STATEMENT OF

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PRESIDING JUSTICE
ILLINOIS APPELLATE COURT, SECOND DISTRICT

BEFORE THE

UNITED STATES SENATE
COMMITTEE ON THE JUDICIARY
SUBCOMMITTEE ON HUMAN RIGHTS AND THE LAW

HEARING ENTITLED

"HUMAN RIGHTS AT HOME:
MENTAL ILLNESS IN U.S. PRISONS AND JAILS"

SEPTEMBER 15, 2009

Chairman Durbin, Ranking Member Coburn, and distinguished members of the Senate Judiciary Subcommittee on Human Rights and the Law, thank you for the opportunity to testify before you today at this important hearing on persons with mental illnesses in our jails and prisons. My name is Kathryn Zenoff, and I am the Presiding Justice of the Illinois Appellate Court, Second District. The Second District is comprised of the thirteen northernmost counties in Illinois, from Lake Michigan on the east to the Mississippi River on the west. I also serve as the National Co-chair of the Judges' Criminal Justice/Mental Health Leadership Initiative (JLI).

Prior to my assignment to the Appellate Court in Illinois, I served as a trial judge and Chief Judge of the Seventeenth Circuit, which consists of Winnebago and Boone counties. Winnebago County is the second largest county outside of metro Chicago, covering 513 square miles and including the city of Rockford. The 2000 U.S. Census indicates a population of 278,418 people. Recent local statistics indicate there were 22,808 bookings in the Winnebago County jail in 2008. During my tenure as Chief Judge, I had the privilege of organizing and facilitating a community-wide task force in Rockford, Illinois, to examine the problem of persons with serious mental illnesses cycling in and out of our Winnebago County jail. One of the accomplishments of the task force was the development and implementation of a mental health court (Therapeutic Intervention Program), which we opened in Winnebago County in February 2005. While I was Chief Judge of the Seventeenth Circuit, I served as the presiding judge of that problem solving court for over two years. I hope that my experience and my perspective can assist the Subcommittee.

OVERVIEW OF THE PROBLEM[1]

In the last fifty years, persons with serious mental illnesses have gone from being institutionalized in psychiatric hospitals to being institutionalized in our jails and prisons. The phenomenon has been called the "criminalization of the mentally ill" and has had adverse consequences both for our communities and for those persons with mental illnesses. When psychiatric hospitals closed in the l960s and the community-based mental health providers never received funding–or at least adequate funding–to support the move from institutional to community-based treatment, our jails and prisons saw a significant increase in persons with mental illnesses cycling in and out of their doors. According to Bureau of Justice statistics, 7 to 16% of those incarcerated were diagnosed with a serious mental illness, as compared with a much lower percentage of those persons with mental illnesses in the general population.[2] The impact was significant. There was no, or woefully inadequate, treatment for those with mental illnesses. The criminal justice system saw an increase in arrests and the number of cases that needed to be handled, straining an already overburdened system. Costs rose for counties and states as police made repeated arrests, and tax dollars went to pay for additional court functions and staff.[3]

Recent booking statistics and data are even more alarming. According to Bureau of Justice statistics, during the twelve months ending in mid-2007, there were thirteen million admissions to local jails in the United States. The numbers of adult male and adult female inmates had increased 24% and 42%, respectively, since mid-2000. Over 2.2 million were acutely mentally ill bookings, with 75 to 80% having a co-occurring substance abuse disorder.[4] A recent study of

the prevalence of serious mental illness among jail inmates in five communities in 2002-2003 and 2005-2006 reported prevalence rates of current serious mental illness as 14.5% for incarcerated men and 31% for women![5] While a narrow study, it confirms that the number of inmates with serious mental illnesses in our jails is still substantial, and the report recommends continued study and explication of the contributing factors and discussion of the appropriate responses.

