CITY COUNCIL
CITY OF NEW YORK

------------------------X

TRANSCRIPT OF THE MINUTES

of the

JOINT COMMITTEE ON JUVENILE JUSTICE, MENTAL HEALTH AND PUBLIC SAFETY

------------------------X

October 28, 2008
Start: 10:14 am
Recess: 12:38 pm

HELD AT: Council Chambers
City Hall

B E F O R E:
G. OLIVER KOPPELL
PETER F. VALLONE, JR.
SARA M. GONZALEZ
Chairperson

COUNCIL MEMBERS:
Joseph P. Addabbo, Jr.
Helen D. Foster
Melinda R. Katz
David Yassky
Vincent J. Gentile
Daniel R. Garodnick
Anthony Como
Gale A. Brewer
Simcha Felder
Annabel Palma
Helen Sears
Maria del Carmen Arroyo
Miguel Martinez

A P P E A R A N C E S (CONTINUED)

Rima Cohen
Director of Health and Social Services
Office of Deputy Mayor for Health and Social Services

Karen Agnifilo
General Counsel
John Feinblatt, NYC Criminal Justice Coordinator

Jack Donahue
Inspector
Office of Management Analysis and Planning, NYC PD

Wendy Perlmutter
Deputy Mayor Linda Gibbs

Joel Copperman
President & CEO
CASES

Claudia Montoya
Attorney
Legal Aid Society's Enhanced Defense-MICA

Dr. Gerald Landsberg
Professor/Director
School of Social Work at NYU and Initiative Against Violence

Jennifer Parish
Director of Criminal Justice Advocacy
Urban Justice Center

2 CHAIRPERSON KOPPELL: Go ahead, you
3 want, you want to, okay. Good morning, I'm City
4 Councilman Oliver Koppell, Chairman of the
5 Committee on Mental Health, Mental Retardation,
6 Alcoholism, Drug Abuse, and Disability Services,
7 if we have nothing else, we have the longest title
8 of any committee. Joined today by Peter Vallone,
9 the Chairperson of the Committee on Public Safety
10 and also by Council Member Sara Gonzalez, the
11 Chairperson of the Committee on Juvenile Justice
12 and we're here to examine the report of the city's
13 Mental Health Criminal Justice panel and
14 recommendations to Governor David Paterson and
15 Mayor Bloomberg issued in June 2008 dealing with
16 how mentally disturbed persons are handled in the
17 criminal justice system. We have already examined
18 this subject before, the committee held hearings
19 involving the interaction between criminal justice
20 and mental health systems. On February 28th, 2008,
21 the committee, along with Council Member Vallone's
22 committee, held a joint hearing to examine the
23 roles of the police department and the Department
24 of Mental Health and Mental Hygiene in responding
25 to calls to the police involving emotionally

2 disturbed people. In November 2007, the committee
3 examined whether mentally impaired individuals
4 were receiving appropriate services to maintain
5 stability and safeguard the health and welfare of
6 New York City's residents. The committee's
7 hearings were held specifically after two
8 incidents in which emotionally disturbed persons
9 were shot by police officers while responding to
10 emergency calls. Tragically, a little more than a
11 month ago, the issue of interaction between law
12 enforcement and the mentally ill was again brought
13 to the forefront of the public's attention. On
14 September 24th, 2008--
15 CLERK: First panel is--
16 CHAIRPERSON KOPPELL: --the police
17 arrived at the apartment of Iman Morales following
18 a 911 call, which was placed because Mr. Morales's
19 mother was concerned that he would not answer his
20 door. When the police arrived, Mr. Morales fled
21 from them and after a chase, climbed out the
22 window and onto a ledge. He suffered a fatal fall
23 after being shot with a taser stun gun by a police
24 officer. According to friends and neighbors, Mr.
25 Morales suffered from mental illness and been

2 having trouble with medication. Now, before this
3 incident, the New York State and New York City
4 convened a panel to examine cases, consider expert
5 opinion, and recommend actions to improve services
6 and promote safety. The panel was convened by
7 Deputy Secretary for Health and Human Services of
8 the state, Dennis Whalen and New York City Deputy
9 Mayor for Health and Human Services, Linda Gibbs.
10 Members of the panel included state and city
11 officials in mental health, substance abuse,
12 criminal justice, and adolescent services. We're
13 going to hear on their findings and I don't want
14 to go into them at length, but they did talk about
15 serious gaps in both the mental health and in the
16 coordination between the mental health system and
17 the criminal justice system and we look forward to
18 hearing whether any of those recommendations have
19 been followed up on or will be followed up on. I
20 also might mention that since we are considering
21 specifically the Morales incident, that the Police
22 Commissioner and the police have admitted publicly
23 as I understand it or as I read it that mistakes
24 were made in connection with that incident and
25 obviously there was an additional tragedy because

2 a police officer involved in the incident
3 committed suicide. The problem is that I don't
4 believe that this is necessarily indicative only
5 of a mistake or a human failure. I think it
6 indicates that there are problems in procedure and
7 problems in coordination between the criminal
8 justice and the mental health system and that
9 incidents such as this should not occur and should
10 not have occurred and there are ways, I believe,
11 that we can better deal with these incidents. We
12 want to hear from the witnesses, I'm not going to
13 summarize my recommendations before we hear, but I
14 do have some ideas on things that we might be able
15 to do. I want to thank the staff of my committee
16 and I know my co-chairs will thank their staff for
17 their assistance in putting this together, Tracy
18 Udell, our counsel; Michael Benjamin, who is
19 program analyst, the policy analyst; Rocco
20 D'Angelo, financial analyst, and Jamin Sewell, my
21 personal counsel who also works closely with the
22 committee. Now I'd like to turn over the
23 microphone to my co-chairs. Thank you.
24 [Pause]
25 CHAIRPERSON VALLONE: Thank you,

2 chair. [Pause] Thank you, Chair Koppell, it's an
3 honor to be chairing this hearing with both you
4 and Sara Gonzalez, formerly a subcommittee of the
5 Public Safety Committee, now out on our own in the
6 world. Good to see you back. We are here to
7 discuss this report that Chair Koppell mentioned
8 and what's important from a public safety
9 standpoint is that we limit interaction as much as
10 possible between our police and the public and the
11 emotionally disturbed and so hopefully this report
12 will come up with some concrete ways to do that.
13 Once--that does not occur, however, once there is
14 interaction, we need to figure out the best way to
15 keep that interaction as safe as possible. And
16 we're going to discuss today a piece--also discuss
17 in addition to what Chair Koppell mentioned, a
18 piece of legislation which I sponsored which would
19 establish a database of police contacts with
20 emotionally disturbed persons so that an officer
21 in responding to a call involving an emotionally
22 disturbed person could look up their identifying
23 information in a database, verifying whether there
24 has been a previous encounter with this individual
25 and thereby access valuable information about that

2 previous interaction. I sponsored this bill after
3 the hearing that we held back in February and so
4 before the panel had made its report or its
5 recommendations and it turns out that one of the
6 panel's recommendations is this very same sort of
7 database that we had discussed here this hearing.
8 So that says that is a welcome addition to your
9 recommendations. At the last hearing, we did, you
10 know, we did hear testimony that when police
11 showed up at a scene involving an EDP, there was
12 almost no way for them to know--and there still
13 may not be, we will see--whether or not there had
14 ever been a previous call at that location and
15 what the results had been so they would know
16 whether they were encountering a potentially
17 violent individual or someone who gets--calls 10
18 times a month from the family member or something
19 like that. So we will see if there's been any
20 improvement in the last year and what the future
21 holds with regard to police information regarding
22 EDPs at potential response scenes. So now let me
23 turn the floor over to our Council Member
24 Gonzalez, the Chair of our Juvenile Justice
25 Committee.

2 CHAIRPERSON GONZALEZ: Good morning,
3 everyone. First of all, I am Council Member Sara
4 Gonzalez, I'm the Chair of the Juvenile Justice
5 Committee, and I would like to thank Council
6 Member Oliver Koppell, the Chair of the Committee
7 on Mental Health and Council Member Peter Vallone,
8 the Chair for the Committee on Public Safety for
9 having this joint hearing today. I would also
10 like to thank my colleagues and mostly the staff,
11 especially Lisette Camillo and William Hongach who
12 worked very hard on all the research in respect to
13 this committee, as well as the public for their
14 attendance and participation in today's hearing.
15 I want to keep my remarks brief in the interest of
16 obtaining more information and moving on, but I'd
17 just like to share with you that the New York
18 State/New York City Mental Health Criminal Justice
19 panel report and recommendations highlighted a
20 very important issue--that there needs to be
21 better coordination between the mental health and
22 the criminal justice systems to provide more
23 effective treatment for individuals with serious
24 mental health issues that have involvement with
25 those systems. The mental health of the detained

2 juvenile population in our city and state is a
3 vitally important issue. One of the committees on
4 juvenile justice has held a number of hearings.
5 Specifically we have held hearings--
6 MALE VOICE: [Crosstalk] I wouldn't
7 have agreed with that.
8 CHAIRPERSON GONZALEZ: --on the
9 Collaborative Family Initiative, CFI, a family
10 focused reentry program for youth with mental
11 health needs that is administered by the
12 Department of Juvenile Justice. Today's hearing
13 serves as a continuum in examining the obstacles
14 youth with mental health issues face while in
15 detention and the different ways we can improve
16 the current process of administering mental health
17 services to New York City's and state's most
18 prized possession--our children. I would now like
19 to turn the floor back to Chairman Koppell. Thank
20 you.
21 CHAIRPERSON KOPPELL: Thank you.
22 Before we call witnesses, I'd like to mention that
23 we're joined by Simcha Felder from Brooklyn, a
24 very diligent member of the Mental Health
25 Committee I might say, he's always present and

2 very much involved in trying to address the issues
3 we face and maybe, my Chairs, I see we have
4 another councilman but he's not on my committee so
5 maybe the chair--
6 MALE VOICE: You don't know who he
7 is?
8 CHAIRPERSON KOPPELL: I know who he
9 is, but I thought the Chair should introduce him.
10 [Off mic]
11 CHAIRPERSON VALLONE: Who's the guy
12 on the end? I don't know.
13 CHAIRPERSON KOPPELL: Okay. Vincent
14 Gentile, councilman from Brooklyn, member of the
15 Public Safety Committee. I always think that the
16 Chairs should introduce their members, I apologize
17 if I omitted you, it wasn't intentional.
18 MALE VOICE: You can make it up by--
19 [Off mic]
20 [Pause]
21 CHAIRPERSON KOPPELL: Do you want to
22 call. Why don't you call them?
23 CHAIRPERSON VALLONE:: The first
24 panel we'll hear from today is Rima Cohen, Deputy
25 Mayor Gibbs' office and Karen Agnifilo from our

2 Criminal Justice Coordinator's office. Thank you
3 for joining us and we look forward to your
4 testimony today.
5 [Pause]
6 RIMA COHEN: Thank you. Thank you,
7 Chairpersons Koppell, Vallone, and Gonzalez and
8 members of the Committees on Mental Health,
9 Juvenile Justice, and Public Safety for inviting
10 me to testify at this oversight hearing. My name
11 is Rima Cohen and I'm Director of Health and
12 Social Services in the Office of the Deputy Mayor
13 for Health and Human Services, Linda Gibbs. As
14 you know, Deputy Mayor Gibbs was one of the co-
15 chairs of the joint New York City New York State
16 Mental Health and Criminal Justice Panel, which
17 developed a comprehensive set of recommendations
18 last June for improving the quality and
19 consistency of care provided to individuals with
20 serious mental illnesses and for reducing the risk
21 of violence to themselves and others. I'm here
22 today with my colleague Karen Agnifilo from the
23 office of the New York City Criminal Justice
24 Coordinator to discuss this report. In addition
25 to Deputy Mayor Gibbs, the panel was co-chaired by

2 New York City Criminal Justice Coordinator John
3 Feinblatt, the state Office of Mental Health
4 Commissioner Mike Hogan, and the state Division of
5 Criminal Justice Services Commissioner, Denise
6 O'Donnell. Its members included top state and
7 city officials in the mental health, substance
8 abuse, criminal justice, and adolescent services.
9 The panel's work was informed by a review of
10 several cases in New York City involving
11 individuals with serious mental illnesses who
12 engaged in violent behavior and may have
13 encountered law enforcement and the criminal
14 justice system, as well as a broader assessment of
15 how New York's mental health and criminal justice
16 systems respond to adults and adolescents with
17 mental illnesses. Panel members noted that the
18 vast majority of those with mental illnesses are
19 not violent and that mental illness is not a major
20 driver of violent crime. Panel members did,
21 however, identify many ways in which the mental
22 health and justice systems could improve their
23 ability to help adults and adolescents with mental
24 illnesses and reduce the risk of poor outcomes.
25 The panel's report included more than 20

2 recommendations that flowed from its analysis.
3 Mayor Bloomberg and Governor Paterson accepted the
4 recommendations in their entirety when the report
5 was issued last June and the city and state have
6 moved forward since that time to implement each of
7 the reforms. Appended to my testimony are a list
8 of panel members and a full list of the report's
9 recommendations. This morning, I will discuss how
10 the panel was convened, the challenges that
11 identified, and key improvements that it put
12 forward. Ms. Agnifilo will focus on the criminal
13 justice findings and recommendations. [Pause] In
14 terms of the panel process, in the wake of several
15 highly publicized violent incidents, as Chairman
16 Koppell mentioned, in New York City involving
17 individuals with mental illnesses, Deputy Mayor
18 Gibbs and Dennis Whalen, who was then the New York
19 State Deputy Secretary for Health and Human
20 Services, convened the Mental Health and Criminal
21 Justice Panel in January 2008. The panel's charge
22 was to examine these cases, consider expert
23 opinions, and recommend actions to improve
24 services and promote public safety. The panel
25 brought together representatives from city and

2 state agencies that historically were not at the
3 same table looking at these complicated issues
4 through a shared lens. Members included
5 representatives from the Governor's and Mayor's
6 offices, the city Department of Health and Mental
7 Hygiene, the state Office of Mental Health, the
8 Office of Alcoholism and Substance Abuse Services,
9 OASAS, and the Office of Children and Family
10 Services, OCFS, and the Division of Probation and
11 Correctional Alternatives. In the months
12 preceding the panel's formation, both Mayor
13 Bloomberg and Governor Spitzer had separately
14 charged senior officials in their administrations
15 with undertaking similar efforts. City and state
16 officials decided that they could develop and
17 implement more effective approaches if they worked
18 collaboratively. In addition to reviewing several
19 cases involving justice-involved adults with
20 serious mental illnesses and adolescents with
21 serious emotional disturbance, or SED, panel
22 members conducted a broad assessment of the mental
23 health and criminal and juvenile justice systems
24 and obtained input from national experts about the
25 state of the art in mental health treatment, risk

2 assessment, and the intersection of mental health
3 and criminal justice. The panel focused on
4 opportunities to improve services for the subset
5 of individuals with serious mental illnesses who
6 are at risk of poor treatment outcomes,
7 involvement with the justice system, and harm to
8 themselves or others. This very targeted emphasis
9 is supported by data indicating that people with
10 mental illnesses receiving appropriate care commit
11 violent acts at a rate slightly below that of the
12 general population and account for a very small
13 proportion of serious crimes. The research also
14 suggests, however, that violence among people with
15 serious mental illnesses increases if they abuse
16 alcohol or drugs and that this risk is compounded
17 if they fail to get treatment or receive
18 inadequate care. In terms of the panel findings
19 and recommendations, panel members identified four
20 broad categories of challenges to providing
21 effective mental health care and assisting those
22 with serious mental illnesses who are involved in
23 the justice system one. And those four areas are-
24 -the first one is poor coordination, fragmented
25 oversight, and lack of accountability in the

