

**Testimony of Karen Agnifilo
Office of the Criminal Justice Coordinator
New York City Council
Committees on Public Safety, Juvenile Justice, and Mental Health
October 28, 2008**

Good morning, Chairpersons Vallone, Gonzalez, and Koppell and members of the Council. My name is Karen Agnifilo, and I am General Counsel to John Feinblatt, the City's Criminal Justice Coordinator. I am joined by Deputy Criminal Justice Coordinator Michele Sviridoff.

Thank you for the opportunity today to talk about our work in the area of mental health, particularly the City-State Mental Health-Criminal Justice Panel and report.

The Bloomberg Administration has long been committed to ensuring not only that individuals with mental illness receive the highest quality care and treatment, but also that the criminal justice system responds appropriately when these individuals enter the system to protect public safety. The City was instrumental in helping develop and implement programs such as the Nathaniel Project, an alternative to incarceration program for mentally ill felony offenders, and supporting the City's mental health courts.

As Ms. Cohen explained, the charge to the panel was to recommend actions to improve services to individuals with mental illness and promote the safety of all New Yorkers. The panel's work was informed by research conducted by experts in the field. As Ms. Cohen explained, the vast majority of those with mental illness are not violent and mental illness is not a major driver of violent crime. However, the research indicates that the failure to receive adequate treatment increases the risk of violence among individuals with serious mental illnesses. The panel therefore concluded that connecting individuals with serious mental illness to care and treatment could enhance the safety of these individuals and the general public.

Citywide, it is estimated that approximately 18% of offenders in the justice system have a serious mental illness. The panel recognized that contacts with the criminal justice system are potentially important opportunities to identify a significant number of individuals with mental illness and either ensure continuity of treatment or provide links to appropriate mental health services. This could, in turn, reduce the risk of violence and promote public safety. We also recognized that the current legal framework imposes significant limitations on how much the criminal justice system can do. Two of the four major findings in the report relate to the ability of the criminal justice system to capitalize on these opportunities.

First, the panel found that there is limited capacity to share information between the mental health and criminal justice systems. Barriers imposed by privacy laws, which are intended to safeguard personal health information, prevent sharing mental health information with the criminal justice system without consent, even when that information could help ensure continuity of care or help determine whether an individual may be an appropriate candidate for treatment-based alternatives. Second, the panel found that the criminal justice system could be

enhanced to provide better training, supports, and tools to identify and engage individuals with mental illness.

The panel developed numerous recommendations to capitalize on these opportunities within the current legal framework, both on a City and a State level. Allow me to summarize some of our recommendations.

Police Response

Turning first to police response, the panel recognized that the NYPD is enormously successful in responding to calls involving emotionally disturbed persons. Of the 10 million 911 calls received annually, roughly 90,000 involve emotionally disturbed persons. The highly-trained Emergency Service Unit (“ESU”) is an elite group of officers who receive 16 hours of tactical training on emotionally disturbed persons and 40 hours of emergency psychiatric training in addition to the full-day training received by all recruits. ESU is dispatched for 100% of calls involving emotionally disturbed persons. ESU ultimately responds to roughly 25% of these calls because the unit is often called off when other officers reach the scene and conclude that the presence of ESU is not necessary. The vast majority of calls involving emotionally disturbed persons are handled without incident. Of these roughly 90,000 calls, the NYPD arrests less than 1% of emotionally disturbed persons, typically opting instead to take these individuals to a hospital or provide a referral to another agency.

Given the success of the NYPD in this area, the panel asked what additional information could be provided to officers to enhance this already extraordinary response to calls involving emotionally disturbed persons. The panel considered numerous options for providing police officers with relevant mental health information. Initially, we had similar concerns to Chairman Vallone and considered an approach like that contemplated by Intro. 799. This approach would mine the NYPD databases and identify individuals who have been the subject of prior calls involving emotionally disturbed persons to alert responding officers to any future calls involving such individuals. However, after much deliberation, it was ultimately determined that a location-based database – which I will explain in a moment – would provide the most useful information to responding officers. This is because the utility of a name-based database is limited, as location is the most important piece of information communicated to a 911 operator. Indeed, 911 calls often involve information only about a location, rather than identifying the specific individuals involved in an incident. In fact, if the caller knows the name of the individual involved, the caller is also likely to know that the individual has a mental health issue and would thus likely provide that information to the operator. And, an identification from a name-based database, without other confirming information, could lead to mistaken identification and potential confusion, rather than providing useful information to the responding officers.

After collaborating with the NYPD, the panel instead recommended that the NYPD focus on locations that are likely to involve emotionally disturbed persons. The NYPD is in the process of establishing flags in its 911 database to identify locations that will trigger the dispatch of ESU, specifically locations that have been the subject of prior calls involving emotionally disturbed persons and known housing locations with supports for individuals with mental illness. This system will provide responding officers with instant information regarding the possibility

that the call involves an emotionally disturbed person and will facilitate the early dispatch of ESU to these locations.

The panel also considered the issue of police training. In the City, the training curriculum for new recruits regarding emotionally disturbed persons is created with extensive input from the mental health community. The LINK Committee was established to review this portion of the curriculum and explore new ideas for training. Composed of members of the NYPD, the City Department of Health and Mental Hygiene, advocacy groups, consumers, hospitals, and the legal and academic communities, this committee meets quarterly to review the NYPD's training curriculum and ensure that it reflects best practices in law enforcement training for handling situations involving emotionally disturbed persons. The panel recommended that this committee continue this important work. Additionally, the NYPD plans to expand this training to officers who may not have received it during new recruit training.

Information Sharing

A second important issue discussed by the panel was whether sharing information between the mental health and criminal justice systems could be useful in ensuring continuity of care and providing links to treatment, as well as protecting public safety. The panel determined that such information sharing could be beneficial; however, there are significant impediments to this information sharing, including privacy laws, the lack of mechanisms in the criminal justice system to routinely screen for mental illness, and the inability of criminal justice and mental health data systems to facilitate the sharing of information.

The panel considered recommending statutory changes to permit limited mental health information sharing with the criminal justice system. Several concerns were raised about this option, however, including that information sharing could potentially stigmatize individuals with mental illnesses and lead to punitive criminal justice system responses, raise privacy concerns, and significantly alter current practice. It should be noted that only one state, Texas, has a statute permitting sharing mental health information with the criminal justice system, and only then in very limited circumstances. After much deliberation, we decided instead to pursue several pilot projects to determine if the information sharing gap can be bridged without statutory changes.

The panel recommended three pilot programs that we are in the process of implementing in the City to identify individuals with mental illnesses in the criminal justice system who might benefit from being linked to long-term services. The goal of these projects is to determine whether information sharing under current laws can enhance continuity of care and reduce the likelihood that individuals with mental illnesses will repeatedly cycle through the criminal justice system.

First, we are developing a pilot program to identify individuals with serious mental illness who have become involved in the justice system. When an individual is arrested, the new database Ms. Cohen described will be searched to see if this individual is already receiving mental health services. If so, information regarding this person's arrest will be provided to a member of the Mental Health Care Monitoring Team ("CMT"). The CMT will then notify community-based treatment providers and case managers. This notification system will ensure

that the treatment providers are fully informed about an individual's contacts with the criminal justice system so that providers can re-engage that individual in appropriate services and treatment. We will also place mental health professionals in the courtroom who will work closely with the CMTs to identify justice-involved individuals who are currently receiving high-intensity mental health services. This will help to better coordinate care within the criminal justice setting and determine whether a defendant may be appropriate for diversion to treatment-based alternatives.

We are also in the process of implementing two additional pilot programs intended to measure whether short-term court-monitored engagement in treatment will promote longer-term participation in mental health services. A study of the Manhattan-based Exit program, launched in 2003, demonstrated that brief court-mandated engagement efforts for misdemeanants could successfully link them to longer-term treatment. Roughly 40% of participants continued in voluntary case management for over four months after the mandated treatment. We hope to build on the success of this early program.

One pilot will involve the use of post-arraignment mental health screening in the Bronx Criminal Court for defendants sentenced to brief community-based programs. This screen will seek to identify appropriate candidates for more in-depth mental health assessment, intensive engagement, and voluntary case management as an alternative to the original sentence.

Another pilot involves an alternative to detention program with a special mental health track designed to provide assessment, case management, supervision, and community-based treatment. This program will target defendants who are likely to be detained in jail while their criminal cases are pending and who do not pose a high risk of either recidivism or flight. This program will also assist judges in making appropriate sentencing decisions by helping them assess whether an individual is an appropriate candidate for a treatment-based alternative in lieu of a jail or prison sentence.

Probation

The panel also considered what supports could be implemented within criminal justice agencies to better serve the population of individuals with mental illness. The panel made two recommendations aimed at the Department of Probation ("DOP"). First, the panel recommended that DOP create a dedicated mental health unit of probation officers with reduced caseloads who will establish relationships with their probationers' mental health providers, assist probationers in receiving appropriate services, and provide closer supervision. Second, the panel recommended that DOP begin using a brief, validated mental health screen during pre-sentence investigations to allow the agency to alert judges to defendants who may need a deeper clinical assessment and may benefit from treatment-based alternatives or special probation conditions.

Statewide Recommendations

In addition to these recommendations that focus on City agencies and resources, the panel also issued recommendations aimed at the state as a whole. First, the panel recommended building on the successes of the mental health courts and alternative to incarceration programs

that link offenders to court-monitored mental health treatment implemented in the City by expanding these courts and programs to additional jurisdictions throughout the state. There are currently 17 mental health courts statewide and we anticipate the creation of an additional 8 such courts in the next few years.

The panel also concluded that it was important to keep track of the small number of individuals with mental illness who were criminally prosecuted but determined to be not responsible for their criminal conduct due to "mental disease or defect." Upon recommendation of the panel, the State Division of Criminal Justice Services is going to begin providing the agencies that supervise these individuals with real-time notification of arrests of these individuals who are in the community.

With respect to law enforcement response throughout the state, the panel found that 911 dispatchers often do not effectively elicit information about whether mental illness is relevant to a 911 call. This information could be used to determine when to deploy specialized resources, such as ESU in the City. The panel therefore recommended that the state create a training protocol for 911 dispatchers to better elicit information about whether a person involved in an incident has a history of mental illness.

Thank you again for the opportunity to discuss the findings and recommendations of the City-State panel as they relate to criminal justice. The Bloomberg Administration is committed to ensuring that individuals with mental illness not only receive the best possible care and treatment, but also that the criminal justice system responds appropriately to incidents involving these individuals and protects public safety.

I'll be happy to take your questions.

New York City Council

Committee on Public Safety jointly with the
Committee on Juvenile Justice and the
Committee on Mental Health, Mental Retardation,
Alcoholism, Drug Abuse & Disability Services

Oversight - Report and Recommendations of the
New York State/New York City Mental Health-
Criminal Justice Panel

Tuesday, October 28, 2008

Testimony by Joel Copperman
CASES

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My name is Joel Copperman. I am the President and Chief Executive Officer of CASES. Thank you for the opportunity to testify this morning.

CASES provides alternative sentences to defendants in the New York City Courts. For over 40 years CASES has been working with the Courts to provide alternative sentences to defendants in New York City. For almost nine years we have been serving individuals with serious and persistent mental illness. We appear before the Council today to in support of those recommendations of the Mental Health – Criminal Justice Panel that call for increasing those services.

The last 10 years has seen many important efforts to improve the communication and understandings between the criminal justice and mental health systems. I commend Governor Patterson and Mayor Bloomberg for convening the New York State / New York City Mental Health - Criminal Justice Panel. Deputy Mayor Gibbs, Criminal Justice Coordinator Feinblatt and other members of the panel showed great sensitivity to individuals with mental illness and produced a report and recommendations that makes an important contribution to those efforts.

I would like to briefly tell you about some of the mental health services that CASES provides and some of the outcomes that we have achieved. I would then like to focus on two issues that are raised in the report:

- identification of individuals in the Criminal Court – those charged with misdemeanors – in need of mental health services and connecting them to services; and
- connecting mental health consumers to supported employment.

