SOCIAL COSTS: CRIMINAL JUSTICE AND MENTAL HEALTH SYSTEM GAPS WHICH CONTRIBUTE TO THE CRIMINALIZATION OF MENTALLY DISORDERED PERSONS

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For more than a decade, I have served as the supervising judge of the Mental health Department of the Superior Court in Los Angeles County. In those years, and the years preceding, when I served in the superior and municipal courts' criminal departments and as a criminal defense lawyer prior to my appointment to the Bench, I have witnessed the phenomenon which I call the "criminalization"of persons with mental illness. Although the causes for this tragic occurrence are many and complex, we, as citizens and policy leaders, have the responsibility to understand the reasons for, and the tragic consequences of criminalization. We have the duty to make right a situation which no civilized society ought allow to occur.

In my remarks today, I hope to identify problem-areas which contribute to this blight and to offer solutions that, with intelligence, wisdom, cooperation, and commitment to a common goal, should go far toward ending the inappropriate, inhumane and wasteful incarceration of persons with severe mental disorders, provide them with cost-effective care and treatment, and advance public safety.

THE NUMBERS

As of February 2000 the United States incarcerated in its jails and prisons more than 2,000,000 people, up from one million in 1998.

National studies over the last decade clearly establish that at least 15% of local jail population nationally and 10% of our state prison population comprise persons who are severely mentally ill.

With a prison population of approximately 160,000 people, California's prisons have the dubious distinction of housing more than 21,000 inmates who suffer from severe and persistent mental illness.

In Los Angeles County our jail constitutes the largest mental institution in the nation.

In its 2000 Budget Analysis the California Legislative Analyst reported that in California more than 10,400 persons who are diagnosed as seriously mentally ill are booked annually into California's county jails — usually for a short length of stay. At any given time in 1998, more than 2500 persons being held in jail were mentally ill — a 118% increase over the number held in 1996! There is no reason to believe that the numbers are different

today.

The Legislative Analyst further reported that the numbers of seriously mentally ill offenders receiving treatment in state prison have also dramatically escalated over the last decade. A 1998 study identified less than 800 inmates having psychiatric problems who received any significant level of treatment on state prison grounds. The 2000-2001 budget plan allocated $139 million for providing more than 21,000 inmates treatment services.

I can assure you that while California leads the nation in the number of mentally ill prisoners, an objective examination of your state's penal population will produce similar statistical results.

The sad truth is that our prisons have replaced the mental institutions closed as a result of de-institutionalization in the late 1960s and 1970s.

WHY CRIMINALIZATION HAS OCCURRED

1. Lack of consistent, compassionate, tailored community services

Most of our mentally disordered offenders, whether in local or state custody, are nonviolent and are imprisoned largely as a result of the lack of appropriate and consistent community based mental health care and individualized social services. These services, promised by the proponents of de-institutionalization, have never replaced the institutions.

In the communities to which such offenders are released, mental health care is inconsistent, if available at all. Thus, these ill offenders are doomed to recycle through the criminal justice system, a costly and wasteful outcome of using the criminal justice system as it is currently constituted.

2. Mandatory Sentencing: The removal of judicial discretion

Many of these offenders are the recipients of harsh mandatory sentences which punish recidivism without regard to the causes of the person's criminal behavior. The enactment in California of the Three-Strikes Law, for example, dramatically escalated the numbers of persons with mental illness sentenced to prison – for 25 years on a second strike and for life on a third.

I am confident that the sentencing laws of your states, to the extent that they require mandatory jail and prison sentences and denial of probation without regard to the offender's circumstances, also contribute to the problem in your state.

3. Lack of treatment in jails and prisons

While in jails and prisons offenders with severe mental illness are frequently victimized by custodial staff and other inmates, who are antagonized by their disorganized behavior or speech. Untrained prison guards frequently target these ill inmates for punitive treatment, simply because they are manifesting behaviors which are symptomatic of their mental disorders and because these inmates are unable to understand or adhere to custodial

rules and regulations.

Exacerbation of the mental disorders, serious physical injury and even death result in these inappropriate custodial environments.

Although as a result of federal court intervention in the case of California's state prison system and a threatened Department of Justice lawsuit in the case of the Los Angeles County Jail, steps have been taken to provide better treatment to these offenders locally, in most jails and prisons in the United States, adequate, consistent and appropriate mental health treatment is largely nonexistent.

