

**Testimony before Senate Judiciary Committee
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S. 1194, The Mentally Ill Offender and Crime Reduction Act of 2003

*Justice Evelyn Lundberg Stratton, Supreme Court of Ohio,
Chair, Supreme Court of Ohio Advisory Committee on Mentally Ill in the Courts*

Finding effective strategies for working with mentally ill persons in the criminal justice system is important to me, both personally and professionally.

As a family member of a person who once suffered from depression, I am aware of the stigma of mental illness. It is not a popular subject, but it is one that I am passionate about. As a former trial judge, I saw first hand the effects of mental illness on the legal system. I am extremely concerned about keeping people with mental illness out of jail and diverted into appropriate mental health treatment.

The passage of S. 1194 is the right thing to do as well as a concept whose time has come. The statistics tell the story of why this bill is so needed.

- In 1955, there were 558,239 severely mentally ill patients in our nation's public psychiatric hospitals. In 1994, there were 71,619. Based on population growth, at the same per capita utilization as in 1955, estimates are that there would have been 885,010 patients in state hospitals in 1994. E. Fuller Torrey, M.D. in *Out of the Shadows: Confronting America's Mental Illness Crisis*, John Wiley & Sons, New York, 1997, page 8 -9

- Where have these severely mentally ill patients gone? Our jail population of people with mental illness has swelled to 285,000. According to a U.S. Department of Justice July 1999 Report, 16% of state prison inmates and 16% of those in local jails reported either a mental condition or an overnight stay in a mental hospital.
- According to that same study, half of mentally ill inmates reported 3 or more prior sentences. Among the mentally ill, 52% of state prisoners, and 54% of jail inmates reported 3 or more prior sentences to probation or incarceration.
- In fact, according to March 2000 statistics from the Ohio Department of Rehabilitation and Correction, there were 6393 mentally ill inmates, 3051 of who were classified as severely mentally disabled.
- Many of the severely mentally ill who have been released into the community through de-institutionalization, are now part of the 600,000 people in America who are homeless. Of these, it is believed that at least a third are mentally ill. U.S. Department of Health and Human Services, 1992.

A revolving door problem has developed in this country. Jails and prisons have become the de facto mental health system of our day. We must reverse this trend. Over the past few years, innovative diversion programs and other pioneering efforts across the nation have been successful in attacking this crisis. We must persevere to be able to provide community treatment for this population who were previously “warehoused,” but who now are slipping through the cracks of our safety nets.

If not for altruistic reasons, this change is crucial in terms of the cost savings to the taxpayer. Mentally ill inmates require far more jail and prison resources due to treatment and crisis intervention. But this revolving door has other costs, too. Taxpayer dollars are paying for police officers to repeatedly arrest, transport and process mentally ill defendants, as well as for jail costs associated with treatment and crisis intervention, salaries of judges and court staff, prosecutors and defense attorneys, and many more hidden costs. The question becomes would we rather spend these dollars to keep mentally ill citizens homeless, revolving in and out of our criminal justice system, or would we rather spend these dollars to help them to become stable, productive citizens?

In Ohio to address this problem, we have formed the Ohio Supreme Court Advisory Committee on the Mentally Ill in the Courts, made up of representatives from the Ohio Department of Mental Health, Ohio Department of Alcohol and Drug Addiction Services, the Ohio Department of Rehabilitation and Correction, the Ohio Department of Mental Retardation and Developmental Disabilities, the Ohio Office of Criminal Justice Services, Judges, law enforcement, mediation experts, housing and treatment providers, consumer advocacy groups, and other officials from across the state. It is a collaboration effort that is the heart of this bill.

The Advisory Committee is working to establish local task forces in each local county to bring similar local representatives together to collaborate and work on the issues of the mentally ill in the criminal justice system. We encourage each

county to start a mental health specialty docket to deal with the issues, but have also found that the collaboration that results when all these groups get together goes far beyond the courtroom. The Advisory Committee provides guidance, resources, materials and information to the local task forces. We provide role models of other successful mental health court dockets, and pass on grant and other funding opportunities to the task forces.

There are three projects from our Advisory Committee that I would like to highlight to provide a sample of our progress in this area. First, in 2001, NAMI-Ohio (National Alliance for the Mentally Ill) developed a curriculum for jail and court personnel entitled, "Working with People with Mental Illness in the Criminal Justice System." Participants learn about diagnoses, treatment, symptoms, dual diagnosis (substance abuse and mental illness), psychotropic medications, crisis de-escalation, and jail suicide prevention. Jail personnel report this is some of the best training they have received in an area they feel woefully unprepared to handle.