About CASES Mental Health Programs

One of the recommendations of the Panel was the expansion of the number of “alternative-to-incarceration programs that link offenders to court monitored mental health treatment as an alternative to transitional case processing.” CASES provides such alternatives in the Supreme Court – our award-winning **Nathaniel Project** and in the Criminal Court – the **Transitional Case Management** Program.

The Nathaniel Project began in January 2000 and has provided comprehensive services, supervision and support to more than 360 felony offenders with mental illness since inception. In June 2003, the Nathaniel Project received ACT team certification from the NYS Office of Mental Health and began providing evidence-based ACT services as a two-year alternative to incarceration (ATI), serving a maximum of 68 clients at any one time, according to established ACT standards.

The Nathaniel Project was the first ATI program in NYC for felony offenders with serious and persistent mental illness. Named for a schizophrenic homeless man whose illness went untreated for 15 years as he cycled in and out of the criminal justice system, the Nathaniel Project has become a model for engaging mentally ill offenders in treatment and supervising these individuals safely in the community. Nathaniel ACT is a

24-month ATI program that places participants in transitional and permanent housing, engages them in mental health and integrated substance abuse treatment, helps them to obtain entitlements, provides case management, and offers wraparound and therapeutic support services to ensure participants' retention in housing and treatment, while providing regular updates to the Court of participants' progress in services.

Nathaniel ACT provides a safe alternative to jail or prison for offenders with serious mental illness who are more humanely and effectively served by treatment and supervision in the community. When the multiple needs of offenders with mental illness are not met, people typically cycle through a "revolving door" of arrest, confinement, release, and re-arrest. CASES' support enables consumers to break the cycle and move towards independent living in the community, free from further involvement in the criminal justice system. A recidivism study prepared in July 2006 looked at 95 individuals who participated in Nathaniel ACT services during the three years between June 2003 and June 2006.

The Nathaniel ACT diversion occurs after conviction and prior to sentencing. Participants are subject to deferred sentencing and their participation in Nathaniel ACT is typically monitored for 24 months by Supreme Court judges. Some participants are sentenced before two years, in which case participants usually receive five years of probation, or three years of probation if the felony conviction is reduced to a misdemeanor. Continued participation in Nathaniel ACT services then becomes a condition of probation. Approximately 20% of active Nathaniel participants are currently serving sentences of probation. Program completion does not occur until a participant no longer requires the current level of services provided by the ACT team—in which case the team assists the participant to establish him/herself in other more appropriate services—or is transferred to another ACT team, as might be the case if a participant secures permanent housing attached to another ACT provider. The ATI portion of the program is thus limited to two years in most cases, allowing for the discretion of the judge; whereas the length of Nathaniel ACT services may be extended on the basis of clinical need. The average length of stay of ACT program completers to date is two years and eight months.

Nathaniel ACT services are delivered by a mobile, multi-disciplinary mental health treatment team that includes a psychiatrist, nurses, a peer specialist, and clinical staff who act both as generalist case managers and trained specialists in substance use, family functioning, vocational/educational guidance, and other disciplines. The team provides treatment services in the community whenever possible, in order to support participants in meeting the day-to-day challenges of community living. Nathaniel services are provided in shelters, participants' apartments, program residences, parks and cafés, health clinics and hospitals, and education and work sites in the five boroughs. The ACT team meets daily to coordinate the massive outreach that is required to provide services to each participant where they are most needed. Support groups for participants are also held at our offices in lower Manhattan, and currently include a harm reduction group, a men's group, and a work readiness group. Services are easily accessible and are available 24 hours a day, 7 days a week.

The New York State Office of Mental Health licenses the Nathaniel ACT Team. Nathaniel ACT receives funding from the City Department of Health and Mental Hygiene, Medicaid, the Office of the Criminal Justice Coordinator, the State Division of Probation and Correctional Alternatives, the New York City Council and private foundations and individuals.

Of the 100 participants who began Nathaniel ACT services more than two years ago, 66% have either successfully completed the program or continue to receive services at CASES.

72% of Nathaniel ACT participants had no subsequent re-arrest and 82% had no criminal convictions, during an average post-release period of 19 months.

At intake 68% of Nathaniel ACT clients are homeless and 26% live with family; one year later, 26% are long term permanent housing, 45% are with family and 20% are in short term housing.

The **Transitional Case Management Program** connects defendants charged with misdemeanors in the Criminal Court with mental health services. TCM is a voluntary program that identifies defendants with repeat misdemeanors and serious mental illness and provides them with comprehensive case management services in the community. TCM addresses participants' complex social needs while it simultaneously reduces recidivism, decreases the costs associated with incarceration, and maintains public safety.

If admitted to TCM, participants are provided comprehensive case management services in the community. TCM also links consumers to long-term mental health services. Case management goals may include connection to public benefits, medications, psychiatric evaluation, supportive counseling and mental health treatment, integrated substance abuse treatment, vocational/educational services, crisis housing, and longer-term housing.

TCM builds on CASES' experience running EXIT, an alternative to incarceration program for repeat misdemeanants with mental illness. EXIT was funded in 2002 with a three-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). Through EXIT, which served 173 clients, CASES developed expertise and demonstrated the benefit of ATI programs for misdemeanants with mental illness. This new program builds on EXIT's strengths and addresses the barriers that EXIT encountered, namely the difficulty of providing comprehensive assessments in the holding pens given the fast pace of the arraignment process, and the lack of an effective cross-agency stakeholder group to change systems and to support, publicize, and sustain the program

The Office of the Criminal Coordinator, the U.S. Department of Justice and private foundations and individuals support TCM.

Identifying Criminal Court Defendants with Mental Health Needs and Connecting Them to Services

One of the recommendations of the Panel called for sharing information between criminal justice and mental health treatment systems. The purpose of sharing information would be to facilitate treatment.

CASES Transitional Case Management initiative (described above) would benefit if an information-sharing program were put in place. CASES, in partnership with the City's Departments of Correction and Health and Mental Hygiene, has brought together key staff from City and State Government, justice agencies, advocacy organizations and non profit service providers to explore how to effectively utilize limited resources to address the untreated mental illness, co-occurring substance abuse problems, poverty, homelessness and recidivism of individuals at risk of being repeatedly sentenced to short jail terms and being returned to the community without adequate supports. The cross-system collaboration has generated the invaluable support of the JEHT Foundation. With the support of the JEHT, CASES has hired two senior policy consultants to spearhead the policy efforts that will allow us to tackle the complex issues related to identifying individuals appropriate for the program, getting them through the court system and connecting them to services.

One of the challenges that we are currently facing is identifying appropriate defendants within the 24 hours between arrest and arraignment. In Manhattan, where CASES is piloting the TCM initiative, almost 94,000 defendants were arraigned in 2007. Over half of those defendants' cases were disposed at arraignment. Our program seeks to catch cases at this stage of the proceeding in order to serve a group of mentally ill individuals who would otherwise be released and be back in the community without services.

We use the Brief Jail Mental Health Screen (BJMHS), a tool to screen incoming detainees in jails and detention centers for the need for further mental health assessment. The eight-question screen, designed for quick administration and easy incorporation into the booking process by corrections officers was developed by the National GAINS Center, a division of Policy Research Associates, with funding from the National Institute of Justice. If the screening tool flags a defendant, a CASES social worker completes a mental health assessment of the defendant and we advocate for the defendant's acceptance into our program.

Our challenge is limited time, limited resources and inadequate information. We do our work at the end of the arrest to arraignment cycle. We don't have the staff to cover all of the arraignment sessions – there were over 1,300 arraignment sessions in Manhattan in 2007. And our information about the defendant's mental health history is self-reported.

As pointed out in the Panel's Report information sharing presents privacy issues and very limited capacity to share information between the mental health and criminal justice systems. Our Stakeholders Group will be working to address these issues.

Connecting Mental Health Consumers to Supported Employment

Implicit in the Panel's recommendation to expand alternative to incarceration programs is the expansion of the services provided by those programs. CASES believes that a very important area for expansion is supported employment programs.

Research has demonstrated that stable recovery from mental illness and co-occurring substance abuse disorders is associated with four quality of life factors: 1) having a trusting relationship with a clinician who helps with recovery from both illnesses; 2) having stable, safe, and substance-free housing; 3) having a social network of non-substance abusers; and 4) *having a meaningful daily activity such as work*. Yet, adults with mental illness face a number of barriers to employment and can require intensive supports to find and retain a job.

In the United States, the employment rate for individuals with severe disabilities is approximately 25%. The employment rate for individuals with psychiatric disabilities is often even lower, as low as 15%. A 2001 NYS Office of Mental Health survey reported that 17% of adults served in non-institutional mental health settings are competitively employed full or part time. For NYC ACT team clients, who are often characterized by histories of profound functional impairment as a result of mental illness, the employment rate is even lower. Citywide, only 3.8% of ACT team participants are engaged in competitive employment. For current Nathaniel ACT participants, the number is only slightly higher: 5.7%.

Motivation to participate in employment services among current Nathaniel ACT participants is high. In a recent survey of current ACT participants' attitudes toward employment and education, 43% of our participants state that finding a full-time job is important, 43% state that finding a part-time job is very important and 24% state that they want to obtain a GED. When asked to state where they would like to see themselves one year from now, 57% report that they want to be working full-time. Further, our ACT program data shows that participation in education and employment activities reduces substance use amongst participants and may have other positive correlates to compliance with court obligations, increasing the possibility of successful diversion for clients who work.

CASES seeks to create a supported employment program that provides people with severe mental illness with direct placement in jobs in competitive, real-world settings with accompanying on-site support services as needed to help individuals perform their job. Unlike more traditional vocational approaches, supported employment programs use a rapid job search and placement approach to help consumers obtain jobs directly, rather than providing them with pre-employment vocational training or placement in non-competitive employment. Supported employment staff and consumers

identify individualized job placements based on consumer preferences, strengths, and work experiences. An important feature of supported employment is equitable compensation: wages and benefits must be the same as other workers in similar jobs receive. Supported employment provides opportunities for people with severe mental illness to foster independence via gainful employment.

Thank you for this opportunity to testify on these important issues.



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FOR THE RECORD

Statement of the New York Civil Liberties Union

presented to

The New York City Council Committee on Public Safety

regarding

Intro. 799, which directs the NYPD to create and maintain a database of information regarding emotionally disturbed persons

The New York Civil Liberties Union (“NYCLU”) has serious concerns about Intro. 799 and urges the City Council to withdraw this proposal and to consider alternative approaches to police interactions with emotionally disturbed persons (“EDPs”). This legislation is intended as a response to the findings and recommendations in a June 2008 report published by the New York State/New York City Mental Health-Criminal Justice Panel (“the Panel”).¹ However, the bill’s directive – that the New York City Police Department (“NYPD”) create a database of individuals believed to be EDPs – is inconsistent with the report’s recommendations.

While the legislation is well-intentioned, the NYCLU is concerned that this proposal will do little to improve the effectiveness of the NYPD’s response to incidents involving emotionally disturbed persons. It will more likely compromise and undermine the police response to emergency calls regarding emotionally disturbed persons, and it will certainly compromise the statutory privacy protections afforded EDPs and persons *believed* to be emotionally disturbed.

I. The proposed NYPD database of emotionally disturbed persons will do little to facilitate an effective police response to incidents involving EDPs

In describing the bill’s legislative intent, Section 1 states that it seeks to “require the creation of a database of pertinent information involving calls of emotionally disturbed people which will be readily accessible to responding police personnel in the event they know the name of the emotionally disturbed person or other identifying information such as the address of the emotionally disturbed person or the location of the incident.”²

¹ New York State/New York City Mental Health-Criminal Justice Panel, *Report and Recommendations*, June 2008, http://www.omh.state.ny.us/omhweb/justice_panel_report/.

² Intro. 799, Section 1, Declarations of Legislative findings and intent.

The proposal is based upon the premise that an individual who makes an emergency call to the NYPD regarding emotionally disturbed persons will provide the names and addresses of such individuals. This is a false premise. It mistakenly assumes that when there is a call to the police regarding an EDP, the caller is able to identify the individual; that the individual has at some point previously given what is his or her real name; and that an EDP who repeatedly engages in potentially harmful behavior does so in a predictable manner that is restricted to the same locations. Because these assumptions are unfounded, Int. 799 is likely to be of minimal assistance and potentially more harmful to the interests of emotionally disturbed persons.