THE RESPONSE

As communities across the country began to recognize the problem, the question became what were the solutions and whose job was it to implement them? While it certainly was possible for the responsibility to be placed on the legislative or executive branches, as they control our tax dollars and run our prisons and jails, that is not what happened. Instead, non-traditional collaborations were forged among stakeholders, such as mental health providers, law enforcement and corrections personnel, members of the legal profession and judiciary, and representatives of state and local governments and agencies. Innovative initiatives, such as mental health courts,[6] pre-trial diversion programs, and special crisis response training programs for law enforcement, were started. At the forefront of these collaborations were judges who stepped forward to assume key leadership roles.

Winnebago County's Therapeutic Intervention Program

I think that as judges we are in a unique position to assist in addressing the problem. We have the ability to use our authority and visibility in the community to convene stakeholders and to urge them to develop new collaborations and partnerships. In fact, that is the role I played in my own community. In June 2003, the Seventeenth Circuit Court and local mental health professionals felt that the time for talk had ended and a call to action was needed. A snapshot of the Winnebago County jail demonstrated that 14% of the inmates had serious mental illnesses, such as schizophrenia, bipolar disorder, and depression. Moreover, the additional costs of psychotropic medication alone boosted the daily cost of housing those inmates with mental illnesses way above the $50 to $60 per day for other inmates. The jail was terribly overcrowded.

On behalf of the Circuit, I convened a seventy-person/agency Community Mental Health Task Force (Task Force), which met regularly for eighteen months. We documented the scope of the problem and studied what steps and models other communities had adopted. The result was that in February 2005, the Therapeutic Intervention Program Court (TIP) opened in Winnebago County. TIP accepted referrals of persons charged with both misdemeanors and non-violent felonies who had been diagnosed with serious mental illnesses.[7] Participation was voluntary. A multi-disciplinary team of legal and mental health professionals was assembled to work with the defendants in the court. The Task Force also drafted protocols that were signed by the judiciary, the state's attorney, public defender, law enforcement, corrections, and court services, all coordinating their responses to persons with mental illness. The city police and sheriff's deputies began crisis intervention training to enable them to more efficiently respond to emergency situations in the community so that they could avoid arrests where appropriate and

divert persons with mental illness to treatment. A Community Mental Health Coordinating Council was formed to succeed and build on the accomplishments of the Task Force.

TIP has been referred to as an “invention”; it was something new to our community and uniquely adapted to the needs of Winnebago County. Certainly, it represents an innovative collaboration and partnership of a wide range of stakeholders committed to a common goal and to leaving their individual and agency agendas behind. The common mission of this problem solving court was and is to enhance and protect public safety, while also restoring the liberty and community functioning of defendants with severe mental illnesses through comprehensive and therapeutic judicial intervention.

TIP has been operating for over four years with a team working together to provide defendants with case management, mental health and probation services, and linkages to housing and other entitlements. We had weekly staffings to discuss each defendant's compliance with a structured set of goals. Each defendant appeared in court on a weekly basis for a review of his or her progress. Shortly after beginning operations, it became evident that almost 50% of TIP's participants had a co-occurring substance abuse disorder, which required intensive treatment. I convened a local summit in March 2006, inviting community leaders to inform a solution. Approximately sixty representatives attended. The spirit of collaboration and cooperation that had permeated the Task Force motivated two exceptional agency directors, Mr. Frank Ware of the Janet Wattles Center, our community mental health center, and Mr. Phil Eaton of the Rosecrance Health Network, a well-known substance abuse treatment facility, to find a way to overcome obstacles, such as financial reimbursement, to create an integrated dual-diagnosis day treatment group for the defendants in TIP, one of only a few such dual-diagnosis programs in the entire state. Yet another local mental health agency, Stepping Stones, came forward to provide living space for appropriate TIP clients in its supervised mental health residential treatment facility.

I am pleased that further enhancement of the TIP program was possible when a two-year federal enhancement grant was awarded in 2007, allowing the addition of a trauma therapist, a dual-disorder specialist, and a family advocate specialist to the ten-person team. The program has continued to develop and expand to sixty-eight current participants under the expert guidance and leadership of my successor, Chief Judge Janet Holmgren.

