jails and prisons have become de facto mental health institutions. Sheriffs, corrections professionals, police, prosecutors, defense attorneys and criminal justice advocates agree that this is a function they are poorly equipped to serve. Federal support for collaborative mental health and criminal justice efforts as provided for under this legislation would help reduce the unnecessarily high level of involvement of the mentally ill in the criminal justice system and also enable that system to respond better to those mentally ill offenders whose crimes warrant incarceration.

Last year, Human Rights Watch released a report, "Ill Equipped: U.S. Prisons and Offenders with Mental Illness," which focused on the staggering proportions of prisoners who have serious mental illnesses, the poor treatment they receive in prison, and the profound misalignment between the goals and culture of mental health services and the goals and culture of corrections.

As the report documents, somewhere between one in five and one in six prisoners is mentally ill, and the number of mentally ill in prison greatly exceeds the number in mental health hospitals. Prisons and jails, in fact, have become the nation's default mental health system.

Unfortunately, it is a function they are ill equipped to serve. While there have been considerable improvements in prison mental health services over the last couple of decades, the soaring number of mentally ill inmates has outpaced the progress. Prisons across the country lack sufficient mental health staff and facilities to provide appropriate care for the two to three hundred thousand prisoners who suffer from serious mental illness, including schizophrenia, bipolar disorder, and major depression.

As a result, incarcerated prisoners often receive little or no mental health treatment. Moreover, mentally ill prisoners confront prison regimes and rules that do not accommodate mental illness. Prison staff, for example, punish the mentally ill for displaying symptoms of their illness, such as banging their heads on the wall, covering themselves in feces, self-mutilating and even attempting suicide. Many prisoners with mental illness end up in segregated confinement where the isolation and idleness can push them into acute psychosis.

The high rate of incarceration of the mentally ill is a consequence of under-funded, disorganized, and fragmented community mental health services. Neither private insurance nor public benefits enable all those who need mental health services to obtain them. The difficulty of accessing treatment is particularly acute for those with mental illness who are poor, homeless, or struggling with substance abuse problems. If they do commit a crime, like anyone else they are swept into the criminal justice system. Punitive mandatory sentencing policies preclude judges from exercising sentencing discretion to provide alternatives to incarceration, even for low-level nonviolent offenders.

The Mentally Ill Offender Treatment and Crime Reduction Act of 2004 does not purport to address all of the causes and consequences of the incarceration of offenders with mental illness. Nevertheless, it could provide much-needed support for initiatives to reduce the unnecessary incarceration of low-level nonviolent offenders with mental illness as well as to ensure that those mentally ill offenders who are incarcerated receive appropriate mental health services. For these reasons, we urge you to support S. 1194.

Should you have any questions, please contact me in New York at 212-216-1212 or Wendy Patten, U.S. Advocacy Director at Human Rights Watch in Washington, at 202-612-4349.

Sincerely,

Jamie Fellner, Esq.
Director, U.S. Program

June 21, 2004

The Honorable Howard Coble
Chairman, House Subcommittee on Crime,
Terrorism and Homeland Security
207 Cannon House Office Building
Washington, DC 20515-6226

Dear Chairman Coble:

On behalf of the National Association of Counties (NACo), I write to express our enthusiastic support for H.R. 2397, the Mentally Ill Offender Treatment and Crime Reduction Act of 2003.

We support the legislation because it will promote the use of alternative programs for non-violent offenders with mental illness and seeks to foster collaboration among the criminal justice, juvenile justice, and mental health treatment and substance abuse systems. In addition, it contains language to promote collaboration and intergovernmental partnerships among municipal, county and state governments.

By keeping the non-violent mentally ill within the community health and human services system, we can better monitor their condition, provide treatment and dispense medication if needed. The public safety is better served. Implementing a community-based systems approach also makes sense in terms of addressing the multiple issues facing this population. Enclosed is NACo's monograph, ***Ending the Cycle of Recidivism: Best Practices for Diverting Mentally Ill Individuals from County Jails.***

We appreciate your leadership in convening this hearing. For additional information, please contact Associate Legislative Director Donald Murray at 202/942-4239.

Sincerely,

Larry E. Naake
Executive Director

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RECYCLED

NACO National Association of Counties

Counties Care for America

Ending the Cycle of Recidivism

Best Practices for Diverting Mentally Ill Individuals from County Jails

About the National Association of Counties

Founded in 1935, the National Association of Counties (NACo) is the only national organization in the country that represents county governments. With headquarters on Capitol Hill in Washington, D.C., NACo's primary mission is to ensure that the county government message is heard and understood in the White House and in the halls of Congress.

NACo's purpose and objectives are to:
- Serve as a liaison with other levels of government;
- Improve public understanding of counties;
- Act as a national advocate for counties; and
- Help counties find innovative methods for meeting the challenges they face.