Studies establish that a major reason why jail and prison services are so poor is because of a lack of adequate screening of jail and prison admittees to determine whether they have a major mental disorder.

After all, custodial officials have an interest in not knowing the true need: To acknowledge the need would necessitate that services be provided and might risk federal intervention, as in California.

Most screening, if it exists at all, is conducted by custodial staff, not mental health professionals, and screening is based upon the admittee reporting whether he or she has ever been diagnosed or hospitalized for a mental disorder. Because of embarrassment, stigma, and fear of being identified by staff and inmates as "crazy" because they fear being medicated or are simply poor historians, many persons with mental disorders, if simply asked, will deny any mental health history and hope to "pass" as normal. Thus, the numbers identified have historically been lower than experience and mental health experts tell us.

Even if trained mental health personnel are used as screeners, a system which depends upon self- reporting is going to overlook many persons who do not display positive symptoms of illness, who do not talk or act bizarrely, while responding to internal stimuli. It is common knowledge that those suffering extremely serious illness, but who are withdrawn, isolated, and noncommunicative, are routinely overlooked by custodial authorities as well as mental health screeners . . . Those not identified are subjected to mistreatment by other inmates as well as custodial staff, who view the behaviors of mentally ill inmates not as symptoms of a mental disorder but as an act of willful defiance of rules.

4. Inflexible legal standards relating to legal insanity and incompetence to stand trial. The need for a statutory change to authorize a finding of guilty but mentally disordered.

Because of the stringent legal standards for incompetence to stand trial ("unable, due to mental disorder, to understand the nature of the proceedings or to cooperate with counsel in a rational manner"), the anachronistic "right/wrong" M'Naghten test for legal insanity and the requirement that the plea of NGI be entered by the defendant personally, the vast majority of even severely and persistently mentally disordered offenders on conviction are sentenced to jail or prison. With little or no treatment, they are eventually released back to the community without a plan for aftercare, no place to live, and no means of support.

The current state of the criminal law therefore contributes to criminalization. Criminal judges are not generally authorized by law to commit a person with mental illness to treatment unless the person is found incompetent to stand trial due to mental illness or is

found not guilty by reason of insanity pursuant to an NGI plea. There is an urgent need to modify existing law to authorize a finding of guilty but mentally disordered, which would trigger the sentencing alternative of treatment rather than punishment.

5. No diversion under court monitoring of nonviolent, mentally disordered offenders who are willing to accept treatment.

In California and most other jurisdictions, there currently exists no formal statutory procedure by which an identified mentally disordered defendant can be voluntarily treated while criminal proceedings or sentence are held in abeyance. Efforts by the Alliance for the Mentally Ill which sponsored such legislation for nonviolent disordered defendants died in the California legislature a few years ago due to opposition by the California District Attorney's Association. Such "diversion" legislation for mental illness is almost universally opposed by most prosecuting agencies. Yet, it is abundantly clear that without offering treatment alternatives most such offenders simply recycle through the criminal justice system. This result is expensive and fails to serve either the mentally disordered offender or public safety.

I am pleased to report, however, that in Los Angeles County, at least, there does exist a non-statutory diversion system for mentally disordered, nonviolent offenders who agree to receive treatment and who willingly waive the right to a speedy trial. The program is funded by the Los Angeles County Department of Mental Health but depends for its implementation in each case upon the willingness of the court, the prosecution and the defense to allow the program to operate at all. Generally, the defendant is required to enter a guilty plea which the court sets aside upon successful participation in mental health treatment.

OTHER CAUSES FOR "RECYCLING"

1. The SSI cut off

In California and, I suspect, in most other states, those who had been receiving SSI are cut off from benefits while in a hospital for thirty days or in jail or prison. This is an option that states can exercise under federal law.

2. Lack of discharge planning in the jails and prisons

Even without legislative change in the states, prisons and jails lack social services necessary to initiate the renewal of benefits prior to the inmate's release.

For those whose thought processes and perceptions of reality are so grossly impaired, applying for a renewal of benefits under SSI becomes a superhuman task.

Even if somehow they do manage to file a renewal application, nonetheless Social Security will be denied to those homeless applicants who lack an address or payee.

