

**JUSTICE**  **CENTER**  
THE COUNCIL OF STATE GOVERNMENTS  
*Collaborative Approaches to Public Safety*

**Statement by**

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**Committee on the Judiciary**

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Chairman Grassley, Ranking Member Leahy, and distinguished Members of the Committee:

Thank you for the opportunity to discuss the over-representation of persons with mental illnesses in our criminal justice systems. I am Dr. Fred Osher, the director of health systems and services policy for The Council of State Governments (CSG) Justice Center. The CSG Justice Center is a national nonprofit organization that serves policymakers at the local, state, and federal levels from all branches of government. We strive to provide practical, nonpartisan advice and evidence-based, consensus-driven strategies to increase public safety and strengthen communities. As a community psychiatrist for the past 35 years, I have had a front-row seat to this growing national tragedy. I work in a community mental health center in my hometown of Charleston, South Carolina, and see so many patients who desperately want to avoid criminal justice contact, but find themselves caught in a cycle of arrest, incarceration, release, and rearrest. Without adequate alternatives, more and more patients find themselves caught in revolving doors of justice.

## **Background**

Each year, an estimated 2 million people with serious mental illnesses are admitted to jails across the nation. That's equivalent to the populations of Vermont and New Hampshire—combined. Almost three-quarters of these adults also have co-occurring drug and/or alcohol use disorders. Once incarcerated, individuals with mental illnesses tend to stay longer in jail, and, upon release, are at a higher risk of returning to incarceration than those without these illnesses. The human toll of this problem—and its cost to taxpayers—is staggering.

Policymakers understand that having a mental illness is not tantamount to having a “get-out-of-jail-free” card; all people need to be accountable for their actions. Too often, however, people with serious mental illnesses are incarcerated, oftentimes for minor offenses, when they would be better served in the community. Though jails have a constitutional mandate to treat the mental illnesses of their inmates, they are often ill-equipped to meet their needs, or even to assess what those needs might be. Without accurate information about the needs of individuals coming into correctional settings—the CSG Justice Center's county work suggests very few facilities collect

this information—decisions about who to release, who to treat, and who to segregate are often ill-informed.

Jails spend two to three times more money on adults with mental illnesses than on those without those needs, yet they often do not see a return on those investments in terms of improved public safety or health of those individuals. Although states and localities have made tremendous efforts to address this problem, they are often thwarted by significant obstacles, including inadequate data to inform policy changes, minimal resources, and a lack of coordination between criminal justice, mental health, substance use treatment, and other agencies. For individuals with mental illnesses, contact with the criminal justice system often starts a cycle of arrest, incarceration, release, and rearrest that can pose nearly insurmountable challenges to recovery. As they face increasingly serious charges, or fail to comply with conditions of release, prisons become the institutional homes for these individuals. However, most criminal justice and community-based treatment personnel agree that corrections environments are poor settings for individuals with mental illnesses.

Without change, large numbers of people with mental illnesses will continue to cycle through our jails and prisons, often resulting in tragic outcomes for these individuals and their families, missed opportunities to link to effective treatment, inefficient use of funding, and a failure to improve public safety.

## **Understanding the Issues**

People with mental illnesses (most of whom have co-occurring substance use disorders) are over-represented at every stage of the criminal justice system. Researchers documented serious mental illnesses in 14.5 percent of males in jail and 31 percent of females in jail<sup>1</sup>; these rates are more than three to six times those found in the general population.<sup>2</sup> Generalized to the fact that

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<sup>1</sup> H. J. Steadman, F. C. Osher, P. C. Robbins, B. Case, and S. Samuels, “Prevalence of Serious Mental Illness among Jail Inmates” *Psychiatric Services* 60, no. 6 (2009): 761-765..