For more information on the topic of diverting non-violent mentally ill individuals from county jails, please contact:

Lesley Buchan
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Primary writing by Lesley Buchan
With contributions from Tom Goodman, Donald Murray, Gary Gortenburg, Stephanie Osborn, and Brad Banks of NACo; and John Kies, Clermont County Mental Health & Recovery Board, John Staup, Butler County Mental Health Board, Martha Guerrero, Los Angeles County Department of Mental Health, Judge Steven Leifman, Miami-Dade County, Janice Bogner, The Health Foundation of Greater Cincinnati, and Mary Carol Melton, Hamilton County Court Clinic

Design by Lindsay Snow Osborn and Jack Hernandez

June 2003

Table of Contents

2 Letter from NACo President Ken Mayfield

3 Acknowledgements

4 What is Jail Diversion?

5 Presidential Initiative

6 About the Programs

- Los Angeles County California
- Clermont County Ohio
- Butler County Ohio
- Hamilton County Ohio
- Miami-Dade County Florida

15 Program Central Themes

16 State and National Resources

NACo National Association of Counties

Counties Care for America

June 2003

Dear Fellow County Official,

The nonviolent mentally ill should not be in county jails. I first realized this when I was a prosecutor in Dallas County and came to understand fully how the justice system works. As a Dallas County Commissioner, I became committed to changing the system that deposits the mentally ill in jail because there is no other place to put them. For that reason, one of my initiatives as President of NACo focuses on encouraging counties to develop programs to divert the non-violent mentally ill from jails.

A key objective of this initiative is to educate and train county officials and partners in the community about the mentally ill, so that the mentally ill are identified and handled appropriately if and when they enter the criminal justice system.

According to the U.S. Department of Justice, of the 10 million admissions to jails each year, approximately 16 percent of the inmate population is mentally ill. This is a treatment and custodial problem for counties, both during the jail term and in the person's reentry to the community.

Too often, the mentally ill tend to follow a revolving door, from detention to the streets and then back again. The longer non-violent people with mental health problems are incarcerated, the more their condition will deteriorate—and then they may very well become a public safety risk.

Jail diversion programs can save counties money, provide better treatment for the mentally ill, and improve public safety and the safety of the jail.

As part of the initiative, I made three site visits to learn about successful county programs. The programs examined were in Los Angeles County, California; Hamilton, Butler and Clermont Counties, Ohio; and Miami-Dade County, Florida. Accompanying me on these site visits were Commissioner Tony Bennett of Ramsey County, Minnesota, and chair of the Justice and Public Safety Steering Committee and Commissioner Bill Kennedy of Yellowstone County, Montana, and chair of the Health Steering Committee.

This report outlines the programs from these counties and how they were developed. It presents the key elements for starting a diversion program, describes the program operation, and demonstrates results of the cost savings and improved services for the mentally ill. The report shows the level of commitment within the county and the groups that must become involved for the program to succeed.

I encourage you to use this guide to develop your jail diversion program or expand your program if you already have one in place. One of the most important lessons that we learned is that none of the programs are alike. Some of the elements are similar, but no program is identical with another.

A good program to divert the non-violent mentally ill from jail must fit the needs of its county. So, take the elements from these programs that work best for your county and develop a program. A successful program will have a positive impact on your county and your citizens.

New legislation, the Mentally Ill Offender Treatment and Crime Reduction Act of 2003 has been introduced in Congress to increase public safety and community health by facilitating collaboration among the criminal justice, juvenile justice, mental health treatment, and substance abuse systems. The legislation will help divert individuals with mental illness away from the criminal and juvenile justice systems and treat them within the mental health and substance abuse systems.

NACo was successful in getting language into the bill that will promote collaboration and partnership between cities and counties and between states and local governments. I strongly support this legislation and urge you to do so, too.

Sincerely,

Kenneth A. Mayfield

Kenneth A. Mayfield
NACo President
Commissioner, Dallas County, Texas

Acknowledgements

NACo would like to thank all of the individuals from the counties visited who made the visits a valuable learning experience. NACo appreciated the time and effort that many people put into demonstrating their programs and sharing their experiences and insight.

NACo is especially grateful to the following individuals:

Commissioner Tony Bennett, Ramsey County Minnesota, Chair of NACo's Justice and Public Safety Steering Committee

Commissioner Bill Kennedy, Yellowstone County Montana, Chair of NACo's Health Steering Committee

Steve Szalay, Executive Director
California State Association of Counties

Elizabeth Howard
California State Association of Counties

Larry Long, Executive Director
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John Leutz
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The Health Foundation of Greater Cincinnati

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John Staup, Executive Director
Butler County Mental Health Board

Martha Guerrero, Legislative Analyst, Government Relations Department
Los Angeles County Department of Mental Health

Tom Joseph, Deputy Legislative Advocate
Los Angeles County

The Honorable Steven Leifman, County Judge
State of Florida 11th Judicial Circuit

The Honorable Yvonne Brathwaite Burke
Chair of the Los Angeles County Board of Supervisors

The Honorable Bob Proud
President, Clermont County Board of Commissioners

The Honorable Mary Walker
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The Honorable John Dowlin
Hamilton County Board of Commissioners

The Honorable Courtney Combs
Butler County Board of Commissioners

The Honorable Charles Furmon
Butler County Board of Commissioners

The Honorable Michael Fox
President, Butler County Board of Commissioners

The Honorable W. Reed Madden
President, Greene County Board of Commissioners

The Honorable Dr. Barbara Carey-Shuler
Chair of the Miami-Dade Board of County Commissioners

The Honorable Harvey Ruvin
Clerk of the Courts

The Honorable Katy Sorenson
Vice Chair of the Miami-Dade Board of County Commissioners

The Honorable Natacha Seijas
Miami-Dade Board of County Commissioners

NACo would like to especially thank The Health Foundation of Greater Cincinnati for hosting a dinner forum in honor of the NACo visit to the Southwestern Ohio counties.