In fact, a summary of news accounts on police interactions with emotionally disturbed persons reveals that many incidents which resulted in injury to the EDP and or other individuals involved police misunderstanding of the alleged “disturbed person” or a flawed or inappropriate police response to the individual.³ Rather than providing more effective services to the emotionally disturbed, this proposal is more likely to encourage the notion that EDPs are prone to violent behavior and constitute a threat to the general public. Research, however, indicates that emotionally disturbed persons are more likely to be the victims of violence as compared to persons from the general population. What’s more, they may well be arrested for their disability rather than treated for it.⁴

II. The bill is inconsistent with and undermines the objectives of the Panel’s recommendations

The Mental Health–Criminal Justice Panel report recognizes that individuals with mental illnesses face an increased risk of poor treatment outcomes, violence, and involvement with the justice system in New York State.⁵ In the effort to provide improved services to this population, the Panel made a number of recommendations, including a pilot program which would require the NYPD to establish database flags for *locations* [and not individuals] that may trigger the dispatch of the specially trained Emergency Service Unit.⁶ In its recommendations, the Panel sought to address the limited capacity for information sharing between the mental health and criminal justice systems. But these recommendations also sought to prevent the release of sensitive private information.

³ Nina Bernstein, *Some Question Police Guidelines in Confrontations With the Mentally Ill*, New York Times, Sept. 1, 1999, <http://query.nytimes.com/gst/fullpage.html?res=940DE4DE163AF932A3575AC0A96F958260>; Trymaine Lee and Christine Hauser, *Brooklyn Man Dies After Police use a Taser Gun*, New York Times, Sept. 25, 2008, <http://www.nytimes.com/2008/09/25/nyregion/25tased.html?scp=1&sq=%22brooklyn%20man%20dies%20after%20police%20use%20a%20taser%20gun%22&st=cse>; Robert D. McFadden and Al Baker, *Police Kill a Man Armed With a Broken Bottle*, New York Times, Nov. 19, 2007, <http://www.nytimes.com/2007/11/19/nyregion/19shoot.html?scp=1&sq=%22police%20kill%20a%20man%20armed%20with%20a%20broken%20bottle%22&st=cse>; Michael Wilson, *When Mental Illness Meets Police Firepower; Shift in Training for Officers Reflect Lessons of Encounters Gone Awry*, New York Times, Dec. 28, 2003, <http://query.nytimes.com/gst/fullpage.html?sec=health&res=9804EEDE123EF93BA15751C1A9659C8B63&scp=1&sq=%22when%20mental%20illness%20meets%20police%20firepower%22&st=cse>.

⁴ Eugene O’Donnell, *Cops and the Mentally Ill: How Police Can Better Handle Emotionally Disturbed Citizens*, July 31, 2008, <http://www.newsweek.com/id/149630> (According to the National Institute of Justice, a federal agency, once a mentally ill person is arrested for disorderliness, that person is labeled a “criminal” and will likely continue to be arrested when acting out in the future, rather than receive treatment).

⁵ New York State/New York City Mental Health – Criminal Justice Panel, *supra* note 1, at 1.

⁶ *Id.* at 23.

The Panel's report states that such information sharing "could potentially stigmatize individuals with mental illnesses and lead to punitive criminal justice system responses, raise privacy concerns..."⁷ The proposed legislation, however, fails to heed these warnings. Intro. 799 poses a risk of harm to emotionally disturbed persons – the very harms the Panel sought to prevent, including the misidentification of emotionally disturbed persons, the violation of personal privacy, and the further stigmatization of this population. Under this proposal, the database would include, "at a minimum, the name and address of the emotionally disturbed person and the nature of the incident."⁸ Based on this language, the NYPD database could easily encompass the clinical and hospital records of emotionally disturbed persons who come into contact with law enforcement personnel. As a practical matter, this legislation would promote the violation of the State's medical privacy laws.⁹

III. New best-practice protocols are needed so that the Department of Health and Mental Hygiene ("DOHMH") and NYPD can provide effective and coordinated responses to incidents involving EPDs

In June of 2008, seventeen members of the City Council introduced a resolution calling on city agencies (DOHMH and NYPD) to "reevaluate their protocols and response to field incidents concerning the apprehension of, restraint of, and use of lethal force against emotionally disturbed persons."¹⁰ Intro. 799, however, merely creates a database – one whose design is flawed. The NYCLU urges the City Council to develop a more comprehensive best-practice protocol for police interactions with emotionally disturbed persons that is consistent with the Panel's recommendations.

Pursuant to its findings, the Panel made two recommendations that are essential to promoting public safety and providing EDPs with improved services: the establishment of Mental Health Care Monitoring Teams, which would help coordinate and track the care of high-need clients as a preventative measure, and the improved training of 911 dispatchers so that they may elicit information that would better aid police officers in responding to situations that may involve emotionally disturbed persons. As an additional matter, the City Council should also consider implementing a Crisis Intervention Team model for handling interactions with EDPs. This approach, which has been proven effective in communities throughout the country, would promote the de-escalation of conflict and confusion in emergency situations.

In light of the foregoing, the NYCLU urges the City Council to reconsider Intro. 799.

⁷ *Id.* at 22.

⁸ Intro. 799, Section 2, proposed amendment to Chapter 1 of title 14 of the administrative code of the city of New York.

⁹ New York Mental Health Law §33.13 and Public Health Law §2803-c (Intro. 799 would not fall under MHL §33.13's "law enforcement agency" exception because a treating psychiatrist or psychologist must determine that a patient or client presents a serious and imminent danger to that person, and the proposal does not specify that this requirement would be satisfied).

¹⁰ Res. 1249-A, Resolution calling on the Mayor, the NYPD, and the NYC DOHMH to continually reevaluate their protocols and response to field incidents concerning the apprehension of, restraint of, and use of lethal force against emotionally disturbed persons (Sponsoring Council Members included: Dickens, Vann, Brewer, Felder, Fidler, James, Koppell, Liu, Mendez, Sanders Jr., Seabrook, Stewart, White Jr., Barron, Foster, Jackson, and Palma).

Statement of

Rima Cohen

Director of Health and Social Services

Office of the

New York City Deputy Mayor for Health and Human Services

Oversight: Examining the Recommendations of the City-State Panel on Mental
Health and Criminal Justice

Before the

New York City Council Committees on Mental Health, Juvenile Justice, and
Public Safety

October 28, 2008

Thank you Chairpersons Koppell, Vallone and Gonzalez and members of the Committees on Mental Health, Juvenile Justice, and Public Safety for inviting me to testify at this oversight hearing on the recommendations of the City-State Panel on Mental Health and Criminal Justice. My name is Rima Cohen and I am Director of Health and Social Services in the Office of the Deputy Mayor for Health and Human Services, Linda Gibbs.

As you know, Deputy Mayor Gibbs was one of the co-chairs of the joint New York City/New York State Mental Health and Criminal Justice Panel, which developed a comprehensive set of recommendations last June for improving the quality and consistency of care provided to individuals with serious mental illnesses and reducing the risk of violence to themselves and others. I am here today with my colleague Karen Agnifilo from the office of the NYC Criminal Justice Coordinator's office to discuss that report.

In addition to Deputy Mayor Gibbs, the Panel was co-chaired by NYC Criminal Justice Coordinator John Feinblatt, NYS Office of Mental Health Commissioner Mike Hogan, and NYS Division of Criminal Justice Services Commissioner Denise O'Donnell; its members included top State and City officials in mental health, substance use, criminal justice and adolescent services. The Panel's work was informed by a review of several cases in NYC involving individuals with serious mental illnesses who engaged in violent behavior and may have encountered law enforcement and the criminal justice system as well as a broader assessment of how New York's mental health and criminal justice systems respond to adults and adolescents with mental illnesses.

Panel members noted that the vast majority of those with mental illnesses are not violent, and that mental illness is not a major driver of violent crime. Panel members did, however, identify many ways in which the mental health treatment and justice systems could improve their ability to help adults and adolescents

with mental illnesses and reduce the risk of poor outcomes. The Panel's report included more than 20 recommendations that flowed from its analysis. Mayor Bloomberg and Governor Paterson accepted the recommendations in their entirety when the report was issued last June, and the City and State have moved forward since that time to implement each of the reforms. Appended to this testimony are a list of Panel members and the full list of the report's recommendations.

This morning I will discuss how the Panel was convened, the challenges that it identified, and key improvements that it put forward. Ms. Agnifilo will focus on the criminal justice findings and recommendations.

Panel Process

In the wake of several highly publicized violent incidents in New York City involving individuals with mental illnesses, Deputy Mayor Gibbs and Dennis Whalen, who was then the NYS Deputy Secretary for Health and Human Services, convened the Mental Health and Criminal Justice Panel in January 2008. The Panel's charge was to examine these cases, consider expert opinions, and recommend actions to improve services and promote public safety. The Panel brought together representatives from City and State agencies that, historically, were not at the same table looking at these complicated issues through a shared lens. Members included representatives from the Governor's and Mayor's offices, the City Department of Health and Mental Hygiene (DOHMH), the NYS Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), Office of Children and Family Services (OCFS), and the Division of Probation and Correctional Alternatives (DPCA).

In the months preceding the Panel's formation, both Mayor Bloomberg and Governor Spitzer had, separately, charged senior officials in their respective administrations with undertaking similar efforts. City and State officials decided

that they could develop and implement more effective approaches if they worked collaboratively.

In addition to reviewing several cases involving justice-involved adults with serious mental illnesses and adolescents with serious emotional disturbance or SED, Panel members conducted a broad assessment of the mental health and criminal and juvenile justice systems, and obtained input from national experts about the State of the art in mental health treatment, risk assessment and the intersection of mental health and criminal justice.

The Panel focused on opportunities to improve services for the subset of individuals with serious mental illnesses who are at risk of poor treatment outcomes, involvement with the justice system, and harm to themselves or others. This targeted emphasis is supported by data indicating that people with mental illnesses receiving appropriate care commit violent acts at a rate slightly below that of the general population and account for a very small proportion of serious crimes. The research also suggests, however, that violence among people with serious mental illness increases if they abuse alcohol or drugs, and that this risk is compounded if they fail to get treatment or receive inadequate care.

Panel Findings and Recommendations

Panel members identified four broad categories of challenges to providing effective mental health care and assisting those with serious mental illnesses who are involved in the justice system: 1) poor coordination, fragmented oversight and lack of accountability in the mental health treatment system; 2) inconsistencies in the quality of care within the mental health treatment system; 3) limited capacity to share information within and between the mental health and criminal and juvenile justice systems; and 4) insufficient training, supports and tools to identify and engage justice-involved individuals with mental illnesses. The report proposes specific measures to address these challenges.

I will elaborate on the first three of these challenges and the Panel's key recommendations with respect to mental health treatment and juveniles with SED; Ms. Agnifilo will discuss the recommendations related to the criminal justice system and adults with mental illnesses. Before we delve into these details, I want to point out that the Panel focused on areas where there was room for improvement in the mental health and criminal and juvenile justice systems; consequently its report does not detail the extent to which thousands of mental health, law enforcement, and justice professionals are dedicated to ensuring both public safety and the well-being of individuals with mental illnesses. The many strengths and successes of these professionals and the systems within which they operate must not be overlooked as we strive to make improvements.

Finding: Poor Coordination, Fragmented Oversight and Lack of Accountability in the Mental Health Treatment System

In the cases it examined, the Panel saw examples of fragmented care and a failure to respond to signs of inadequate care, deterioration in mental health, and increasing signs of potential violence. The same lack of coordination and accountability is evident in the care provided to adolescents with SED within the juvenile justice system, especially when youth transition in and out of the system. Care providers do not routinely communicate with one another and review each others' records, families are not consistently engaged in their children's care, and discharge plans do not always provide for consistent aftercare services that are essential for successful re-entry into the community.

The Panel also noted that individuals with co-occurring substance use disorders and mental illnesses lack access to and information about treatment, and too few providers offer coordinated, evidenced-based integrated care.