Recent statistics show that among the graduates of TIP, few re-arrests have occurred and fewer hospitalizations have been required.[8] Also remarkable in this entire process was the willingness of the Winnebago County Board Chairman, Mr. Scott Christiansen, and the County Board members not only to become informed, but also to become truly educated about the problem and the proposed TIP program and to be willing to assist with some key funding through appropriations from a county supplemental sales tax revenue source.

The impact of TIP on our community and on the lives of the participants has been significant. At graduation, one defendant wrote:

> “My life has undergone a shift from the constant unwellness of most of the previous decade to a life worth living. This change occurred slowly, and in many different ways.

> The three main keys to my success, that truly got the ball rolling towards wellness, are the backbone of the court structure (TIP), my support system, and both mental and behavioral tools used to stay above my illness. The constant responsibility to appear before the judge, and meet with various (mental health case managers) were the essential first step...."

Another commented: "The whole TIP team has watched, helped and guided me through my recovery.... I would be deathly afraid to know where I would be or what sort of person I would've become if it wasn't for this program. Because of this program I feel like I finally have my life back."

While there have been a few ongoing studies examining various aspects of court operations of several of the now-over-175 mental health courts around the country, we do not yet have all of the results. It is imperative that as we continue to look at the problem and decide what programs and solutions are most successful, we define success. Of course, success can be measured in different ways. One way is to consider whether the quality of life of persons with mental illnesses has been improved in the sense that the court defendants/participants and graduates have taken increased responsibility for their own treatment and recovery. A second is whether the revolving-door cycle has decreased, resulting in fewer visits to our jails and hospitals and in lower recidivism rates, which, in turn, results in increased public safety. Under either of these methods, the statistics kept by TIP demonstrate that TIP certainly has been successful. Still, questions remain unanswered by researchers examining mental health courts: Will improved mental health outcomes in individuals consistently and broadly result in long-term improved public safety? Is special emphasis also needed on criminogenic factors to achieve the goal of long-term improved mental health and public safety?

Part of TIP's success and the difference it and other mental health courts around the country have made, in my view, has to do with the synergy of the presiding judge and the team, in addition to the interaction of the team and the judge with the defendants. While I have been privileged to be on the bench since 1995 and to have handled many different assignments, I found my role as presiding judge in this specialized problem solving court to be especially challenging and rewarding. Unlike judging in a regular criminal call, a judge in a mental health court must form a rapport or relationship with the defendants themselves by using the knowledge of their mental illnesses and their criminal background to inspire confidence and trust and to set realistic, but firm, expectations. The presiding judge in a mental health court must also use and balance incentives (such as being called earlier in the order of cases on status days, or fewer court appearances being scheduled) and sanctions (such as sitting through an additional court call on another day, writing an essay, or even minimal jail time) to hold defendants accountable. Judges must also recognize that many defendants in the court, though, do not just have a serious mental illness, but also a co-occurring substance abuse disorder, which complicates treatment and recovery.

National Judges' Criminal Justice and Mental Health Leadership Initiative

I believe that judges need to serve as catalysts for change and transformation not only in our communities, but also at the state and national level if there is to be continued change and

improvement in the response to persons with mental illness who become involved in the criminal justice system. To that end, the National GAINS Technical Assistance and Policy Analysis (TAPA) Center[9] recognized this need several years ago and in 2004, together with the Council of State Governments,[10] with support from the Bureau of Justice Assistance (BJA) and U.S. Department of Justice, Division of Mental Health/Substance Abuse and Mental Health Services Administration (SAMHSA), assisted in the formation of the national Judges' Criminal Justice and Mental Health Leadership Initiative (JLI). The resources and activities of JLI are open to any judge in the country. Its mission is to support and enhance the efforts of judges who have taken leadership roles on these difficult and complicated issues in their communities and to promote leadership among those who are considering how to become involved in forming mental health courts or creating other diversion programs to improve community responses to justice-involved persons with mental illnesses. The JLI, through its Advisory Board, the Council of State Governments Justice Center, and the GAINS Center, has worked tirelessly to complete several projects, including publication of a *Judges' Guide to Mental Health Jargon* in 2007, and the *Judges' Guide to Mental Health Diversion Programs* (forthcoming this fall). A quarterly electronic newsletter, with updates from the field, is distributed to over three hundred fifty judges nationwide.[11]