Thank you to all of the counties that expressed interest in hosting the Ken Mayfield delegation and submitted information on their programs. Although all could not be visited, NACo recognizes the excellent leadership role of counties in initiating and implementing effective jail diversion programs.

What is Jail Diversion?

The nation's local jails have increasingly become the place of last resort for the mentally ill. Beginning in the late 1950's and early 1960's, individuals with mental illness were released from state-run hospitals without alternative placement. Many of these individuals subsequently have committed repeat non-violent crimes, resulting in incarceration, release from jail, and repeat offense and arrest – a cycle of recidivism. By default, jails in many communities have become the primary source of care for the mentally ill, a function for which they are neither equipped nor designed to handle. Moreover, there are cases of individuals struggling with mental illness who intentionally break the law as a way to receive treatment services. This cycle of recidivism is a clear symptom of an unhealthy system.

In a landmark Bureau of Justice Statistics report by Paula M. Ditton published 1999, Mental Health and Treatment of Inmates and Probationers, it was estimated that 16 percent of local jail populations are suffering from mental illness. The study found that 70 percent of the mentally ill population was comprised of non-violent offenders.

What county officials and the public should know about the incarcerated, mentally ill population is not just that these individuals will significantly benefit from a system of comprehensive services, such as housing, health, and human services, but also that such a strategy would be less expensive and more effective in the long-term. For a minor offender, community based mental health care is far less expensive than maintaining the individual in jail.

Moreover, implementing a community based social services system is infinitely more preferable to jail in terms of humane care and treatment, and in addressing the multiple issues facing this population. By keeping the mentally ill within the health and human services system, counties are better able to monitor their condition, provide treatment, and dispense medication if needed. And the public safety is better served.

Jail, on the other hand, has the opposite effect. It can traumatize the mentally ill and result in worsened mental health. For the county health department psychiatrist, it often means working twice as hard to get individuals back to the better, though not entirely healthy, condition they were in when they entered the jail. For the sheriff, it often means assigning a deputy to carefully monitor the individual in jail.

There is an additional, significant fiscal impact. In many states, even a short stay in the county jail is enough to disqualify a mentally ill person from such entitlements as Social Security, Medicaid 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 benefits to be restored.

In response to this cycle of recidivism, the mental health, judicial, and law enforcement systems at the county level have begun to work together to develop solutions to this growing crisis. Some counties have developed programs that demonstrate the benefit of these systems working together to more effectively respond to individuals with mental illness. These programs demonstrate interventions to divert people at different stages in the criminal justice process, including before arrest, after arrest, and after release from jail.

An ideal diversion program would include interventions for mentally ill offenders at all stages of the criminal justice process. The first stage (or approach), often referred to as the "crisis intervention team" approach, diverts the individual at the scene of the disturbance by training police officers to recognize signs of mental illness. Under this approach, the offender is transported

directly to a treatment or housing facility as an alternative to jail.

Another approach, called the "mental health court," diverts mentally ill individuals after they have been arrested and charged with an offense. In this instance, the court system has a program to allow for an alternative course of action. This action often involves having the individual enter into treatment and case management, while the court monitors the individual through probation.

Sometimes a person will fall through the cracks and not be diverted at either of the two stages described above, ultimately leading them to jail. A "post-incarceration intervention approach" to transition individuals from jail to community based treatment services helps to ensure that they do not re-offend and re-enter the criminal justice system.

Finally, a key component in sustaining the success of a comprehensive diversion system is the availability of a long-term, supervised residential housing program for individuals with mental illness. This strategy has been found to be very effective in preventing individuals from re-entering the criminal justice system; however, it can be cost prohibitive. Nonetheless, with the coordination, strategizing, and sharing of resources between the criminal justice and mental health systems, counties have successfully implemented these types of housing programs.

Presidential Initiative

NACo President Kenneth A. Mayfield has long recognized the serious problem of maintaining non-violent individuals with mentally illness in county jails. Therefore, Commissioner Mayfield made this issue a focus of his presidency during 2002-2003. The human and dollar cost of the increasing number of individuals with mental illness being housed in the nation's jails is a major problem for counties, Mayfield believes.

Commissioner Mayfield pursued this initiative to raise awareness among county officials that there are alternative strategies to treat non-violent offenders with mental illness, and that these strategies can be cost-effective. Diversion programs can improve care for the mentally ill, reduce costs for counties, and improve safety within the jails. Solutions exist and counties can take the lead in being part of those solutions. By encouraging the collaboration of mental health and criminal justice systems, county officials can initiate comprehensive programs to divert individuals with mental illness from jail.

"One of my goals as NACo president was to look at gathering support and getting counties involved in making leadership decisions to divert the non-violent mentally ill from our jails," Mayfield said during a visit to Los Angeles County.

More and more counties across the country have begun to implement promising strategies in the treatment and management of individuals with mental illness in the jail system. During his presidency, Commissioner Mayfield visited five such county models throughout the country to learn about the key elements that made for their jail diversion programs' success. Mayfield, along with other NACo officials, toured and studied these model programs. They found that these programs reduced the fragmentation of services for the mentally ill, demonstrated cost savings, and could be replicated in counties nationwide.