2 mental health treatment system; the second one is
3 inconsistencies in the quality of care within the
4 mental health treatment system; the third is
5 limited capacity to share information within and
6 between the mental health and criminal and
7 juvenile justice systems; and the last one is
8 insufficient training, supports, and tools to
9 identify and engage justice-involved individuals
10 with mental illnesses. The report proposes
11 specific measures to address these challenges, and
12 as I mention there's a full list of the
13 recommendations appended to your testimony. I
14 will elaborate on the first three of those
15 challenges and the panel's key recommendations
16 with respect to mental health treatment in
17 juveniles with serious emotional disturbance, SED.
18 Ms. Agnifilo will discuss the recommendations
19 related to the criminal justice system and adults
20 with mental illnesses. First though I want to
21 point out that the panel focused on areas where
22 there was room for improvement in the mental
23 health and criminal and juvenile justice systems.
24 Consequently, its report does not detail the
25 extent to which thousands of mental health, law

2 enforcement, and justment--and, excuse me, justice
3 professionals are dedicated to ensuring both
4 public safety and the well-being of individuals
5 with mental illnesses. The many strengths and
6 successes of these professionals and the systems
7 within which they operate must not be overlooked
8 as we strive to make improvements. As I
9 mentioned, the first finding was that there's poor
10 coordination, fragmented oversight, and lack of
11 accountability in the mental health treatment
12 system. In the cases it examined, the panel saw
13 examples of fragmented care and a failure to
14 respond to signs of inadequate care, deterioration
15 in mental health, and increasing signs of
16 potential violence. The same lack of coordination
17 and accountability as evident in the care provided
18 to adolescents with SED in the juvenile justice
19 system, especially when youth transition in and
20 out of the system. Care providers do not
21 routinely communicate with one another and review
22 each other's records, families are not
23 consistently engaged in their children's care, and
24 discharge plans do not always provide for
25 consistent aftercare services that are essential

2 for successful reentry into the community. The
3 panel also noted that individuals with co-
4 occurring substance use disorders and mental
5 illness lack access to and information about
6 treatment and too few providers offer coordinated
7 evidence-based integrated care for co-occurring
8 disturbances. Our key recommendations in this
9 area include establishing care monitoring teams
10 for high need adults and create a database to
11 track the mental health care provided to high need
12 adults. I'm going to describe This
13 recommendation, which is one of the linchpins of
14 addressing the gaps in the mental health treatment
15 system. The New York State Office of Mental
16 Health and the City Department of Health and
17 Mental Hygiene are jointly establishing Care
18 Monitoring Teams, CMTs, in New York City that will
19 be directly accountable for monitoring the care of
20 high need individuals and the programs that serve
21 them, such as Assertive Community Treatment, ACT,
22 and intensive case management. Care Monitoring
23 Teams will have access to a database of
24 encounters--and this is going to be a new
25 database--initially populated with existing data

2 that including Medicaid claims of high need adults
3 in the public mental health system. The database
4 will enable Care Monitoring Teams to track care
5 patterns so that they can identify and address
6 interruptions in care or escalating need for
7 services. This is an ambitious initiative that
8 when fully implemented will put New York at the
9 forefront of providing interventions for those
10 with serious mental illnesses before an individual
11 encounters the hospital or the criminal justice
12 system. A second recommendation under this
13 challenge is to implement family care coordinators
14 for justice-involved youth. Let me describe that.
15 Adolescents with SED in the juvenile justice
16 system and their families may qualify for a family
17 care coordinator, and that's an individual with
18 first-hand experience with the children's mental
19 health system, who will follow placement-bound
20 youth through their discharge. The coordinator
21 will help families navigate the juvenile justice,
22 mental health, and other systems and facilitate
23 information sharing among providers and their
24 families--and the youth's families. Another
25 recommendation involves improving OCFS discharge

2 planning and aftercare services. Discharge
3 planning will begin within 30 days of admission to
4 an OCFS facility and will engage the youth,
5 family, and community providers. To facilitate
6 discharge planning and aftercare, adolescents will
7 be assigned community service workers, and these
8 are individuals who provide aftercare services and
9 follow up, to collaborate with the family care
10 coordinators that I just mentioned. As youth are
11 discharged from OCFF provided services, referrals
12 will be made and confirmed to community-based
13 mental health services. [Pause] Another
14 recommendation is to enhance clinical
15 interventions, excuse me, for youth with SED in
16 the Department of Juvenile Justice or OCFS
17 facilities. [Pause] The Department of Juvenile
18 Justice has successfully implemented the
19 Collaborative Family Initiative, as Chairperson
20 Gonzalez mentioned, which ensures that mental
21 health services are provided in a youth's
22 community and begin immediately upon release from
23 detention. OCFS, in addition to offering more
24 evidence-based treatments for youth with mental
25 health needs, is conducting a three-year phase-in

2 of the Sanctuary model in all of its facilities,
3 which provides a safe and therapeutic environment
4 for youth and staff. A final recommendation under
5 this challenge was to implement the
6 recommendations of the New York State Office of
7 Mental Health and OASAS Task Force on co-occurring
8 disorders. OMH and OASAS are overseeing
9 implementation of recommendations from a 2007 task
10 force on co-occurring disorders that was convened
11 to make improvements in the care for individuals
12 with co-occurring mental health and substance use
13 treatments--treatment needs. The panel supported
14 the task force recommendations which included the
15 issuance of guidelines, the call for screening for
16 both mental health and substance use disorders in
17 all clinics that treat these disorders--something
18 that's not routinely done now--training for this
19 type of screening and reimbursement for evidence-
20 based treatments for co-occurring disorders. The
21 second finding was inconsistencies in the quality
22 of care within the mental health treatment system.
23 In reviewing the cases, the panel noted instances
24 where explicitly stated guidelines of clinical
25 care would have helped to guide outpatient mental

2 health clinics and clinicians. The standards
3 would address issues regarding caseloads and
4 supervision, thorough psychiatric and substance
5 use evaluation, assessment of a patient's degree
6 of dangerousness to self or others, engagement of
7 family members in treatment, and appropriate
8 responses when patients disengage from their
9 treatment plans. [Pause] The panel also noted
10 that there's no protocol for conducting--that New
11 York State has no protocol for conducting system-
12 level quality assurance reviews with multiple city
13 and state agencies and community providers of
14 critical incidents involving individuals with
15 mental illnesses. Such reviews could identify
16 failures in the provision of care and point to
17 quality improvement steps, systemic improvements,
18 that could be taken to mitigate future incidents.
19 With respect to Assisted Outpatient Treatment,
20 AOT, which is commonly referred to as Kendra's
21 Law, the panel noted that access to and discharge
22 from AOT is not sufficiently standardized or
23 review and lapses in care can result when AOT
24 orders expire. The panel did not, however,
25 undertake a comprehensive analysis of the program

2 because an independent research team is currently
3 evaluating Kendra's Law and will issue a
4 comprehensive report next June. In fact, I'm told
5 that they may come out with their report a couple
6 months early short of that deadline.
7 CHAIRPERSON VALLONE:: When you say
8 next June, that means...
9 RIMA COHEN: June 2009. [Pause]
10 And I'm told that they may actually have the
11 report ready in April. Key recommendations with
12 respect to the finding about lapses in quality
13 care within the system include conducting critical
14 incident reviews. With respect to that
15 recommendation, the city and state are vigorously
16 promoting legislation that authorizes the state
17 Office of Mental Health to conduct intensive case
18 reviews with the participation of city and state
19 officials of critical incidents involving
20 individuals with mental illnesses in order to
21 reduce care errors and improve public safety.
22 Pending passage of this legislation--and we're
23 cautiously optimistic that the legislature will
24 take up and pass this legislation in the next
25 session--OMH and the city Department of Health and

2 Mental Hygiene will continue to collaborate with
3 each other on the review of critical incidents in
4 compliance with existing law. Another
5 recommendation was to issue and monitor the use of
6 standards of care for mental health outpatient
7 clinics. With the publication of the report, the
8 state Office of Mental Health issued standards of
9 care that provide clear guidance on issues that
10 include coordination with other services, such as
11 case management, they also address initial and
12 ongoing risk assessment of patients, changing
13 treatment plans when an individual's mental health
14 deteriorates or he or she is not engaged in care,
15 the supervision of care providers in the treatment
16 system, and the of caseloads of those providers.
17 These elements of quality care are more explicitly
18 described for other mental health services, but
19 not for outpatient clinics where most people
20 receive care and where staff can intervene earlier
21 in treatment. OMH and the City Department of
22 Health will incorporate these standards into their
23 licensing and programmatic reviews of providers.
24 With respect to implementing improvements to AOT,
25 Assisted Outpatient Treatment or Kendra's Law, the

2 panel chose, as I mentioned, not to recommend
3 statutory changes to AOT while the program is
4 being evaluated, but it did recommend that the
5 City Department of Health and Mental Hygiene,
6 which oversees AOT in New York City, increase
7 outreach to hospitals to improve the rate of
8 appropriate AOT referrals and also clarify AOT
9 enrollment and renewal criteria and establish an
10 independent clinical review of decisions not to
11 accept or renew AOT orders. The third finding was
12 the limited capacity to share information within
13 and between the mental health and criminal justice
14 and juvenile justice systems. Evidence suggests
15 that information related to an individual's
16 treatment often is not shared between care
17 providers leading to poor coordination and lack of
18 continuity of care. Similarly important treatment
19 and educational records do not typically follow
20 adolescents through the juvenile justice system
21 and when youth transition into and out of that
22 system. Important aspects of individuals'
23 previous treatment, as well as information from
24 families can and should be transmitted between
25 clinical programs treating the same individual to

2 the fullest extent permitted by law, yet
3 consumers, providers, and families are often
4 unsure about what can be appropriately disclosed
5 to facilitate the provision of good care. With
6 respect to key recommendations under this finding,
7 Ms. Agnifilo will discuss the bulk of the
8 recommendations that flow from this finding as
9 they relate to information sharing in the adult
10 criminal justice system. I will highlight two
11 recommendation that affect adults and youth with
12 serious mental illnesses in the mental health
13 treatment system. The first was to enable
14 information to follow adolescents through
15 transitions in the juvenile justice system. OCFS,
16 the Office of Children and Family Services, and
17 the New York City Departments of Probation and
18 Juvenile Justice will establish policies to seek
19 consent from parents to share otherwise
20 confidential information, such as the results of
21 mental health assessments, to determine how best
22 to meet the needs of adolescents as they move
23 through detention, placement, and aftercare.
24 Procedures will be established by which all mental
25 health caregivers for children will provide

2 information, with consent, to the Department of
3 Juvenile Justice clinicians about treatment needs
4 of youth in care and city and state agencies will
5 advance training for child mental health providers
6 on these procedures. Another recommendation was--
7 under this finding was to include information
8 sharing protocols in the clinic standards of care
9 that I mentioned. The clinic standards of care
10 that the State Office of Mental Health issued--
11 when we issued the report in June, includes clear
12 guidance for providers regarding appropriate and
13 effective communication with other service
14 providers, families, and other caregivers. This
15 is an area that we found where there was a great
16 deal of confusion and that actually there was more
17 flexibility and sharing information between
18 clinical providers. [Pause] In conclusion, the
19 recommendations that I outlined today and those
20 that Ms. Agnifilo will describe in a moment, can
21 improve mental health services and criminal
22 justice interactions for individuals with mental
23 illnesses and enhance the safety of these
24 individuals and the public. It is important to
25 recognize, however, that there are no quick fixes

2 or magic bullet solutions. Furthermore, even a
3 perfect system would not be able to predict and
4 prevent every violent incident involving a person
5 with mental illness, just as we have not
6 eliminated violence in the general population.
7 And even with improved information sharing, there
8 are substantial limitations to the data that
9 exists and that can be shared, including reporting
10 lags, data quality issues, and confidentiality
11 issues. Having said that, the panel is confident
12 that the implementation of these ambitious but
13 practical recommendations, along with the ongoing
14 collaboration between city and state officials and
15 the involvement of the community, that both public
16 safety and the quality of care for individuals
17 with mental illnesses can be improved. Thank you
18 again for this opportunity to testify and I look
19 forward to working with you, Chairpersons Koppell,
20 Vallone, and Gonzalez and your colleagues to
21 promote the well-being and safety of all New
22 Yorkers.
23 [Pause]
24 KAREN AGNIFILO: Good morning,
25 Chairpersons Vallone, Gonzalez, and Koppell, and

2 members of the council. My name is Karen
3 Agnifilo, and I'm General Counsel to John
4 Feinblatt, the City's Criminal Justice
5 Coordinator. Thank you for the opportunity today
6 to talk about our work in the area of mental
7 health, particularly the city state Mental Health
8 Criminal Justice Panel and the report. The
9 Bloomberg administration has long been committed
10 to ensuring not only that individuals with mental
11 illness receive the highest quality of care and
12 treatment, but also that the criminal justice
13 system responds appropriately when these
14 individuals enter the system and to protect public
15 safety. The city was instrumental in helping
16 develop and implement programs such as the CASES
17 Nathaniel Project, an alternative to incarceration
18 program for mentally ill offenders, and for
19 supporting the city's mental health courts. As
20 Ms. Cohen explained, the charge to the panel was
21 to recommend actions to improve services to
22 individuals with mental illness and to promote the
23 safety of all New Yorkers. The panel's work was
24 informed by research conducted by experts in the
25 field and, as Ms. Cohen explained, the vast

2 majority of those with mental illness are not
3 violent and mental illness is not a major driver
4 of violent crime. However, the research does
5 indicate that the failure to receive adequate
6 treatment does increase the risk of violence among
7 individuals with serious mental illness. The
8 panel therefore concluded that connecting
9 individuals with serious mental illness to care
10 and treatment could enhance the safety of these
11 individuals and the general public. Citywide, it
12 is estimated that approximately 18% of offenders
13 in the justice system have a serious mental
14 illness--just to put it in context and perspective
15 for you. The panel recognized that contacts with
16 the criminal justice system therefore are
17 potentially important opportunities to identify a
18 significant number of individuals with mental
19 illness and either ensure continuity of treatment
20 for them or provide links to appropriate mental
21 health services. This could in turn reduce the
22 risk of violence and promote public safety. We
23 also recognize that the current legal frame
24 imposes--I'm sorry, the current legal framework
25 imposes significant limitations on how much the

2 criminal justice system can do. Two of the four
3 major findings in the report relate to the ability
4 of the criminal justice system to capitalize on
5 these opportunities. First, the panel found that
6 there is limited capacity to share information
7 between the mental health system and the criminal
8 justice systems. Barriers imposed by privacy
9 laws, which are intended to safeguard personal
10 health information, prevent sharing mental health
11 information with the criminal justice system
12 without the consent of the individual. Even when
13 that information could actually help ensure
14 continuity of care or help determine whether that
15 individual may be an appropriate candidate for
16 treatment-based alternatives, privacy laws still
17 prevent that information sharing absent consent.
18 Second, the panel found that the criminal justice
19 system could be enhanced to provide better
20 training supports and tools to identify and engage
21 individuals with mental illness. The panel
22 developed numerous recommendations to capitalize
23 on these opportunities within the current legal
24 framework both on a city and state level and I'd
25 like to now summarize some of these

2 recommendations for you. Turning first to police
3 response, the panel recognized that the New York
4 City Police Department is enormously successful in
5 responding to calls involving emotionally
6 disturbed persons. Of the 10 million 9-1-1 calls
7 received annually, roughly 90,000 involved
8 emotionally disturbed persons. The highly trained
9 Emergency Service Unit, also known as ESU, is an
10 elite group of officers who receives 16 hours of
11 tactical training on emotionally disturbed persons
12 and 40 hours of emergency psychiatric training,
13 that's in addition to the full-day training
14 regarding emotionally disturbed persons that all
15 police recruits receive. ESU is dispatched for
16 100% of calls involving emotionally disturbed
17 persons, but they ultimately respond to roughly
18 25% of these calls because the unit can be called
19 off when other officers reach the scene and
20 conclude that the presence of ESU is no longer
21 necessary. The vast majority of calls involving
22 emotionally disturbed persons are handled without
23 incident. Of these roughly 90,000 calls, the NYPD
24 arrests less than 1% of emotionally disturbed
25 persons, typically opting instead to take these