The valuable work of JLI was recognized and encouraged by the United States Conference of Chief Justices in its adoption of "Resolution 11" on January 18, 2006. In that resolution, the Conference recognized that "mental illness is a far-reaching problem with enormous impact on the judicial system; and ... in examining the best practices for improving community responses to offenders with mental illness, the common element was effective leadership." The Conference then referred to its previously adopted "Resolution 22," which endorsed problem-solving courts and their value in the court system. Resolution 11 concluded by encouraging each Chief Justice to take a leadership role to address "the impact of mental illness on the court system through a collaborative effort involving stakeholders from all three branches of government," and by expressing its unequivocal support of JLI.

At the end of 2006, funding for JLI's Chief Justice Initiative program was secured. This unique project has provided policy guidance and technical assistance through the Council of State Governments and the GAINS TAPA Center to eleven states whose Chief Justices are spearheading the formation of statewide task forces to make system-wide improvements to the states' criminal justice systems for persons with mental illnesses.[12] Policy forums were held in Atlanta in 2007 and in Philadelphia in 2009. Unfortunately, although strides have been made by these states, ongoing technical support will be greatly limited in the future, as private funding for this project will expire at the end of 2009.

While JLI has made significant inroads, it is now at a key juncture in continuing its mission, as funding is no longer available from BJA and SAMHSA for staff support provided by the Council of State Governments and the GAINS Center for JLI's activities. Our leadership is currently faced with the daunting task of either determining how to address JLI's mission without that support or finding alternative sources of funding in this difficult economic climate.

Illinois Initiatives

Although Illinois did not participate in JLI's Chief Justice project, it certainly has been in the forefront of other important initiatives. Several years ago, the Illinois Conference of Chief Judges formed a Specialty Courts Committee, which I chaired. We authored a comprehensive report on mental health courts and drug courts in 2006.[13] The Illinois General Assembly, in 2008, passed one of the first statutes in the country authorizing the establishment of mental health courts, the Mental Health Court Treatment Act.[14] In 2004, the General Assembly passed a bill allowing county boards to adopt resolutions imposing fees on defendants in certain circumstances to help finance mental health courts.[15] To date, there are ten mental health courts operating in nine jurisdictions in Illinois, with several more in the planning stages.

Remarkable and unprecedented interdisciplinary and interagency collaborations have taken place to address the challenges we face. These challenges have been especially daunting with 22,000 individuals in the jail population in 2005 and 42,000 currently in our prisons.

Members of the judiciary in Illinois, with support from Director Cynthia Cobbs of the Administrative Office of the Illinois Courts, have collaborated at the invitation of the Illinois Department of Human Services, Division of Mental Health, to map available resources and identify the gaps in services for persons with mental illnesses and substance abuse issues involved in the criminal justice system. Dr. Lorrie Rickman Jones, Director of the Department of Human Services, Division of Mental Health, and Dr. Anderson Freeman, Deputy Director for Forensic Services of the Division of Mental Health, have been remarkable leaders. They convened an advisory board and began planning meetings in early 2008, pursuant to a Transformation Transfer Initiative grant from SAMHSA through the National Association of Mental Health Program Directors. Policy Research Associates, Inc. (PRA) of Delmar, New York, was hired to provide technical assistance to facilitate the mapping project and to inform the transformation efforts. Representatives from the five regions in the state met in each region to identify gaps in services and needed enhancements, using a visual and conceptual model termed the "sequential intercept model."[16] A final detailed report was prepared by PRA, with specific cross-disciplinary recommendations.[17] I look forward to assisting Dr. Jones and Dr. Freeman with convening a statewide committee this fall to examine these recommendations and to develop a statewide strategic plan on how best to implement them. The process also engendered interest and collaboration for the submission of a grant application last April to BJA for the establishment of a Center of Excellence in Illinois to develop the infrastructure to support mental health and justice collaborations and enhancements in the future.