Key Recommendations

- **Establish Care Monitoring Teams for High-Need Adults and Create a Database to Track the Mental Health Care Provided to High-Need Adults**

OMH and DOHMH are jointly establishing Care Monitoring Teams (CMTs) in NYC that will be directly accountable for monitoring the care of high-need individuals and the programs that serve them, such as Assertive Community Treatment (ACT) and Intensive Case Management. CMTs will have access to a database of encounters—initially populated with existing data, including Medicaid claims—of high-need adults in the public mental health system. The database will enable CMTs to track care patterns so that they can identify and address interruptions in care or escalating need for services. This is an ambitious initiative that, when fully implemented, will put New York at the forefront of providing interventions for those with serious mental illnesses before an individual enters the hospital or the criminal justice system.

- **Implement Family Care Coordinators for Justice-Involved Youth**

Adolescents with SED in the juvenile justice system and their families may qualify for a Family Care Coordinator—an individual with first-hand experience with the children's mental health system—who will follow placement-bound youth through discharge. The Coordinator will help families navigate the juvenile justice, mental health and other service systems and facilitate information sharing among providers and families.

- **Improve OCFS Discharge Planning and Aftercare Services**

Discharge planning will begin within 30 days of admission to an OCFS facility and will engage the youth, their families, and community providers. To facilitate discharge planning and aftercare, adolescents will be assigned community service workers—individuals who provide aftercare services and follow-up—to collaborate with the Family Care Coordinators.

As youth are discharged from OCFS-provided services, referrals will be made (and confirmed) to community-based mental health services.

- **Enhance Clinical Interventions for Youth with SED in DJJ or OCFS**

DJJ has successfully implemented the Collaborative Family Initiative, which ensures that mental health services will be provided in a youth's community and will begin immediately upon release from detention. OCFS, in addition to offering more evidence-based treatments for youth with mental health needs, is conducting a three-year phase in of the Sanctuary model in its facilities, which provides a safe and therapeutic environment for youth and staff.

- **Implement Recommendations of the NYS OMH/OASAS Task Force on Co-Occurring Disorders**

OMH and OASAS are overseeing implementation of recommendations from a 2007 Task Force on Co-Occurring Disorders that was convened to make improvements in the care for individuals with co-occurring mental health and substance use treatment needs. The Panel supported the Task Force recommendations, which include the issuance of guidelines that call for screening for both mental health and substance use disorders in all clinics that treat these disorders, training for screening, and the use of and reimbursement for evidence-based treatments.

Finding: Inconsistencies in Quality of Care within the Mental Health Treatment System

In reviewing the cases, the Panel noted instances where explicitly stated standards of clinical care would have helped to guide outpatient mental health clinics and clinicians. Standards would address issues regarding caseloads and supervision, thorough psychiatric and substance use evaluations, assessment of a patient's degree of dangerousness to self or others, engagement of family

members, and appropriate responses when patients disengage from their treatment plans.

The Panel also noted that New York has no protocol for conducting system-level quality assurance reviews— with multiple City and State agencies and community providers—of critical incidents involving individuals with mental illnesses. Such reviews could identify failures in the provision of care and point to quality improvement steps that could be taken to mitigate future incidents.

With respect to Assisted Outpatient Treatment (AOT)—commonly referred to as “Kendra’s Law”—the Panel noted that access to and discharge from AOT is not sufficiently standardized or reviewed, and lapses in care can result when orders expire. The Panel did not, however, undertake a comprehensive analysis of the program because an independent research team is currently evaluating Kendra’s law and will issue a report next June.

Key Recommendations

- **Conduct Critical Incident Reviews**

The City and State are vigorously promoting legislation that authorizes OMH to conduct intensive case reviews, with the participation of relevant State and City officials, of critical incidents involving individuals with mental illnesses in order to reduce care errors and improve public safety. Pending passage of this legislation, OMH and DOHMH will continue to collaborate with each other on the review of critical incidents in compliance with existing law.

- **Issue and Monitor the Use of Standards of Care for Mental Health Clinics**

With the publication of the report, OMH issued standards of care that provide clear guidance on issues that include coordination with other

services such as case management, initial and ongoing risk assessment, changing treatment plans when an individual's mental health deteriorates or he or she is not engaged in care, supervision of care providers, and appropriate caseloads. These elements of quality care are more explicitly described for other mental health services but not for clinics, where most people receive care and where staff can intervene earlier in the course of treatment. OMH and DOHMH will incorporate these standards into their licensing and programmatic reviews.

- **Implement Systemic Improvements to Assisted Outpatient Treatment**
The Panel chose not to recommend statutory changes to AOT while the program is being evaluated, but it did recommend that DOHMH increase outreach to hospitals to improve the rate of appropriate AOT referrals, clarify AOT enrollment and renewal criteria, and establish an independent clinical review of decisions not to accept or renew AOT orders.

Finding: Limited Capacity to Share Information Within and Between the Mental Health and Criminal and Juvenile Justice Systems

Evidence suggests that information related to an individual's treatment often is not shared between care providers, leading to poor coordination and lack of continuity of care. Similarly, important treatment and educational records do not typically follow adolescents through the juvenile justice system and when youth transition into and out of that system. Important aspects of individuals' previous treatment as well as information from families can and should be transmitted between clinical programs treating the same individual to the fullest extent permitted by law. Yet consumers, providers, and families are often unsure about what can be appropriately disclosed to facilitate the provision of good care.

Key Recommendations

Ms. Agnifilo will discuss the bulk of the recommendations that flow from this finding as they relate to information sharing in the adult criminal justice system; I will highlight two that affect adults and youth with serious mental illnesses

Enable Information to Follow Adolescents through Transitions in the Juvenile Justice System

OCFS and the NYC Departments of Probation (DOP) and Juvenile Justice (DJJ) will establish policies to seek consent from parents to share otherwise confidential information—such as the results of mental health assessments—to determine how best to meet the needs of adolescents as they move through detention, placement, and aftercare. Procedures will be established by which all mental health caregivers for children will provide information, with appropriate consent, to DJJ clinicians about treatment needs of youth in their care, and City and State agencies will advance training for child mental health providers on these procedures.

Include Information Sharing Protocols in the Standards of Care

The clinic standards of care that I previously discussed include clear guidance for providers regarding appropriate and effective communication with other service providers, families and other caregivers.

Conclusion

The recommendations I outlined today, and those that Ms. Agnifilo will describe in a moment, can improve mental health services and criminal justice interactions for individuals with mental illnesses and enhance the safety of these individuals and the public. It is important to recognize, however, that there are no quick fixes or magic bullet solutions. Furthermore, even a perfect system would not be able to predict and prevent every violent incident involving a person with mental illness, just as we have not eliminated violence in the general population. And even with improved information sharing, there are substantial limitations to the

data that exists and that can be shared, including reporting lags, data quality issues, and confidentiality issues.

Having said that, the Panel is confident that the implementation of these ambitious but practical recommendations along with the ongoing collaboration between State and City officials and the involvement of the community, both public safety and the quality of care for individuals with mental illnesses can be improved.

Thank you again for this opportunity to testify. I look forward to working with you, Chairpersons Koppell, Vallone, and Gonzalez and your colleagues to promote the well being and safety of all New Yorkers.

Panel recommendations grouped by system

Adult mental health treatment system

- Establish Care Monitoring Teams to strengthen oversight of high-need adults and high-intensity providers
- Create database to track the mental health care of high-need adults
- Conduct reviews of critical incidents involving the care of individuals with mental illnesses
- Issue standards of care for mental health clinics serving adults
- Implement systemic improvements to AOT to improve outreach, standardize enrollment/renewal, and review decisions not to renew orders
- Implement measures to better identify and enhance care for individuals with co-occurring mental health and substance abuse disorders

Adolescent system of care

- Create Family Care Coordinators for justice-involved youth to assist families in navigating the mental health system
- Improve OCFS discharge planning and aftercare services
- Enable information to follow adolescents through transition points in the juvenile justice system
- Enhance clinical interventions for youth with SED in DJJ or OCFS custody

**Adult criminal
justice system**

- Pilot a program for sharing information, with individual consent, between the criminal justice and mental health treatment systems
- Increase information available to NYPD dispatch to allow for specialized responses for incidents involving individuals who may have a mental illness
- Monitor individuals determined to be not responsible for criminal conduct due to "mental disease or defect"
- Pilot a NYC alternative-to-detention program to allow eligible individuals to be supervised in the community while receiving treatment & services
- Create a dedicated mental health unit at the NYC DOP to assist eligible probationers in receiving appropriate mental health treatment services
- Include brief mental health screenings in pre-sentence investigations
- Pilot mental health screenings in the Bronx Criminal Court for individuals sentenced to community-based sanctions
- Expand new mental health courts and alternatives-to-incarceration programs providing court-monitored mental health treatment
- Train 911 call takers and dispatchers to better elicit information about whether an incident involves a person with mental illness
- Sponsor a Statewide Mental Health-Law Enforcement Summit to enhance relationships between police and mental health professionals
- Continue ongoing review of best practices to inform NYPD's training curriculum for dealing with incidents involving "emotionally disturbed persons"

APPENDIX A: Panel membership

Co-Chairs:

John Feinblatt, NYC Criminal Justice Coordinator
Linda I. Gibbs, NYC Deputy Mayor for Health & Human Services
Michael F. Hogan, Ph.D., Commissioner, NYS Office of Mental Health
Denise E. O'Donnell, Commissioner, NYS Division of Criminal Justice Services

Adolescent Workgroup Co-Chairs:

Gladys Carrión, Commissioner, NYS Office of Children and Family Services
Ronald Richter, NYC Family Services Coordinator

Panel and Workgroup Members:

Karen Friedman Agnifilo General Counsel, Office of NYC Criminal Justice Coordinator	Rima Cohen , Director of Health and Social Services, Office of the NYC Mayor
Nina Aledort Assistant Commissioner for Program Services, NYC Department of Juvenile Justice	Vaughn Crandall Special Assistant, NYC Department of Probation and NYC Department of Correction
Anita Appel, L.C.S.W. Director, NYC Field Office, NYS Office of Mental Health	Colonel James L. Harney Deputy Superintendent, New York Division of State Police
Joseph Baker Assistant Deputy Secretary for Health and Human Services, Office of the NYS Governor	Myla Harrison, M.D., M.P.H. Assistant Commissioner for Child and Adolescent Services, Division of Mental Hygiene, NYC Department of Health and Mental Hygiene
Scott Bloom Director of School Mental Health Services for Office of School Health, NYC Department of Health and Mental Hygiene	Mary Kavaney Deputy Commissioner and Special Counsel, NYS Division of Criminal Justice Services
Joyce Burrell Deputy Commissioner, NYS Office of Children and Family Services	Liwen Grace Lee, M.D. Medical Director, Bureau of Forensic Services, NYS Office of Mental Health
Chelsea Chaffee Legislative Counsel, Office of NYC Criminal Justice Coordinator	Robert Maccarone State Director of Probation and Correctional Alternatives, NYS Division of Probation and Correctional Alternatives
Meggan Christman Senior Advisor and Special Projects Director, Office of the Executive Deputy Commissioner for Mental Hygiene Services, NYC Department of Health and Mental Hygiene	Rochelle Macer Director of Mental Health, Policy and Planning in Office of Clinical Policy, NYC Administration for Children's Services

Tamiru Mammo
Advisor for Health Policy, Office of the NYC Mayor

Trish Marsik
Assistant Commissioner for Mental Health,
NYC Department of Health and Mental Hygiene

Frank McCorry, Ph.D.
Director NYC Field Office, NYS Office of Alcohol
and Substance Abuse Services

Richard Miraglia
Associate Commissioner, Division of Forensic Services,
NYS Office of Mental Health

Robert Myers
Ph.D., Senior Deputy Commissioner, Director of Division
of Adult Services, NYS Office of Mental Health

Pedro Perez
First Deputy Superintendent, NYS Police

Wendy Perlmutter
Deputy Family Services Coordinator,
Office of the NYC Mayor

David A. Rosin, M.D.
Executive Deputy Commissioner for Mental Hygiene
Services, NYC Department of Health and Mental Hygiene

Patrick Runnels, M.D.
Columbia Fellow in Public Psychiatry,
NYS Office of Mental Health