2 individuals to a hospital or provide a referral to
3 an agency. Given the success of the NYPD in this
4 area, the panel asked what additional information
5 could be provided to officers to enhance this
6 already extraordinary response to calls involving
7 emotionally disturbed persons. The panel
8 considered numerous options for providing police
9 officers with relevant mental health information.
10 Initially, we had similar concerns to Chairman
11 Vallone and considered an approach like that
12 contemplated by Intro 799. This approach would
13 mine the NYPD databases and identify individuals
14 who have been the subject of prior calls involving
15 emotionally disturbed persons to alert responding
16 officers to any future calls involving such
17 individuals. However, after much deliberation, it
18 was ultimately determined that a location-based
19 database, which I'll explain momentarily, as
20 opposed to a name-based database, would actually
21 provide the most useful information to the
22 responding officers. This is because the utility
23 of a name-based database is very limited, location
24 is really the most important piece of information
25 communicated to a 9-1-1 operator. Indeed, 9-1-1

2 calls often involve only information about a
3 location rather than identifying the name of the
4 specific individual involved in an incident. In
5 fact, if the caller, the person who calls 9-1-1
6 actually knows the name of the individual
7 involved, the caller is also likely to know that
8 the individual has a mental health issue and would
9 thus likely provide that information to the
10 operator already. [Pause] And an identification
11 from a name-based database without offering
12 confirming information could lead to mistaken
13 identification and potential confusion to the
14 officers rather than providing useful information.
15 [Pause] After collaborating with the NYPD, the
16 panel instead recommended that the NYPD focus on
17 locations that are likely to involve emotionally
18 disturbed persons. The NYPD is in the process of
19 establishing flags in its 9-1-1 database to
20 identify locations that will trigger the dispatch
21 of ESU, specifically locations that have been the
22 subject of prior calls involving emotionally
23 disturbed persons, as well as locations that are
24 known housing locations with supports for
25 individuals with mental illness. This system will

2 provide responding officers with instant
3 information regarding the possibility that the
4 call involves an emotionally disturbed person and
5 will facilitate the early dispatch of ESU to these
6 locations. [Pause] The panel also considered the
7 issue of police training. In the city, the
8 training curriculum for new recruits regarding
9 emotionally disturbed persons is created with
10 extensive input from the mental health community.
11 [Pause] The LINK Committee, as it's called, was
12 established to review this portion of the
13 curriculum and explore new ideas for training.
14 The LINK Committee is composed of members of the
15 NYPD, the City Department of Health and Mental
16 Hygiene, advocacy groups, consumers, hospitals,
17 and the legal and academic communities. This
18 committee meets quarterly to review the NYPD's
19 training curriculum and ensure that it reflects
20 best practices in law enforcement training for
21 handling situations involving emotionally
22 disturbed persons. The panel recommended that
23 this committee continue this important work and
24 additionally, the NYPD plans to expand this
25 training to officers who may not have received it

2 during new recruit training. [Pause] A second
3 important issue discussed by the panel was whether
4 sharing information between the mental health and
5 criminal justice systems could be useful in
6 ensuring continuity of care and providing links to
7 treatment, as well as protecting public safety.
8 The panel determined that such information sharing
9 could be beneficial. However, there are
10 significant impediments to this information
11 sharing, as I said, including privacy laws, but
12 also the lack of mechanisms in the criminal
13 justice system to routinely screen for mental
14 illness and the inability of the criminal justice
15 and mental health data systems to facilitate the
16 sharing of information. [Pause] The panel
17 considered recommending statutory changes to
18 permit limited mental health information sharing
19 with the criminal justice system. Several
20 concerns were raised about this option, however,
21 including that information sharing could
22 potentially stigmatize individuals with mental
23 illness and lead to punitive criminal justice
24 system responses. It could also raise privacy
25 concerns and significantly alter current practice.

2 It should be noted that only one state in this
3 country, Texas, has a statute that permits sharing
4 mental health information with the criminal
5 justice system and in that instance it's only
6 under very limited circumstances. [Pause] After
7 much deliberation, we decided instead to pursue
8 several pilot projects to determine if the
9 information sharing gap can be bridged without
10 statutory change. The panel recommended three
11 pilot programs that we are in the process of
12 implementing in the city to identify individuals
13 with mental illness in the criminal justice system
14 who might benefit from being linked to long-term
15 services. The goal of these projects is to
16 determine whether information sharing under
17 current laws can enhance continuity of care, thus
18 reducing the likelihood that individuals with
19 mental illness will repeatedly cycle through the
20 criminal justice system. [Pause] First, we're
21 developing a pilot program to identify individuals
22 with serious mental illness who become involved in
23 the justice system. The way this will work is
24 when an individual is arrested, the new database
25 that Ms. Cohen described containing information

2 about people with serious mental illness will be
3 searched to see if this individual is already
4 receiving mental health services. If so,
5 information regarding that person's arrest will be
6 provided to a member of the Mental Health Care
7 Monitoring Team that Ms. Cohen described and I'm
8 going to call them CMTs for ease of discussion.
9 The CMT will then notify community-based treatment
10 providers and case managers about this arrest.
11 The notification system will ensure that treatment
12 providers are fully informed about individual's
13 contacts with the criminal justice system so that
14 providers can reengage that individual in
15 appropriate services and treatment. We will also
16 be placing mental health professionals in the
17 courtroom, who will work closely with the CMTs to
18 identify justice-involved individuals who may not
19 have been identified in that database, who are
20 currently receiving high-intensity mental health
21 services. This will help to better coordinate
22 care within the criminal justice setting and
23 determine whether a defendant may be appropriate
24 for diversion to treatment-based alternatives.
25 [Pause] We're also in the process of implementing

2 two additional pilots intended to measure whether
3 short-term court monitored engagement and
4 treatment will promote longer-term participation
5 in mental health services. A study of the
6 Manhattan-based Exit program launched in 2003, for
7 example, demonstrated that brief court mandated
8 engagement efforts for misdemeanants could
9 actually successfully link them to longer-term
10 treatment. In fact, roughly 40% of the
11 participants continued in voluntary case
12 management for over four months after the mandated
13 treatment. We hope to build on the success of
14 this early program. One pilot will involve the
15 use of post-arraignment mental health screening in
16 Bronx criminal court for defendants sentenced to
17 brief community-based programs. This screen will
18 seek to identify appropriate candidates for more
19 in-depth mental health assessment, intensive
20 engagement, and voluntary case management as an
21 alternative to the original sentence, thus linking
22 them to services. Another pilot involves an
23 alternative to detention program with a special
24 mental health track designed to provide
25 assessment, case management, supervision, and

2 community-based treatment. This program will
3 target defendants who are likely to be detained in
4 jail while their criminal cases are pending, but
5 who do not pose a high risk of either recidivism
6 or flight. This program will also assist judges
7 in making appropriate sentencing decisions and
8 helping them assess whether an individual is an
9 appropriate candidate for a treatment-based
10 alternative in lieu of jail or prison. [Pause]
11 The panel also considered what supports could be
12 implemented within criminal justice agencies to
13 better serve the population of individuals with
14 mental illness. [Pause] The panel made two
15 recommendations aimed at the Department of
16 Probation. First, the panel recommended that the
17 city's probation department create a dedicated
18 mental health unit of probation officers with
19 reduced caseloads who will establish relationships
20 with their probationers' mental health providers,
21 assist probationers in receiving appropriate
22 services, and provide closer supervision. Second,
23 the panel recommended that the Department of
24 Probation begin using a brief validated mental-
25 health screen during pre-sentence investigations

2 to allow the agency to alert judges to defendants
3 who may need a deeper clinical mental health
4 assessment and who may benefit from treatment-
5 based alternatives or special probation
6 conditions. In addition to these recommendations
7 that focus on city agencies and city resources,
8 the panel also issued recommendations aimed at the
9 state as a whole. First, the panel recommended
10 building on the successes of the mental health
11 courts and alternative to incarceration programs
12 that link offenders to the court monitored mental
13 health treatment, which is implemented in the city
14 by expanding these courts and programs to
15 additional jurisdictions throughout the state.
16 Currently there are 17 mental health courts
17 statewide and we anticipate the creation of eight
18 additional courts in the next few years. [Pause]
19 The panel also concluded that it was important to
20 keep track of the small number of individuals with
21 mental illness who are criminally prosecuted, but
22 determined to be not responsible for their
23 criminal conduct due to mental disease or defect.
24 Upon recommendation of this panel, the state
25 Division of Criminal Justice Services is going to

2 begin providing the agencies that supervise these
3 individuals with real-time notification of
4 subsequent arrest of these individuals who are in
5 the community. [Pause] With respect to law
6 enforcement response throughout the state, the
7 panel found that 9-1-1 dispatchers often do not
8 effectively elicit information about whether
9 mental illness is relevant to a 9-1-1 call. This
10 information could be used to determine when to
11 deploy specialized resources, such as ESU in the
12 city. And the panel therefore recommended that
13 the state create a training protocol for 9-1-1
14 dispatchers to better elicit information about
15 whether a person involved in an incident has a
16 history of mental illness. [Pause]. Thank you
17 again for the opportunity to discuss these
18 findings and recommendations as they result to the
19 criminal justice portion of the city state panel.
20 The Bloomberg administration is committed to
21 ensuring that individuals with mental illness not
22 only receive the best possible care and treatment,
23 but also that the criminal justice system responds
24 appropriately to incident involving these
25 individuals and to protect and promote public

2 safety and [pause] Ms. Cohen and I are happy to
3 take your questions at this time.
4 [Pause]
5 CHAIRPERSON KOPPELL: Thank you very
6 much. I'll ask a few questions and we'll move it
7 along. I note we've been joined by Council Member
8 Melinda Katz from Queens. Oh, I see other people
9 down there that I didn't notice before, Dan
10 Garodnick, Councilman Como, Annabel Palma, Gale
11 Brewer, Councilman Martinez, and I mentioned
12 Council Member Katz, all of them are here and I
13 didn't even notice them 'cause I was looking at
14 the statement. Let me ask, how was this panel,
15 Ms. Cohen, how was this panel put together? That
16 is to say who--why were there only government
17 officials on the panel? I'll be directly pointed
18 in my questioning.
19 RIMA COHEN: The panel was convened,
20 as I mentioned, both Mayor Bloomberg and then
21 Governor Spitzer had charged top city and state
22 officials respectively with looking into various
23 incidents and coming up with recommendations--this
24 happened separately in the fall of 2007--and when
25 we became aware of each other's work, we decided

2 to work collaboratively. I would say that
3 officially the panel members were all government
4 officials, however, we consulted very widely with
5 others. We brought in experts on mental health
6 and criminal justice and the interaction between
7 those systems. We had many meetings with people
8 here that I see in the room, with advocacy
9 community healthcare providers, and organizations
10 representing individuals with mental illness, but
11 the actual deliberations for a couple of reasons
12 were just with government officials. One of the
13 reasons was that we were looking at specific cases
14 that in their confidentiality rules surrounding
15 those cases, and we could not have a wider group
16 looking at some of the information, and ultimately
17 we were going to be issuing recommendations that
18 have to be implemented by the agencies and
19 individuals in city and state government.
20 However, we did seed a lot of input and, in fact,
21 read through all the testimony of hearings that
22 you and your colleagues have held on these issues
23 and so forth.
24 CHAIRPERSON KOPPELL: Do you have
25 any public hearings of your committee?

2 RIMA COHEN: We do not have public
3 hearings, no.
4 CHAIRPERSON KOPPELL: And did you
5 investigate the possibility of perhaps providing
6 some sort of appointment, if confidentiality was
7 an issue, to lay members--that is, members of the
8 public who might not be government officials or
9 legislators who could therefore see this
10 confidential information because they got some
11 special appointment, 'cause you have lots of
12 government officials who saw the information, I
13 assume if you appointed a member of the panel, you
14 could give them some sort of government title that
15 might put them in the same category as the
16 Assistant Deputy Commissioner or whatever that I
17 see on the list?
18 RIMA COHEN: We do not do that or
19 consider that.
20 CHAIRPERSON KOPPELL: I see. Well
21 let me just mention that I'm not a newcomer to
22 government. I've been an elected official for 30
23 years in the state and city, I have never, ever--
24 and they may exist--I've never, ever seen a panel
25 created to study a subject like this that involves

2 only government officials and it doesn't have
3 public hearings. And I'm not quarreling with your
4 recommendations, many of them I--seem to be good.
5 But to put only government officials on a panel of
6 this sort and then issue this as recommendations
7 and then move ahead with these recommendations
8 without any public comment or review is simply
9 outrageous. Furthermore, as a member of the--more
10 as a member of the legislature, but I was a member
11 of many special committees set up by the
12 legislature and by the governor which included
13 always legislative members. And in my own
14 personal experience, by being a member of those
15 committees, I played a major role in the
16 legislature in getting legislation adopted that
17 the panel that I served on recommended. So it
18 made a great deal of sense to have a legislator on
19 the panel, because then that legislator can become
20 a champion of the recommendations of the panel in
21 the legislative body, and I note that your panel
22 has legislative recommendations. So I will tell
23 you that I learned about your panel as Chair of
24 the Mental Health Committee of this Council the
25 day before the recommendations were issued.

2 That's my first information that there was such a
3 committee and I could--you can bring it back to
4 the Mayor to the Deputy Mayor Gibbs, this is
5 totally inappropriate to do a panel of this sort
6 without appropriate public input. Now we're
7 having this hearing, and I look forward to hearing
8 recommendations, but I also might observe that it
9 is the nature of government officials to be self-
10 protective. I'm actually fairly impressed at the
11 criticism of the panel because in a sense it's
12 self-criticism, and often times, government
13 officials are very reluctant to criticize
14 themselves or their colleagues. So to that
15 extent, I'm impressed that they were willing to
16 make such criticisms. Nonetheless, there may be
17 other criticisms--and maybe we'll hear them today-
18 -that the panel didn't go near because they were
19 self-protective. An example of that, by the way,
20 is that, while I think the police do do a
21 fantastic job and with 90,000 calls a year, it's
22 quite amazing how relatively few incidents there
23 are, but if I look at what you just testified or
24 your colleague just testified to as the amount of
25 training that police officers give--get to deal

2 with mentally ill people, it's laughable. It's
3 laughable compared to a mental health professional
4 that goes through a whole regiment and gets a
5 Masters degree and a Ph.D. degree and then works
6 with the mentally ill throughout their career,
7 compare that to these police officers. I'm
8 surprised they can do what they can do with, what
9 60 hours of training and, oh, it's terrific, they
10 got an additional day of training. I mean, it's,
11 as I said, it's no surprise that sometimes
12 inappropriate things happen with that level of
13 training and there are ways, in my opinion, and
14 there are models in other cities of having truly
15 well-trained people dispatched to these incidents-
16 -it could only help. Not, as I said, I think the
17 police do a terrific job, but the tools that
18 they're given are so inadequate, it's, really,
19 it's laughable to say that a few days of training
20 is sufficient to deal with these incidents. And
21 if you want to respond to that, you can.
22 [Pause]
23 RIMA COHEN: I will take back your
24 comments and suggestions to the Mayor and Deputy
25 Mayor Gibbs and I understand your frustration, I

2 think the panel was trying to do the best it could
3 in a fairly compressed period of time for the
4 charge that was given us and you're right that we
5 did not hold public, you know, official public
6 hearings, but we did attempt to gather information
7 widely, as I said, with many people in the room
8 and we read extensively and we had many experts
9 who came in to talk with us and we--you can always
10 do a better job in terms of including people, but
11 we stand by the recommendations and welcome the
12 scrutiny of the committees as we implement them
13 and welcome your input and collaboration as we
14 implement these recommendations and hope that we
15 can work together to try to make them positive.
16 And, to the extent, that they're not successful,
17 that we can collaboratively develop solutions that
18 do work.
19 CHAIRPERSON KOPPELL: Have you--one
20 last question and in line with what I said before-
21 -have you considered the involvement of a
22 professional team of mental health workers or
23 [pause] assistants who would be available to work
24 with the police when they can be called on? We do
25 have these crisis intervention teams around the

