H.R. 2387: The Mentally Ill Offender Treatment and Crime Reduction Act of 2003

U. S. House of Representatives

Committee on the Judiciary

Subcommittee on Crime, Terrorism, and Homeland Security

Testimony of

John Monahan, Ph.D.

Henry and Grace Doherty Professor of Law, University of Virginia

Director, MacArthur Research Network on Mandated Community Treatment

June 22, 2004

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 treatment 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.

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 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.

References

[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/NationalPerspectiveonDiversionanLinkage.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.

[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