Lloyd I. Sederer, M.D.
Medical Director, NYS Office of Mental Health

Michael Seereiter
Program Director for Mental Hygiene Services,
Office of the NYS Governor

Lois Shapiro
Director, Bureau of Behavioral Health,
NYS Office of Children and Family Services

Thomas Smith, M.D.
Research Scientist, Division of Mental Health Services
and Policy Research, NYS Psychiatric Institute

Michele Sviridoff
Deputy Coordinator for Research and Policy,
Office of the NYC Criminal Justice Coordinator

Susan Thaler
Director of Children's Services, NYC Field Office,
NYS Office of Mental Health

Erika Tullberg
Assistant Commissioner for Office of Clinical Policy,
NYC Administration for Children's Services

Previn Warren
Advisor on Criminal Justice and Economic Opportunity,
Office of NYC Mayor

Linda Wernikoff
Executive Director, Office of Special Education Initiatives,
NYC Department of Education

Bernard Wilson
Manager of Shared Services Programs, NYS Division
of Probation and Correctional Alternatives

Testimony of
The Legal Aid Society

at a public hearing on

**The Report and Recommendations of the New York State/New York City
Mental Health Criminal Justice Panel**

Presented to:

**The New York City Council Committee on Public Safety and
the Committee on Mental Health, Mental Retardation, Alcoholism, Drug
Abuse and Disability Services**

Presented by:

Claudia Montoya

Attorney

Enhanced Defense-MICA (Mentally Ill-Chemically Addicted) Project

October 28, 2008

Introduction

Good morning. My name is Claudia Montoya, attorney for The Legal Aid Society's Enhanced Defense-MICA Project. The Legal Aid Society welcomes the opportunity to testify at this joint public hearing before the New York City Council Committee on Mental Health, Mental Retardation, Alcoholism, Drug Abuse and Disability Services and the Committee on Public Safety regarding Int. No. 799 which requires the New York City Police Department (NYPD) to create and maintain a database of information collected after police contacts with emotionally disturbed people.

Since 1876, The Legal Aid Society has provided free legal services to New York City residents who are unable to afford private counsel. Annually, through our criminal, civil and juvenile offices in all five boroughs, our staff handles about 295,000 cases and legal matters for poor families and individuals. The services we provide reflect the entire gamut of the needs of our clients, from immigration representation for the newest arrivals, to health care benefits for the oldest New Yorkers.

By contract with New York City, The Legal Aid Society serves as the primary defender of poor people prosecuted in the State court system, at both trial and appellate levels. Although newer public defender agencies have been created in New York City, the Society continues to serve as the primary defender and play the central defense role in the City's criminal justice system. The Society is involved in the planning or implementation of specialized court parts dealing with mental health, drug treatment, domestic violence and juvenile offenders. The Society has also sought to compel the State to fund more residential placements for persons with both a mental illness and a chemical addiction (MICA) and has been involved in seeking better

discharge planning for mentally ill inmates so that they have the medication, housing and counseling they need immediately upon release.

The Legal Aid Society employs nearly 50 forensic social workers in the Criminal Defense Practice. Within this large practice is our Enhanced Defense MICA Project, which is geared to break the cycle of arrest by fostering long-term psychiatric and substance abuse treatment among New Yorkers charged with crimes who are dually-diagnosed with serious mental illness and substance abuse/dependence issues. The Society's project teams attorneys and licensed social workers who are experienced in working with clients who have both mental illness and addiction. In addition to providing basic criminal defense legal services, project teams will link clients with other governmental agencies, community-based treatment providers and advocacy groups, and provide case management services to ensure that clients remain in treatment. Additionally, project staff provides training and consultation to other attorneys and criminal justice professionals and also spearheads advocacy for systematic reforms in New York City.

Since the Project's inception in 2002, we have screened over 1200 defendants. Almost 600 have successfully completed the prescribed monitoring period. A recent review of recidivism among our client caseload showed a 50% reduction in re-arrests. In the past year alone the staff consulted on an additional 1200 cases. We dedicate our efforts to improving the quality of services available to our clients in order that their chances of a return to the criminal justice system can be minimized. Whether measured by the volume of cases handled and or the expertise and support provided to each and every client the Society's dedication to constituents living with mental illness is unmatched in the criminal justice field.

Int. No. 799

Int. No. 799, requiring the police department to create and maintain a database of information collected after police contact with emotionally disturbed people (as defined in the New York City Patrol Guide), needs revisions in certain respects that we have detailed below in this testimony in order to protect constituents who may be emotionally disturbed. We agree that there is a need for comprehensive changes to current EDP procedures and policies. However, the proposed legislation should be revised to address the complex issues impacting police responses to EDP calls. First and foremost, the proposed legislation should require best practices in the police department's training and responses to EDP calls. Further, revisions are needed to make sure that the required database provides the police with the most relevant and timely information needed to effectively manage each and every EDP call. The current version of the legislation may both violate the confidentiality rights of constituents who would be included in it and potentially misidentify EDPs as a person with mental illness.

Concerns and Recommendations

This proposed legislation seeks to create and maintain a NYPD database of any individual perceived by the police to be a person with mental illness who is conducting him or herself in a manner likely to result in serious injury to self and others. If enacted, this database would allow the NYPD to track, at a minimum, the "names, addresses and nature of the incident" for all EDPs transported to a local hospital. The proposal raises serious concerns for following reasons:

- Police responses to EDP calls are all unique in terms of the nature of the crisis, the current

presenting behaviors of the EDP and other important facts such as the presence of weapons, hostages, suicidality etc. This vital information is unique to the specific 911 call.

Consequently, the proposed database would not provide responding police with the most timely and relevant information related to the 911 call. For example, information collected on John Doe two years ago might be completely irrelevant to the present call. It is well established that persons with mental illness can experience different symptoms and present varying behaviors at different times. Using dated and possibly misleading information about prior EDP responses could jeopardize the safety of all involved. A more effective way to inform police responding to EDP calls should focus on collecting the most relevant information during the current 911 call. This would require training 911 dispatchers to better elicit crucial information from the 911 caller. Implementation of such a training protocol is one of the recommendations made by the New York State/New York City Criminal Justice Panel in June 2008 (“Panel” hereafter).

- The legislation should also be revised to address the inadequate training provided to police officers responding to EPD situations. Far too many EDP calls result in the subject of the EDP call being arrested or injured. Likewise, too often police officers are injured during the intervention. Police responding to these EDP calls are not adequately trained in understanding mental illness, substance abuse, and trauma, nor do they have the skills to most effectively engage this population and de-escalate highly volatile situations. The Panel recommended a review of NYPD training to reflect “best practices,” and the legislation should be amended to address this police training issue. We recommend that the New York City Police Department be required to create Crisis Intervention Teams (CIT) to improve police encounters with persons with mental illness. The nationally recognized CIT model
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provides police officers with extensive training on mental health issues and crisis intervention techniques and teams police officers with mental health professionals who together respond to EDP calls. The CIT programs are closely linked with the community mental health system which provides resources for resolving EDP calls in an effective and humane manner. This model has been adopted in thirty-five states. The outcome studies indicate that CIT programs are successful in reducing arrests and re-arrests, increasing referrals and participation in mental health treatment, reducing officers injuries, reducing involvement of SWAT teams, and decreasing police shootings of individuals with mental illness.

- The proposed legislation should also be amended to take into account the reality that many EDP calls are generated in situations involving persons who have no mental illness. For example, a person under the influence of mind altering substances, one suffering from a medical crisis (seizure or reaction to a medication), or someone who experienced a significant trauma or loss of a loved one might all be the subject of an EDP and require transport to a local hospital. These EDP subjects have no mental illness and should not be subject to database monitoring, particularly in light of the possible stigmatization of persons listed in the database (non-mentally-ill and mentally –ill).
 - The current language in the legislation is overly broad and does not specifically instruct the NYPD and DOH-MH what information other than “name, address and nature of the incident” should be collected and entered into a database. Any “pertinent information” collected for the a database cannot violate the EDPs right to privacy and confidentiality. The Panel concluded that even with improved information sharing, confidentiality concerns impose a substantial limitation on the data that can be shared. For this reason the Panel’s
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recommendations did not include the use of individual names or their addresses or any other information specific to that person with mental illness. To the contrary, the Panel report recommends a database that flags for “locations” rather than people. Accordingly, we recommend that the database include locations of prior EDP calls and supportive housing for the mentally-ill. The proposed legislation should be amended to reflect the Panel’s recommendations.

- The legislation requiring the creation of an EDP database should be amended to include a due process mechanism by which an identified subject can challenge their inclusion. Other groups tracked by databases, such as sex offenders or those convicted of weapon possession, have due process protections to challenge mistakes. We believe the involuntary inclusions of EDPs have a right to the same protections.

Conclusion

The Legal Aid Society has a long history of defending the rights of New York City’s most vulnerable groups, including those in crisis. We have noted several significant aspects of the pending legislation that require revisions. We stand ready to work with the Council to effectuate these revisions. Thank you for this opportunity to testify. If you have any questions you can contact me at (718) 579-3117 or John Volpe, the Director of our MICA Project at (212) 577-3340.

Testimony of Dr. Gerald Landsberg, Professor/Director of the Initiative Against Violence;
Silver School of Social Work and New York University
October 28, 2008

Dear Councilpersons:

I welcome the opportunity to speak to you today not only on Int No. 799- with respect to the police creating and maintaining a database of information collected after the police contacts with emotionally disturbed people but also on the present systems of treatment/intervention with emotional disturbed persons in New York City and New York State and their interactions with the criminal justice system. Prior to my comments, I'd like to briefly highlight my experience in working with and researching this topic. This has been an area of interest for me for over 25 years. In this time I have (a) from 1984 to 1986 worked with the NYS Office of Mental and the NYS Commission of Correction to assist in the development and implementation of the Jail Suicide Prevention Model and (b) from 1987 to 1991. When I served as an Assistant Commissioner for the NYC Department of Mental Health one of my responsibilities was the development and oversight of mental health services for the criminally involved emotionally disturbed persons. Since joining the faculty at NYU and establishing the Initiative against Violence, I have continued my work in the area of forensic mental health. These activities have included: (a) serving as the principal Investigator of the New York City site of a SAMSHA funded 9 site examination of Alternatives to Incarceration Programs. (Among the results from this research was the alternatives to incarceration can be effective, especially, if treatment is mandated; use of A.T.I. programs can result in major cost savings i.e.; placing the emotionally disturbed individuals in treating and residential care cost approximately \$35,000 annually compared to the \$100,000 cost of incarcerating someone at Rikers Island and that arraignment courts are

an excellent place to screen and begin preadmission placement of the mentally ill) (N. Brenner's article, cites #23 in the joint committee report). (b) serving as the Principal Investigator of a Federal Department of Justice, Victims of Crime project that focused on Victims of Mentally Ill Offenders () and (c) from 2002-2004 serving as the Project Director of the New York City Community Trust funded project that examined systems of care for emotionally disturbed persons in NYC. Involved with, or at Risk of Involvement with the Criminal Justice System. That project, focused on adults, involved input from over 250 representatives of criminal justice organizations mental health treatment and advocacy organizations and consumers. (The summary report from that project issued in January 2004 is an attachment to this testimony). I have written and presented extensively on the subject.

Before commenting on the proposed creation of a police database or on the NYS/NY City Mental Health /Criminal Justice Panel report, let me say that unfortunately neither NY State nor NY City has played a national leadership role in addressing this topic. Other states and localities have created models that in fact have provided direction to the mental health criminal justice systems. Let me now direct my comments first to the proposed police data based and then to the panel's overall report. Is the data base a good idea? My answer is yes, however, much depends about what is done about reviewing the data and being able to obstruct use of the program information. There are possible downsides; by focusing initially on the police/ mentally ill person interactions has several potential negative aspects. The need to drastically reform the overall system is crucial. In my research, the general impression is the NYC Police overall do a good job in handling EDP emergencies. Can their training be improved and updated and made continuous? The answer is yes. Should the NYC Police

experiment with other models- i.e., specially trained local precinct teams, i.e.- the Memphis model, teams of police and mental health professionals as first responders (Birmingham, Alabama, Rochester, New York) and reducing the number of hospitals emergency rooms that police bring EDP clients to and then by reducing waiting times in emergency rooms. With respect to the Mental Health/Criminal Justice Panel recommendations, I would like to indicate that many of those are contained in the 2004 Report. What happened in the last four and a half years that the recommendations were not followed? Further, the Panel's report lacks timetables and doesn't establish parameters for action. Who is going to ensure that these actions occur and occur in a timely fashion? The mentally ill need an expedited response otherwise the major problems will continue and unnecessary costs not aimed at treatment accumulate.

