House Committee on Corrections & Juvenile Justice

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NAMI Kansas is the state organization of the National Alliance on Mental Illness, a grassroots organization whose members are individuals living with mental illnesses and their family members who provide care and support. NAMI Kansas provides programs of peer support and education by and for our members through a statewide network of 13 local affiliates and support groups. We advocate for individuals who are living with mental illness to ensure their access to treatment and supportive services.

NAMI Kansas supported the juvenile justice reforms enacted in SB 367 in 2016. As we stated last year, the provisions of SB 367 were designed to strengthen Kansas's juvenile justice system, improve outcomes for children and families, protect public safety, and ensure more effective use of taxpayer dollars by:

- Preventing deeper juvenile justice system involvement
- Providing courts in all areas of the state with access to appropriate community-based services for juvenile offenders and their families while focusing out-of-home placements on more serious offenders who pose the greatest public safety risks
- Reducing expenditures on out-of-home placements and reinvesting savings in more effective alternatives that can strengthen families
- Creating effective oversight to monitor the implementation of reforms

Our interest in juvenile justice reform begins with our understanding that about one in ten children have a serious mental or emotional disorder.[1] This means that more than 31,000 children in Kansas live with serious mental health conditions.[2] One-half of all lifetime cases of mental illness begin by age 14, three-quarters by age 24.[3] Fewer than half of children with a diagnosable mental disorder receive any mental health services in a given year. Suicide is the third leading cause of death among youth and young adults aged 15-24.[4] Among children between 10 and 17 years of age, suicide is the

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2nd leading cause of death.

Over 50 percent of students with a mental disorder age 14 and older drop out of high school—the highest dropout rate of any disability group.[5] Approximately 53 percent of Kansas students aged 14 and older living with serious mental health conditions who receive special education services dropped out of high school.[6]

A report from the National Center for Mental Health & Juvenile Justice found that 70 percent of youth in juvenile justice systems have at least one mental health disorder with at least 20 percent experiencing significant functional impairment from a serious mental illness. Many end up in the system simply because they need mental health services and can't access them in their community. Yet while in custody, many don't receive the treatment they need. They end up getting worse, not better. While detained, these adolescents are kept from their families who they need the most. Youth in custody have a four times greater risk of suicide than their peers. Once they have entered the criminal justice system, they are likely to stay in it. Re-arrest rates are as high as 75 percent within three years after confinement. There should be options for diversion to treatment and continued support during and after confinement.

NAMI believes that everyone should have access to mental health care. We must partner with youth-serving agencies and criminal justice leaders to ensure that youth with mental health treatment needs get the support they need to stay out of jail. Those involved in nonviolent offenses should be diverted into effective home and community-based treatment programs.

Regarding HB 2264, we would like to see language included to require the Oversight Committee to study and make recommendations by January 1, 2019 to address disparities in treatment, including the adequacy of resources, for youth with mental health needs and other disabilities, as well as the disproportionate punishment of youth of color. This enhancement of the statute is consistent with language in SB 367 which requires the Oversight Committee to make recommendations for continued improvements in the juvenile justice system. We would also like to see language which ends the practice of indiscriminate shackling of youth during court proceedings which raises concerns about unnecessarily re-traumatizing youth offenders.

Furthermore, we urge the Committee to <u>not</u> make changes to the 2016 legislation that would reverse the progress being made to reform our juvenile justice system. We must stay the course. Steady progress is being made with the $2 million investment from 2016. Any attempt to roll back provisions of this landmark legislation will create uncertainty and confusion at all levels of the system, especially for families. We must recognize that the implementation of reforms of this magnitude take time and we must give the responsible state agencies and the Oversight Committee ample time to continue their work.

Should any "rollback" revisions to SB 367 be contemplated, those changes should be very narrowly construed. We do not want to see loopholes created in the law that will reverse the objectives of the reforms and lead to increased incarcerations and out of home placements.

Thank you for your consideration of these comments relative to HB 2264.

[1] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1999, pp. 408-409, 411.
[2] U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda, (Washington, DC: Department of Health and Human Services, 2000).
[3] Kessler, R., Berglund, P., Demler, O., Jin, R., Merikangas, & Walters, *Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Co-morbidity Survey Replication (NCSR). General Psychiatry, 62, June 2005, 593-602.*
[4] National Institute of Mental Health, "Suicide in the U.S.: Statistics and Prevention,"2009, http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-preevntion/index.shtml
[5] U.S. Department of education. *Twenty-third annual report to Congress on the implementation of the Individuals with Disabilities Act. Washington, D.C., 2006.*
[6] U.S. Department of Education, Office of Special Education Programs, Data Accountability Center, IDEA Data, "State Rank-Ordered Tables," Table 1.3b, DANS (July 15, 2008)