How would any of us survive living on the streets without income, support, shelter or

food? Clearly, a revision of state laws allowing the cut off of benefits under the Social Security Act is long overdue. To continue the present system is being "penny wise and pound foolish": The costs of hospitalization, exacerbation of physical and mental illnesses, the cost to society in terms of victimization, arrest, prosecution, and trial -- for largely nonviolent and nuisance offenses is far more costly than maintaining the minimal income supports provided by SSI or providing the social services in custodial settings to provide adequate release planning.

3. The "culture" of community mental health providers

Another cause of "recycling" is the barriers to treatment which the mental health system itself erects. In Los Angeles County, for example, community mental health clinics are not open on weekends or at night. If someone has a crisis or is in need of a prescription when the clinics are closed, they must find their way to a hospital emergency room, where they may wait for hours before being seen.

Even when Los Angeles County Department of Mental Health clinics are open, however, patients have reported an indifferent attitude by staff to the patients' needs. Sometimes patients are told they have come to the wrong clinic and are redirected to a clinic far across the county, which they may find difficult or impossible to get to. After all, what do you do for bus fare when you are penniless?

Such an attitude displayed to any of us would be a disincentive to pursue help.

Moreover, most California county mental health departments refuse to provide services to parolees. These agencies argue that providing mental health care in this situation is a "state responsibility". Apparently, it matters not that the county mental health agencies receive their funding from the state!

This shortsightedness is merely a manifestation of a strange phenomenon I have observed in the mental health "culture"–at least in California: Local mental health departments simply refuse to serve persons with mental illness who have been "criminalized". This attitude is pervasive from the state level through the county level in most cases. Although the agencies will argue that they have been poorly resourced and that this lack of funding has caused them to deny services to some in preference for others, nonetheless there exists an underlying antipathy to working with mentally ill offenders. There exists little acknowledgment that those who have been caught up in the criminal justice system are among those most in need of consistent and appropriate care!

I suspect the same "cultural blindness" may exist in your jurisdictions as well. I certainly encourage you as state leaders to find out.

4. The "leave me alone" phenomenon

Another barrier to treatment lies in the experience which patients have when hospitalized involuntarily or on an emergency basis. I have heard so many reports of callous, insensitive treatment by staff, and have witnessed it on occasion myself. I suspect that anyone experiencing such treatment would be reluctant to want anything to do with the

mental health system.

A common example of what occurs is the following:

A patient will come to a hospital emergency room for treatment of a physical illness, such as an infection of the feet from living on the streets or to obtain a prescription. Because the person appears and acts strangely, the ER staff call in a psychiatrist, who then decides, often without explanation to the person, to hospitalize the person against his or her will. Frequently a struggle with security guards and hospital staff ensues. The person is subdued, placed in five-point restraints and administered by injection a psychoactive drug that frequently causes severe side effects. Whether or not the hospitalization was legally and medically appropriate, it is little wonder that a person, exposed to unwanted force and unconsented to medication, would be "gun-shy" of the system.

5. The failure of mental health agencies and the courts properly to execute the jurisdiction's mental health laws

A further cause of criminalization and lack of community treatment is the failure of the conservatorship system, at least in Los Angeles County and probably other jurisdictions as well to accept referrals for conservatorship investigations of persons not then in a hospital. In other words, although a state's mental health law may authorize referrals for persons not hospitalized, the mental health agency refuses to process such applications. The result of this policy is that gravely disabled persons released from custody of penal institutions or hospitals to the streets will not be investigated for conservatorship, even if referral is made by a designated mental health professional. Requiring continuing hospitalization is a wasteful additional cost to taxpayers, causes the loss of limited hospital beds for others in need of hospitalization, and leaves a large number of mentally ill persons unable to provide for basic necessities but likely to come to the attention of law enforcement.

This is certainly the situation in Los Angeles County and is a practice which you as state leaders should investigate within your own states.

6. Lack of case management for those on mental health conservatorship

Even for those in Los Angeles County who are under conservatorship with the Public Guardian as conservator, there appears to be no case management or services provided to the conservatee, even though the California mental health laws require them. Although recent additions to staff of the Los Angeles County Public Guardian are intended to upgrade the quality of services it is supposed to perform, it remains to be seen whether case management, which entails a close degree of contact and provision of services to the conservatee will actually result. The independent tradition of the Public Guardian, which formally was a separate office apart from the county's Mental Health Department, has proved unyielding in old practices and traditions to the efforts of Mental Health's management to establish new ways of discharging the former's legal duties.