Testimony of Dr. Gerald Landsberg, Professor/Director of the Initiative Against Violence;
Silver School of Social Work and New York University
October 28, 2008

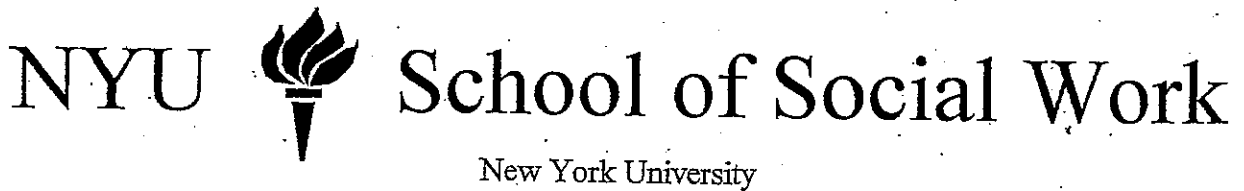
Dear Councilpersons:

I welcome the opportunity to speak to you today not only on Int No. 799- with respect to the police creating and maintaining a database of information collected after the police contacts with emotionally disturbed people but also on the state of present systems of mental health and criminal justice system interventions with emotional disturbed persons in New York City and New York State. Prior to my comments, I'd like to briefly highlight my experience on this topic. Forensic mental health has been an area of interest for me for over 25 years. In this time I have (a) from 1984 to 1986 worked with the NYS Office of Mental Health and the NYS Commission of Correction to assist in the development and implementation of the Jail Suicide Prevention Model and (b) from 1987 to 1991, when I served as an Assistant Commissioner for the NYC Department of Mental Health one of my responsibilities was the development and oversight of mental health services for the criminally involved emotionally disturbed persons. Since joining the faculty at NYU and establishing the Initiative against Violence, I have continued my work in the area of forensic mental health. These activities have included: (a) serving as the principal Investigator of the New York City site of a SAMSHA funded 9 site examination of Alternatives to Incarceration Programs. (Among the results from this research was the alternatives to incarceration can be effective, especially, if treatment is mandated; use of A.T.I. programs can result in major cost savings i.e.; placing the emotionally disturbed individuals in treating and residential care costs approximately \$35,000 annually compared to the \$100,000 cost of incarcerating someone at Rikers Island and that arraignment courts are an excellent place to screen and

begin pre-dention placement of the mentally ill) (N. Brenner's article, cites #23 in the joint committee report). (b) serving as the Principal Investigator of a Federal Department of Justice, Victims of Crime project that focused on Victims of Mentally Ill Offenders (2002-2002) and (c) from 2002-2004 serving as the Project Director of the New York City Community Trust funded project that examined systems of care for emotionally disturbed persons in NYC. Involved with, or at Risk of Involvement with the Criminal Justice System. That project which focused on adults involved input from over 250 representatives of criminal justice organizations mental health treatment and advocacy organizations and consumers. (The summary report from that project issued in January 2004 is an attachment to this testimony). I have written and presented extensively on the subject.

Before commenting on the proposed creation of a police database or on the NYS/NY City Mental Health /Criminal Justice Panel report, let me say that unfortunately neither New York State nor New York City has played a national leadership role in addressing this topic. Other states and localities have created models that in fact have provided direction to the mental health/criminal justice systems across the country. Let me now direct my comments first to the proposed police data based and then to the panel's overall report. Is the data base a good idea? My answer is yes, however, much depends about what is done about reviewing the data and being able to abstract and information for program development. There are possible downsides; by focusing initially on the police/ mentally ill person interactions has several potential negative aspects including the need crucial and immediate need to drastically reform the overall system. In my research, the general impression is the NYC

Police overall do a good job in handling EDP emergencies. Can their training be improved and updated and made continuous? The answer is yes. Should the NYC Police experiment with other models- i.e., specially trained local precinct teams, i.e.- the Memphis model, teams of police and mental health professionals as first responders (Birmingham, Alabama, Rochester, New York) and reducing the number of hospitals emergency rooms that police bring EDP clients to and thereby reducing police waiting times in emergency rooms. With respect to the Mental Health/Criminal Justice Panel recommendations, I would like to indicate that many of those are contained in the 2004 Report prepared by NYU for the New York City Community Trust. What happened in the last four and a half years that the recommendations were not followed? Further, the Panel's report, although useful, lacks timetables and doesn't establish parameters for action. What are the priorities for action? Where are the funds coming from? Who is going to ensure that these actions occur and occur in a timely fashion? The mentally ill need an expedited response otherwise the major problems will continue and their plight is largely unaddressed. Further, the city will continue to spend funds on incarceration when more effective uses of shrinking dollars can possible.



**CHANGING SYSTEMS OF CARE FOR EMOTIONALLY DISTURBED PERSONS IN NYC,
INVOLVED WITH, OR AT RISK OF INVOLVEMENT WITH THE
CRIMINAL JUSTICE SYSTEM
RECOMMENDATIONS FOR ACTION**

EXECUTIVE SUMMARY – JANUARY 2004

Project Director: Dr. Gerald Landsberg*
Project Coordinator: Henrietta L. Shannon, CSW

This Executive Summary highlights the recommendations which emerged from the Forensic Mental Health Planning and Advocacy Project (July 2001-June 2003) implemented by the Institute Against Violence of the Ehrenkranz School of Social Work of New York University. The project was funded by the New York Community Trust

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For full copies of the report go to NYU School of Social Work's website at:
www.nyu.edu/socialwork

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INTRODUCTION:

"The criminalization of mental illness" is the phrase most frequently used to describe the growing number of individuals with mental illness who are being incarcerated in US jails and prisons. According to the Bazelon Center for Mental Health Law (2003b), at the end of the year 2000 nearly one million individuals with mental illness were involved with some aspect of the criminal justice system. Sixteen percent of local jail inmates, 16.2% of state prison inmates and 7.9% of federal prison inmates were individuals diagnosed with mental illness, and 614,000 individuals with mental illness were on probation or parole. In NYC and NY State the statistics reflect the national trend. According to Heather Barr of the Urban Justice Center (1999:3), on any given day New York houses 7,680 people with mental illness in its jails and prisons. Rikers Island, with an average daily population of 2,500 mentally ill inmates could be considered the largest psychiatric facility in the state. It is further estimated that of the 90,000 plus inmates/detainees passing through Rikers Island each year, a minimum of 15% have significant mental health problems.

Incarcerating large numbers of individuals with mental illness who have committed low level offenses is a costly practice that has few benefits for society and the incarcerated individuals and does not appear to act as a deterrent to crime or assure that further crimes are not committed. For individuals with mental disorders, incarceration is a trauma that may further exacerbate their illness. Treatment services in jails and prisons are often inadequate. Mentally ill individuals become easy targets for other inmates and are often victims of violence while incarcerated. Further, while incarcerated, these individuals become disconnected from any treatment or services that they may have been receiving in the community and isolated from their family and friends. Their disability benefits are cut off, and they will most likely lose their housing (Barr, 1999:26-33). It is not surprising that, after "serving their time" many of these individuals return to their communities, traumatized, extraordinarily disadvantaged, and in a precarious psychological state that greatly increases the likelihood of re-arrest. Recidivism rates for individuals diagnosed with mental illness can reach over 70% in some jurisdictions (Council of State Governments, 2002) and the 1998 Bureau of Justice nationwide survey of prison inmates found that 52% of inmates with mental illness had three or more prior sentences (Moras, 2001).

The large number of persons with mental illness who are caught up in the cycle of arrest and re-arrest also places an enormous strain on an already taxed criminal justice system (Council of State Governments, 2002). The costs associated with the criminalization of mental illness are extraordinarily high. The cost of incarceration may readily exceed \$50,000 - \$60,000 per year. In locations like New York City, the cost may actually be higher. These costs include those associated with incarceration in jail or prison and the time involved in criminal justice system e.g., processing, police work, court expenses, prosecutor's time, probation and other related costs.

In NYC, as across the United States, much progress has been made addressing the plethora of problems associated with the increasing numbers of individuals with mental illness in jails and prisons. The past decade has seen development and implementation of innovative programs designed to divert mentally ill offenders *from* correctional custody, *to* community-based and residential treatment programs and to ensure the continuity of care for incarcerated mentally ill offenders upon their release. These programs have drawn support at the federal, state and local levels. In NYC, programs which divert mentally ill offenders from the criminal justice system, such as the LINK Program, the Nathaniel Project and The Brooklyn Mental Health Court, have been implemented.

However, despite the implementation of these noteworthy projects, much remains to be done in New York City. The program initiatives that have been implemented thus far have been, for the most part, very narrow in their scope, targeting only a few pieces of an incredibly complex problem (e.g., improved jail discharge planning, diversion through mental health court programs, diversion through the establishment of police/mental health crisis teams). What has been missing from these efforts is the development of a broad conceptual framework that identifies and establishes: (1) the needed range of mental health, substance abuse and criminal justice interventions for mentally ill offenders both inside and outside of the criminal justice system, and (2) the systems and policies necessary to ensure proper linkage and accountability among these services. Without this framework and implementation of key recommendations for change, any efforts intended to address the problems associated with the criminalization of mental illness in NYC will fall far short of their mark.

To this end, the New York Community Trust funded the Institute Against Violence of the NYU School of Social Work to conduct a Forensic Mental Health Planning and Advocacy Project (July 2001-June 2003). The project was an outgrowth of earlier systems change activities conducted by the Institute through SAMSHA Jail Diversion Research Funding. In the two years of the project input was provided by over 300 stakeholders representing government and non-profit agencies, advocates and consumers from criminal justice, mental health, substance abuse and other systems. In this executive summary we provide the reader with the conceptual roadmap developed by this project, and with the highlights of systems and service area recommendations.

CONCEPTUAL ROADMAP:

In the initial meetings of the Task Groups, as project staff and Task Group members began to explore questions and concerns related to specific program initiatives and broader policy and systems issues regarding the criminalization of mental illness, we discovered that to effectively address this extraordinarily complex issue we would have to first answer some more substantial questions -- *who are the individuals we are attempting to serve; what do we consider*

diversion; and, in addressing the issue of the criminalization of mental illness, what are we attempting to achieve? As more and more questions arose we soon realized that we would need to develop conceptual bases for pursuing a systems change, which would assist us in addressing this issue in its complexity, and across the diverse systems involved. This led the project staff to begin working on the development of a broad conceptual framework or what we have since defined as a *Conceptual Roadmap* (see Exhibit 1).

The *Roadmap* presents, in clear and simplified terms, a basic framework for addressing the issue of mental illness in localities. The creation of this framework facilitated the analysis of the strengths and weaknesses of the current systems, programs and services in New York City, and the obstacles to change and also assisted both staff and Task Group members in developing effective proposals for change. In this sense, the *Roadmap* became the basis for many of the policy recommendations laid out in this paper. As an accompaniment to Exhibit 1, the following section will explain and present, in narrative form, the logic of and the basic information contained within the *Roadmap*.

The *Roadmap* identifies six critical intervention points: prevention; pre-booking diversion or police response to incidents in the community; post-booking diversion or court-system actions; probation and parole; early discharge and discharge planning from jails and prisons; and, community treatment and housing services post-incarceration. For each point of intervention, the *Roadmap* defines the client population served; the goals or objectives of interventions at this point; the actions which facilitate achieving the proposed goals and objectives; and the agencies which facilitate both the implementation of services and the development of policy. In this sense the *Roadmap* provides a clear overview of the recommendations developed through this project.