About the Programs

Los Angeles County, California

■ The County of Los Angeles Department of Mental Health Criminal Justice Diversion Programs for Mentally Ill Offenders

Los Angeles County has developed many strategies for diverting individuals with mental illness from the criminal justice system. The county faces special challenges as their jail, the Twin Towers Correctional Facility, holds approximately 22,000 inmates, with 10 percent receiving mental health services. The Los Angeles County Sheriff acknowledges that the jail should not be the place for individuals to receive mental health services, and that the lack of alternative mental health treatment options has left the jail as the last resort.

In response, the county has developed programs not only to prevent non-violent mentally ill individuals from entering the jail, but to treat mentally ill offenders upon re-entry to the community.

County size: 9,637,494
Program started: 1993

Martha Guerrero, MSW
Legislative Analyst
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County of Los Angeles
Department of Mental Health

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"The matter remains that there are too many Americans who have mental challenges, and jails should not be the answer."

- Los Angeles County Sheriff Lercy Baca

Pre-arrest Diversion

■ Law Enforcement/Department of Mental Health Clinician Teams (Mental Evaluation Teams, MET)

This element of Los Angeles County's program pairs law enforcement officers with mental health clinicians to respond to 911 calls involving mentally ill citizens. Team members have been specially trained to identify, evaluate, and locate appropriate placement for the mentally ill citizen. Placements can include shelters, medical facilities, or jail if necessary. The Department of Mental Health has developed similar partnerships with the police departments of the cities of Los Angeles, Long Beach, and Pasadena.

This cooperative project between law enforcement and the mental health system began as one MET team serving one section of the county. 20 MET teams now serve the county because of the improved public safety and popularity among residents.

The main objective of the law enforcement-mental health teams is to provide rapid, compassionate response. To achieve this, teams provide intervention, referral, or placement for mentally ill persons while allowing field officers to focus on maintaining public safety. The program prevents the unnecessary incarceration, and facilitates the hospitalization when necessary, of these individuals. Another objective is to return the sheriff's deputies back to service in a timely manner. On average, it takes 3-4 hours to evaluate and transport the individual to the appropriate facility. The average response time to get officers back on scheduled duty is now 29 minutes.

One of the challenges of the MET program has been establishing trust between the sheriff's deputy officer and the mental health clinician. Officers, used to having their partners be from law enforcement, had to adjust to having civilian partners. Building that trust was one of the barriers that needed to be overcome for the teams to be effective.

When diverting a mentally ill person in need of medical care, the team also determines if the person has Medicaid or private insurance, enabling the team to pinpoint the appropriate hospital that would accept the person's medical benefit. If a person requires hospitalization, the teams research

the private insurance or verify Medicaid benefits and then transport the person to either a county or private hospital. According to the program's statistics, of the individuals diverted, about one-third are placed in county hospitals, another one-third are placed in private hospitals, and the rest are transported to community providers.

County Leadership

The Los Angeles County Board of Supervisors played a key role in establishing the law enforcement Mental Evaluation Teams with the Sheriff's Department and the City of Los Angeles, and in expanding that model to other police departments throughout the county. The ongoing leadership of the Board of Supervisors has played a key role in the successful interagency collaboration for the treatment of mentally ill offenders. The cornerstone of the county's jail diversion initiative is the partnership among the Los Angeles County Sheriff's Department, Probation Department, Department of Mental Health, and the cities within the county. This kind of cooperation and shared vision among these departments has created systemic change that is not only cost effective, but also designed to improve the lives of the mentally ill in Los Angeles County.

Results

In FY 2001-2002, the law enforcement-mental health teams responded to 7,121 calls for intervention. Of these, only 107 resulted in arrest. Given the national recognition of this model, Sacramento County, California, and Baltimore County, Maryland, have investigated initiating similar models.

Re-entry into the Community/Housing Strategies

■ Strategies: Village Integrated Service Agency, Integrated Services for Homeless Mentally Ill Offenders

This program is funded through special legislation, Assembly Bill 34, established by the state of California in 1999 to reduce homelessness and incarceration among people with mental illness. The Village Agency is one of several agencies contracted by Los Angeles County to provide comprehensive care for the homeless mentally ill.

This community-based program provides treatment, housing assistance, linkages to health care, employment and vocational services, advocacy in the legal system, and assistance in applying for public benefits to mentally ill individuals who are homeless or at risk of incarceration. The program also serves those who recently have been released or are pending release from the criminal justice system. The purpose of the program is to reduce incarcerations, hospitalizations, and homelessness while moving people into housing through an integrated services approach. The program also provides crisis intervention 24 hours per day, seven days per week.

Professional staff members work closely with jail mental health services to link individuals in jail with community agencies. Therefore, when individuals are released from jail, they are already connected to services. There are a total of 1,680 individuals enrolled in the program.

Results

Comparing data for 720 participants 12 months prior to their enrollment to the 12 months after enrollment in the program demonstrated the following results:

77% increase in permanent housing

65% reduction in the number of incarcerations

80% decrease in the total number of days participants were incarcerated

33% reduction in hospital admissions

250% increase in the number of participants employed full-time

The success of the village integrated-services approach has sparked much national interest. The federal Substance Abuse and Mental Health Services Agency is funding programs in counties across the country to develop models based on the village program.