I suspect that in your jurisdictions as well a like situation exists. In any event, I

respectfully urge you to consider whether your mental health laws are being faithfully executed by the agencies, including the courts, of your state. To the extent that they are not, to that extent the right to treatment and community-based care is being short-changed. To that extent so are the taxpayers of your state.

7. The exclusion from drug treatment of mentally disordered substance abusers

A final major cause of criminalization is the exclusion from treatment of offenders who are both mentally ill and who abuse or are addicted to drugs or alcohol. It is critical , that mentally ill substance abusers and addicts receive proper treatment for both conditions. Studies uniformly demonstrate that substance abuse and severe mental disorder are co-occurring conditions in a vast majority of our homeless population. National estimates made several years ago had put the percentage at about 40%. There is good reason to believe that this estimate is much too low: Recent screening at the Los Angeles County Jail shows, for example, a much higher percentage for men and reach well over 70% for women admitted to our jail.

Currently, most of the drug courts operating in our nation exclude from eligibility persons with serious mental illness. This exclusionary policy pervades almost all substance abuse treatment providers, whose policies were formulated on the basis of governmental funding restrictions that exclude persons with mental illness from eligibility for treatment.

At the same time, mental health agencies refuse treatment to substance abusing or addicted persons with severe mental illness. With some justification, mental health treatment providers explain that one cannot deal effectively with symptoms of mental illness when patients continue to abuse substances.

Without treatment of both their mental disorder and substance abuse or addiction, these people will recidivate criminally, will be high users of hospitals, and eventually will die. It is recognized by treatment and mental health experts that this population is the most difficult to treat, is most likely to relapse and to decompensate, and most slow to progress in treatment. This, of course, is no excuse to deny them treatment! For they are also the most likely to recidivate and to commit violent crimes.

Laws at the federal and state levels must be reformed to eliminate the barriers to treatment of co-occurring diagnoses.

Drug and mental health treatment must employ treatment techniques and styles that are quite distinct from the approach to drug offenders who do not carry a psychiatric diagnosis of severe mental disorder, on the one hand, or persons with mental illness who are not abusers of drugs or alcohol, on the other.

As I have said, the institutional unwillingness to treat persons with both diagnoses is undoubtedly a significant reason why mentally ill persons find themselves criminalized and institutionalized under the criminal justice system. Yet, in this country there are only a handful of treatment providers willing and able to deal with this dually diagnosed group.

Because substance abuse treatment providers are unequipped to treat mental illness and mental health providers are untrained to treat substance abuse and addiction, it is critical that drug treatment providers able and willing to render drug treatment be teamed with mental health professionals able and willing to render psychiatric treatment to this

population. Such treatment must be coordinated and tailored to meet the population's special characteristics.

In cases involving criminal prosecution of those with these co-occurring diagnoses, it is crucial that counsel for both sides and the court understand the need to exercise the court's power to ensure the delivery of treatment and services by all responsible agencies in a coordinated fashion. Courts must adopt a jurisprudential approach which takes account of the special characteristics of this population: their treatment needs, psychiatric symptoms, and the interrelationship of both conditions as they relate to the individual's compliance with conditions of release. The court's attitude, as with the treatment providers, must be firm, consistent, non-permissive or excusing of treatment noncompliance. Yet, the court's attitude must also reflect an understanding and special patience of the peculiar difficulties which these offenders face.

8. Effective discharge planning and probation or parole supervision

Few jails and prisons in this country engage in pre-release discharge planning or provide effective supervision of mentally disordered offenders post-release.Obviously to the extent that there is no treatment in our jails --or even recognition of the need for treatment-- discharge planning is also an unrecognized need. Hence mentally disordered offenders are generally released to the streets with no income, housing, support or treatment system in place.

Moreover, neither probation nor parole officers receive any special training sufficient to equip them to deal with persons with severe mental disorders or co-occurring diagnoses.

California, with rare exceptions which I will discuss later, is unfortunately the same as the rest of the nation. Although there is some discharge planning that has recently been instituted for some of the most severely mentally disordered prisoners, most are left to their own devices at the expiration of their terms of imprisonment. The California Department of Corrections appears content largely to rely on the system of parole to meet the needs on release of most mentally disordered inmates. Unfortunately, rates of recidivism conclusively prove that such reliance is unrealistic: Parole officers lack training with respect to mental illness and lack limited, specialized caseloads to ensure effective community supervision. The same is true with respect to county probation officers.