2 city that go out when a disturbed person, they
3 often go out before the police and sometimes they
4 call the police to help them. Have you
5 considered--and I think other cities have this
6 model--of a team of professionals, non-police
7 professionals who would be dispatched in
8 connection with some incidents to supplement the
9 police? Have you considered that?
10 KAREN AGNIFILO: We did consider
11 that, we looked at areas that do have that type of
12 model, I think Memphis is one of the areas and
13 Rochester, New York also has that model, and we
14 looked at the feasibility of whether that would
15 make sense for a large city such as New York.
16 When you look at the number of police responses
17 and the number of people in those smaller
18 communities, it makes much more sense in that kind
19 of a community and, logistically speaking, it was
20 very difficult to figure out how that could
21 actually be implemented here with--given the
22 90,000 calls, 24 hours a day, 7 days a week in our
23 large city. And so that we did very seriously
24 consider it and look at those models.
25 [Pause]

2 CHAIRPERSON KOPPELL: Well thank
3 you, I want to let my colleagues pursue it. I
4 think that should be looked at further, let me
5 just say that.
6 [Pause]
7 CHAIRPERSON VALLONE:: Thank you,
8 Chair Koppell. Let me second your objection. I
9 mean, I'm amazed that someone with the experience
10 you have, that the Chair of our--well the
11 committee with the really long name that revolves
12 around mental health wasn't even aware of this
13 report until after it was released, I wasn't and,
14 in fact, my Bill, which is one of your major
15 recommendations, was the subject of much
16 deliberation, I was never even made aware of this,
17 so the content of this panel is something we have
18 a problem with. On that topic, was there a member
19 of the NYPD on this panel?
20 KAREN AGNIFILO: Yes.
21 CHAIRPERSON VALLONE:: On the panel?
22 Good. Good.
23 KAREN AGNIFILO: Yes.
24 CHAIRPERSON VALLONE: Let me--one of
25 the most important recommendations, I believe, is

2 clearly is the database that will allow the police
3 information when they arrive at a scene, which
4 will allow them to have, to perhaps not make
5 split-second decisions which in certain instances
6 may not be the right ones. And I did put in a
7 Bill and you have stated in your testimony that
8 after much deliberation that because my Bill is a
9 name-based database, you believe that a location-
10 based database is a better one and, therefore,
11 going to go your way. Now, Oliver called it self-
12 protection, but, you know, I've heard of tortured
13 excuses to do it your way instead of ours, but
14 this one really takes the cake. I mean, let--my
15 Bill is maybe five lines long, so let me read the
16 perfect few lines here. The Commissioner shall
17 promulgate rules establishing the creation of a
18 database to be created and maintained by the
19 department which shall include, at a minimum, the
20 name and address of the emotionally disturbed
21 person in the nature of the incident. How you
22 could possibly misread that after much
23 deliberation into I want name-based and you want
24 location-based, I don't know. I don't know what
25 you were deliberating, but I could have saved you

2 a lot of deliberation. We agree that name and
3 address, not just one, because people move, are
4 very, very important to a database and I'd
5 actually like you to comment on how you could have
6 misinterpreted my Bill so badly.
7 KAREN AGNIFILO: I apologize if I
8 misinterpreted what your Bill says. Clearly we're
9 on the same page about what it is we're looking
10 for, but perhaps I can turn that question over to
11 Inspector Jack Donahue, who's Inspector with the
12 Office of Management Analysis and Planning with
13 the New York City Police Department who could
14 better describe what would be useful in these
15 circumstances.
16 CHAIRPERSON VALLONE: Thank you.
17 Before we begin, I just want to--we've discussed
18 this a little bit before you went on and at our
19 last hearing, it was determined--just to give a
20 little background to the Council Members who
21 weren't on my committee--that when police officers
22 arrived at a scene there was, basically this was
23 last February, no way for them to know whether
24 officers had previously ever dealt with an
25 individual at the scene in any manner, especially

2 an emotionally disturbed manner and we also
3 learned then that the determination as to whether
4 it was classified as an EDP or not was made by the
5 9-1-1 operator, which, again, the people up here
6 did not think was the best way to do it because
7 who knows who's making the call, an observer
8 saying an altercation and you have made
9 improvements that we discussed and you're bound to
10 explain in that system, but we would like to know
11 what is available now to a police officer. What
12 do you think should be available based on your--on
13 this committee's findings?
14 JACK DONAHUE: Certainly. As Ms.
15 Agnifilo said, I'm Jack Donahue, Commanding
16 Officer of the NYPD's Office of Management and
17 Analysis and Planning. With respect to Intro 799,
18 which asked for name and locational data to be
19 maintained in the database, it's true with the
20 panel, we looked at what would be most relevant to
21 the officers that would show up at the scene of a
22 potentially emotionally disturbed person event.
23 The information that's most important, obviously,
24 in any 911 phone call and is the first information
25 that a 911 operator solicits from a caller is the

2 locational information. So certainly basing
3 information or a search of what information or
4 quantum information that's available to the 911
5 operator absent a prolonged discussion with the
6 caller will allow the system, our current 911
7 Sprint system it's called, to engage in a search,
8 for what we anticipate now and are planning to
9 implement, the location having repeat calls for a
10 emotionally disturbed person event and the reason
11 we chose the locational data, obviously, is that
12 it would start the search immediately at the
13 beginning of the phone call. The information that
14 in--and then officer and, regardless if there was
15 a dropped phone call while the person was on the
16 line with the 911 operator, the search would not
17 be limited, however, only for those phone calls
18 that were made to 911 operators regarding a known
19 or a potential emotionally disturbed individual at
20 that moment, but instead would search the database
21 regardless of the type of phone call that came in
22 and regardless of how the 911 operator was coding
23 it, notwithstanding how the 911 operator codes it,
24 at intake. Thus, a phone call that comes in for a
25 potential shots fired or person with a gun, family

2 dispute or an assault in progress would all be
3 searched for what may have been at that location a
4 prior emotionally disturbed person history, so for
5 repeat calls. And it's important to also let the
6 Council Members know that the 911 system, when a
7 police officer responds to the scene of a EDP run
8 or is eventually determined to be an EDP run, it's
9 not solely the determination of the 911 operator
10 as to how that job is placed in the system, so--as
11 it's finalized. In fact, the information that the
12 officers get while they're at the scene, so if
13 they come upon a say a family dispute, but in
14 fact, it really wasn't a family dispute, it was an
15 emotionally disturbed person that perhaps wasn't
16 taking their medication and then that person is
17 then removed to the hospital and is treated as an
18 emotionally disturbed person. That job, which
19 initially may have gone in as a family dispute, is
20 then recoded within our Sprint system as an
21 emotionally disturbed person job.
22 CHAIRPERSON VALLONE:: And I would
23 assume you're searching the aided reports to come
24 up with that information?
25 JACK DONAHUE: It is not the aided

2 cards that are being searched with that
3 information. It is, in fact, the 911 system. So
4 that it's where we've--and it's done on the fly.
5 Some of the limitations that we had on the aided
6 system that you refer to is the ability to
7 integrate it currently with our 911 system and
8 having multiple systems operating in the 911
9 platform as we've--I know you've had hearings in
10 the past on it.
11 CHAIRPERSON VALLONE:: It's better
12 that it's not the aided card, because they're not
13 always filled out. So let's say they don't remove
14 someone to the hospital, they show up and it's a
15 family dispute, no one needs to be removed to the
16 hospital, it does an involve an emotionally
17 disturbed person, then what happens?
18 JACK DONAHUE: If it does involve an
19 emotionally disturbed person, but they're not
20 removed to the hospital, say perhaps they are
21 referred for services or given the opportunity to
22 referred for services, it would still be
23 classified as the officers give back a disposition
24 on that job as an emotionally disturbed person,
25 but not referred to the hospital. So it would

2 still be captured [crosstalk]--
3 CHAIRPERSON VALLONE:: So you're
4 searching communications, sounds difficult. Who's
5 actually doing that and inputting this information
6 into a database?
7 JACK DONAHUE: The information is
8 captured currently by the 911 operators so that
9 the information that gets transmitted from the
10 field from those officers that is physically at
11 the scene would be transmitting it back to the
12 operators and they have the ability to update
13 those jobs that they're entering into the system.
14 The 911 call takers, the operators--I'm sorry, the
15 911 dispatchers are the ones that are actually
16 making that entry into the system. So it's
17 happening live while the officers are out there.
18 I would like to say that the solution and the
19 value that this brings is not only to the officers
20 that are at the scene and maybe then come aware of
21 the fact that there's an emotionally disturbed
22 person history at the location, but as Ms.
23 Agnifilo said, the dispatch of the special
24 services, the police department, whether it's a
25 supervisor or the Emergency Services Unit are

2 dispatched at the time the call is thus
3 compressing the time that those personnel may be
4 required once the officers get at the scene.
5 CHAIRPERSON VALLONE:: So you don't
6 need this law to do what you--say you're during--
7 so is this something that's going to be
8 implemented, is being implemented, when is it
9 going to be done?
10 JACK DONAHUE: What we have done is
11 we've conducted the technical testing to ensure
12 that, as you know, the Sprint system is an older
13 system and every change is potentially
14 problematic, so we've conducted the technical
15 testing to ensure that what we've designed it to
16 do can operate. We've designed the training for
17 the 911 call takers and dispatchers and we look
18 forward to having it actually implemented before
19 the end of November. I want to say it's
20 aggressive the end of this month, but certainly by
21 the end of November.
22 CHAIRPERSON VALLONE:: Okay. We've
23 been joined by Council Member Addabbo, Council
24 Member Sears. What other information, now you're
25 talking about a database of only police

2 information and police responses and we've heard
3 about privacy rights, we've heard about--and I'm
4 going to let other council members delve into this
5 more deeply, the problems in communication between
6 the different agencies, but do you have access to
7 any other information? Do you foresee, based on
8 what you've--your study, any access to any other
9 information being available to police officers as
10 they arrive at a scene?
11 JACK DONAHUE: Well, I think the
12 value that an officer may have when they arrive at
13 the scene and additional information that they may
14 have to help them make decisions is really going
15 to be guided by what happens, what unfolds, and
16 what they're exposed--to the officers, that is--
17 when they're presented with the emergency that
18 they've responded to. So instead of information
19 overload in advance of the officers showing up at
20 the scene, which may misinform them if taken in
21 total and prejudice their decisions before
22 arriving at the scene, we think it's knowing that
23 there is a history, being able to dive down
24 literally, what the 911 dispatchers will be able
25 to do is to drive down into those past jobs and

2 see information that's in those past jobs so that
3 they could, if necessary, inform the officers of
4 what had transpired or, as you know, we have many
5 multiple dwellings in the city, if there are, if
6 those calls have come from numerous , we'd be able
7 to tell them, well one came from apartment, you
8 know, A, apartment B, so they may or may not be
9 related. So it's having some information, it's
10 having the more rapid response of the people that
11 have been trained that is extremely important.
12 And just to address something that Council Member
13 Koppell had stated earlier about the amount of
14 training we receive, what's helpful for the
15 officers that show up on those EDP jobs is having
16 someone that is very well trained. As you're
17 aware, you may be aware and I think Chief Gianelli
18 in his February testimony alluded to the fact that
19 each of our emergency service officers are
20 emergency psychological technicians, they received
21 that training in their reissue [phonetic]
22 training, so it is a step above and it's actually
23 getting them to the scene a lot sooner is very
24 helpful for the officers. So it's--while
25 additional information is always better in some

2 sense, it may not always be helpful to those
3 officers.
4 CHAIRPERSON VALLONE:: I'm not
5 disagreeing or agreeing, but I think the answer to
6 my question is that there is no other information
7 other than your own police information available
8 to police officer. So the first time you arrive
9 at a scene, had you never been there before and
10 had someone been in a hospital--been hospitalized
11 many times for a violent incident, which, let's
12 say didn't result in an arrest, there's no way for
13 you to know.
14 JACK DONAHUE: That is correct.
15 CHAIRPERSON VALLONE:: Okay. And
16 that's--let me go to Ms. Agnifilo for a second--
17 that's because, as you mentioned, there are--you
18 discussed, you had much deliberation, which gets
19 me nervous, but you had discussed recommending
20 statutory changes to allow for information sharing
21 and you decided not to. Now, you know, we
22 understand that the balance between public safety
23 and privacy is a tough one, I normally come down
24 on the public safety side, so I'm not sure I agree
25 with you, but I wasn't part of the discussions.

2 What did you discuss? What statutes did you
3 discuss changing or would need to be changed in
4 order to get some information to the police that I
5 believe they might need when they arrive at one of
6 these scenes?
7 KAREN AGNIFILO: We, well we looked
8 at federal law, state law, we looked at the Mental
9 Hygiene law, we looked at HIPAA, and we looked at
10 all the privacy laws, there's education law has
11 privacy information or has privacy restrictions in
12 it, We looked at all the various privacy laws that
13 are out there and we thought rather than
14 recommending statutory change at this time, let's
15 see if we can bridge that information gap with
16 what we already have and we're going to closely
17 study and monitor those pilot project to see if it
18 in fact does have that effect. If it does not, we
19 can always intend to always revisit other issues
20 and other possibilities, including possibility of
21 recommending statutory change in the future.
22 CHAIRPERSON VALLONE:: Okay. You
23 mentioned those pilot programs, and they're all
24 fine, I don't oppose any of them but they all
25 involve, they're all one way, they all involve

2 information from the police department to others,
3 arrest records been provided to the CMT, the
4 Health Care Monitoring Team, post-arraignment
5 mental health screening, alternative detention
6 program and it's all great, but there's none of
7 these programs, unless I missed one, which
8 involves getting information to the police.
9 KAREN AGNIFILO: Absent consent, you
10 can't do that legally and, as we found through our
11 research, that if you provide individuals with
12 mental illness with appropriate treatment, the
13 chance of them actually becoming violent and
14 having an interaction with the police ultimately
15 significantly decreases. So we thought why not
16 focus our efforts on that side of it so that they
17 don't ever get to the point where they're dealing
18 with the police, give the information to the
19 people in the mental health field so that they can
20 know and learn that these individuals have become
21 just as involved. They can help participate in
22 continuity of care while they're in the justice
23 system, whether in the community or incarcerated,
24 they can once--if they are incarcerated and they
25 get out, they can again help provide a transition

2 and make sure that the care is provided to these
3 individuals and hopefully prevent them from
4 becoming involved with the police to begin with,
5 and that's where we focused our efforts.
6 CHAIRPERSON VALLONE:: I agree
7 completely, I just don't like the fact that our
8 police will still wind up showing up without any
9 information at all in many instances and, as with
10 solving our oil crisis, it's not just drilling,
11 it's both sides of the--we have to work both sides
12 of the aisle there. Two quick questions and then
13 I'll move on to colleagues. Implementation, now
14 who's in charge of overseeing these very useful
15 recommendations you have, but they seem, some of
16 them are very ambitious.
17 RIMA COHEN: The four co-chairs of
18 the panel are very involved in the implementation.
19 We have monthly meetings to monitor conference
20 calls and meetings between the city and the state
21 to monitor the implementation and ultimately the
22 panel co-chairs will be held responsible for
23 ensuring that they're implemented and implemented
24 effectively. And I should also note that several
25 of the recommendations have already been

2 implemented and we're now sort of watching,
3 watching them unfold and looking at the results.
4 Others will take a while to get off the ground and
5 we're working very, very hard on those, especially
6 the Care Monitoring Teams, which is a very novel
7 and extremely ambitious approach to trying to
8 strengthen the system for individuals with serious
9 mental illnesses. But, again, ultimately it is
10 the panel, the four panel co-chairs that I
11 mentioned who will be responsible for ensuring
12 that they're implemented. And then, of course,
13 the Governor and the Mayor who are both very
14 supportive of and have made this a priority,
15 ultimately the buck stops with them.
16 CHAIRPERSON VALLONE:: Some of these
17 recommendations involve programs and positions
18 that don't exist right now. There's one in the
19 police department that's supposed to be created,
20 our city agencies are slated for cuts. Has there
21 been discussion yet on who's paying for this?
22 City, state, federal?
23 RIMA COHEN: Yes, some of the
24 recommendations do not have a cost attached to
25 them. For those that do, that involves city and

2 state cooperation, we are splitting the cost and
3 we have an agreement between the Governor and the
4 Mayor to split the cost of those and the majority
5 of the recommendations that have a cost attached
6 to them are city and state. We also anticipate
7 getting Medicaid revenue for a number of the
8 services that are going to be provided. For
9 example, through the Care Monitoring Teams because
10 we're going to be using a database of Medicaid
11 encounters as sort of the basis of the database
12 that the Care Monitoring Teams are going to use
13 and ultimately the goal is going to be to provide
14 better care. We do believe that we can get a fair
15 amount of Medicaid reimbursement for that.
16 CHAIRPERSON VALLONE:: Is there
17 anything we can do as Committee Chairs or as a
18 Council to provide funding or assistance with
19 Albany or the--with legislation or anything like
20 that, just let us know. I have a lot more
21 questions, but I want my colleagues to have a
22 chance. So let's move now to--first of all, we've
23 been joined by Council Member Yassky. Let's move
24 to Council Member Gonzalez.
25 CHAIRPERSON GONZALEZ: Thank you.