<sup>2</sup> The estimate for the prevalence of serious mental illness in the general population is 5.4 percent (R. C. Kessler, C. B. Nelson, K. A. McKinagle, M. J. Edlund, R. G. Frank, and P. J. Leaf, “The Epidemiology of Co-Occurring Addictive and Mental Disorders: Implications for Prevention and Service Utilization. *American Journal of Orthopsychiatry* 6 (1996): 17–31.

almost 13 million jail admissions will occur this year, more than 2 million bookings of people with serious mental illnesses occur annually.<sup>3</sup> It is estimated that more than 15 percent of our state prisoners have serious mental illnesses as well.<sup>4</sup> The presence of so many people with mental illnesses in criminal justice settings is an enormous burden on federal and state corrections and behavioral health systems, communities, families, and those with mental illnesses.

### *Mental Illness and Violence*

There is no doubt that many individuals with mental illnesses who commit violent crimes must be held responsible for their actions. However, it is important to remember that most violence in this country is not committed by people who have a mental illness, *and* most people with mental illnesses are not violent. The risk of violence statistically attributable to serious mental illness is estimated to be 3 to 5 percent; this is comparable to rates among persons without mental illnesses.<sup>5</sup> Because serious mental illness affects a small percentage of the population, it makes—at most—a very small impact on the overall level of violence in society. In fact, people with serious mental illnesses are anywhere from 2.5 times to nearly 12 times more likely to be victims rather than perpetrators of violence.<sup>6</sup>

### *Heterogeneity of the Population*

When discussing persons with mental illnesses in criminal justice settings, it is important to keep in mind the heterogeneity of this group. They differ in their demographics, seriousness of their mental illnesses, charge levels, access to community supports, and criminogenic risks (i.e., the factors that affect how likely they are to engage in criminal behavior). Traditionally, both

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<sup>3</sup> H. N. Snyder, W. J. Sabol, T. D. Minton, *Arrest in the United States, 1990–2010* (Washington, DC: Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2012).

<sup>4</sup> Paula Ditton, *Mental Health and Treatment of Inmates and Probationers* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 1999).

<sup>5</sup> Richard A. Friedman, “Violence and Mental Illness—How Strong is the Link?” *New England Journal of Medicine* 355, no. 20 (2006): 2064–2066.

<sup>6</sup> J.Y. Choe, L. A. Teplin, and K. M. Abram, “Perpetration of Violence, Violent Victimization, and Severe Mental Illness: Balancing Public Health Concerns.” *Psychiatric Services* 59, no. 2 (2008): 153–164.

criminal justice and behavioral health practitioners believed that mental illnesses were the direct cause of criminal justice involvement (because of displays of psychiatric symptoms in public or symptom-driven illegal behavior), and many local programs targeting people with behavioral disorders involved with the criminal justice system were designed with this rationale in mind. It turns out to be more complicated than just accessing mental health treatment. Importantly, the data suggest that people with mental illnesses who have been arrested are also likely to have criminogenic needs commonly associated with all arrested individuals (e.g., antisocial peers, substance use, unstable housing/homelessness, school/work problems, and family/marital deficits).

### *What Factors Drive the Numbers of People with Mental Illnesses in Jail and Prison?*

To develop appropriate responses to persons with mental illnesses in jail and prison, it is important to understand the reasons why they are so prevalent in jail and prison. There are a number of contributing factors.

First, people with mental illnesses are over-represented in homeless populations and, as such, they are more visible to law enforcement. Their behaviors that stem from lack of treatment (e.g., public disturbance) attract attention. As an indicator of how visibility may play into their arrest, incarcerated persons with mental illnesses are much more likely to have been homeless at the time of their arrest than those without mental illnesses.<sup>7</sup> Panhandling and public intoxication are frequent causes of calls to law enforcement. In addition, the lack of stable housing severely complicates the reentry of a person with mental illness following release from prison.

Second, people with mental illnesses are about three times more likely to develop a co-occurring substance use disorder than the general population.<sup>8</sup> This increased prevalence of substance use disorders over the course of their lifetimes, combined with increased arrests for drug-related offenses since 1980, means that more people with mental illnesses will be arrested. Research has

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<sup>7</sup> Paula Ditton, *Mental Health and Treatment of Inmates and Probationers* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 1999).