Another Illinois innovation is the "Data Link" project, funded in part by the Illinois Criminal Justice Information Authority and federal dollars. This project allows electronic sharing of records, pursuant to state statute,[18] by the Illinois Department of Human Services, Division of Mental Health, with the Department of Corrections and local jails for the purpose of continuity of care in admission, treatment, re-entry planning, and discharge of persons with mental illnesses. There are now eight participating counties. The project reports positive results in an overall reduction in hospital events and hospital days.

The Division of Mental Health is also collaborating with the Illinois judiciary and the Council of State Governments on yet another separate project to develop a uniform database for all mental health courts in Illinois.

Two statewide educational conferences with nationally known experts in attendance were held in 2008 and 2009: "Skills and Strategies for Mental Health Courts in Illinois" and "Lessons Learned: Innovative Approaches to Mental Health Courts and Related Services; Generating Hope in Times of Scarce Resources." Each of the conferences, held in Du Page County, drew over four hundred participants from numerous disciplines, including mental health, law enforcement, and the judiciary. Consumers and family members were also in attendance. Our statewide mandatory education conference for judges will include a presentation on mental health courts and veterans courts[19] for the first time in 2010.

Lastly, in June of this year, professionals and consumers interested in promoting statewide collaboration and organization formed the Mental Health Court Association of Illinois. Its mission is "to create a statewide association of professionals, consumers, families, advocates and public officials who support the development and sustainability of Mental Health Courts and criminal justice diversion programs for persons with mental illness in Illinois." The first meeting of the Board of Directors will take place this month. No other state has formed such an association. We hope that it will further coordination of efforts and sharing of expertise here in Illinois.

WAYS TO MOVE FORWARD

Despite these significant steps and collaborations in Illinois and elsewhere in the country, the number of persons with serious mental illness in our jails and prisons has nevertheless increased. In part, this attests to the complexity of the problem, including the stigma attached to mental illness. Our jails and prisons have become the "safety nets" of our unfunded/underfunded system of community health care. How do we find workable solutions? How do we move forward? One key to finding effective and lasting solutions is at last appropriating sufficient resources for our communities to continue the collaborative work that was begun when the problem was first identified. We must now be able to identify which are the most promising programs and evidence-based practices, i.e., practices that integrate the best research evidence with clinical expertise, so as to improve upon our responses to persons with mental illnesses who are involved or at risk of becoming involved with the justice system. As we move forward, we must not lose sight of our goals to reverse the criminalization of mental illness, improve public safety, reduce recidivism, minimize acute care spending, and assist those with mental illnesses in living a life of recovery in our communities.

Where should our focus be? Respectfully, I suggest that the areas that especially need study, action, and resources involve continuity of care, i.e., filling "gaps" and creating additional linkages in the systems involved with persons who have serious mental illnesses. Following is a discussion of my recommendations.

1. Continued/Increased Funding for Mental Health Courts and Diversion Programs

While Congress has authorized the creation of a number of programs in the last several years that have helped fund court related initiatives (Justice and Mental Health Collaboration Program (JMHCP); SAMHSA's Targeted Capacity Expansion (TCE) Program), federal funding must continue and even be increased for mental health courts. While long-term benefits still have not been fully assessed, the short-term effectiveness has been documented. These court programs provide the necessary formal structure for integrated treatment services for defendants released from our jails. Consideration should also be given to expanding funding for even earlier diversion options (See Sequential Intercept Model, Intercepts 1 and 2). Thought should be given to promoting statewide internal coordination efforts to minimize internal competition among various courts and jurisdictions for these limited federal funds. Perhaps grant dollars could be directed to the administrative offices of the state supreme courts or to the supreme courts in conjunction with the state departments of mental health to foster the best use of the resources and appropriate prioritization.