2 And thank you for your testimony. With respect to
3 the recommendations concerning enabling
4 information to follow adolescents through
5 transition points in the juvenile justice systems,
6 how do we overcome the privacy laws that govern
7 disclosure and medical and mental health
8 information? And I know we've sort of answered
9 some of this already because my colleagues have
10 asked, but my concern would be, even in the pilot
11 piece that is there in the recommendations for the
12 future, the age of the children that are in the
13 jurisdiction of DJJ, does that pose another
14 situation with respect to parental consent or is--
15 and I understand that they're also part of the
16 privacy law, but is that another barrier obstacle
17 that we have to look at?
18 RIMA COHEN: The short answer to
19 your question is yes, that there are significant
20 limitations to the information that can be shared
21 both for adults and for juveniles or children in
22 the system. We are trying to exist, as Ms.
23 Agnifilo mentioned, we are trying to--we will
24 implement the recommendations within the existing
25 confidentiality laws primarily HIPAA and the

2 Mental Hygiene law, state Mental Hygiene law. But
3 having said that, we are working on what
4 information we can share and we have learned that
5 more information can be shared than is commonly
6 perceived by providers and consumers alike,
7 especially there's a fair amount of confusion with
8 respect to HIPAA and what it prevents, so we want
9 to do a lot of outreach and education on that. In
10 terms of the specific issues with respect to
11 adolescents, I'm going to ask Wendy Perlmutter
12 from Deputy Mayor Gibbs' staff, she is with the
13 Family Services Coordinator, Ron Richter, and she
14 was instrumental in the workgroup that looked at
15 the adolescent mental health recommendations.
16 WENDY PERLMUTTER: Yes, hi, good
17 morning. Thank you for the opportunity to talk
18 about these recommendations. So yes, you raise a
19 very good point that for adolescents, parental
20 consent is required and currently there are many
21 records that are required for--that are obtained
22 by the Department of Probation. When there's an
23 initial intake, parents do come to the probation
24 office and we're currently exploring whether that
25 would be a good opportunity to--when parents are

2 already there without adding an additional burden
3 to them requiring them to come to court and
4 additional time to have some additional consent
5 forms signed at that time and we're also exploring
6 having a universal consent form, which essentially
7 allows for compounding consent. So parents can
8 choose at that time that their information that
9 they're providing about a child would go to
10 probation, could also be disclosed by probation to
11 Department of Juvenile Justice and could be
12 disclosed by Department of Juvenile Justice to go
13 with the child if they go to a state OCFS facility
14 and parents can elect not to share that
15 information or to share that information with only
16 one of these agencies, they're given that option.
17 CHAIRPERSON GONZALEZ: I was just
18 wondering if a parent of a child cannot be found
19 and that child is in the jurisdiction of DJJ, then
20 is it possible that during these recommendations
21 that you could begin to think about maybe
22 guardians that are assigned to these children so
23 that decisions could be made. I'm just, you know,
24 thinking in respect to the future because there
25 are some children that parents are not available

2 immediately, are they not?

3 WENDY PERLMUTTER: Yes, I'm sure
4 that's the case. I would believe that currently
5 there would need to be someone assigned to the
6 youth, but I don't know very much about that and I
7 will certainly bring that back. You raise an
8 excellent point, because we want all children to
9 receive the same advantages of this system.

10 CHAIRPERSON GONZALEZ: I believe
11 it's very significant that you should look at that
12 for recommendations for the future. The other
13 thing is, I know that the report makes--in order
14 to enhance clinical intervention for youth with
15 SED in DJJ or all OCFS custody, DJJ has testified
16 in previous hearings that detained juveniles
17 obtain mental health care now. So I have a
18 question for you in respect to what we're doing
19 here, do you think there's anything else that DJJ
20 should be doing while these young people are
21 detained in respect to mental health?

22 WENDY PERLMUTTER: Well, I think
23 that DJJ is doing a very good job with the
24 assessment tools that they have and with the
25 services that they have. I think that we've all

2 agreed that where we need to focus is for children
3 that are leaving DJJ and are going on to
4 placement, that we want to ensure the continuity
5 of information about mental health services that
6 were provided to the youth in DJJ to make sure
7 that state facilities or private placements have
8 that information as well so they can adequately
9 start treating children with that information. So
10 the Family Care Coordinators is one of the
11 recommendations to fill that gap and the Family
12 Care Coordinator would be assigned to the child
13 and the family and they would move with the child
14 to a state placement, they would only be working
15 with placement-bound youth and they would help
16 provide continuity of information so that the
17 lessons learned at DJJ about a youth would be
18 transferred to the state.
19 CHAIRPERSON GONZALEZ: Do you know
20 how soon the Family Care Coordinator will be
21 implemented? Into this--
22 WENDY PERLMUTTER: Yes, we're
23 looking at--we're aiming for the end of April
24 right now to have that up and running.
25 [Pause]

2 CHAIRPERSON GONZALEZ: ...you.
3 Council Member--
4 CHAIRPERSON KOPPELL: Oh, okay. I
5 think Gale Brewer was--
6 CHAIRPERSON GONZALEZ: Right.
7 CHAIRPERSON KOPPELL: --next.
8 [Off mic]
9 [Pause]
10 COUNCIL MEMBER BREWER: Thank you.
11 I have a few questions that are really specific to
12 the testimony. The first is on the probation.
13 I've had a lot of foster care kids, they go to
14 jail and they come back, they go upstate and then
15 because they're all mentally ill, they end up with
16 a probation officer who is intensive. So is this
17 a new program or are you reconstituting? 'Cause
18 the last kid was 10 years ago, so maybe the
19 program ended, but we've always had, not from the
20 city, but from the state probation officers who,
21 in fact, both, you know, really do intensive work.
22 So is this a new program?
23 WENDY PERLMUTTER: I believe the
24 program, the probation program that you're
25 describing is the new mental health unit. Is that

2 which program--that program is designed for
3 criminal court.
4 COUNCIL MEMBER BREWER: Okay. I'm
5 talking criminal, you're not talking criminal.
6 WENDY PERLMUTTER: Okay.
7 COUNCIL MEMBER BREWER: I'm talking
8 criminal court, you go upstate, as we call it--
9 WENDY PERLMUTTER: Right.
10 COUNCIL MEMBER BREWER: --you come
11 back to Ward's [phonetic] Island, we take the M35
12 bus, we go visit, and then after the M35 bus is
13 done, then you end up with somebody to assist
14 these individuals to--who have mental health
15 challenges. So I'm just asking, that was 10 years
16 ago, so now did the program end and now we have
17 new--I'm just trying to understand what this
18 program is because--
19 KAREN AGNIFILO: I'm not familiar
20 with the 10 years ago program--
21 COUNCIL MEMBER BREWER: Okay.
22 KAREN AGNIFILO: --but this is a new
23 program that we are implementing for individuals
24 with mental illness on probation.
25 COUNCIL MEMBER BREWER: Okay. The

2 question I have is then how long would this
3 program last? Obviously the length of the
4 probation period?
5 KAREN AGNIFILO: Yes.
6 COUNCIL MEMBER BREWER: And then
7 what?
8 KAREN AGNIFILO: Well, the goal with
9 the probation officer is to work with and link the
10 individual to appropriate services and treatment
11 and they were going to be working closely with
12 those providers and so hopefully that will just
13 continue since those links will be made during the
14 specialized supervision.
15 COUNCIL MEMBER BREWER: Okay.
16 Because the links are often, don't always work.
17 So how do you make sure those links--I can give
18 you--that was really my next question because in
19 another piece you mention here the pilot program
20 for CMT, as an example. So this morning, I'm with
21 APS, APS mental health person in the apartment, I
22 spend a lot of time with APS and the person is
23 mentally ill and APS is cleaning, we're getting
24 rid of the bedbugs, blah, blah, blah, and then she
25 acts out, this individual in the apartment, and we

2 call the police, EMS, St. Luke's, I've had it all
3 this morning. So, but the problem--one of the
4 problems was that when APS and the psychiatrist
5 told a nonprofit, I don't know which one, to
6 contact me, who can talk to the individual who's
7 in the apartment some months ago, I never heard
8 from that nonprofit and I didn't know that they
9 were supposed to call me and the links didn't
10 work. Right? So today the psychiatrist said, oh,
11 Gale, I thought that so-and-so had called you and
12 I said I never heard from them. Links don't work
13 unless somebody's kicking ass to make sure it
14 happens.
15 KAREN AGNIFILO: Well I think--
16 COUNCIL MEMBER BREWER: So who is
17 going to do that in this scenario?
18 KAREN AGNIFILO: Ms. Cohen, I think,
19 testified about--
20 COUNCIL MEMBER BREWER: You said
21 four people, not going to work.
22 KAREN AGNIFILO: No, Ms. Cohen, I
23 think testified about this database, this new
24 database that's going to be created--
25 COUNCIL MEMBER BREWER: Yeah.

2 KAREN AGNIFILO: --and what this
3 database is going to be doing is it's going to be
4 monitoring certain individuals and the services
5 that they're receiving and I'm going to turn it
6 over to Ms. Cohen to address it more specifically,
7 but that is to address your concern.
8 COUNCIL MEMBER BREWER: I'm just
9 saying, even with this individual's APS, if it
10 wasn't for me, she'd be in the DHS system 'cause I
11 called Linda, I said this isn't working, this is
12 what you have to do, you have to do one, two,
13 three. So you need--with mental health, in
14 particular, you have a different--you need to
15 really watch everything.
16 RIMA COHEN:: I couldn't agree with
17 you more and I think that's a lesson that kept
18 coming up over and over, or an observation that
19 came up over and over again among panel members
20 that as, I couldn't have said it better than you
21 did that it's all about the links and a fragmented
22 system, which is especially true in New York City,
23 not because we don't have terrific providers, but
24 because it's an incredibly complex system that
25 involves many, many different agencies and

2 entities who often do not work in collaboration,
3 and you mentioned a few of them, but the social
4 service net, which is in many ways very strong in
5 New York City, but it's enormous and complicated
6 and many of the recommendations are designed to
7 strengthen those links and it may not be a perfect
8 system, but one of the key recommendations to try
9 to tie together, to knit these pieces together are
10 the Care Monitoring Teams. And, as I mentioned,
11 this is a very sort of novel and ambitious
12 approach, but to describe it a little bit more,
13 what we want to do is take encounters that are
14 already available through, particularly through
15 Medicaid claims, but also through data that we
16 have on people who've been in assisted outpatient
17 treatment and so forth. So these are the most--
18 individuals with the most serious mental illnesses
19 who have interfaced with the public mental health
20 system. Gather the information about their
21 encounters in one place and have teams whose sole
22 purpose is to monitor their interactions with the
23 system and to identify when there are gaps, when
24 there are situations that may be escalating, for
25 example, somebody who is in care, but who all of a

2 sudden, you know, shows up--who may have a care--
3 may be in intensive case management but all of a
4 sudden shows up in an emergency room--
5 COUNCIL MEMBER BREWER:
6 [Interposing] Goes off meds.
7 RIMA COHEN: Who goes off of their
8 medication, absolutely. Those kinds of things
9 we're going to be developing flags, if you will,
10 for this database of encounters and, again, we
11 have this information already but nobody is
12 looking at it that closely, but we will have these
13 teams who will be there specifically to look at
14 links that are broken and try to bring people back
15 into care and identify those gaps.
16 COUNCIL MEMBER BREWER:
17 [Interposing] I'm sorry, who are these teams? Is
18 it--APS wasn't part of any of this, by the way,
19 right? I didn't see APS mentioned here--Adult
20 Protective Services.
21 RIMA COHEN: No, but we did have
22 many discussions with people from HRA and others
23 who do have knowledge of APS--
24 COUNCIL MEMBER BREWER:
25 [Interposing] Okay. I would say APS would be

2 something to consider in terms of--'cause they
3 deal--anyway--
4 RIMA COHEN: Yeah.
5 COUNCIL MEMBER BREWER: --so who is
6 this CMT? Who are they, nonprofits? Are they
7 city people? Who are they?
8 RIMA COHEN: Yeah, the city--
9 COUNCIL MEMBER BREWER: And are they
10 24/7?
11 RIMA COHEN: They will be monitoring
12 services that are 24/7, because they'll be looking
13 at the emergency, you know, crisis response and
14 other services. Now these are offices probably
15 borough-based, we're still working out the details
16 [crosstalk]--
17 COUNCIL MEMBER BREWER:
18 [Interposing] Through the Department of Health?
19 RIMA COHEN: Through--it's a joint
20 effort of the State Office of Mental Health and
21 the City Department of Health and Mental Hygiene,
22 so it will be jointly staffed and directed by both
23 offices, which we think is very important because
24 right now--
25 COUNCIL MEMBER BREWER:

2 [Interposing] So what happens on Saturday
3 afternoon when Neefee [phonetic] calls and goes
4 crazy? When somebody calls and goes crazy, what
5 happens?
6 RIMA COHEN: The Care Monitoring
7 Teams are not a substitute for, or designed to be,
8 a Crisis Response Team, rather they're a group to
9 monitor ongoing care and the providers that
10 provide high-intensity services.
11 COUNCIL MEMBER BREWER: Okay.
12 RIMA COHEN: So some of the other
13 recommendations that we mentioned with respect to
14 law enforcement and the criminal justice system
15 and the existing crisis response, they're not a
16 Crisis Response Team rather they're looking
17 ongoing--
18 COUNCIL MEMBER BREWER:
19 [Interposing] Okay. I'm not going to--I know
20 there other questions. Let me just tell you, one
21 of the problems I have with what the city and the
22 state are doing now is you're going very citywide,
23 you're going very borough wide with some of these
24 issues. If I have an individual who has a
25 problem, I want to know that I can call Goddard

2 Riverside Neighborhood Center, Riverdale
3 Community--I want to call somebody local and what
4 you're saying is that this is all going to be sort
5 of a more citywide response. You need a local
6 person, that's how you solve these problems and
7 that's what's concerning me. So that when you
8 have and somebody's going to be monitoring this,
9 with all due respect to city agencies 'cause I
10 deal with them as much as anybody and I actually
11 tell people what to do in terms of social
12 services. You need somebody local and that's the
13 problem with your model, if I may say so. Who
14 knows the 2-0 precinct, who knows this particular
15 building? You need something ground and that's
16 not part of this model, along with what Council
17 Member Koppell said, because you don't have
18 nonprofits on here. This whole city operates on a
19 neighborhood basis, not citywide and not borough-
20 wide. In order to keep people calm, you need
21 somebody who can be trusted and who knows the lay
22 of the land and I'm concerned about that. Okay?
23 RIMA COHEN: Yeah, I understand and
24 share your concern about--I don't think the Care
25 Monitoring Teams are designed to do exactly what