<sup>8</sup> D. A. Regier, M. E. Farmer, D. S. Rae, B. Z. Locke, S. J. Keith, L. L. Lewis, and F. K. Goodwin, "Comorbidity of Mental Disorders with Alcohol and Other Drug Abuse" *Journal of the American Medical Association* 264, no. 19 (1990): 2511-2518.

found that nearly three-quarters of men and women with mental illnesses in jails also have a co-occurring substance use disorder.<sup>9</sup>

Third, the limited access to over-burdened community-based treatment may make individuals with untreated symptoms more likely to be arrested, may increase delays in release from jail and prison, and may limit individuals' ability to successfully reintegrate into their communities. Individuals with mental illness who encounter police are too frequently incarcerated—often for misdemeanor or non-violent infractions—rather than connected with treatment services, simply because of a lack of community resources. If there are no alternatives to incarceration for the individual with a serious mental illness that law enforcement encounters on the streets, officers feel that their only option is to book that person into jail to ensure their safety. Judges may be reluctant to release an individual with mental health needs if they are not confident that they will receive adequate treatment in the community. Recent cuts in mental health services have an impact on the prevalence of mental illnesses in jails and prisons insofar as they make it more difficult for treatment providers to dedicate resources, time, and treatment slots to this population.

Fourth, the conditions in many jails and prisons can have a harmful effect on the mental health of all prisoners. Overcrowded, high-intensity interactions with regular threats to personal safety and limited access to treatment can make the prison experience a prolonged traumatic event. Privacy is nonexistent. The noise levels within jail and prison settings throughout the day and night are excessive and there is absolutely nothing the incarcerated person can do about it.

Fifth, once in jail and prison, people with mental illnesses tend to stay longer, and are less likely to be placed on probation or parole, than others charged with similar offenses.<sup>10</sup> Judges may be reluctant to release a person with mental illness on bail because of the stigma or myths about their inherent dangerousness. Newer research has demonstrated that even short periods of time in

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<sup>9</sup> K. M. Abram and L. A. Teplin, "Co-Occurring Disorders among Mentally Ill Jail Detainees: Implications for Public Policy." *American Psychologist* 46, no. 10 (1991) 1036-45.

<sup>10</sup> The Council of State Governments Justice Center, *Improving Outcomes for People with Mental Illnesses Involved with New York City's Criminal Court and Correction Systems* (New York: The Council of State Governments Justice Center, 2012). Available at [http://csgjusticecenter.org/wp-content/uploads/2013/05/CTBNYC-Court-Jail\\_7-cc.pdf](http://csgjusticecenter.org/wp-content/uploads/2013/05/CTBNYC-Court-Jail_7-cc.pdf).

jail on pretrial status can have a major impact on an individual's ability to stay out of jail.<sup>11</sup> Parole board members may lack confidence in community resources for individuals with mental illnesses, have misconceptions about mental illnesses, or fear negative public reactions. As a result, people with mental illnesses more often serve the maximum sentence allowed by law.<sup>12</sup>

Sixth, as referenced above, persons with mental illnesses have many, and perhaps more, of the criminogenic risk factors associated with arrest. And finally, once released, without adequate treatment, supports, and supervision, people with mental illnesses are more likely to recidivate.<sup>13</sup>

## **Effective Responses**

### *Evidence-Based Practices*

Effective responses begin with an accurate assessment of an individual's behavioral health needs and risk of recidivism. All people arrested should be screened for mental illnesses, substance use disorders, and recidivism risk. With screening and assessment information, decisions can be made about effective supervision and programming. Using this information appropriately requires training for police officers, judges, public defenders, and prosecutors. Treatment and supervision should be data-driven; research indicates that there are a number of services and supports that are effective in addressing the often complex behavioral health and criminogenic needs of people involved in the criminal justice system. These evidence-based practices can be used to mitigate the likelihood of return to custody and improve the process of recovery.