I suspect that the penal systems of your states similarly rely on untrained probation and parole officers to supervise these offenders –with the same same poor outcomes.

To remedy somewhat this situation, I offer the following suggestions: First, probation and parole officers should receive extensive training in recognizing and dealing with persons with severe mental disorders and with co-occurring diagnoses. The latter are the most difficult to manage in the community. Second, these officers should be given incentives (financial or otherwise) to undertake this difficult task of supervision. In addition, their caseloads should be limited in order to afford closer supervision and monitoring for treatment compliance. Finally, decompensating or treatment non-compliant offenders should not be automatically incarcerated as violators but should be hospitalized in the community for short time periods in order to stabilize and return them to probation or parolestatus on a much shorter turn-around time when returned to jail or prison.

In California, current practice is to return parolees to prison on a violation for up to a year. Of course, in prison they get little appropriate treatment. A system of local locked hospitalization would certainly be less expensive than the prison alternative. I suspect in your jurisdictions that returns to prison are expensive and do not result in much treatment being provided. The same of course is true with respect to jailing non-compliant or decompensating probationers.

In California, we have a program of Community Outpatient Treatment which operates in our counties as separate entities from county mental health departments. These Community Outpatient Treatment programs are funded directly by the California Department of Mental Health and serve on an outpatient basis persons released from state hospitals— in the main, these are persons coming from the criminal justice system who have been committed to state hospitals on a finding of incompetence to stand trial or of insanity at the time of the offense. The programs provide intensive case management, psychiatric services, housing, and employment training. They require strict compliance with program rules, provide regular reports to the courts, and can authorize a non-compliant or decompensating participant's return to a state hospital or local locked hospital if necessary.

The recidivism rate statewide for the COT program is 5% and it costs an average of $20,000 per client.

By contrast, the recidivism rate in 1991 for offenders who received mental health treatment in some form in prison is about 94% within two years of release, according to the Legislative Analyst's 2000 Budget Report. There is no reason to believe that the numbers have improved through the years. Thus, release on parole, as parole is presently structured in California, is largely ineffective for this group of offenders.

According to the California Legislative Analyst's 2000 Budget Report, the cost of simply housing mentally ill offenders in our California jails and prisons exceeds $500 million annually — not taking into account the costs of their in-custody treatment, the cost to law enforcement and the courts in dealing with mentally ill offenders caught in the cycle of recidivism nor the cost to victims of their crimes.

Clearly, utilizing the Community Outpatient Treatment model by organizing limited, specialized probation and parole caseloads is likely to be far more successful and less costly than the present system.

Therefore, I encourage you to examine the way in which mentally disordered offenders released from your jails and prisons is structured and consider modeling supervised release of these offenders on a model similar to our Community Outpatient Treatment Program or to the AB 2034 model, which I shall describe later.

9. Establishing specialized mental health courts or, alternatively, assigning specially trained judges and lawyers to cases involving mental disorders and co-occurring diagnoses

It is clear to me that where justified states and counties should establish specialized courts which specialize in hearing civil and criminal cases involving mental disorders and dual diagnoses. The establishment years ago of a specialized Mental Health Department of

the Superior Court in Los Angeles has enabled the bench officers, lawyers, and agencies responsible for the delivery of services to work together for the common good of the patient as well as society. Expertise, agency and patient accountability for treatment compliance, and predictability of decisions have been positive products of such a specialized court. Although the Los Angeles Superior Court's Mental Health Department does not hear criminal cases of the type described, our court does provide a vehicle by which alternatives to punishment under the criminal law may be utilized if criminal cases are referred to our department from the criminal departments of the court.

The Los Angeles County system contrasts with that of most other California counties and most states. Generally, they organize their court system in a much more general way. In these jurisdictions mental health cases are randomly assigned from one bench officer to another. Such a system weakens the judiciary's authority with respect to the enforcement of its orders and engenders a lack of accountability. Moreover, decisions of bench officers tend to lack predictability so that assessments by treatment providers of likely court outcomes become much more a matter of guess work. Finally, there is little opportunity for the court in these circumstances to follow up on the results of its decisions.

This is not to say that Los Angeles County's Superior Court has all the answers nor that the Mental Health Department of our court operates perfectly. The truth is that our court has far to go. Because of our growing and complex caseload and the physical limitations of our facility, we are inefficient: A common but justified complaint among utilizers of our services is the inordinate waiting time before their cases are heard. This "downtime" creates a major disincentive for mental health providers, witnesses and patients to come to court.