Keys to Success

- Outreach in the community and engaging the client in treatment
- Linkage of care from the jail to the community
- Ongoing training, including training by the state on developing partnerships with housing agencies

Butler, Clermont, and Hamilton Counties Ohio

Located in Southwestern Ohio, Butler and Clermont Counties border Hamilton County, home to the City of Cincinnati.

■ The Clermont County Mental Health and Recovery Board Jail Diversion Program

The Clermont County Mental Health and Recovery Board is a public agency established by the state to provide comprehensive mental health services to the community.

Prior to launching their program, this Board conducted a needs assessment and researched other jail diversion programs. The county wanted to develop a system that met local needs and would work well with existing local systems. After that information was collected and reviewed, Clermont County applied for and received two grant funding awards, one from the Ohio Department of Mental Health and one from The Health Foundation of Greater Cincinnati to launch their program.

Clermont County, Ohio
County size: 177,977
Program start date: March 2000

John Kies, MHA
Associate Director
Clermont County Mental
Health and Recovery Board

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Post-arrest Diversion

The jail diversion project diverts individuals after they are charged and brought into the Clermont County Municipal Court system. There are three Municipal Court Judges and a Magistrate who sentence the majority of cases and make referrals to the jail diversion program. Each of the judges plays an integral role in the jail diversion program, and all attended educational sessions on mental health and substance abuse issues.

For the participants in the program, the primary diagnoses were depressive disorder, bi-polar, and generalized anxiety disorder. Driving under the influence ranks as the most frequent charge for individuals potentially served by this program; however, to qualify, a person must be diagnosed with a qualifying mental illness. Often these individuals suffer from both substance abuse and mental illness, called co-occurring disorders. Clermont's jail diversion team consists of a specialized case manager working with a dedicated intensive probation officer whose background and understanding is focused on persons with mental health problems. Most clients participate in the intensive treatment probationary period for 14 months. They must take required medications and stay clean and sober while in the program.

Results

From March 2000 to December 2002, a 34-month period, 252 non-duplicated individuals participated in the program. These 252 individuals referred to jail diversion had been sentenced to 37,629 jail days. With jail diversion, 8,166 days were actually served and 29,463 days were suspended.

At the county jail per diem rate of $57, the sentenced days would have cost $2,144,853. Considering the grant amounts and treatment expenses, costs were $526,089 for the 34-month period, for a savings of $1,618,764. (Please note that

"As a Past President of the Ohio Community Corrections Association, I have seen the benefits of jail diversion programs. It is important to recognize the mental health issues that affect our community. These issues also affect our courts and corrections systems. The jail diversion program supports these individuals in making restitution and becoming more productive members of our community. Also, it frees up jail space for more predatory offenders"

- Clermont County Commissioner Bob Proud

figure represents the maximum amount of savings to the county. The offender may not have served all initially sentenced jail days.)

The recidivism rate during this period was 29, or 11.5% percent.

County Leadership

County officials are convinced programs such as these can result in significant savings in county resources and human capital. The Clermont County Board of Commissioners believes in the success of the project and has decided that the county will begin covering the cost of a staff position to keep the program running smoothly as one of the grant funding sources ends. Beyond the cost savings, the Clermont County jail is experiencing over crowding; therefore, the Sheriff is also very supportive of efforts to divert appropriate individuals to treatment in lieu of incarceration. For the Sheriff, not only is the jail not the best place to be treating these individuals, but liability issues escalate when people with mental illness are housed in the jail.

Keys to Success

- Relationship and partnership between the courts, law enforcement, and mental health treatment system
- Examine existing models and design a program to meet the needs of the local community
- Set clear goals and objectives in planning stage
- Collect data and measure the results

Butler County, Ohio

■ **Substance Abuse Mental Illness Court (SAMI)**

In July 1999, Butler County launched a mental health court program called a Substance Abuse Mental Illness (SAMI) Court. It is one of nine programs in the State of Ohio funded by the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services to demonstrate an integrated substance abuse/mental illness treatment model based on a program developed by researchers at the New Hampshire-Dartmouth Psychiatric Research Center. Butler County was the only court-based project to be funded. It is the only such program in Ohio and one of few in the country. The Health Foundation of Greater Cincinnati also funded the SAMI Court project.

Key stakeholders, including representatives from the local mental health system and the criminal justice system, formed a planning workgroup for the project development. This group participated in an extensive week-long planning conference sponsored by The National GAINS Center for People with Co-Occurring Disorders in the Justice System to foster collaboration between the two systems. The workgroup returned to Butler County with a common vision and joint plan for working together on the SAMI project.

County size: 337,013
Year program started: July 1999

John R. Staup
Executive Director
Butler County Mental Health Board

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jstaup@bcmhb.org

Post-arrest Diversion

The SAMI Court is designed for individuals with co-occurring mental illness and substance abuse who have been charged with a felony in the Butler County Court of Common Pleas.

Once a defendant qualifies, he or she must voluntarily enter a guilty plea and enter the SAMI Court program as a condition of probation. The caseload for SAMI Court program is 25 individuals; it is a relatively small number because the program deals with the most difficult cases in the community. These individuals have moved from crisis to crisis, ending up in emergency rooms, and repeatedly are arrested. All participants would have been sentenced to prison, if not for the SAMI Court treatment option.