It should be noted that the intervention points presented in the *Roadmap* are not discreet entities but rather are intimately interrelated. For example any actions taken with regards to Post-booking Diversion, Discharge Planning from jails and prisons and Probation and Parole are dependent upon the implementation of the actions presented in Community Treatment and Preventive Services. In this sense the development of new and/or the expansion of existing Community Treatment and Preventive Services is the foundation of successfully diverting mentally ill or dually diagnosed individuals from the criminal justice system and reducing the rates of recidivism of these same individuals.

Some of the more overarching recommendations, as reflected in the *Roadmap* are: the need to develop and implement *communication, planning and service coordination* mechanisms between and within the diverse systems involved in this issue; the need to *implement cross-training* of mental health and criminal justice professionals; the need to develop and implement effective *screening and assessment* tools in police precincts, jails, prisons and the courts so as to more quickly identify mentally ill and/or dually diagnosed individuals; and, perhaps most

importantly, the need to *ensure access to appropriate housing, treatment and psychosocial rehabilitation services*. This last point is pivotal, at any point of intervention, to reaching the goals set forth and effectively addressing the issue of the criminalization of mental illness.

Although there are *some* differences in the goals of the actions at each point of intervention, there are some commonalities to all levels of intervention. Thus it is possible to outline a number of common goals for any intervention designed to address the criminalization of mental illness. These goals are: decrease the numbers of mentally ill or dually-diagnosed adults in the criminal justice system; increase psychiatric stabilization and crime-free community tenure of these same individuals; decrease the rates of recidivism of these same individuals; and, as a result of achieving the above mentioned goals, there will be an increase public safety. The following sections present general recommendations which if implemented will assist in reaching the above-mentioned goals.

(A) RECOMMENDATIONS: SYSTEMS RECOMMENDATIONS

There are five recommendations which, due to their nature and importance, we have designated as systems recommendations. Each of these recommendations calls for profound changes within larger, existing systems or the establishment of new systems and the implementation of these recommendations is pivotal to and will greatly facilitate the implementation of the more specific recommendations presented in the later part of this paper. The five proposed systems recommendations are: establishment of a permanent, high level planning and coordination group; development of a designated forensic mental health funding stream; improvement of the system of community care; development of an integrated mental health and substance abuse service system; and, the expansion of appropriate housing for mentally ill and dually diagnosed individuals. The first two of these recommendations are facilitating factors in the implementation of the last three. Further, the integration of the mental health and substance abuse system and the expansion of appropriate housing will contribute to the improvement of the system of community care.

1. Establish a High Level Planning and Coordination Group

To effectively address an issue as complex and far-reaching as the present demands a permanent, formal, high level governmental agency to plan and coordinate service developments in this area. We are recommending that the Mayor's Office of Criminal Justice, because of its position as a high level agency with the ability to do work with governmental and non-governmental agencies, take on the role of developing and implementing this Planning Group. Some of the primary tasks of this group will be: (a) develop and implement a five-year plan with defined goals and to monitor progress that has occurred in meeting those goals; (b) establish a permanent research and evaluation task force to assess and evaluate program and policy changes; (c) develop detailed program and resource inventories; (d) facilitate regular meetings between

key stakeholders to promote coordination of services and programs and promote permanent dialogue; (e) facilitate an ongoing discussion and regarding information sharing strategies - e.g., creating a coordinated management information system; (f) to foster the establishment of continuing education programs in an effort to provide effective cross-training to professionals in the fields of Mental Health, Substance Abuse and Criminal Justice.

2. Advocate for a Designated Forensic Mental Health Funding Source

It is strongly suggested that NYC, working with the New York State Conference of Local Mental Hygiene Directors and the New York State Association of Counties advocate for NYS to adopt the establishment of a specialized forensic mental health funding stream as a legislative priority. Discussions with representatives from the states with these designated funding streams have indicated that they are an invaluable resource for developing and implementing innovative programs and evidence-based practices.

3. Improve the Existing System of Community Care for the Mentally Ill and Dually Diagnosed

Across the country, community care for the mentally ill and the dually diagnosed is extremely deficient. Although there have been recent improvements in community care in NYC (e.g., increased implementation of evidence-based practices such as Assertive Community Treatment) the deficiencies are still quite marked. There continues to be a shortage of appropriate treatment programs and services; a lack of specialized forensic services and integrated MICA (mentally ill chemically abusing) services; a lack of coordination between service agencies both in the provision of direct services and follow-up; a shortage of resources to develop and implement needed programs and services; an under-serving of selected populations such as minorities; deficiencies in training of mental health professionals regarding the needs of the forensic population and interventions tailored for this same group; and, a dire shortage of housing resources.

These shortfalls have a major impact on the provision of services to the mentally ill involved in the criminal justice system. Diversion from jail only works if needed community resources, treatment and housing are available. Effective reintegration on discharge from jails or a prison only works if effective community services exist. Advocates have often suggested that the lack of effective community services promotes the use of the criminal justice system as an option to provide treatment and services to the mentally ill and dually diagnosed. In this sense continued evaluation of the current systems of community care in New York City and subsequent development and implementation of needed programs and services should be seen as a priority.

4. Create an Integrated Mental Health/Substance Abuse Service System

With the overwhelming majority of persons with mental illness who become involved in the Criminal Justice System having a co-occurring substance abuse disorder, developing a system which integrates mental health and substance abuse services is essential to providing

effective and appropriated treatment to these same individuals. Research from across the United States over the past decade has demonstrated the crucial need for integrated treatment. In New York City, as a result of decisions made nearly three decades ago, substance abuse remains outside the supervisory responsibility of the Department of Public Health and Mental Hygiene. This deficit needs to be corrected.

An integrated service model, as fully conceptualized involves linking multiple systems – mental health, substance abuse, criminal justice and social service. Further, an integrated system, based upon models developed across the county, should include coordinated planning (with regard to both program and service development, implementation and funding) and the sharing of clients and information.

The Mayor's Office of Criminal Justice in NYC together with the local mental health and key state agencies needs to develop a comprehensive plan for the integration of mental health and substance abuse services. Note that, in all other counties in NY State, the county supervises both mental health and substance abuse services and thus coordinates both systems of service. Detailed reports from model program from across the country, reviews provided by the GAINS Center and research emerging from SAMSHA sponsored research, strongly support an integrated treatment model.

5. Housing

The importance of providing adequate housing resources and options for all of the mentally ill and especially those involved with the Criminal Justice System, is paramount to recovery, rehabilitation and successful integration into community life. This is demonstrated in the studies which present a strong correlation between criminalization and homelessness. In NYC there is a continuing shortage of needed housing, especially for individuals who have both a history of involvement with the Criminal Justice System and a diagnosed mental illness or dual diagnosis. The expansion of appropriate housing resources must be considered a priority in meeting the needs of the forensic population. Achieving this goal will necessarily involve not only NYC agencies but also state agencies and funders as well.

(B) RECOMMENDATIONS BY SERVICE AREA

1. Preventive Services for At-Risk Populations

Preventive services (as outlined in the Roadmap) actually consist of two components. The first component consists of readily available high quality outpatient mental health, case management and emergency services for clients with a history of involvement with the Criminal Justice System and with a high likelihood of recidivism; and for clients who have no history of involvement with the Criminal Justice System, but with characteristics or circumstances (homelessness, unemployment, noncompliance with treatment, not engaged with treatment, dual diagnosis) that place them at risk of involvement with the Criminal Justice System. The second

component of preventive services consists of specialized community-based social services that will provide intensive interventions to keep clients from involvement with the Criminal Justice System.

Evidence-based treatment practices and programs targeting the forensic population, (such as ACT Teams and the Rochester LINK project) exist, but they are rare and very limited in scope. Development of, or in some cases the expansion of these types of programs is under review in NYC, but priority needs to be given to create more of these programs including the Rochester Link program model.

2. Pre-booking Diversion Services

Pre-booking diversion refers to programs or initiatives implemented before an individual has been arrested or formal charges have been filed, and they consist of systematic efforts on the part of police officers to transport an individual to an appropriate psychiatric facility for evaluation or treatment as an alternative to filing formal charges (Broner et al: 2002). In New York City the systems and agencies involved in mental health emergency and or crisis services are as follows: the New York City Police Department, Psychiatric Emergency Rooms, Comprehensive Psychiatric Evaluation Programs or CPEPs (which are embedded in selected emergency rooms across the city), Mobile Crisis Teams and Lifenet.

Project staff and Task Group members identified many important options to improve the quality and effectiveness of pre-booking diversion programs and initiatives in NYC. Some of the more important recommendations are as follows:

(a) promote improved linkages between the police and mental health services; (b) expand the role of the Comprehensive Psychiatric Evaluation Programs and Mobile Crisis Teams in managing psychiatric crisis; (c) broaden the response capability of Mobile Crisis Teams by expanding their hours of coverage, thus transforming them into another diversion option for Police Officers; (d) improve and expand training for police and mental health workers in the area of psychiatric crisis and emergency response, with an emphasis on cross-training (which also serves to strengthen relationships between Police and Mental Health professionals); (e) streamline psychiatric emergency room procedures to facilitate a reduction in police waiting time and/or establish one psychiatric emergency room, endowed with additional resources, in each borough that would become a designated drop-off center for police; (f) develop pre-booking diversion programs to be implemented as pilot projects and later evaluated with regard to their efficiency, efficacy and effectiveness. These initiatives could then be useful in determining further changes in this area.

3. Post-booking Diversion Services

Post-booking diversion services have an important role; however, there is a need for intense discussion as there are a number of crucial debates which still need resolution. Do post-booking diversion programs, e.g., mental health courts serve to widen and not reduce the

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criminal justice system net? What are the best use of financial and human resources? What are the needs for each borough with regard to post-booking diversion services? With this said there is a strong need to review the current directions in this area and to develop a comprehensive plan for future actions. This, it is strongly recommended that a permanent committee be established, as part of the high level planning group recommended above, to research, evaluate and discuss the myriad of post-booking diversion options. This group should consist of judges, prosecutors, public defenders, consumer and family advocacy groups, among others.

4. Probation and Parole Services

With respect to improving services by Probation and Parole to the population three key recommendations emerged. (a) Probation/parole need to establish or expand specialized forensic mental health units to serve the most difficult to reach individuals in the population. The are current models which exist, including a program in New York City operated by New York State Parole. (b) Probation/parole need to establish and expand relationships with mental health and substance abuse providers to serve this population. (c) Probation/parole need to be involved in the ongoing planning for services/interventions for the population.

5. Early Discharge and Discharge Planning from Jails and Prisons

As the Brad H. lawsuit was still under investigation throughout the duration of this project task Group members chose not to discuss jail/prisons mental health services or the specifics of jail/prison discharge planning. However, there were general discussions on the importance of effective discharge planning and follow-up to insure individuals are connected to community services, housing and benefits. Lack of effective discharge planning was identified as reducing the probability of successful community integration and enhancing the probability of reentry into the criminal justice system.

With the settlement of the Brad H. lawsuit it is hoped that the quality of discharge planning and follow-up responses will improve. Although it is too early to see the impact of the Brad H. settlement, it should be noted that there are limitations anticipated with respect to the settlement. These are related to the narrowness of the class of covered individuals, the continued lack of housing and the ever-present deficiencies in community care.

6. Community Treatment and Housing Services (Post-Incarceration)

In the system recommendations this issue was discussed and the existing problems and the advocacy points were highlighted.

CONCLUSION:

Over the past decade, the issue of serving the mentally ill involved in the criminal justice system has received increased attention from key New York City agencies. We have witnessed the development of selected new alternative programs, e.g. ACT, Brooklyn Mental Health Court, The Link Program and Case Management Services. We have also witnessed the settlement of the Brad H Lawsuit. This progress is to be commended. However, the problems in New York City related to the mentally ill involved in the Criminal Justice System remain significant and the advances to date only serve a small fraction of those in need. In this report, we outlined major system recommendations as well as new initiatives in selected service areas.