Treatment should include the provision of psychiatric medication when necessary, along with structured cognitive-behavioral and skill-building interventions. In addition, case management (including forensic assertive community treatment teams), integrated mental health and substance use services, supported employment, psychopharmacology, family psychoeducation, supported housing, and trauma interventions may be required. To maintain the quality of this approach, regular process and outcome evaluations, as well as reviews of provider-, program-,

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<sup>11</sup> C. T. Lowenkamp, M. VanNostrand, and A. Holsinger, *The Hidden Costs of Pretrial Detention* (Arnold Foundation, 2013).

<sup>12</sup> The Council of State Governments Justice Center, *Criminal Justice/Mental Health Consensus Project Report* (New York: The Council of State Governments Justice Center, 2002).

<sup>13</sup> J. Baillargeon, I. A. Binswanger, J. V. Penn, B.A. Williams, and O. J. Murray, "Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door." *American Journal of Psychiatry* 66 (2009) 103-109.

and system-level integrity to evidence-based (or at least promising or recommended) programming and practices should be conducted. Outcome evaluations of these services should also be supported to ensure that expected results are achieved.

### *Specialized Programs*

There are opportunities to reduce the number of people with mental illnesses in our criminal justice system at every point of contact. Law enforcement agencies are developing specialized police-based responses (e.g., Crisis Intervention Teams (CIT)) to reduce the need for arrest and booking. As an example, the Houston Police Department (HPD) is the leading agency in the state of Texas providing training to its force and to other agencies on how to recognize persons with mental illnesses, de-escalate crises on site, and divert individuals, when appropriate, to treatment alternatives. Since 2014, HPD has provided CIT training to 55 law enforcement agencies. Working in collaboration with the Houston/Harris Center for Mental Health, the HPD has established a Mental Health Division that includes approximately 50 staff members. Working in two-person teams, law enforcement and mental health professionals respond around the clock to individuals with mental illness.<sup>14</sup>

When people are arrested, post-booking diversion can be built in by screening them for behavioral health needs and releasing those who do not pose a flight risk or danger the community. The Hillsborough County Department of Corrections (HCDOC) in New Hampshire has a pretrial supervision program that includes individuals with mental illness who are serving committed sentences. Screenings are conducted at initial detention and classification and defendants qualifying for supervised early release are identified. In these cases, probation staff help each defendant comply with conditions of release, coordinate with courts, and ensure linkage to necessary services including treatment, housing and employment.

At the custody stage, training for corrections staff can improve identification of persons with mental health needs and prevent problems from occurring within facilities. The Minnesota Department of Corrections (DOC) partners with the National Alliance on Mental Illness of Minnesota to implement one of only a few CIT training programs that operates in a state prison

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<sup>14</sup> See <http://www.houstoncit.org/accomplishments-2/> for list of Houston Police Department accomplishments.



system. The partners work together to provide 40-hour CIT trainings to teach staff how to recognize the symptoms of mental illnesses, safely de-escalate a mental health crisis, and connect people to appropriate mental health resources. The Minnesota DOC now has more than 300 active CIT-trained staff, and aims to train 25 percent of security staff in each of the department's 8 adult facilities.

Specialty courts (e.g., drug and/or mental health courts) can offer an alternative to incarceration, connect an eligible individual to treatment, and provide court supervision to ensure adherence to conditions of release. In Outagamie County, Wisconsin, county officials increased access to mental health supports by expanding the mental health court capacity and addressing service gaps in employment and housing for the population served. Additionally, court partners collaborated with the Division of Rehabilitation Services and Innovative Services to provide participants with evidence-based individual placement and supported employment services, and engaged a housing partner to be on the mental health court team to address housing barriers for participants. All participants receive interventions to reduce their risk of recidivism and work through curricula, such as Thinking for a Change and Moral Reconciliation Therapy, that target criminogenic risks.