The program utilizes a specific treatment model focusing on active treatment and relapse prevention. The SAMI Court program treatment team consists of representatives from probation, the court, and the mental health and substance abuse systems. This team of cross-system professionals meets weekly to discuss the cases and treatment planning. Every two weeks, SAMI Court participants are required to appear before the Court, and the entire treatment team is present to review the client's progress.

The probation officer monitors the client on a regular basis, and the client is screened weekly for drug use. The client also receives intensive case management services consistently throughout the program and can access assistance in obtaining housing and enrollment in federal and state benefit programs. A 24-hour crisis intervention service is also available. The average length of stay in the program is one year. After completion of the program, individuals receive ongoing community-based case management services.

Results

From July of 1999 through April of 2002, the courts, probation, attorneys and social service agencies referred over 400 individuals to the program. From this group, 50 were found to meet all legal and diagnostic criteria and were enrolled in the program. Of the 50 clients admitted, 23 failed to complete the treatment and were sentenced to prison. As of May 2002, eight of the remaining 27 have graduated to community-based care and 19 are still active in SAMI Court treatment. Due to the "difficult to treat" nature of this population, success with a few clients is considered by Butler County to be a positive outcome.

The following outcomes are based on data collected on 30 clients who were in SAMI Court treatment for any part of the one-year period from May 1, 2001, through April 30, 2002.

- Hospital costs were lowered by $177,000 for the 30 SAMI Court participants compared with costs for the two years prior to admission.
- Community treatment was less expensive than prison. The cost to house and treat a mentally ill adult in prison is approximately $80.10 per day, compared to an average of $53.92 per day for SAMI Court services. During this one-year study period, the cost of treatment yielded a savings of $76,400.
- By enrolling participants in Medicaid and Medicare federal benefit programs, approximately 40% of SAMI Court treatment costs are paid by the federal government.
- To date, none of the eight SAMI Court graduates have re-offended.

Post-arrest Diversion

Therapeutic Alternative Court (TAC)

Butler County launched a second mental health court in January 2002 at the Fairfield Municipal Court, building from the success of the SAMI Court. The City of Fairfield within Butler County has a population of approximately 42,000. The TAC program is a pretrial diversion program for misdemeanor offenders who have a qualifying mental illness. The understanding behind the program is that these individuals most likely committed a minor offense because of their untreated mental illness, and court monitored treatment would serve as the smarter alternative to jail.

Although the TAC program does not follow a specific treatment model, the focus is on court oversight and supervision, intensive case management, and system coordination. The criteria and procedure for being admitted to the TAC program are very similar to the SAMI Court. A defendant must meet diagnostic criteria, enter a guilty plea, and successfully comply with program requirements.

Pre-arrest Diversion

Shortly after the TAC program began, mental health staff met with the City of Fairfield Police Department staff to discuss the goals of the TAC program and why mental health training for officers would enhance overall diversion efforts. The partnership that developed among the court, law enforcement, and mental health community resulted in the creation of a crisis intervention team approach. In October 2002, mental health training for Fairfield police officers began as an extension of the TAC program.

Results

From the period of July 1, 2002, through February 15, 2003, there have been 47 pre-arrest diversions with none resulting in arrest. In addition to training officers of the police department, mental health staff often rides along with officers several times per month. TAC mental health clinicians are also in communication with the police department on an average of three or more times per week.

Official evaluation of the TAC program is currently underway.

Keys to Success

- During project planning, define the roles of the criminal justice and mental health system in program implementation.
- Consistent and frequent communication between the criminal justice and mental health treatment staff.
- Involving members of the mental health, probation, and court systems in the decision-making process regarding program participants' treatment planning.

Hamilton County, Ohio

■ **Alternative Interventions for Women**

This program, a partnership among the Hamilton County Courts, Department of Pretrial Services, Hamilton County Adult Probation, and Hamilton County TASC (Treatment Alternatives to Street Crimes), was formed in response to the growing number of women offenders entering the criminal justice system and the need to determine alternative treatment strategies. The Health Foundation of Greater Cincinnati and the Hamilton County Commissioners provided start up funding for the project.

County size: 845,303
Year program started: June 2000

Mary Carol Melton
Project Director,
Alternative Interventions for Women
Central Clinic/Court Clinic

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Post-arrest Diversion

Hamilton County's jail diversion project is designed specifically for women with non-violent misdemeanor or felony offenses who have been diagnosed with co-occurring mental illness and substance abuse disorders. The Court Clinic performs a clinical assessment for each woman to determine eligibility. A Judge or Probation Officer can refer a woman once a diagnosis is made and eligibility criteria have been met.

This program enables women to set personal goals for the program and develop, with staff support, an individual treatment plan. Women must participate in the core program for a minimum of five weeks and up to three months. Step down and transition and aftercare services are available to women for up to one year.

Hamilton County also opened its first Mental Health Court, which operates out of the Hamilton County Municipal Court, with funding support from The Health Foundation of Greater Cincinnati and the Hamilton County Community Mental Health Board. The Court is designed to divert non-violent misdemeanor offenders with a qualifying mental illness to community-based treatment.