I also think we should make funding available specifically for initiatives directed toward addressing the mental health needs of our veterans returning from Iraq and Afghanistan. Many of them are suffering from depression, post-traumatic stress syndrome, and substance addictions. We need to act now to prevent them from entering the criminal justice system and our jails and to help those who have been arrested be wrapped into the services of our mental health courts or accepted into the few specialized veterans courts that have been created.[20] One important step taken by the U.S. Department of Veterans Affairs is the creation of Veterans' Justice Outreach Specialists as part of the V.A. Justice Outreach Program. These specialists are to be attached to each Veterans Administration Medical Center and are to be responsible for direct outreach, assessment, and case management for justice involved veterans. Discussions have been ongoing with JLI regarding providing guidance and technical assistance for this program. In addition, and as a result of the May 2009 conference at Columbia University, the National Center on Addiction and Substance Abuse is forming a national commission to make recommendations regarding the problems of returning veterans.

2. Improved Screening and Mental Health Services in Our Jails and Prisons

We must also re-examine the adequacy of mental health screening and services in our correctional settings. While some jurisdictions do have special mental health screening tools used at the booking stage in their jails and specialized mental health units within their jails, many jurisdictions do not. They house prisoners with serious mental illnesses with other inmates. Because those inmates with mental illnesses often exhibit the symptoms of their illnesses and may threaten staff and other inmates or act out, they may be sent to solitary confinement and/or have any accumulated "good time" taken away, which only exacerbates their symptoms and increases the time they must spend incarcerated.

In Winnebago County, Illinois, our jail uses a special screening tool with questions designed to flag a potential mental illness and need for further screening. There are also designated pods for men and women diagnosed with mental illnesses. Two special jail assessors who are licensed

professional counselors assess inmates with signs of mental illness and evaluate them with regard to the need for treatment and/or eligibility for the TIP court program. They also coordinate treatment plans for those inmates being released. An average of over 3,200 inmates are seen each year. The University of Illinois, School of Medicine at Rockford, also contracts for and provides psychiatric consultation, staff, and necessary medications within the jail. Winnebago County bears a heavy cost burden for this arrangement. These measures, while costly, are necessary--and they may prove cost effective in the long run. By careful screening, and by providing necessary medication and treatment, inmates with mental illnesses may be identified as appropriate for earlier release into community programs and/or into mental health courts. Their jail stays may be less volatile. Staff training is an important component and is as essential in our jails as crisis intervention training is for our police on the street in their interactions with persons who have mental illnesses. Transitional case management may be facilitated by programs such as Illinois's Data Link. Jurisdictions that have not explored these issues should be encouraged to come together to find ways to make these changes. Certainly, any federal resources that could be brought to bear would be encouraging.

3. Improved Release Planning

While the goal is diversion from jail to community mental health treatment, for appropriate defendants, diversion is not always an option. Whether jail stays are short or lengthy, mental health treatment in jail and/or prison and transition planning for release of inmates back into our communities is essential.

There are several obstacles that hinder effective release planning: (a) record sharing problems; (b) the Medicaid termination/suspension dilemma; and (c) best practices that are out of line with reimbursement structures. With respect to the problems of record sharing, I am informed that in Illinois, for example, an inmate who requests that jail records be sent to a particular community mental health agency with which he or she will have contact must pay, before his or her release, a charge for the sending of those records. Needless to say, this cost discourages the requests from being made. Then, when the released inmate shows up at the community mental health center, if no records have been sent, the agency must start anew with evaluations, diagnoses, etc. or wait before providing treatment until the records arrive. This gap poses significant risks for the released inmate and the community, as without continued treatment and medications, or even with delays, the risk of re-offending grows. Perhaps additional federal dollars can be found for projects to help address this problem.

Despite the enormous costs of health care in our jails and prisons, my understanding is that federal law prohibits states from receiving federal reimbursement under Medicaid for care or services provided to inmates by these institutions. Often, this is referred to as the “inmate exception” to the Social Security Act. Perhaps consideration can be given to permitting states to receive federal matching funds that could offset these expenses borne exclusively by the states and our counties that tend to impede the delivery of constitutionally required health care for inmates.[21]