Second, the Advisory Committee has worked to encourage Crisis Intervention Training (CIT) state-wide. CIT stands for "Crisis Intervention Team," and refers to a collaborative effort between law enforcement and the mental health community to help law enforcement officers handle incidents involving mentally ill people and to take them to a mental health facility instead of jail where appropriate. The CIT is a community-based collaboration between law enforcement NAMI (National Alliance for the Mentally Ill), mental health

consumers, mental health providers and local universities. Volunteer patrol officers receive 40 hours of training in mental illness and the local mental health system. The training is provided free of charge by the mental health community, providers, consumers and family members. The training focuses on providing practical techniques for de-escalating crises. Because our committee continually promotes CIT as a key to the collaboration effort, interest in training has exploded. We are now expanding to training parole and probation officers and even university, college, and campus police who frequently deal with troubled college students.

Third, our Advisory Committee has recently formed a subcommittee to develop jail standards for detainees with mental illness. Recently, I met an architect charged with designing jail cells for mentally ill detainees. The architect shared with me his frustration that he could find no standards for designing jail cells that would be appropriate for mentally ill, i.e., color, size, restraints etc. In response, our Advisory Committee formed a subcommittee, entitled the Jail Standards Sub-Committee to review this issue. The subcommittee has employed the advice of psychiatrists and other mental health professionals and has drafted 12 proposed standards. After reviewing this matter nationally and finding very little data available on this issue, the sub-committee plans to share these standards with other states.

Finally, I would like to share an example of how the collaboration model has worked in one county.

About a year ago, I was asked to help Franklin County start a task force. As one of the largest counties in Ohio, we had a large population of mentally ill in the local jails, and the mental health department felt very frustrated in how to deal the problem.

We had about 10 people at the first meeting - some mental health and drug and alcohol representatives and a few judges I had called. The judges were not even aware that Franklin County had received a Department of Mental Health grant to work with the mental ill in the jail. The local housing board, which had funding for over 500 beds for the homeless, had never worked with the courts, nor had a leading program to train mentally ill to work. A year later, there are over 55 community representatives on the task force, which also has active sub-committees. The mayor has approved CIT training and two classes of police officers are in training. The Municipal Court has started a mental health docket, and the Common Pleas Court has started a drug court docket that will form the structure for a mental health court docket to be included. The Franklin County courts have jointly obtained two grants, one with thanks to Senator DeWine's first mental health courts bill. The task force has expanded its collaboration effects far beyond just jails. They are finally working together.

The key to all of this is collaboration – working together. We have discovered there are many resources out there that can be more effectively used when we join forces. S. 1194 is a key component to that effort. It provides the

seed money for that collaboration – planning money, implementation money. It is not a whole new system that needs funding but rather needs to work together with specialized funding to help that collaboration process-such as an intake officer or probation officer who is trained in mental health issues, the CIT police officer who takes a person who has stopped taking their medication, to a mental health clinic, not jail.

All the money we now spend warehousing the mentally ill in jail can be rechanneled to mental health care, job training, housing, with permanent solutions, not just a revolving door. A recent study by the Corporation for Supportive Housing found that stabilizing the homeless and mentally ill had resulted in \$16,000 annual savings per year of social, mental health and jail expenses per person. In one New York study alone, the prison use by this population dropped 74% and jail use by 40%. The Corporation for Supportive Housing, June 2001 Report. Pp. 21 and 23. The end result is a reduction in crime and safer communities as well.

Senate Bill 1194, “The Mentally Ill Offender Treatment and Crime Reduction Act of 2003” sponsored by Senator DeWine is a key part of the solution for the mentally ill offender. It provides needed federal dollars for programs that could become models for duplication in other communities. The availability of federal funding is often the catalyst to spur community action and to encourage the communities to work together and collaborate, even in the act of designing a program and applying for the funds. It focuses attention on a

population that is too easy to forget-the defendant and inmate, yet a population that is mostly there because other social safety nets have already failed them. It encourages the collaboration model that Ohio has already used very successfully, but is broad enough and flexible enough to deal with the different social and political environments of each community. One program may emphasize the juvenile, another police training, a third how to integrate the mentally ill who have completed their sentence back into a community that already failed them. Each successful program becomes a model that can be duplicated elsewhere. For these reasons, and many others, I strongly urge you to consider the passage and funding of S. 1194.

In the 1800's, the greatest challenge to the mental health and criminal justice systems was to get the mentally ill out of jails and prisons and into appropriate treatment. Still today, we face the same problem. But by joining forces and working together, we are making a difference. In the end, we save money, but more importantly we save lives.