County Leadership

The leadership and support of the Hamilton County Board of Commissioners has been critical to the creation and expansion of jail diversion efforts.

Results

From March 2001 to December 2002, 4,203 women were screened for mental health and substance abuse disorders at the Hamilton County Department of Pretrial Services. Three hundred sixty-six women qualified for the next phase, in- depth assessment, and a recommendation of appropriate treatment was made to the court. Of the 366 women assessed, 25 women were not found to be in need of treatment services, and 119 entered the Alternative Interventions for Women program. The remaining individuals were referred to other community-based services.

Miami-Dade County, Florida

■ 11th Judicial Circuit Criminal Mental Health Project

Miami-Dade County has the highest percentage of persons with mental illness of any urban area in the country, 9.1 percent of the general population or 200,000 people, and an even higher percentage in its criminal justice system. Less than 13 percent of the mentally ill population receives treatment. County data indicated that the county was paying $15 million annually to house and treat people with mental illness in the county jail. Additional data indicated that the cost to house a non-mentally ill person in jail amounted to approximately $20 per day while the cost for an individual with mental illness undergoing treatment amounted to $125 per day.

Miami-Dade County also faces challenges in treating individuals with mental illness who are not U.S. citizens, and therefore do not qualify for federal benefits. They also face a serious homeless problem; their data indicates that 45 percent of homeless individuals suffer from chronic mental illness or co-occurring mental illness substance abuse disorder.

A grant from the National GAINS Center for People with Co-Occurring Disorders in the Justice System enabled Miami-Dade County to host a summit with key stakeholders in July 2000 to design a comprehensive plan to appropriately treat people with mental illness. The summit resulted in a plan to build a comprehensive community-based care system through which individuals are diverted to local treatment facilities and can access medication, housing assistance, and supported employment.

County size: 2,289,683
Year started: July 2000

Judge Steven Leifman
County Judge
State of Florida 11th Judicial Circuit

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sleifman@jud11.flcourts.org

Pre-arrest Diversion

There are Crisis Intervention Team (CIT) police programs. Police officers volunteer to complete 40 hours of training to learn how to sensitively and effectively interact with individuals in mental health crisis. The County Mental Health Hospital Center, Jackson Memorial Hospital, provides the training at no cost. There are currently 10 police agencies in Miami-Dade County offering the CIT program. Once diverted, CIT officers transport the individual to one of six community mental health center crisis stabilization units (CSU's). These state-funded public receiving facilities stabilize individuals and assist them in accessing services. Once released, the Court Mental Health Project staff tracks and ensures that these individuals are linked with case-management services.

Post-arrest Diversion

The post-arrest misdemeanor diversion occurs through two courts that are not separate specialty mental health courts, but function like specialty courts. If an individual is determined to be in need of mental health services, they are transported by the Department of Corrections within 24-48 hours of arrest to an appropriate CSU.

To enroll and maintain individuals in federal benefit programs for better access to treatment, Miami-Dade County has established a relationship with the local Social Security office to expedite the process of re-establishing or establishing federal benefits for individuals. Under this system, it can take as few as 24 hours to establish a person's benefits.

Housing

There are adult living facilities that provide long-term supervised housing for people with mental illnesses. The Court Mental Health Project refers 500 to 1,000 individuals per year to these adult living facilities.

Collaboration

A group of stakeholders including State's attorneys, public defenders, state and county representatives, family members of people with mental illness, members of the judiciary, the Department of Corrections, mental health providers, and representatives from the 10 police agencies involved in CIT meet on a monthly basis to discuss successes, challenges, and needs of the entire jail diversion program.

The State of Florida has been a key partner with Miami-Dade County in their efforts to properly treat

people with mental illness. Both the county and the state work together in a mutually beneficial way and each contributes to the success of the project. The state has provided funding for a staff person within the court system to link diverted mentally ill individuals to case management services. The state has also offered to help offset costs of treating undocumented immigrants who cannot access benefits. The county provides funding for an additional staff position in the court and also has committed $6 million to build a forensic facility, to expand crisis stabilization, and to provide a transitional living program.

County Leadership

The Miami-Dade Board of County Commissioners provides critical leadership for jail diversion efforts. Not only is the Commission supportive of efforts to find the best alternatives for treating individuals with mental illness, they also are committed to ensure that these efforts not only continue, but expand. The County Board Chair plans to keep the issue of appropriate treatment of mentally ill individuals a top priority in Miami-Dade County.

Results

The City of Miami CIT police officers diverted 2,100 individuals to community based mental health centers over a period of six months, resulting in fewer police injuries, decreased recidivism, and substantial savings to the county.

From 2000 to 2001, the Project has reduced the recidivism rate for the mentally ill population from an estimated 70 percent to 11 percent. The recidivism rate rose slightly, to 18 percent, in 2002. According to the Project's calculations, the overall reduced recidivism rate saved Miami-Dade County $2.3 million in a one year period.

In May 2003, Miami-Dade County was one of seven communities across the country to be awarded a federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to expand its jail diversion program. Additional expansions and improvements to the Project are underway, including enhancing evaluation through a partnership with a local foundation and university, and creating a felony diversion program.