A question that may now be posed is how in this tighter fiscal climate can we afford these changes? In response to this question it is suggested that: (a) Some of the changes recommended throughout this report do not cost money but rather offer ways for more coordinated and integrated services. The recommendations for the establishment of a high level Forensic Mental Health Planning and Coordinating Committee to function under the Mayor's Office of Criminal Justice would have a relatively low cost and serve to link varied city and contract agencies in a more productive (time and cost-saving) manner; (b) Our suggestions for service changes, (e.g. new police approaches to interventions in EDP cases, enhanced housing, and increased ACT programs), should result in long-term cost reduction and the improvement of systems of care by reducing the numbers of the mentally ill and dually diagnosed in the criminal justice system. The research conducted by Research Triangle Institute on the NYC Jail Diversion programs and by others strongly suggests that diversion can be "less costly" than incarceration;

While the City strives to implement changes at the local level it is important that the need for parallel changes at the State level not be neglected. It is thus recommended that the High-Level Planning Group develop an advocacy committee which would work to implement these changes. As mentioned in the report, one key issue at the State level is the adoption of legislation which establishes specialized funding for a forensic mental health program. Of equal importance is increased funding for housing especially designated for mentally ill and dually diagnosed individuals involved with or with a history of involvement with the Criminal Justice System.

Finally, increased work needs to be done by the City with contracted mental health and substance abuse agencies to better serve this population and reduce the dependence on the criminal justice system as a treatment option.

It is hoped that this report and its dissemination and resulting discussions will serve as an impetus for continued progress in this area. A continuing high level dialogue is seen as the crucial next step in effectively addressing the issue of the criminalization of mental illness.

A ROADMAP OF INTERVENTIONS FOR ADULTS WITH MENTAL ILLNESS INVOLVED WITH OR AT RISK OF INVOLVEMENT WITH THE CRIMINAL JUSTICE SYSTEM

PREVENTIVE	PRE-BOOKING DIVERSION	POST-BOOKING DIVERSION
<p>CLIENT POPULATION</p> <ul style="list-style-type: none"> ✓ Clients at risk of becoming involved with the Criminal Justice System (CJS) due to previous involvement with the CJS or due to other risk factors – e.g. homeless, unemployed, non-compliant with treatment, psychiatric crisis, etc. <p>GOALS</p> <ul style="list-style-type: none"> ✓ Reduce involvement with CJS; enhance client functioning; increase psychiatric stabilization and crime-free community tenure. <p>ACTIONS</p> <ul style="list-style-type: none"> ✓ Provide access to benefits, appropriate treatment and rehabilitation services (with an emphasis on evidenced-based practices), and to stable, safe and appropriate housing. ✓ Provide intensive mental health training to mental health professionals. <p>INTERVENTION AGENCIES</p> <ul style="list-style-type: none"> ✓ Community Mental Health & Substance Abuse Agencies; Mental Crisis Teams, Psychiatric ERs & OPEPs, Assisted Outpatient Treatment Teams, Housing Providers, Consumer & Family Advocacy Agencies. <p>POLICY AGENCIES</p> <ul style="list-style-type: none"> ✓ NYC Dept. of Health & Mental Hygiene, OASAS; NYS Office of Mental Health; NYS Dept. of Health & Mental Hygiene; NYS Dept. of Housing Preservation & Development; NYC Criminal Justice Coordinator. 	<p>CLIENT POPULATION</p> <ul style="list-style-type: none"> ✓ Clients who are involved in community incidents with police involvement. <p>GOALS</p> <ul style="list-style-type: none"> ✓ Reduce involvement in CJS; reduce the rates of recidivism; increase public safety; enhance client functioning; increase psychiatric stabilization and crime-free community tenure. <p>ACTIONS</p> <ul style="list-style-type: none"> ✓ Develop & implement effective coordination between the Police and the Emergency Mental Health System; provide cross-training of emergency personnel – criminal justice and mental health. ✓ Provide effective crisis and emergency mental health services; provide effective referral and follow-up services ensuring access to benefits and linkage to appropriate residential and community-based mental health services. <p>INTERVENTION AGENCIES</p> <ul style="list-style-type: none"> ✓ Police, Fire and EMS; Mobile Crisis Units; Psychiatric ERs & OPEPs; Assisted Outpatient Treatment Teams. <p>POLICY AGENCIES</p> <ul style="list-style-type: none"> ✓ NYC Police Dept.; NYC Dept. of Health & Mental Hygiene; NYS OAH; NYC Criminal Justice Coordinator. 	<p>CLIENT POPULATION</p> <ul style="list-style-type: none"> ✓ Clients who have been arrested and charged with a crime (misdemeanor or felony). <p>GOALS</p> <ul style="list-style-type: none"> ✓ Reduce higher levels of criminal justice intervention; enhance client functioning; increase psychiatric stabilization and crime-free community tenure; increase public safety; reduce recidivism. <p>ACTIONS</p> <ul style="list-style-type: none"> ✓ Provide mental health screening and assessment at arrest, arraignment and/or in criminal court to identify possible candidates for diversion programs. ✓ Develop and implement programs which provide alternatives to incarceration for both misdemeanor and felony offenders; provide access to benefits, appropriate treatment and rehabilitation services (with an emphasis on evidenced-based practices), and to stable, safe and appropriate housing. ✓ Develop & implement effective coordination (for treatment and supervision) methods between Criminal Justice and Mental Health professionals; provide cross-training of criminal justice and mental health professionals. <p>INTERVENTION AGENCIES</p> <ul style="list-style-type: none"> ✓ Criminal Justice System Personnel (Police Officers, Judges, Prosecutors and Defenders) ✓ Mental Health & Substance Abuse Treatment Providers; Housing Providers; Family & Advocacy Organizations <p>POLICY AGENCIES</p> <ul style="list-style-type: none"> ✓ NYS Court System; NYC Dept. of Health & Mental Hygiene; OASAS; NYS OAH; NYC Office of Probation; NYC Dept. of Probation & Correctional Alternatives; NYC Dept. of Homeless Services; NYC Dept. of Housing Preservation & Development; NYC Criminal Justice Coordinator.
<p>CLIENT POPULATION</p> <ul style="list-style-type: none"> ✓ Clients who are currently serving a probationary sentence or who are on parole status. <p>GOALS</p> <ul style="list-style-type: none"> ✓ Facilitate successful reintegration into the community; increase the compliance with the terms of probation and parole; enhance client functioning; increase psychiatric stabilization and crime-free community tenure; reduce recidivism; increase public safety. <p>ACTIONS</p> <ul style="list-style-type: none"> ✓ Provide access to benefits, appropriate treatment and rehabilitation services (with an emphasis on evidenced-based practices), and to stable, safe and appropriate housing; provide specialized Case Management for individuals on Probation or Parole – from within the Dept. of Probation or Parole and/or in close coordination with Community Mental Health providers. ✓ Develop & implement evidence-based methods for treatment and supervision) between Probation/Parole and Mental Health professionals; provide cross-training of criminal justice and mental health professionals. <p>INTERVENTION AGENCIES</p> <ul style="list-style-type: none"> ✓ NYC Dept. of Probation; NYS Division of Parole & Correctional Alternatives; Community Mental Health and Substance Abuse Service Providers; Housing Providers; Consumer and Family Advocacy Agencies. <p>POLICY AGENCIES</p> <ul style="list-style-type: none"> ✓ NYC Dept. of Probation & Correctional Alternatives; NYC Dept. of Health & Mental Hygiene; OASAS; NYS OAH; NYC Dept. of Homeless Services; NYC Dept. of Housing Preservation & Development; NYC Criminal Justice Coordinator. 	<p>CLIENT POPULATION</p> <ul style="list-style-type: none"> ✓ Clients who are currently incarcerated in jails or in prisons. <p>GOALS</p> <ul style="list-style-type: none"> ✓ Increase psychiatric stabilization of inmates. ✓ Promote early and comprehensive discharge of clients; improve the continuity of care and effective linkage to mental health treatment and other necessary services (such as housing) in the community. <p>ACTIONS</p> <ul style="list-style-type: none"> ✓ Provide effective mental health and substance abuse screening of all inmates to assess for mental illness & dual diagnosis; provide effective & comprehensive mental health services while an individual is incarcerated. ✓ Provide comprehensive discharge plans for all inmates diagnosed with a mental illness or dually diagnosed. ✓ Develop & implement effective coordination methods between jail mental health providers and community mental health providers; provide cross-training of criminal justice and mental health professionals. <p>INTERVENTION AGENCIES</p> <ul style="list-style-type: none"> ✓ NYC & NYS Dept. of Corrections; Health & Hospital Corporation; Prison Health Initiative; Community Mental Health & Substance Abuse Service Providers; Housing Providers. <p>POLICY AGENCIES</p> <ul style="list-style-type: none"> ✓ NYC & NYS Dept. of Corrections; NYC Dept. of Health & Mental Hygiene; OASAS; NYS OAH; NYC Dept. of Homeless Services; NYC Dept. of Housing Preservation & Development; NYC Criminal Justice Coordinator. 	<p>CLIENT POPULATION</p> <ul style="list-style-type: none"> ✓ Clients with a mental illness who have been recently released from jail or prison (out on Parole or serving a probationary sentence). <p>GOALS</p> <ul style="list-style-type: none"> ✓ Facilitate successful reintegration into the community; enhance client functioning; increase psychiatric stabilization and crime-free community tenure; reduce recidivism & increase public safety. <p>ACTIONS</p> <ul style="list-style-type: none"> ✓ Provide access to benefits, appropriate treatment and rehabilitation services (with an emphasis on evidenced-based practices), and to stable, safe and appropriate housing; provide intensive mental health training to mental health professionals. <p>INTERVENTION AGENCIES</p> <ul style="list-style-type: none"> ✓ Community Mental Health & Substance Abuse Treatment Providers; Housing Providers; Consumer & Family Advocacy Agencies. <p>POLICY AGENCIES</p> <ul style="list-style-type: none"> ✓ NYC Dept. of Health & Mental Hygiene; NYS OAH; OASAS; NYC Criminal Justice Coordinator.

1. The word client is utilized to refer to any individual who has been diagnosed with a severe and persistent mental illness, sometimes referred to chronic mental illnesses (Major Depression, Bipolar Disorder or Schizophrenia) or any individual who has been diagnosed with a chronic mental illness and a substance abuse disorder (dual diagnosis).

2. In this document evidence-based practices for individuals diagnosed with a severe and persistent mental illness or individuals who are dually diagnosed refer to practices which have been proven effective through substantiated studies and include but are not limited to: Intensive Case Management, Assertive Community Treatment, Integrated Treatment (Residential, Inpatient & Outpatient), Crisis Intervention and Outreach, Psychosocial Rehabilitation Services and Family Support Services. For more information please see Community Treatment section in this full report.

3. Some examples of appropriate housing for individuals with severe and persistent mental illness and/or a dual diagnosis include: Supportive Housing and Supported Housing. For more information please see Housing Section in the full report.

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

in favor in opposition

Date: 10/28/08

(PLEASE PRINT)

Name: Karen Aquilino

Address: Criminal Justice Coordinator's office

I represent: _____

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

in favor in opposition

Date: _____

(PLEASE PRINT)

Name: Joel Capperman

Address: _____

I represent: CASES

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card

I intend to appear and speak on Int. No. 799 Res. No. _____

in favor in opposition

Date: 10/28/08

(PLEASE PRINT)

Name: Jennifer Parish

Address: 123 William St., NY, NY

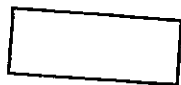
I represent: Urban Justice Center

Address: _____

Please complete this card and return to the Sergeant-at-Arms

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card



I intend to appear and speak on Int. No. _____ Res. No. _____
 in favor in opposition

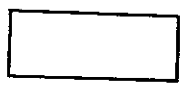
Date: _____

(PLEASE PRINT)
Name: Claudia Montoya
Address: _____
I represent: Legal Aid Society
Address: _____

▶ Please complete this card and return to the Sergeant-at-Arms ◀

**THE COUNCIL
THE CITY OF NEW YORK**

Appearance Card



I intend to appear and speak on Int. No. 799 Res. No. _____
 in favor in opposition
yes, but

Date: _____

(PLEASE PRINT)
Name: Dr. Gerald Landsberg
Address: NY School of Social Work
I represent: _____
Address: Old Washington Sq No NY NY 10003

▶ Please complete this card and return to the Sergeant-at-Arms ◀