2 you had mentioned--
3 COUNCIL MEMBER BREWER:
4 [Interposing] But who is?
5 RIMA COHEN: --but they--
6 COUNCIL MEMBER BREWER: Who is going
7 to do that? That's the--and what I'm trying to do
8 is get the problem solved and you need somebody
9 who's on the ground to help do that.
10 RIMA COHEN: The providers
11 themselves are on the ground and what this is
12 designed to do is to make sure that the providers
13 essentially are doing their jobs and know when
14 there's interruptions in care and so forth, that's
15 what it's designed to do. But the provide--there
16 will be a lot of contact with these, and again
17 they're local, they're not going to be on every
18 street corner, but they are designed to be much
19 more local than the system that we have right now.
20 COUNCIL MEMBER BREWER: Right. It
21 needs help.
22 [Pause]
23 CHAIRPERSON VALLONE:: Chair
24 Gonzalez?
25 CHAIRPERSON GONZALEZ: Yeah, I

2 [pause] for DJJ and my biggest concern and our
3 biggest concern and some of our colleagues just
4 spoke about it is in tracking the youth from DJJ.
5 Is there--is DJJ in the forefront of this plan
6 ongoing and will they be able to, you know, be
7 part of that?
8 WENDY PERLMUTTER: Yes, DJJ has been
9 very involved in this plan. In fact, we have
10 weekly calls with our state partners and city
11 partners to talk about the development of the
12 Family Care Coordinators and other issues that
13 come up and DJJ is on those calls. So I think
14 that all of the agencies that are going to--that
15 are touched by the recommendations are very
16 involved with the plan.
17 CHAIRPERSON GONZALEZ: Right and
18 also in the light of the percentage is extremely
19 high with emotional disturbances of youth, so I
20 think that's very significant that we understand
21 that they're there in the forefront. Thank you.
22 Wendy: Yes.
23 [Pause]
24 CHAIRPERSON KOPPELL: Let me just
25 say that I think the better monitoring of cases is

2 a very good thing and all these recommendations
3 are salutary, but I am focused still on the issues
4 raised by several incidents that have come up and
5 the testimony of the police, I think, was very
6 revealing in response to Chair Vallone's
7 questions. They are using their own database,
8 there is--there's been no indication in all this
9 testimony of any--and the report talks about
10 better coordination between the police and the
11 mental health system, it talks about it. Again
12 and again and mentioned in your testimony too, but
13 there's been no testimony of any way in which
14 those two are going to come together. The police
15 testified their only database is their own reports
16 of prior activity, so if someone is emotionally
17 disturbed, let's assume for the first time is
18 acting out, they don't have any idea about it,
19 they may have been in a mental facility for
20 treatment and taking medication for 10 years, but
21 the police have no idea about this when they go
22 out to respond to an incident. And you talked
23 about coordination between the police and the
24 mental health, but you've not said anything about
25 it, you talked about that this is a major problem,

2 but you haven't revealed any solution to that
3 problem. You say there are privacy concerns, I'm
4 sure there are, but you haven't discussed how
5 those can be overcome, you haven't proposed
6 legislation, you say well you're nervous about it,
7 so therefore you're looking at other approaches.
8 But the base question is, how are you going to
9 deal with better coordination between the law
10 enforcement people and the mental health system?
11 I haven't heard that.
12 KAREN AGNIFILO: There's several
13 issues you raise and we struggled with a lot of
14 the things that you're bringing up as well, as
15 issues. But I want to sort of separate out two
16 different things, there's coordination of mental
17 health information and then there is emergency
18 response. And coordination of mental health
19 information is much more comprehensive, there's
20 much more information available and much more--you
21 need more information to give better care and to
22 make better decisions. Police--and I'll turn it
23 over to Inspector Donohue momentarily--but police
24 are responding to emergencies and the question is,
25 what do they need for that emergency and how

2 quickly and accurately and reliably can we
3 deliver that information. And so the question of
4 just that particular question, putting aside for a
5 minute the other bigger question you raise about
6 information sharing, what information could be
7 useful for the police in that emergency response.
8 And we learned through exploration of these issues
9 that people sometimes use the word emotionally
10 disturbed person and mentally ill as synonymous,
11 but they're not synonymous necessarily, you can be
12 emotionally disturbed and not suffer from a mental
13 illness--
14 CHAIRPERSON KOPPELL: Impossible.
15 That just makes--that makes no sense, in my
16 opinion, knowing the English-language--
17 KAREN AGNIFILO: I will--
18 CHAIRPERSON KOPPELL: --emotional
19 disturbance doesn't have to do with a broken leg,
20 it has to do with something wrong in someone's
21 psyche, in someone's emotions, that's a mental
22 health issue. If you're emotionally disturbed,
23 you may not be, I don't know, a schizophrenic, it
24 may not be one particular defined condition, but
25 you cannot--if you say to me that someone's

2 emotionally disturbed and that's not a mental
3 health issue, that just makes no sense.
4 KAREN AGNIFILO: Well, I didn't--
5 what I meant to say was it's not a mental illness
6 necessarily, not that it's not a mental health
7 issue, but it's not a mental illness where there
8 might be records or it might be information. For
9 example, a person--
10 CHAIRPERSON KOPPELL: [Interposing]
11 But telling me that emotionally disturbance is not
12 a mental health issue?
13 KAREN AGNIFILO: It's not a mental
14 illness. For example, a person could be very
15 upset about a particular situation and react
16 emotionally in a way that somebody calling on the
17 phone might relate to a 9-1-1 operator information
18 that that person will be classified as what they
19 call an EDP or an emotionally disturbed person.
20 Does that mean that that person is, in fact,
21 emotionally disturbed or that person has a mental
22 health issue? It's unclear but for purposes of
23 police response--
24 CHAIRPERSON KOPPELL: [Interposing]
25 May be temporary, but it is a mental health issue

2 at the time, it may not be permanent.
3 KAREN AGNIFILO: Absolutely, and we
4 couldn't agree with you more, but the question is,
5 what information in that circumstance is there
6 that could be available to the police and in that
7 particular circumstance there wouldn't be any
8 other information because that's just, it's
9 happening right then and there. And even in a
10 situation where person has a prior mental health
11 history, again, the question for the police is
12 what about that information would be helpful for
13 them in that emergency response. And that's where
14 we were looking to see what information could be
15 provided to them and it was the location of the
16 call that was more helpful for the reasons
17 Inspector Donahue described. For example, if
18 you've got a 9-1-1 call and say, for example, you
19 have a name and the name is a very common name and
20 it searches some kind of a database or some kind
21 of information system quickly, because this is an
22 emergency response situation, so it has to be
23 quick, it's not going to be a more detailed or
24 lengthy identification process, how useful is that
25 information for the police that Jack Smith, you

2 know, there's a Jack Smith with a prior mental
3 health history. So that was why it was the
4 location-based information was what was determined
5 to be most useful.
6 [Pause]
7 CHAIRPERSON KOPPELL: The police
8 testified, and appropriately so in my opinion,
9 that it's useful for them to know whether there
10 were prior incidents that indicate that the person
11 has emotional disturbance or has mental health
12 issues. They keep a record of that, maybe it's
13 not a great record, but they keep a record that
14 there have been prior incidents with this
15 individual displaying emotional disturbance,
16 mental health issues. That seems to be useful to
17 them. It results in the dispatch of more
18 experienced personnel, which is a good thing.
19 Now, the problem is that many times that record is
20 not available to them because it may not have
21 involved prior police activity, but it may well
22 have involved prior activity in the mental health
23 arena. The person may have been hospitalized, the
24 person may have been brought to the clinic or to
25 the hospital by the family, not necessarily with

the police. So the question is can the--if it's useful for the police to know that a person has a prior history of mental illness and perhaps acting out as a result, then they should know that even if the person doesn't have a prior police history and you haven't given me any indication of how this information can be accessed by the police.

[Off mic]

[Pause]

MALE VOICE: That's right.

[Pause]

JACK DONAHUE: The information that an officer needs when they arrive at the scene is what can be used by them is largely going to be dictated by the circumstances, as I said before, that are presented to them at that time. Whether--and what the officers do when they arrive is obviously assess the situation and determine what would be needed to safely and quickly resolve the situation that they're presented with. I said that information obviously in a vacuum would not be helpful, it would obviously need to be accurate and put and contextualize it to the situation that the officers have. I think that when they respond

2 and they see something that evidence is that a
3 person is having an immediate situation of extreme
4 emotional disturbance or a temporarily deranged
5 and not necessarily something that is a long-term
6 illness. The quantum of information that's
7 available to them at that time lets them act
8 appropriately. If there are situations where
9 clinicians have made determinations about a
10 person's health that the police are unaware of, I
11 think the panel attempted to address those
12 situations in trying to wrest the information from
13 the areas and people that have it, but I think
14 that we could only speculate the value in any
15 individual circumstance the information that we
16 would get from clinicians or doctors that are
17 aware of something that has happened in the past
18 with that individual.
19 CHAIRPERSON KOPPELL: Well wait a
20 minute now, you said that you want to know whether
21 there has been a problem with an emotionally
22 disturbed person or a mentally ill person at the
23 location so that when the police officer is
24 dispatched, let's say there's a person who is
25 acting in a threatening manner, you want to know

2 whether this person's been involved before in this
3 kind of behavior, right?
4 JACK DONAHUE: The information that
5 we're looking for is not as specific to the
6 individual and, but it's to the location. So
7 we're differentiating with the individual and the
8 location. One of the reasons that we did that--to
9 elaborate a little bit more on my prior
10 statements--is that in several instances,
11 individuals move around from scatter site housing,
12 well the location may be in the inventory of a
13 community-based organization or HRA where people
14 are temporarily housed, the individuals may be
15 transient and they may not stay. So the locations
16 are very useful for us to know that we may be
17 potentially going into a situation where that
18 location is used by people with mental illnesses
19 or that we have responded to locations that have
20 repeat call histories. Not that the individual
21 does.
22 CHAIRPERSON KOPPELL: Well, now wait
23 a minute, you're talking about two completely
24 different things here. One, you're saying you
25 want to know if the location is like a halfway

2 house where there a lot of people with emotional
3 disturbance, I can understand you want to know
4 that, but that's different than a house where
5 there's been a mentally disturbed man, let's say,
6 where the police have had come out four times
7 before when this man acted in an irrational manner
8 and started throwing furniture around, as just an
9 example, right? Do you want to know whether this
10 man has been throwing furniture around in the
11 past? Is that something that's useful to you?
12 JACK DONAHUE: And if that
13 individual has been--if the job that the police
14 have responded to in the past--
15 CHAIRPERSON KOPPELL: Yes.
16 JACK DONAHUE: --has been determined
17 that it was a response to an emotionally disturbed
18 person event--
19 CHAIRPERSON KOPPELL: Yes.
20 JACK DONAHUE: --by our database,
21 then, yes, we would know about it and our new
22 protocols will capture that information and make
23 that available to the officers that are
24 responding.
25 CHAIRPERSON KOPPELL: So this is not

a halfway house, it's not a mental health facility, it's just a home, but there's a gentleman there who, because of emotional disturbance, has been--the police have been called four times before, because he's been throwing furniture around the house. That's useful for you to know.

JACK DONAHUE: If in the past, those situations--he's been throwing furniture around because that person is experiencing emotional disturbance--

CHAIRPERSON KOPPELL: Yes, yes, that's right.

JACK DONAHUE: --that is what we would capture.

CHAIRPERSON KOPPELL: Okay. Well but and you would know this because you've studied your prior reports and you have a database that you can access when the fifth call comes in that he's throwing furniture around, right?

JACK DONAHUE: That is correct.

CHAIRPERSON KOPPELL: Yeah. So, would it not therefore be useful to know that this individual was throwing furniture around four

2 times before, but no police were involved. Each
3 time his father took him to the clinic and he got
4 medication and he calmed down. Same thing as with
5 the police--in one instance, the police came and
6 took him to the clinic or to the hospital, in the
7 other instance, his father did, same history.
8 Wouldn't it be useful to know that his father took
9 him four times to the hospital, say?
10 JACK DONAHUE: Without delving and
11 speculation, I think that given the exact same
12 scenarios when the police are not involved, there
13 is a likelihood that it would be useful.
14 CHAIRPERSON KOPPELL: Okay. I think
15 that the point I'm trying to make, I'm not going
16 to belabor it any further, is that the report
17 talks about better coordination, I realize that
18 coordination is important in the parole, in the
19 probation process, say, but I'm focused mostly
20 because this hearing arose out of incidents where
21 we believe that mentally disturbed persons were
22 not perhaps dealt with as best they could be, I'm
23 focused on that aspect and I don't think, frankly,
24 you've answered it and I'm not going to ask you to
25 respond any further, but I'm going to ask that

2 that be looked into further and if you, by the
3 way, have a report that you've done on the privacy
4 issues, I'd like to explore that and explore the
5 possibility of possible change in legislation--and
6 I know there are people in the audience who may be
7 very concerned about what I'm saying because
8 they're concerned about privacy issues, and I am
9 too, but I'm also concerned about what I talked
10 about and I don't need a response.
11 [Pause]
12 CHAIRPERSON VALLONE:: Thank you,
13 Chair Koppell. We've got four other witnesses to
14 testify so even though we have some more
15 questions, we'll follow up with, as the Chair
16 said, with some writings and stay involved with
17 the application of that database and make sure it
18 goes along smoothly. Thank you for the work
19 you've done on this report, though, it's immensely
20 helpful. And it's our job to sometimes criticize
21 and make things better, at least what we believe
22 to be better, but that's our oversight function,
23 but you've done a tremendous job here. It's a
24 great tool for all of us to begin to serve the
25 mentally ill better and to definitely increase the

2 information available to the police, if possible.
3 We want to work with you on that, so thank you
4 both for everything you guys have done and we look
5 forward to working with you. We now will call
6 [pause] no questions, okay. We now call Jennifer
7 Parish from the Urban Justice Center and Claudia
8 Montoya from Legal Aid Society. The next and last
9 panel after that will be Dr. Gerald Landsberg and
10 Joel Copperman. We were joined by Council Member
11 Maria del Carmen Arroyo and Helen Foster is also
12 here, I believe, yes. [Pause] You can begin in
13 whatever order you like [off mic]. [Pause] Turn
14 on the mic and introduce yourself.
15 [Pause]
16 CLAUDIA MONTOYA: Good.
17 [Off mic]
18 [Pause]
19 CLAUDIA MONTOYA: Okay. Good
20 morning. I am here on behalf of the Legal Aid
21 Society. My name is Claudia Montoya, I'm an
22 attorney in the Enhanced Defense of the MICA
23 Project and we're here to talk about Introduction
24 799. Now although we are in support in changing
25 and measures of responses to EDP calls, we do not

2 support this measure as comprehensive response to
3 those calls. [Pause] [off mic] Okay. So I'm
4 just going to outline, you have my testimony here,
5 I'm just going to briefly outline some of the
6 things and concerns that we have. The first
7 thing--
8 CHAIRPERSON KOPPELL: [Interposing]
9 You are very much better than most of the people
10 who come on, insist on reading every word.
11 CLAUDIA MONTOYA: Okay. Well I
12 won't.
13 CHAIRPERSON KOPPELL: I find it much
14 more useful to hear a summary and then responding
15 to questions. So thank you for your being
16 considerate.
17 CLAUDIA MONTOYA: Thank you. Well
18 the first point actually I'm going to address is
19 more about what you were talking about, Mr.
20 Koppell, which is what is important in EDP call
21 and why the databank is not--I'm sorry, is it [off
22 mic] oh, closer? Okay. What's really the most
23 important thing. Now, you need to look at the
24 unique nature of a crisis of a person and you want
25 to look at the behaviors of what it is that a

2 person is exhibiting at the time that there is a
3 call. So, for example, the kinds of factors you
4 want to look at is what is the person doing; are
5 there any weapons involved; are there people
6 involved; are there hostages; does the person want
7 to kill themselves. And the way that this
8 information obviously would come in through would
9 be most through the 9-1-1 call and this is more
10 important than any prior information that might be
11 in a databank because it helps the police really
12 assess the situation when they arrive. It's the
13 most pertinent information that they can have to
14 be able to deal with the situation. For example,
15 let's say we have John Doe and four years ago
16 there was a call that came in and his symptomology
17 might be completely different from what he's
18 experiencing on that day. So what you want the
19 police to have is, what is the person experiencing
20 at the time of the call so that they can assess
21 the situation. And if the police were to rely on
22 prior incidents, they might not really be able to
23 respond properly to the incident. So we do
24 support the recommendation of the panel that they
25 train 9-1-1 dispatchers to elicit better