Keys to Success

- Partnership and cooperation among state, county, and city agencies
- Cooperative agreements with hospitals and other mental health providers to build the continuum of mental health care.
- Having a coalition of key stakeholders meet regularly as a group to strategize on how to continue leveraging local, state, and national resources. Approaching potential funding sources as coalition with a shared cause can increase chances of success.
- Ongoing and frequent communication among the key agencies involved in the jail diversion program
- Leadership of the County Commission

Program Central Themes

County Leadership

In each of the sites visited, the County Board, County Sheriff, and members of the judiciary played key roles in launching jail diversion efforts. In many cases, the support and leadership of elected and appointed county officials created the political will for programs to be developed. Additionally, county elected officials can play a key role in financially sustaining programs after grant funds or start-up funds expire.

Strategic Planning

As demonstrated by the visits, there are innovative strategies for counties of all sizes. Counties certainly should investigate and examine existing models for jail diversion and decide what pieces/aspects will work best for their community. What will work effectively in one community may not in another. The best approach often depends on the social needs of the county, the problems particular to their region, and the structure of local systems.

City/County Collaboration

Another common theme was the division of labor between municipal and county governments and the need for collaboration. Counties have a major responsibility for funding felony courts, operating jails and detention centers, and providing for public health and human services at the local level. Municipal governments have major responsibility for municipal police, public housing and misdemeanant courts. It is essential that they plan and work together.

Mental Health/Criminal Justice Collaboration

The need for collaboration between criminal justice and health and human service agencies at the local level in dealing with the mentally Ill was another central theme of the programs we visited. The ability of these two systems to effectively work together and share responsibility for treating this population played a key role in the success of the programs.

State/Local Partnerships

The sharing of responsibility between the state and counties for the humane and appropriate treatment of individuals with mental illness is essential. In each of the local programs visited there was State support of the programs. Whether through special legislation (LA County), grants from State Mental Health Departments (Ohio), or the state being open to and responding to requests for assistance from the county (Miami-Dade), the state and local governments need to work with each other to put a final end to this crisis. Each has much to gain by the improved public safety, reduced costs, improved lives, and even lives saved.

Future Opportunities

Counties are inherently regional governments and as such are often engaged in countywide and multi-county solutions. (There are 2500 counties with populations of less than 50,000.) Progress in developing new systems at the local level will depend on creating new partnerships between state and county governments and strengthening relationships between city and county governments.

State and National Resources

Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Mental Health Services (CMHS)
Phone: (301) 443-0001

Center for Substance Abuse Treatment (CSAT)
Phone: (301) 443-5700

Room 12-105 Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
Email: info@samhsa.gov
Web: www.samhsa.gov

U.S. Department of Justice
Office of Justice Programs
Bureau of Justice Assistance

950 Pennsylvania Avenue, NW
Washington, DC 20530-0001
Phone: (202) 616-6500
Email: AskBJA@ojp.usdoj.gov
Web: www.ojp.usdoj.gov/BJA/

The National GAINS Center for People with Co-Occurring Disorders in the Justice System
Policy Research Associates

345 Delaware Avenue
Delmar, NY 12054
Phone: (800) 311-4246
Email: gains@prainc.com
Web: www.gainsctr.com

National Resource Center on Homelessness and Mental Illness
Policy Research Associates

345 Delaware Avenue
Delmar, NY 12054
Phone: (800) 444-7415
Email: nrc@prainc.com
Web: www.nrchmi.com

National Sheriffs' Association

1450 Duke Street
Alexandria, VA 22314-3490
Phone: (703) 836-7827
Web: www.sheriffs.org

National Association of State Mental Health Program Directors (NASMHPD)

Phone: (703) 739-9333
Web: www.nasmhpd.org

National Association of County Behavioral Health Directors (NACBHD)

1555 Connecticut Avenue NW
Suite 200
Washington, DC 20036
Phone: (202) 234-7543
Email: Lauren@nacbhd.org
Web: www.nacbhd.org

Bazelon Center for Mental Health Law

1101 15th Street NW
Suite 1212
Washington, DC 20005-5002
Email: materials@bazelon.org
Web: www.bazelon.org

President's New Freedom Commission on Mental Health

5600 Fishers Lane
Room 13C-26
Rockville, MD 20857
Phone: (866) 326-4563
Email:
staff@mentalhealthcommission.gov
Web:
www.mentalhealthcommission.gov

Police Executive Research Forum (PERF)

1120 Connecticut Avenue NW
Suite 930
Washington, DC 20036
Phone: (202) 466-7820
Email: perf@policeforum.org
Web: www.policeforum.org

The Health Foundation of Greater Cincinnati

Janice Bogner, Program Officer
3805 Edwards Road, Suite 500
Cincinnati, Ohio 45209-1948
Phone: (888) 310-4904 (Toll Free)
Email:
jbogner@healthfoundation.org
Web: www.healthfoundation.org

The Maryland Mental Health and Hygiene Administration

Dr. Joan Gillece, PhD
Director of Special Needs
Populations
201 West Preston Street
Baltimore, MD 21201
Phone: (410) 724-3235

Florida Partners in Crisis Advocating for Improved Mental Health and Substance Abuse Services in the State of Florida

100 Bush Boulevard
Sanford, FL 32773
Phone: (407) 665-6731
Web:
www.floridapartnersincrisis.org

Criminal Justice/Mental Health Consensus Project
Council of State Governments

Phone: (212) 912-0128
Web: www.consensusproject.org