

Congress of the United States
Washington, DC 20515

July 29, 2015

Chairman Bob Goodlatte
Judiciary Committee
2138 Rayburn House Office Building
Washington, D.C. 20515

Ranking Member John Conyers
Judiciary Committee
2138 Rayburn House Office Building
Washington, D.C. 20515

Chairman Goodlatte and Ranking Member Conyers,

We applaud your leadership on the formation the Judiciary Committee's criminal justice reform initiative. As the Committee undertakes a step-by-step approach to address a variety of criminal justice issues, including over-criminalization, sentencing reform, prison and reentry reform, protecting citizens through improved criminal procedures and policing strategies, we offer our insight and recommendations.

As the primary sponsors of the Helping Families in Mental Health (H.R. 2646), we believe we can offer meaningful reforms to advance innovative, effective, and evidence-based programs and policies to keep those with a mental illness out of our nation's jails and prisons.

An alarmingly high rate of individuals with serious mental illness are institutionalized in jails and prisons across our country. Recent estimates reveal the number could be as high as 1.5 million Americans with an identifiable, diagnosable, and treatable mental illness are incarcerated - many of whom would not be in the criminal justice system had they received appropriate treatment earlier in life. According to the United States Bureau of Prisons, more than half of all prison and jail inmates have a mental health condition, including 56% of state prisoners, 45% of federal prisoners, and 64% of jail inmates. Furthermore, over 70% of those incarcerated with a serious mental illness have a co-occurring substance use disorder.

Where does that leave us?

Correctional institutions have become the modern day asylums. The financial cost and human toll are compounded by the lack of treatment once behind bars: between 83 and 89% of people with mental illness in jails and prisons do not receive appropriate psychiatric care.

As you know, as Chairman of the House Committee on Energy and Commerce Subcommittee on Oversight and Investigations, I launched a review of the nation's mental health system following the tragedy at Newtown, Connecticut. In that time, I have convened a series of nationwide public forums and investigative hearings aimed at discerning how federal dollars devoted to mental illness are prioritized as well as the challenges faced by local communities.

Set in motion fifty years ago by the Community Mental Health Centers Act, there has been a substantial decrease nationally in the number of public psychiatric beds due to deinstitutionalization. In 1955, there were 558,000 inpatient psychiatric beds in the United States. Today, there are fewer 45,000 total psychiatric beds. This deinstitutionalization has been

accompanied by an increase in mentally ill persons who are homeless or confined to jails and prisons because the community-based system of care has not met the needs of the hardest to treat cases. The country's three biggest jail systems (Cook County, Illinois, Los Angeles County, California and New York City, New York) have an estimated 11,000 prisoners under treatment for mental illness on any given day. By comparison, the three largest state-run mental hospitals have a combined 4,000 beds.

At a 2014 Energy and Commerce Committee hearing entitled *Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage*, Sheriff Thomas Dart of Cook County testified that his county spends between 2 and 3 times more on inmates with serious mental illness, than those without. And, a 2009 study of Washington State prisons found that the most seriously mentally ill prisoners cost \$101,653 each, compared to approximately \$30,000 per year for other prisoners. Earlier this year a study by the Arkansas Public Policy Panel found that one year's worth of trial and jail time for each mentally ill person costs the state about 20 times more than crisis treatment and counseling for the same person with mental health condition.

The findings of this year-long investigation became the basis for our bipartisan legislation, the Helping Families in Mental Health Crisis Act (H.R. 2646). Our legislation addresses the shortage of psychiatric beds, expands community based treatments, and enhances jail diversion programs for those with the most serious diagnoses of mental illness.

While the entirety of the Helping Families in Mental Health Crisis Act works to address the need for a policy framework for what can be termed "crisis psychiatry," we call your attention to three specific areas for the Judiciary Committee to examine that will relate to criminal justice reform, address prison overcrowding, and reduce government spending in this area so that it may be dedicated to where it is most appropriately spent and most needed: Assisted Outpatient Treatment (AOT), Mental Health Courts (MHC) and Crisis Intervention Teams (CIT). Each of these evidence-based policies allows for individuals with a serious mental illness to access treatment at different points during their engagement with the justice system.

Assisted Outpatient Treatment (AOT)

Assisted Outpatient Treatment has been proven to be a successful jail and prison diversion program for those with serious mental illness cycling through the system, but never receiving needed care. Established in 45 states and dozens of counties across the country, court-ordered AOT allows the court to direct treatment in the community for the hardest-to-treat patients whose condition will worsen without care. It applies to a small population of those who have a history of arrest, repeat hospitalizations, and violence because of their illness requiring them to comply with treatment while living in the community.