In my years as supervising judge I have come to see that the mental health court is an essential component of the mental health system. A court operating in a horse and buggy style clearly fails as a component of the system: When those charged with a patient's care are unable to rely with relative certainty upon the court's ability to decide cases in a timely fashion ,needed treatment and services are delayed or withheld; and unjustifiable infringement of a patient's liberty and right to treatment occur. For these reasons, it is essential that the court and its adjunct agencies receive the public resources they require in order to carry out their legal responsibilities to the parties and to society. Unfortunately, in Los Angeles County, historically these resources have not been forthcoming. Essentially, just as mental illness is stigmatized, so it is that those of us working in this area of the law seem to be stigmatized as well.

Recently Congress passed legislation and funding to establish a hundred pilot mental health courts around the country. Such mental health courts would operate to divert into treatment mentally ill persons charged with criminal offenses. The bill, authored by Senator Pete Domenici and Representative Ted Strickland, represents a national recognition of the problem of criminalization and offers the states an opportunity to take appropriate remedial steps to establish courts designed to ensure appropriate, humane and effective treatment for persons with mental illness. I hope that you will prevail upon the leadership of your states to take advantage of the opportunity which the bill offers.

What other steps must we take to reverse the trend toward criminalization?

JUDGES AND LAWYERS

- **Training of criminal judges to recognize symptomotology of mental illnesses and to identify agencies and resources able to provide reatment and services.**
- **Training of judges and lawyers staffing our courts to know the mental health laws and the alternatives which they may offer to criminal sanctions.**
- **Encouraging judges to adopt an approach which is proactively therapeutic in relation to mentally ill offenders rather than inappropriately punitive. Encouraging judges to attend judicial education courses teaching the principles of Therapeutic Jurisprudence.**

AGENCY REORIENTATION

- **Recognition by agencies charged with carrying out their responsibilities that their mission is not to protect their budgets or to attempt to shift responsibility for services to other agencies: Their mission is to deliver the services for which these agencies were created.**
- **Recognition of the duty of agencies to cooperate with one another for the patient's benefit and society's protection. Encouraging them, where appropriate, to form partnerships between law enforcement and mental health agencies similar to the SMART and METteam models which I have described.**

LAW ENFORCEMENT AND CORRECTIONS

- **Training of law enforcement to recognize symptomotology of mental illness, to be aware of options other than arrest, and to exercise those options where appropriate.**
- **Training of correctional personnel to identify mentally ill inmates who display negative as well as positive symptoms of mental illness and to learn appropriate methods of dealing with them.**
- **Better screening, including access to treatment records, family members and others familiar with the person being assessed in order to make reliable evaluations concerning the existence or not of mental illness.**
- **Mental health screening to be conducted by mental health professionals, not correctional staff.**
- **Encourage probation and parole agencies to establish specialized and limited caseloads for mentally ill offenders supervised by specially trained parole/ probation officers able to provide intensive supervision, supportive services and linkages to the mental health and social service systems.**

POLICYMAKERS

- **Education of policy-makers and politicians at all levels of government concerning the enhancement of treatment availability in order to eliminate the inappropriate, cruel and even dangerous funneling of non-violent mentally ill offenders through the criminal justice system.**
- **Ensuring that the state's mental health laws are being faithfully implemented in order to ensure proper delivery of services and the highest possible functioning of the patient.**
- **Enacting legal reforms, where necessary, to enable patients to receive voluntarily assisted outpatient treatment under court supervision.**

- **. Establishment of drug treatment courts and treatment programs for those with co-occurring (dual) diagnoses. Encourage the states and federal governments to foster creation and expansion of treatment programs for persons who have the co-occurring diagnoses of mental disorder and substance abuse or addiction by eliminating funding restrictions which prevent treatment of co-occurring conditions.**
- **Revise state laws curtailing SSI benefits or, alternatively, providing adequate discharge planning and social services which will enable the inmate or patient to receive SSI as soon as discharged from incarceration or hospitalization.**
- **Improve discharge planning in the jails and prisons so that persons receive individualized social services designed to meet their basic necessities as well as to provide physical and mental health care.**
- **Make mental health treatment in the community consistently available through long term funding which is not so dependent on the business cycle.**
- **Simplify the mental health system and the laws relating to mental health treatment, hospitalization and medication.**
- **Restore sentencing discretion to the courts, eliminating mandatory sentences and probationary conditions in cases in which the defendant is reliably identified as mentally ill and is willing to accept treatment.**
- **Encourage our states to enact mental health diversion legislation which allows mentally ill defendants the option of voluntarily accepting treatment under court monitoring in exchange for dismissal of charges upon sustained participation in treatment.**