2 information and that that training protocol, you
3 know, exists is a very good thing. The second
4 thing that we recommend is best practices for EDP
5 calls. Now I know that there was a--the prior
6 speaker spoke about. Briefly, about the Crisis
7 Intervention Teams and that is what we support
8 here in this city and what the Crisis Intervention
9 Team or the CIT does, it creates, improves police
10 encounters with people with mental illnesses in
11 these calls. For example, what they would have
12 is, and I think this was alluded to before, is
13 extensive training of police officers along with
14 mental health professionals and they are actually
15 a team and they respond to these EDP calls really
16 I think would be so beneficial. There have been
17 outcomes studies of this model and they're
18 actually just note that this model is in 35 states
19 But anyway, getting back to the outcomes studies,
20 they have been successful in reducing arrests,
21 increase--did I say that correctly? Yeah.
22 Reducing arrests, I thought for a minute I said
23 that incorrectly. There have been an increase in
24 referrals and participation in mental health
25 programs, it reduces police officer injuries and

2 any involvement of SWAT teams and it decreases
3 police shootings of people with mental illnesses.
4 So we recommend that this model be strongly looked
5 at and we do recommend that this be a model for
6 the city. [Pause] One of the things also is that
7 with this proposed amendment, people who would be
8 subject to this database might not necessarily
9 have mental illness and it was, I know there was
10 the prior discussion, what is a person who's
11 mentally disturbed versus a person who has mental
12 illness. So one of the EDP calls that could come
13 in would be somebody--it could be a person
14 suffering from drug-induced psychosis or they
15 could have suffered some sort of trauma, a family
16 member died and, you know, they want to kill
17 themselves or they may have traumatic brain injury
18 and those symptoms sometimes mimic psychiatric
19 ailments. They may not necessarily be people with
20 mental illnesses and they would be subject to
21 being part of this databank. So that in addition
22 would create a problem and that really it doesn't-
23 -there's no mechanism for people to challenge
24 their inclusion in this databank. [Pause] And
25 lastly, we just feel that the language of

2 Introduction 799 is overly broad and it fails to
3 specify how to instruct the NYPD and DOHMH on what
4 information other than name and addresses. What
5 would be pertinent information that would go into
6 this databank and we're very concerned that, in
7 fact, it does violate confidentiality laws and
8 people's rights to privacy. So we don't support
9 that any names go into any databank and we do
10 support the panel's recommendations that locations
11 be flagged, rather than people's names or any kind
12 of pertinent information about a particular
13 individual. So thank you very much for this
14 opportunity to testify. And Ms. Parish.
15 CHAIRPERSON KOPPELL: Before we ask
16 questions, we'll let you talk.
17 JENNIFER PARISH: My name is
18 Jennifer Parish, I'm here because I work at the
19 Urban Justice Center's Mental Health Project, I'm
20 the Director of Criminal Justice Advocacy and we
21 focused for almost 10 years on the intersection of
22 mental illness and the criminal justice system and
23 I do think it's very important for the City
24 Council to take on this issue of police
25 interactions with people who are in a psychiatric

2 crisis, so we thank you for that. The police do
3 need to be held accountable as public service for
4 their interactions with people with mental
5 illness. However, this legislation does not
6 really address the heart of the problem. The
7 focus of this legislation is on getting
8 information to the police. However, the real
9 question and the real focus needs to be on how the
10 police use that information when they're at the
11 scene of these crises. The responders, and for
12 them to be able to use this information
13 effectively, the people who are responding need to
14 have a level of expertise and judgment that allows
15 them to use this information effectively and I
16 think that that's really where the Council needs
17 to focus and, as Ms. Montoya mentioned, there are
18 models out there and they're not just in places
19 like Memphis, Tennessee, they're used in Los
20 Angeles, Chicago, Houston, big cities trying to
21 address this problem by crisis intervention teams
22 and there are different models for doing this,
23 some involving creating experts within the police
24 force and some involve incorporating mental health
25 professionals into these teams who respond to

2 these situations and have the tools and the
3 temperament to effectively bring down the tensions
4 in the ,situation stabilize the situation and make
5 sure that the outcome is a positive one both for
6 the person in crisis and for the police
7 department. For instance, in the situation that
8 you mentioned, Council Member Koppell, of Iman
9 Morales, there wasn't a question about is he an
10 emotionally disturbed person, has he had contact
11 with the mental health system in the past. They
12 knew that, the mother provided information, he is
13 a mental health consumer, he's had a change in his
14 medication, he was obviously destabilized, but the
15 police officers who respond to the scene did not
16 have the judgment to be able to determine how to
17 end that situation effectively and it resulted in
18 his death. So we really need to look at how the
19 responders use that information and I think it's
20 important for the City Council to fashion
21 legislation that will require them to look at
22 these models and to figure out how we can
23 implement that in New York City. While it may be
24 different from the way it's implemented across the
25 country, we can certainly start out with, I mean,

2 this city state commission had several points
3 where they recommended pilot projects. Well why
4 not have a pilot project in a certain couple of
5 precincts in the Bronx, for example, and see, you
6 know, can we implement these sorts of situations.
7 And I can tell you that this is not something that
8 you can leave to the NYPD to do on its own. It
9 has shown that it is not interested in pursuing
10 this at all. I remember, I can't remember whether
11 it was you, Council Member Koppell, or someone
12 else on the committee who asked the officer
13 Gianelli or one of the other police officers who
14 testified at that hearing, are you willing to look
15 at these other models and that they said that they
16 would and they haven't. There is this LINK
17 committee, which is referenced in the state city
18 commission report, but that committee has narrowed
19 its focus to the specific issue of the training it
20 now does and how to improve that training and
21 maybe expand it to some other areas, but they will
22 not--and, in fact, removed one of the
23 subcommittees that was supposed to be looking at
24 the issue of whether we should adopt these Crisis
25 Intervention Teams. So they need direction from

2 you as the City Council to tell them we want you
3 to look at this, we want pilot projects done, we
4 want a response to ending these crises. Thank
5 you.
6 CHAIRPERSON KOPPELL: Thank you very
7 much. Since you said what I believe, I don't need
8 to ask you a question because I agree with you and
9 I think we should do this modeling and I think
10 that excuse that it works in little cities like
11 Memphis or Rochester is completely nonsensical,
12 frankly, because we can divide New York City and
13 we do divide New York City for a lot of purposes
14 into smaller units and there's no reason why we
15 can't divide New York City into smaller units when
16 we have police precincts, we have Community Board
17 districts, we have boroughs. There are many ways
18 in which we can make New York City into smaller
19 units that function essentially independently of
20 one another. So I couldn't agree more with your
21 testimony, I don't fully agree with your colleague
22 or your partner for purposes of this panel,
23 because I think it is important to know some
24 background. So anybody else want to say anything
25 or ask anything? No?

2 JENNIFER PARISH: But I think you
3 would find that there are nonprofit mental health
4 treatment providers who would be willing to work
5 with the police if they were approached by police
6 in their precinct to try to set up some sort of
7 model. So I think the mental health community is
8 definitely interested in creating that
9 partnership, but we can't get the NYPD to come to
10 the table on that issue.
11 CHAIRPERSON KOPPELL: But we
12 actually have in each part of the city Emergency
13 Response Teams run by, as far as I know, they're
14 mostly by nonprofits. For instance, in my
15 particular area, the visiting nurse service is the
16 Emergency Response Team, and I may not be using
17 the right team, and when they get a report of an
18 emotionally disturbed person, they send a team
19 out, without the police, but they can also call
20 the police to get involved. They would be a
21 natural partner of the police in responding, but
22 they're not called upon because we don't have that
23 model operating. We could start it tomorrow.
24 JENNIFER PARISH: Exactly, those
25 mobile crisis teams that you're--

2 CHAIRPERSON KOPPELL: Yeah.

3 JENNIFER PARISH: --referring to
4 have, and we've had some meetings with them and
5 they've expressed interest in doing that, but
6 going to individual precincts and trying to speak
7 with them, while there may be some police officers
8 who are interested on that level, they always say
9 we have to have direction from One Police Plaza,
10 we can start a pilot project on their own, which,
11 you know, is understandable, but the mobile crisis
12 teams would be a natural ally to that. However,
13 family members are loath to call them in a real
14 crisis because they have 72 hours to respond, so
15 they're not really the kind of crisis intervention
16 that the police are. So there could be some
17 changing of that model, but we have to have NYPD
18 at the table.

19 CHAIRPERSON KOPPELL: Appreciate
20 that. Gale, did you want to say…?

21 COUNCIL MEMBER BREWER: Oh, thank
22 you. My neighborhood is Rosedale Hospital and
23 they do, do a good job. My question is the city
24 just outlined a model that had city agencies
25 trying to be the coordinator in terms of linking

2 services and I'm just wondering if you think that
3 would work, 'cause the way it was layers earlier
4 is that there would be a agency that I guess is
5 working with the individual, could be a halfway
6 house or it could be somebody from a mental health
7 agency that's working with the meds and so on, and
8 then the second layer would be a city agency team
9 that would be making sure the linkages are there.
10 But I just worry that this is a lot of linkages, a
11 lot of layers and not doing what you're
12 suggesting. So I'm just wondering 'cause you both
13 have experience dealing with these individuals,
14 either through the court system or trying to make
15 sure that their rights are preserved. So I'm just
16 wondering, which of these models do you think
17 would work and do we need this extra layer of
18 making sure the services work? 'Cause I thought
19 that's what the agencies are supposed to do now.
20 JENNIFER PARISH: Well I think it
21 could be helpful to have someone who's overseeing
22 getting the information that a client has been
23 arrested and letting the agency know that. I
24 think that could be helpful because then the
25 agency could get involved right away, rather than,

2 you know, a couple of weeks later when they're
3 looking for the person. Certainly agencies call
4 us and say I can't find a consumer, are they in
5 the criminal justice system and we help connect
6 them, but some oversight probably could help,
7 however, I am concerned about just creating more
8 linkages. What we need are real services and then
9 to hold those services accountable, not just
10 another link because a lot of times people think,
11 oh, there's a link that's taking care of that and
12 that's how people fall through the cracks.
13 CLAUDIA MONTOYA: And just in
14 addition, also with this oversight committee, if
15 they do find that there are deficiencies in the
16 person's treatment, what are the consequences? Do
17 they just observe it or do they actually have some
18 sort of power to do something to make sure and
19 effectuate that there is proper treatment of the
20 person, so that's not clear to me. I do agree
21 though, as somebody who represents people who are
22 arrested and often incarcerated, that it does help
23 if somebody--if there is treatment out there for
24 the person and that they are notified that that
25 provider then reach out to the lawyers so that,

2 you know, something could be worked out for the
3 person.
4 [Pause]
5 FEMALE VOICE: Thank you.
6 CHAIRPERSON VALLONE:: Thank you,
7 both, and the next panel will consist of Dr.
8 Gerald Landsberg and Joel Copperman? [Pause]
9 CASES. [Pause]. Thank you, gentlemen. Why
10 don't, Mr. Copperman, you go first since we had
11 your card first.
12 [Off mic]
13 JOEL COPPERMAN: Who goes first?
14 CHAIRPERSON VALLONE: Whoever is
15 show from cases.
16 [Off mic]
17 CHAIRPERSON VALLONE: Okay. Thanks
18 'cause your card was up first.
19 [Pause]
20 JOEL COPPERMAN: Okay. Is this on?
21 Yeah, so, my name is Joel Copperman, I'm the
22 Director of CASES, which is an alternative to
23 incarceration program here in the city and we have
24 been providing alternatives to incarceration in
25 this city for over 40 years and for the last 10

2 years, we've been working with people who have
3 mental illness through the Nathaniel Project,
4 which was mentioned in the city's testimony as
5 [off mic] as the Exit Program, which was also
6 mentioned by the city. And so what I'd like to do
7 is just briefly tell you about those programs and
8 then identify two issues that came up in the
9 report that I think that needs some focus. So the
10 Nathaniel Project was started in the year 2000, it
11 serves people in the Supreme Court, people who are
12 charged with felonies and it provides them with
13 mental health services. It is an ACT team, an
14 Assertive Community Treatment team that is
15 licensed by the State Department of office of
16 Mental Health. In the eight years that we've been
17 in existence, we have served over 360 felony
18 offenders with great success, which I'll describe
19 later. As an aside, the program was named the
20 Nathaniel Project after a schizophrenic homeless
21 man whose illness was untreated for 15 years as he
22 cycled in and out of the city's and state's jail
23 and prison system and that is the point of the
24 project. The point of the project is to help
25 people obtain entitlement, to provide case

2 management. substance abuse services, wraparound
3 services, therapeutic support services, to ensure
4 people can get into housing, can stay in the
5 housing, and receive treatment. In addition, we
6 do that while providing regular updates to the
7 court 'cause people are coming to us as part of
8 they're in the court system, they're coming to us
9 as an alternative to incarceration. So our
10 relationship is with the court and we are
11 continually updating the court for services. And
12 so we believe this is a better alternative, a
13 safer alternative to jail or prison for people who
14 are coming into the program and we believe that
15 the data around the program supports that: 72% of
16 Nathaniel and ACT participants had no subsequent
17 re-arrest and 82% had no criminal convictions over
18 a post-release period of 19 months, and so we have
19 an enormous amount of success in that program.
20 Another program of CASES that I'd like to allude
21 to is, Ms. Agnifilo mentioned the Exit program,
22 which was a program that operated in the criminal
23 court trying to identify individuals who are
24 before the court who have committed misdemeanor
25 offenses, as opposed to the Nathaniel felony

2 program, that program was funded with some federal
3 funds, which expired. We are now operating that
4 program again under something called transitional
5 case management, we're running a pilot program in
6 Manhattan where we are trying to identify people
7 with mental illness in the criminal court. This
8 is a much harder task thank doing this in the
9 Supreme Court because at the speed at which the
10 criminal court moves. And in fact, we've decided
11 to take on the additional task of trying to
12 identify people between the arrest to arraignment
13 process, that 24-hour process, we are trying to
14 identify people in the courts between arrest to
15 arraignments who have mental illness and could use
16 the benefit of a case management program and
17 mental health services. So this is where one of
18 the recommendations of the panel comes into play
19 and that's the issue about access to information
20 and this is a difficult and complicated issue, but
21 in identifying people coming through the justice
22 system, people who have been arrested, people who
23 have mental health issues, the figure commonly
24 used is 16% of the people coming through the
25 justice system have mental health issues. Trying

2 to identify those people and connecting them to
3 services is the issue that CASES is trying to work
4 on and we chose to try to do that between the
5 arrest to arraignment process because only 50% of
6 the cases are disposed of at arraignment, and so
7 you have this moment, this opportunity, this door
8 if you will that people are coming in. But 50% of
9 them are leaving at the point of arraignment and
10 so if we can connect them with services, that
11 would be an excellent opportunity to do so. Of
12 course, we're faced with the hugeness of the
13 system--94,000 arraignments in Manhattan in the
14 year 2007. We used--they made reference to a
15 screening instrument, we use something called a
16 brief jail meant health screen, Ms. Agnifilo made
17 reference to that, as a way of identifying people
18 and then we try to connect them to services. You
19 should be--you may be interested that the Jed
20 Foundation is supporting this effort and we have
21 put together a group of government officials, not
22 for profits, advocacy organizations, many of the
23 people who were sitting at this table from the
24 city earlier are involved in this effort to try to
25 figure out some of these issues that will help us

2 identify people between that arrest to arraignment
3 process so that we can provide effective services,
4 and we would be happy to keep you informed about
5 that and in any way that we could. I just want to
6 briefly mention one other issue the panel--the
7 city state panel looked at the services that
8 talked about alternative to incarceration
9 services. One of the important services that gets
10 too often overlooked is that the kinds who come
11 into our program are interested and need
12 employment and so there is an opportunity, far too
13 few of current clients in our program, only 5 1/2
14 percent of them are employed. However, 43% say
15 they want and they are interested in obtaining
16 employment and it is going to be one of our
17 initiatives over the next year to try to make that
18 happen that, you know, meaningful daily activity
19 is an important part of the recovery for anybody
20 who has mental illness and so it's our goal to try
21 to connect people in our programs to employment
22 and supported employment services. So those are
23 the two issues that I wanted to address with you
24 this morning and I'm happy to answer questions or
25 to give you more information about the efforts