Indeed the mental health care community can and must build a cooperative and inclusive approach to treat patients with serious mental illness, and these methods should come first. But when those methods fail, there must be other tools that providers, law enforcement, and families can effectively use to prevent an individual with SMI from deteriorating. One such tool is AOT, which has proven to be an effective alternative to involuntary inpatient hospitalization and incarceration.

AOT has been shown to reduce incarceration, homelessness, and emergency room visits by upwards of 70% for participants. A comprehensive study of New York State's AOT program found that of those who participated in the program found that 87% fewer experienced incarceration, 83% fewer experienced arrest; 77% fewer experienced psychiatric hospitalization; and 74% fewer experienced homelessness.

AOT also improves access to services, treatment plan development, discharge planning, coordination of service planning and collaboration between mental health and judiciary systems. What makes AOT such a unique policy approach to this issue is the existing research on how making this evidence based treatment model available reduces government spending. A recent Duke University study found in the one year before participating in AOT, individuals with serious mental illness cost the criminal justice and healthcare system \$104,753. In the one year after discharge from AOT, costs fell by 44% to \$59,924. The second year after AOT, costs on average for a mentally ill patient were \$52,386.

We encourage the Judiciary Committee to further examine how Mental Health Courts can fully utilize AOT. AOT is not coercion. And neither AOT nor any form of involuntary treatment should be used on a person who does not need it. Rather, AOT is an invaluable option for those individuals who have been, and will likely again, be involuntarily committed to a hospital as a result of their untreated illness, or end up in the criminal justice system.

Mental Health Courts (MHC)

Mental Health Courts have a track record of success in decreasing criminal justice costs associated with arrest and incarceration, recidivism, and court costs by delivering a pathway to psychiatric care through collaboration between the mental health and criminal justice systems. Mental health courts meet public safety and community restitution objectives with better outcomes than the traditional courtroom setting for those with serious mental illness that for too long have cycled in and out of court and jail.

A recent meta-analysis examined MHC in four jurisdictions and found that participants were less likely to be arrested and spent fewer days incarcerated during the one and one-half years of follow-up after program entry compared to people with similar profiles that only went to jail. MHC participants spend less time in jail than comparison groups. A RAND Corporation evaluation of an Allegheny County, Pennsylvania Mental Health Court found that over a two-year period, both average mental health services costs and jail costs were reduced, suggesting that the MHC program can help to decrease total taxpayer expenditures. The largest savings were generated by avoiding jail and hospitalization for the subgroups with the most severe psychiatric needs. We encourage the Committee to continue to improve on the success of MHC by reauthorizing and expanding the use of the program through the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA).

Crisis Intervention Training (CIT)

A study of Pennsylvania police departments found that 47% of respondents did not believe that they were "qualified to manage persons with mental illness."

Research shows that CIT — teams of police officers trained on how to appropriately handle and refer individuals with mental illness — increases the connection of persons with mental illness to

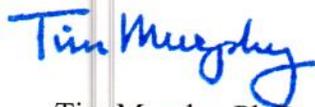
psychiatric services in the community and diverts them from unnecessary and expensive contacts with the greater criminal justice system.

CIT trained officers are 25% more likely to transport a person to community treatment, emergency evaluation, and mental health facilities than police without special training. An evaluation conducted by officials in New Mexico reported that since the implementation of CIT in Albuquerque, the use of high-cost SWAT teams as a response to mental health crisis situations decreased by 58%.

We encourage the Committee to examine making Byrne JAG Grants available to provide specialized training to law enforcement officers to recognize individuals who have mental illness and how to properly intervene with individuals with mental illness, and to establish programs that enhance the ability of law enforcement agencies to address the mental health, behavioral, and substance abuse problems of individuals encountered in the line of duty. And, make grants available to provide support for academy curricula, law enforcement officer orientation programs, continuing education training, and other programs that teach law enforcement personnel how to identify and respond to incidents involving persons with mental health disorders or co-occurring mental health and substance abuse disorders.

Nearly each week we read headlines about another individual with untreated mental illness manifesting their symptoms and acting out in a manner that engages a response from law enforcement, and ultimately the judicial system. Yet more often than not federal dollars are put into ineffective services with vague goals of behavioral wellness or the criminal justice system instead of focusing on treatment options for the most serious psychiatric illnesses such as schizophrenia, bipolar disorder, or severe depression. An honest examination of criminal justice reforms requires an examination of our nation's broken mental health system. By working cooperatively in this endeavor, we can truly transform lives. We stand ready to assist in any way.

Sincerely,



Tim Murphy, Ph.D.
Member of Congress



Eddie Bernice Johnson, R.N.
Member of Congress