In many states, including Illinois, when an eligible individual receiving medical benefits under Medicaid is incarcerated, the benefits are automatically terminated. Applications cannot even be submitted while an inmate is still in jail, even if the person is otherwise eligible. For those inmates with mental illnesses and/or substance addictions this is especially problematic, as service agencies may not be able to provide needed care, treatment, and medications without a Medicaid card in hand when the inmate is released. This gap in treatment certainly can lead to difficult re-entry into the community and greater risk of re-offending and re-entering the revolving door back into jail. Ironically, federal law does not require states to automatically terminate the benefits of an otherwise eligible prisoner upon incarceration. Federal officials might consider assisting states in implementing suspension procedures together with expedited re-application mechanisms for ensuring that these persons receive continuous care upon their release from custody. The American Bar Association's Criminal Justice Section made this recommendation in its 2007 Report to the ABA House of Delegates, as well as the recommendation that the "inmate exception" be repealed. The recommendations are worthy of serious consideration.

While SAMHSA has developed best practices for an integrated recovery model for persons with mental illnesses that includes supported housing, vocational training and supported employment, as well as psychiatric services and medications, it is my understanding that the services unrelated to health are not reimbursable or are subject to fragmented reimbursement at best. A complete examination of this anomaly would be in order. Further consideration could be given to supporting states that would open their Medicaid service plans to include billable service definitions that do include these supports, as well as trauma informed care and case management/linkage services for jail diversion planning.

4. Funding for JLI Technical Support

Effective leadership in our communities is one of the ways that we can improve upon what we have already accomplished. JLI is now in its fifth year and has helped communities across the nation make great strides in jail diversion efforts for persons with mental illnesses. Those accomplishments have already been detailed and discussed in this Statement. I believe that JLI's activities are essential components of the solution to what we all acknowledge is a complex problem. I strongly urge federal dollars be reallocated to the Council of State Governments and the GAINS TAPA Center to provide us with this key staff support to allow us to continue these vital contributions.

5. Funding for Centers of Excellence

Continued federal funding, or even increased funding, for the creation of Centers of Excellence, discussed earlier in this Statement, on a statewide or regional basis can also facilitate the necessary research, study, and dissemination of best practices and cross-disciplinary training for professionals. They can also lead the way in involving consumers and the National Alliance for Mental Illness (NAMI) in the process of finding solutions.

6. The Health Care Debate

Getting others to think about mental illness as a disease is one step that can reduce the stigma and can encourage people to get treatment for their illnesses before they come in contact with the justice system. Now that the national health care debate is engaged, it may be a good time to discuss access to treatment and broader coverage for mental illnesses and substance addictions even for those outside our jails and prisons.

CONCLUSION

The task of this Subcommittee is as daunting as the problem is complex, and I acknowledge that the resources may be limited. I am pleased to see that the Subcommittee nevertheless has undertaken these hearings, as the problem affects us all as professionals and as citizens concerned about public safety and the status of those with mental illnesses in our jails, prisons, and communities. In reflecting on my role as a judge and the work I have been privileged to do in the area of mental health and the criminal law, I am reminded of the sage words of retired Illinois Chief Justice Mary Ann McMorrow to a group of new judges:

> "As judges, we look beyond the legal formalities of a particular dispute - to remain aware of the human dilemma that underlies almost every case brought before us, and, always within the bounds of our authority, try to resolve the problems presented to us in a manner that satisfies both the legal and the human aspects of the case. Let us not forget that the law is first and foremost about human beings and their problems."

I sincerely hope that I can continue to play a meaningful role in this very human problem.

NOTES

1. Portions of this testimony originally appeared in Kathryn E. Zenoff, *Foreword: Confronting the Challenges of Persons Who Are Mentally Ill: A Judge's Perspective*, 29 N. ILL. U. L. REV. 477 (2009).

2. Press Release, Bureau of Justice Statistics, More Than a Quarter Million Prison and Jail Inmates are Identified as Mentally Ill (July 11, 1999), *available at* http://www.ojp.usdoj.gov/bjs/pub/press/mhtip.pr.

3. Bureau of Justice Statistics, Direct Expenditure by Level of Government, 1982-2006, http://www.ojp.usdoj.gov/bjs/glance/expgov.htm
http://www.ojp.usdoj.gov/bjs/glance/expgov.htm(last visited Sept. 8, 2009).