Reentry planning personnel can identify requisite community services, while specialized community corrections teams can effectively supervise individuals upon release. Although many communities have some of these programs, most do not have all, and the scale of existing programs tends to be far smaller than the number of individuals who could participate. Through a comprehensive combination of alternatives to incarceration, scaled to demand, as well as collaborative strategies for diversion, effective treatment, and court-ordered supervision, four key outcomes can be attained: a reduction in the number of people booked into jails; shorter lengths of stay for people with mental illnesses once they are booked into jail; a larger percentage of people with mental illnesses being connected to the appropriate services and supports when leaving jail; and a reduction in the rate of recidivism among these individuals.

## **Supporting Policies and Initiatives**

### *Comprehensive Justice and Mental Health Act*

We are grateful for the work of the Senate Judiciary Committee in raising awareness of crisis incidents involving people with disabilities and untreated mental illnesses. The Comprehensive Justice and Mental Health Act (CJMHA), introduced in the Senate by Senators Al Franken (D-MN) and John Cornyn (R-TX), reauthorizes the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA). In 2004, Congress authorized the Justice and Mental Health Collaboration Program (JMHCP) through MIOTCRA. This \$50 million grant program, administered by the U.S. Department of Justice's Bureau of Justice Assistance (BJA), was created to help states, local governments, and tribal organizations improve responses to people with mental illnesses who are involved with the criminal justice system. The funding has varied over the last nine years from an initial investment of \$5 million in FY2006 to \$8.5 million in FY2015.

Since 2006, BJA has awarded 349 JMHCP grants to jurisdictions across 49 states and territories and the District of Columbia. Underscoring the collaborative nature of this program, all grants require a joint application from a mental health agency and unit of government responsible for criminal and/or juvenile justice activities.

Grant recipients may use the grants for a broad range of activities, including crisis intervention teams and other specialized law-enforcement-based responses; mental health courts; mental health and substance use treatment for individuals who are incarcerated or involved in the criminal justice system; community reentry services; and cross-training of criminal justice and mental health personnel.

The Justice and Mental Health Collaboration Program has helped BJA identify promising models to respond to this vulnerable population, and approaches that effectively support law enforcement and other components of the criminal justice system.

### *Second Chance Act*

Signed into law on April 9, 2008, the Second Chance Act (Public Law 110-199) was designed to improve outcomes for people returning to communities from prisons and jails. It authorizes federal grants to government agencies and nonprofit organizations to provide employment assistance, substance use treatment, housing, family programming, mentoring, victims support, and other services that can help reduce recidivism.

A significant number of individuals who are incarcerated and returning to the community have chronic substance use and mental disorders and are in need of treatment in order to successfully complete their supervision. First funded in 2010, the Second Chance Act co-occurring treatment grant program provides funding to state and local government agencies and federally recognized Native American tribes to implement or expand integrated treatment programs for individuals with co-occurring substance use and mental health disorders. It is designed to improve outcomes for adults with co-occurring substance use and mental disorders through the screening and assessment of incarcerated individuals, and the availability of some pre-release programming, leading to the provision of appropriate evidence-based services and treatment after incarceration.

*S.2002 - The Mental Health and Safe Communities Act of 2015*

This bill was introduced by Senator Cornyn and has a number of provisions that would address the over-representation of persons with mental illnesses in the criminal justice system. Among its provisions, the bill authorizes pretrial screening, assessment, and supervision programs to improve outcomes for people with mental illnesses by ensuring that they are accurately diagnosed and receive appropriate need-based treatment that focuses on increasing public safety; an increase in the use of treatment-based alternatives to incarceration for people with mental illnesses; improvements to reentry programming for people with mental illnesses who are released into the community by authorizing Forensic Assertive Community Treatment (FACT) teams to ensure that this population receives appropriate case management and treatment; and the expansion of specialized law enforcement crisis intervention teams, which respond to and de-escalate mental health crises for federal law enforcement personnel. The bill also incorporates the Comprehensive Justice and Mental Health Act.