- **Formalize a system in which the court is responsible for ensuring that the defendant's individual treatment plan is executed by all agencies involved carrying out their responsibilities in a cooperative fashion and in which the**

patient is held accountable for treatment non-compliance. To this end, establish nationwide specialized mental health courts where appropriate or, alternatively, the assignment on a regular basis of specified bench officers to preside over mental health cases

It is extremely important that you, as leaders in your states, encourage the establishment of appropriate treatment alternatives for this neglected population and to encourage your justice systems to develop a therapeutic jurisprudential approach in cases involving offenders with co-occurring diagnoses.

SOME HOPEFUL TRENDS

1. Specialized law enforcement-mental health teaming

Now that I have you all depressed, let me talk about some hopeful areas in which we are making progress toward de-criminalization and cost-effective alternatives to prisons and jails.

First, an important innovation in Los Angeles County and in some cities within the County is the teaming of law enforcement officers with mental health personnel. The joint project begun by the Department of Mental Health and Sheriff's Department to establish specialized law enforcement-mental health teams to respond to calls from regular deputies suspecting that a person detained may be mentally ill. The teams assess the person and, after confirming a probable mental disorder, taking over responsibility for the person. These specialized teams then determine whether the person should be hospitalized, returned home or arrested. These teams have reduced the numbers of people arrested and placed in custody, have linked them to mental health services, and have generally been instrumental in eliminating "mercy bookings". These teams now operate county-wide. The program has been replicated in the cities of Los Angeles and Long Beach. These teams have demonstrated cost-savings in terms of avoiding arrest, jail and prosecution, avoiding needless hospitalizations, and in freeing up field deputies to engage in their regular law enforcement duties.

In addition, these teams have trained law enforcement in the field concerning the signs and symptoms of mental illnesses, and how to respond appropriately to persons displaying such symptoms. Such training has avoided needless injuries and deaths, saved our public agencies costly lawsuits and the bad publicity which ensue when a person with mental illness is injured or killed by the police.

It is my understanding that like programs exist in other parts of the country. They desperately need to be replicated at least in all urban areas of our nation.

2. Pilot projects for mental health case management of mentally disordered offenders: The AB 2034 Program

Another positive step has occurred with the implementation in the mental health field of case management, a trend which appears to be nationwide.

In California, state grants are given to counties which institute case management and provide individualized services to meet the needs of persons released from jail. Providing case management, supervising medications, assisting with housing, clothing, and other needs, the program, authorized by Assembly Bill 2034 (Steinberg) has produced outstanding results in terms of dramatic reductions in the rate of recidivism. hospitalization and homelessness.

According to a state legislative report issued this year, since its inception in November, 1999, the program has enrolled 1100 people in a few participating counties.

Utilizing a new generation of psychotropic medications, aggressive outreach, and the promise of housing and vocational training, the AB 2034 program encourages its participants to remain in treatment, has reduced homelessness, provides intensive counseling and medical attention, group therapy, and money management.

Hospitalizations for program participants decreased by nearly 78% , the days spent in jail declined by 84.6%, and the number of days spent homeless decreased by 69%.

The money saved as a result exceeded $7.3 million. The total cost of the program's initial year of operation was $14 million dollars, with a total net cost of less than $7 million.

These spectacular results have encouraged the state to expand the program to 32 other California cities and counties and to increase funding to $55 million.

Unfortunately, only two of the participating counties–Los Angeles and San Francisco-- extend services to parolees.

The AB 2034 program clearly proves that an intelligent, well-thought out, and individualized approach to case management meeting individual needs does work!

Unfortunately, the California grant program is a pilot project and, as far as I know, has not been replicated in other states.

As a result of the success of the AB 2034 program, Los Angeles County Sheriff Lee Baca has designed a system of screening and referral to community services for all of our county jail inmates, including those with mental illness, in order to link them to appropriate community-based mental health , substance abuse and supportive services.

I hope that my remarks today will be helpful to you as you search for solutions to these extraordinarily difficult issues.

Thank you for the privilege of having addressed you today.