4. WILLIAM J. SABOL & TODD D. MINTON, U.S. DEP'T OF JUSTICE, JAIL INMATES AT MIDYEAR 2007 (2008), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/jim07.pdf.

5. Henry J. Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERVICES 761 (2009).

6. A mental health court is a structured judicial intervention process for treatment of eligible defendants that brings together mental health professionals, local social service programs, and intensive judicial monitoring. It substitutes a problem solving model for traditional case processing.

7. Serious mental illnesses include a broad range of psychological disorders that are severe and persistent and involve impairment of functioning, such as schizophrenia, bipolar disorder, and depression. *See* AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, Axis I (4th Ed. 1994).

8. For example, TIP statistics from January 1, 2005, to July 31, 2009, show that of the current participants, 59 had over 12,000 jail days before being accepted into the program, for a cost of over $738,000 (at $60 per day). After being accepted, they had 761 days for a cost of $45,670. Hospitalizations for TIP defendants who graduated from the program between January 1, 2005, and December 31, 2008, were 3,614 days before entering the program and only 15 days after leaving the program.

9. The GAINS TAPA Center has operated since 1995 as a policy and technical assistance center for systems integration and the development of comprehensive plans for service delivery among state and local behavioral health and criminal justice systems. It is funded through the Center for Mental Health Services of SAMHSA as part of the CMHS Transformation Center.

10. The Council of State Governments is a national nonprofit organization serving policymakers at the local, state, and federal levels of all branches of government. Its Justice Center coordinates the Criminal Justice/Mental Health Consensus Project and provides technical

assistance to grantees of the Justice and Mental Health Collaboration Program, an initiative of the Bureau of Justice Assistance of the Office of Justice Programs.

11. Judges' Criminal Justice/Mental Health Leadership Initiative, http://gainscenter.samhsa.gov/listserv/judges/jli_8_25_09.html (last visited Sept. 9, 2009).

12. A competitive application process resulted in the following states being selected: California, Florida, Georgia, Missouri, Nevada, Texas, Vermont, Wisconsin, Delaware, Idaho, and New Hampshire.

13. SPECIALTY COURTS: A REPORT TO THE ILLINOIS CONFERENCE OF CHIEF JUDGES (2006).

14. Mental Health Court Treatment Act, 740 ILL. COMP. STAT. 168/1 to 168/35 (Supp. 2007).

15. *See* 55 ILL. COMP. STAT. 5/5–1101(d-5) (2008).

16. The sequential intercept model was developed by Patty Griffin, Ph.D., and Mark Munetz, M.D. (2006). See Mark R. Munetz & Patricia A. Griffin, *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, 57 PSYCHIATRIC SERVICES 544 (2006) (describing the sequential intercept model as a framework for "considering the interface between the criminal justice and mental health systems as they address concerns about criminalization of people with mental illness" and explaining that the model "envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system"). It was used by Policy Research Associates, Inc. as a tool for discussion of diversion possibilities in Illinois at the various stages or "intercepts" in the criminal justice system: (1) law enforcement/emergency services; (2) initial detention/initial court hearings; (3) jails/courts; (4) re-entry; and (5) community corrections/community support.

17. POLICY RESEARCH ASSOCIATES, TRANSFORMING SYSTEMS AND SERVICES FOR JUSTICE-INVOLVED PERSONS WITH MENTAL ILLNESS: FINAL REPORT (2008).

18. *See* 740 ILL. COMP. STAT. 110/9.2 (2008).

19. Two veterans courts are operating in Illinois, one in New York, and only a handful of others in other states. These specialty courts are designed as diversion programs and accept United States veterans who have been charged with misdemeanor and/or non-violent criminal offenses. The goal is to provide comprehensive services to these veterans to assist them in staying out of jail and prisons and in leading productive lives.

20. *See supra* note 19.

21. AM. BAR ASS'N CRIMINAL JUSTICE SECTION, REPORT TO THE HOUSE OF DELEGATES (August 2007).