*Stepping Up: A National Campaign to Reduce the Number of Persons with Mental Illnesses in*

### *Our Nation's Jails*

Policies have relied on outdated data to determine the scope and nature of this problem. As state corrections budgets are stretched to their limits and state mental health budgets are being slashed, there has not been a more critical time for policymakers to consider the implications of mental illnesses in jails. Recognizing the critical role local and state officials play in supporting change, the National Association of Counties (NACo), the CSG Justice Center, and the American Psychiatric Association (APA) Foundation have come together to lead a national initiative to help advance counties' efforts to reduce the number of adults with mental and co-occurring substance use disorders in jails. With support from the U.S. Department of Justice's Bureau of Justice Assistance, the initiative will build on the many innovative and proven practices being implemented across the country. The initiative is about creating a long-term, national movement—more than a moment in time—to raise awareness of the factors contributing to the over-representation of people with mental illnesses in jails, and then using practices and strategies that work to drive those numbers down. The initiative has two key components:

1. A CALL TO ACTION demonstrating strong county and state leadership and a shared commitment to a multistep planning process that can achieve concrete results for jails in counties of all sizes. As part of this call to action, county elected officials are being asked to pass a resolution in support and then work with other leaders (e.g., the sheriff, district attorney, treatment providers, and state policymakers), people with mental illnesses and their advocates, and other stakeholders on the following six steps:

- Convene or draw on a diverse team of leaders and decision-makers from multiple agencies who are committed to safely reducing the number of people with mental illnesses in jails;
- Collect and review prevalence numbers and assess individuals' needs to better identify adults entering jails with mental illnesses and their recidivism risk, and then use that baseline information to guide decision-making at the system-, program-, and case-levels;
- Examine treatment and service capacity to determine which programs and

services are available in the county for people with mental illnesses and co-occurring substance use disorders, and identify state and local policy and funding barriers to minimizing contact with the justice system and providing treatment and support in the community;

- Develop a plan with measurable outcomes that draws on the jail assessment and prevalence data and the examination of available treatment and service capacity, while considering identified barriers;
- Implement research-based approaches that advance the plan; and
- Create a process to track progress using data and information systems, and to report on successes.

To date, 215 counties have stepped up and passed resolutions.

2. A NATIONAL SUMMIT will convene in April 2016 to help counties advance their plans and measure progress and to identify a core group of counties that are poised to lead others in their regions. Follow-up assistance will be provided to participants to help try new strategies that can be used in counties across the nation. Although much of the initiative focuses on county efforts, states will be engaged at every step to ensure that their legislative mandates, policies, and resource-allocation decisions do not create barriers to plan implementation. To date, almost 200 counties have applied to participate.

## **Conclusion**

Dorothea Dix, Superintendent of Army Nurses during the Civil War, crusaded for humane responses to the needs of incarcerated people with mental illnesses in the mid-1800s. Her advocacy was translated into state asylums for persons with mental illnesses, to trade punishment for care. We have come full circle and find ourselves asking the same question that she posed 150 years ago: Why are we incarcerating people with mental illnesses when we know recovery is possible if they are afforded adequate care? Participants in the National Leadership Forum on Behavioral Health and Criminal Justice concluded: “This national disgrace, kept hidden for too

long, represents one area in civil rights where we have actually lost ground.”<sup>15</sup>

Thank you for the opportunity to address the critical issue of persons with mental illnesses in our jails and prisons. By acting now, we can both alleviate systemic problems that are choking capacity in law enforcement and corrections, and enable these individuals to achieve their full potential.

Mr. Chairman, Ranking Member Leahy, and Members of the Committee, this concludes my testimony. Thank you for the opportunity to testify today, and I would be glad to answer any questions you may have.

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<sup>15</sup> Report of the National Leadership Forum on Behavioral Health/Criminal Justice Services, *Fixing an American Tragedy: Addressing the Needs of Justice-Involved People with Mental Illnesses and Co-occurring Disorders*. 2009, in press.