2 that we are providing--services we're providing.
3 CHAIRPERSON VALLONE:: Thank you.
4 Dr. Landsberg?
5 [Pause]
6 DR. GERALD LANDSBERG: My name is
7 Dr. Gerald Landsberg, I'm a professor at the
8 School of Social Work at NYU and Director of the
9 Initiative Against Violence. I have worked in the
10 area of forensic mental health for the last 25
11 years, both as a professional and as a research
12 and academic, including with respect to the city,
13 as Assistant Commissioner for the Department of
14 Mental Health from 1987 to 91. One of my
15 responsibilities was creating the Forensic Mental
16 Health Response System. Since going to NYU, I've
17 had a variety of major grants both federal, state,
18 and foundation grants to look at the forensic
19 mental health system. We had a huge grant to look
20 at jail diversion and its effectiveness, we're one
21 of nine sites with respect to jail diversion
22 projects, that was an immensely informative
23 project. We also actually, a part of that project
24 actually brought New York City police trainers to
25 Memphis to look the CIT model, as you see that was

2 in about eight years ago and we've not seen any,
3 you know, changes since. But the other key issues
4 we found that alternatives to incarceration work,
5 often they work a little bit better if you mandate
6 them. P, a second is you can save a huge amount
7 of money by keeping people out of jail. As part
8 of the diversion project, we had a team of health
9 economists look at the cost of community care and
10 housing, which was about $35,000 a year and look
11 at what it costs to keep an individual in Riker's,
12 which is about $100,000 a year. Especially in
13 this time of budgetary needs, that's an important
14 issue, but sometimes gets ignored. If we can keep
15 more people out of Riker's and it's estimated at
16 25% of the inmates in Riker's have substantial
17 mental health problems and, in fact, stay for a
18 significantly longer periods of time than non-
19 mentally ill offenders. In 2002, I was given a
20 grant by the New York Community Trust to look at
21 systems of treating forensic mentally ill
22 individuals, these focused on adults. That was a
23 very, very intense project. During that time, we
24 probably met with over 250 agency representatives,
25 consumers, government representatives, city, and

2 state, various other players, we met extensively
3 with the police department. We spent--we had one
4 separate committee on dealing with emergency
5 response systems and looked intensely. I met with
6 local and major players from the police department
7 from Brooklyn, from the ESS, ESU to look at what
8 the police response was. We, in fact, in January
9 2004, issued a report which was sent to many
10 different people, including the office--Mayor's
11 Office of Criminal Justice, so the question is,
12 which I think you raised before, is what happens
13 to some of these things and who's going to, you
14 know, continue oversight to make sure things move
15 ahead? A number of those recommendations in fact-
16 -well let me talk about police response too.
17 Overall, the police response and the proposed law,
18 I think the proposed law has some potential
19 benefits, if it in fact gets out I think the issue
20 of coordinating with the mental health system is a
21 key one, but the issue is how do we understand and
22 use that data for, in fact, making program
23 changes? The average police officer, when he
24 brings a client to an emergency room, if it's not
25 a specialized emergency room, known as a CPEP

2 [phonetic], will spend four to six hours waiting,
3 doesn't give much of a bonus for taking someone to
4 an emergency facility. In a CPEP, they in fact,
5 just drop the patient off and turn it over to the
6 individuals. But of the something like 33 or 34
7 ERs that take psychiatric patients, only I think
8 are six or seven are CPEPs. So one issue that
9 came up and was raised is can you actually create
10 more intensive--couple more intensive emergency
11 services in each borough, so, therefore, save
12 money on police waiting time. Second major issue
13 that we raised with police is people talking about
14 police training. Most of that training occurs
15 when the people are in the police academy. How
16 much training occurs, often none, when the
17 individual police officer goes to the police--to
18 the precinct. The question was also raised about
19 how well the sergeants are trained and, as you
20 heard before, only one in 20--25% of the ESU
21 office is brought in, so the police training is a
22 key issue. As well as the other thing that was
23 mentioned, and I think this is very important, is
24 one of the recommendations in 2004 was to look at
25 alternative models like a CIT model or, in some

2 cases, a mental health police response system that
3 some counties, including some places, including
4 Los Angeles have been effectively being able to
5 do. I think we need to re-look at, you know, the
6 police issue. Going beyond that, I think in 2004
7 we called for Mayor's Office of Criminal Justice
8 to establish a high-level city committee to
9 coordinate these things on a given way, not only
10 with the government offices, but the nonprofit
11 agencies and consumers. That, to my knowledge,
12 has not happened and perhaps this report is, you
13 know, an indication that something was done. We
14 also, in fact, called on parole and probation to
15 establish specialized mental health units which
16 they have never done, but basically indicated was
17 a very, very serious need. We also called,
18 because this has been done in some states, there
19 are specialized forensic mental health funding
20 sources, like California has it, Texas has a bit
21 of it, New York has not any kind of forensic
22 mental health funding source to take care of these
23 individuals. The whole issue of dual diagnosis is
24 a very important one, it has been talked about for
25 the last 20 years and we've seen very, very little

2 progress to do it and unless that's being done
3 because we know the people who get involved in the
4 criminal justice system are the duly diagnosed.
5 We need for housing is a very, very big issue
6 because where are people going to go once their,
7 you know, get out of jail or Riker's or upstate
8 prisons? Big issue. We talked about pre-booking
9 diversion because as part of our work we looked at
10 the ability to screen in the detention and
11 arraignment facilities and it can be done in
12 people as, Joel said, can be moved out from there
13 immediately without going into, you know, jail and
14 there are models across the state. We also need
15 to look at early planning and discharge from jails
16 and prisons, especially for the mentally ill whose
17 sentences are longer. And we need to in fact very
18 much look at the community-based treatment system
19 for the mentally ill.
20 [Pause]
21 CHAIRPERSON KOPPELL: Thank you very
22 much. I agree with what you all saying and
23 appreciate your support. I'm sort of diverting a
24 little bit here from the subject, but Mr.
25 Copperman, it's interesting what you do and one of

2 the interests of our committee is the availability
3 of transitional housing for people with mental
4 illness and I was--are you finding it easy
5 difficult to get the kind of housing that you
6 offer?
7 JOEL COPPERMAN: It's not easy.
8 It's not difficult, it's impossible. It's just
9 dramatically difficult. We have six beds that we
10 operate in New York, New York, three beds for
11 clients who are homeless. But connecting people
12 to housing is just takes an enormous amount of our
13 time and our resources and it's just a great
14 challenge for our clients and, you know, stable
15 housing is obviously key to an individual's
16 stability and it's--so we put people in crisis
17 centers, we move them because they can only be in
18 crisis centers for defined short periods of time,
19 we move them until we're able to find stable
20 housing for them. We have had some success in
21 reconnecting people to their families and so we do
22 that where we have, where we can, and try to
23 support their families and the individuals in that
24 settings as well, but housing is an overwhelming
25 challenge to our program.

2 CHAIRPERSON KOPPELL: You say you
3 have six beds, you said?
4 JOEL COPPERMAN: We have six beds
5 that we operate for our 68 clients. I mean, we
6 work with other providers around the city trying
7 to identify beds and we're not a housing provider,
8 but we have six beds under the New York, New York
9 [crosstalk]--
10 DR. GERALD LANDSBERG: [Interposing]
11 Just a comment, when we look at the housing, we
12 estimated we needed several thousand beds just for
13 this population that, you know, to make their
14 return to the community effective.
15 CHAIRPERSON KOPPELL: I just would,
16 you know, suggest to my colleagues that this is,
17 as far as I'm concerned, if you look overall at
18 the problems of the mentally ill and the poor in
19 general, the problem of housing is just an
20 overwhelming one and your testimony just now was
21 indicative--
22 JOEL COOPERMAN: Yeah.
23 CHAIRPERSON KOPPELL: I was hopeful
24 you'd say something else 'cause you talked in your
25 testimony about how you provide transitional

2 housing and then you move people--

3 JOEL COPPERMAN: Right.

4 CHAIRPERSON KOPPELL: --into more

5 permanent housing--

6 JOEL COPPERMAN: [Interposing] And

7 we have success doing that.

8 CHAIRPERSON KOPPELL: --gee, this is

9 terrific, we're doing this and then you tell--and

10 then my--and I was hoping your answer would be the

11 more optimistic one.

12 JOEL COPPERMAN: It takes an

13 enormous amount of our resources to do this. It's

14 a tremendous challenge for us to do this.

15 [Pause]

16 CHAIRPERSON KOPPELL: Thank you.

17 Anybody else? Yes, Gale.

18 COUNCIL MEMBER BREWER: Regarding

19 the probation that the Criminal Justice

20 Coordinator talks about that they're recommending

21 that there be a dedicated mental health unit of

22 probation officers for those with mental illness,

23 I thought that already existed.

24 DR. GERALD LANDSBERG: Not according

25 to--

2 COUNCIL MEMBER BREWER: Well I was
3 asking Joel, hold on a second, Joel, do you know?
4 DR. GERALD LANDSBERG: Oh, oh, Joel
5 sorry.
6 JOEL COPPERMAN: Not that I'm aware
7 of, I mean, we've had some conversations with the
8 Commissioner about this, but and, you know, we
9 would be, you know, more than happy to try to help
10 [crosstalk]--
11 COUNCIL MEMBER BREWER:
12 [Interposing] But it used to exist, for those of
13 us who have been around for a long time, so…
14 JOEL COPPERMAN: Not that I recall--
15 COUNCIL MEMBER BREWER: [Crosstalk]
16 JOEL COPPERMAN: --but you know, you
17 do.
18 COUNCIL MEMBER BREWER: I do because
19 I participate. No, I was there, I met the people
20 and I know them, so I was just surprised, it must
21 have been discontinued.
22 JOEL COPPERMAN: No, there is, I
23 believe, on the state level, parole has--
24 COUNCIL MEMBER BREWER:
25 [Interposing] State level, I'm talking about the

2 state level.

3 JOEL COPPERMAN: No, I [crosstalk]--

4 COUNCIL MEMBER BREWER: State level,

5 state level it existed.

6 JOEL COPPERMAN: State level, it

7 existed and it still exists, I believe.

8 COUNCIL MEMBER BREWER: Okay. So

9 they're talking about--

10 JOEL COPPERMAN: On the city level--

11 COUNCIL MEMBER BREWER: --the city

12 level--

13 JOEL COPPERMAN: --it does not

14 exist.

15 COUNCIL MEMBER BREWER: No, no, the

16 city never did, state always did--

17 JOEL COPPERMAN: Yes.

18 COUNCIL MEMBER BREWER: --did the

19 state level work from your experience?

20 JOEL COPPERMAN: The parole, I don't

21 have any direct experience with the[crosstalk]--

22 COUNCIL MEMBER BREWER: Okay.

23 DR. GERALD LANDSBERG: He--the

24 just--

25 JOEL COPPERMAN: There are people in

the audience who do, though.

COUNCIL MEMBER BREWER: Okay.

DR. GERALD LANDSBERG: The numbers of people--part of the problem, the one problem was because we had people from state parole at these hearings is that the numbers of people that the--staff they have for the percentage of people who are mentally ill coming out is too small.

COUNCIL MEMBER BREWER: Okay. Joel, the second question I have is for this arraignment program, which sounds like what it, it should have, it's the right program, two questions, one, do you have any information yet about the persons whom you interviewed and second, where do you--are you able to find programs if there is somebody identified in the, you know, in that 24 hour or 48 hour period. And then how do you link them up so quickly and is there funding to do so, etc.

JOEL COPPERMAN: So we have--it's been a small pilot program so far and we have been able to identify people coming through the system using this brief jail mental health screen followed by an interview by a social worker who does a more extensive mental health analysis, if

2 you will, of the person and what we're able to do
3 is we have case managers working in the program,
4 we have the director of the program, one case
5 manager who's a social worker, and one peer
6 specialist and we are connecting people to
7 services. We recently--one of the fellows in the
8 program, we were able to put him into the CASES
9 provided housing--this is a homeless gentleman who
10 had resisted coming in off the streets and it took
11 us a lot of work to get this gentleman to come in
12 off the streets and he has in the last couple days
13 entered into our housing and we'll be able to, we
14 hope, connect him--more effectively connect him to
15 services now, but our case managers are making the
16 linkages in the community. To do that we are part
17 of this undertaking that's being primarily
18 supported by the Jed Foundation is to take a look
19 at how we do all these things and we've hired a
20 couple of very good consultants, including a guy
21 named Henry Stedman, who's pretty well known
22 around this field and so Hank is going to be
23 working with us and his organization to try to
24 sort some of these things out because the problems
25 of identification in the court system and the way

2 that we want to do it, at the point we want to do
3 it rather, and then connecting people to services
4 [crosstalk]--
5 COUNCIL MEMBER BREWER:
6 [Interposing] So are there any database now
7 available to you on these--
8 JOEL COPPERMAN: No.
9 COUNCIL MEMBER BREWER: --
10 individuals that are supportive? No.
11 JOEL COPPERMAN: No, we using this
12 brief jail mental health screen and we are and
13 then interviewing the client. Unlike the Supreme
14 Court where you have people who are in detention
15 and you have time, you can call the hospitals,
16 people tell you I was there at Bellevue, I was
17 here, there, and everywhere. You have time to
18 make the calls because they're in detention and
19 nobody--no Supreme Court judge is releasing
20 anybody--
21 COUNCIL MEMBER BREWER: Right.
22 JOEL COPPERMAN: --until they know
23 there is--
24 COUNCIL MEMBER BREWER: Some
25 program.

2 JOEL COPPERMAN: --a program there--

3 COUNCIL MEMBER BREWER: Right.

4 JOEL COPPERMAN: --there's housing
5 there, everything is in place and people sit in
6 detention--

7 COUNCIL MEMBER BREWER: Right,
8 right, right.

9 JOEL COPPERMAN: --while that
10 happens, but I'm not disagreeing with that
11 approach.

12 COUNCIL MEMBER BREWER: Okay. Thank
13 you.

14 CHAIRPERSON VALLONE:: Anybody else?
15 Yes, yes? Okay.

16 FEMALE VOICE: Thank you very much,
17 it's just a comment and it has to do with the
18 difficulties that you have in housing. Fact is,
19 that the state does it and the state sends them to
20 Community Boards and Community Boards have an
21 enormous record of voting down housing for those
22 that are mentally ill and for those that are
23 mentally retarded. So I think that we need to be
24 aware that when it comes to a community issue,
25 which housing is, your hands are greatly tied. So

2 it seems to me that one of the issues is how do we
3 educate the public that when they are to some
4 degree independent but certainly administered if
5 there's medication of how we are able to do that
6 and not have such hostility to that.
7 JOEL COPPERMAN: I mean, there are a
8 lot of really terrific housing providers in the
9 city for [off mic] and I'm sure you've had
10 interactions with them and, you know, this is, as
11 I talk to them and we talk about this is the issue
12 that they're dealing with all the time, is how to
13 get it by the Community Boards.
14 CHAIRPERSON KOPPELL: Well, as you
15 know, we do have the Padavan Law, which does
16 somewhat limit the ability to block these, but
17 there's still as always a lot of community
18 opposition.
19 JOEL COPPERMAN: Yeah, yeah.
20 CHAIRPERSON KOPPELL: And you're
21 right about that [off mic] of course. Anybody
22 else? No? Do we have any other witnesses? So
23 with that, I think we'll close the hearing and
24 thank you for a very interesting testimony.
25 JOEL COPPERMAN: Thank you.

C E R T I F I C A T E

I, Tammy Wittman, certify that the foregoing transcript is a true and accurate record of the proceedings. I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

Signature Tammy Wittman

Date November 14, 2008