Testimony of Judith F. Kornberg, Ph.D. to be submitted for the record to the New York City Council Hearing Committee on Mental Health and Public Safety on February 28, 2008.

Thank you for this opportunity to submit testimony on this important issue.

I am Judith F. Kornberg, Ph.D., Dean of the College's Office of Continuing and Professional Studies, John Jay College of Criminal Justice of The City University of New York.

John Jay College of Criminal Justice is dedicated to education, research, and service in the fields of criminal justice, fire science, and related areas of public safety and public service. The College has a proud history of working closely with the areas of practice most closely aligned with our criminal justice specialty. We were founded 40 years ago as a liberal arts college serving police officers, and our reach now extends into every dimension of the world of criminal justice and public safety—including policing, corrections, public management, forensic science, security management and fire science.

John Jay College's Office of Continuing and Professional Studies was established in 2005 to meet the changing educational and professional needs of members of the criminal justice, law enforcement, public safety and related communities by designing and implementing innovative seminars, workshops, and training programs.

When Eleanor Bumpurs was fatally shot in 1984 by New York City police officers, public outcry over the incident strongly encouraged the department to re-examine its handling of the mentally ill. The shooting led to the development of a psychological training component which, 23 years later, is still used to train members of the NYPD's Emergency Services Unit and its Hostage Negotiation Team.

Since 1985, the Office of Continuing and Professional Studies, and previously the College's Office of Special Programs has provided training in Managing Situations Involving Mentally Disturbed Persons for the New York City Police Emergency Service and Hostage Negotiation personnel Department. Each year, the College conducts one-week (Monday-Friday) thirty–hour sessions (excluding travel time to and from training site) for 150 ESU and HNT officers and detectives. The course focuses on a variety of

topics, including basic negotiation issues, types of mental illness, assessing behavior and dangerousness, substance abuse, officer suicide and domestic violence. Participants are led through role-playing exercises by actors and trainers in collaboration with John Jay psychology faculty and NYPD trainers to explore the various situations ESU officers and negotiators may face, as follows:

- Information on the various mental disorders, the states of mind and the needs of people with these disorders when they are in crisis; the management challenges they pose to the various helping professions; and the techniques and approaches that maximize safety and increase the probability of satisfactory resolutions in situations involving disturbed persons. Medications, substance abuse issues, and treatment availability will be examined, particularly as these pertain to crisis situations.

- Review of Mental Hygiene laws, the NYPD Patrol Guide, and the procedural guidelines of the Department of Health and Metal Hygiene, in relation to Situations Involving Mentally Disturbed Persons.

- Simulations of a broad range of Crisis Situations Involving Mentally Disturbed Persons. These simulations will be presented by actor trainers. Participating police personnel and other professionals in attendance will work to resolve these simulated situations safely and effectively. The expertise of each of the training group members will be brought to bear on the simulated situations. Training group members will learn how the various helping professions including police, medicine, social work, etc. respond to crisis situations and how these various caregivers can best articulate with each other. In addition to ESU and HNT police personnel, other professionals who play key roles in responding to crisis situations involving emotionally disturbed persons are regularly invited to attend and participate fully in the "Managing Situations" course.

In 2002, the NYPD asked John Jay College to expand the EDP Program to include new sergeants. Approximately 500 newly appointed Patrol Supervisors participate in the one-day, seven-hour program annually. This course provides:

- Examination of the Patrol Supervisors role in communicating the vulnerability of persons who are mentally ill, and the responsibilities and risks that confront police personnel responding to situations involving disturbed persons.
- Analysis of the different kinds of mental illnesses; the challenges that patients with these illnesses face in crisis situations, and the ways these situations can best be managed by police in order to obtain help for persons in need.
- Examination of the supervisor's role in communicating proper response and communication approaches in situations involving disturbed persons.
- Discussion of the broad range of problems and issues that can emerge in responding to situations involving disturbed persons and examination of problem solving strategies and techniques.
- Exploration of the ways in which police supervisors can encourage cooperation among Police, Mental Hygiene, EMS, Psych Emergency Hospital Personnel and other care givers in working with disturbed persons.

In September 2003, John Jay College per the request of the NYPD began providing training in Patrol Response to Situations Involving Emotionally Disturbed Persons to all recruits in the Academy. Approximately 1,300 newly- hired police officers participate in this one–day seven hour session, as follows:

- Understanding of the different types of mental illness, the challenges that patients with these illnesses pose in crisis situations, and the ways to safely manage these situations and obtain help for the disturbed person.
- Examination of the problems emotionally disturbed persons experience in crisis situations and the police interventions used to manage these situations.
- Analysis of communication problems that emotionally disturbed persons pose to the police.
- Assessment of communication approaches used by police including simulations that test the efficacy of these approaches.

- Discussion of the vital roles that each of the various caregivers, police, mental hygiene, EMS, etc. play in responding to psychiatric emergencies including exploration of the ways in which caregivers' roles articulate with each other, and the problems that sometimes occur because of misunderstandings.

John Jay College of Criminal Justice is proud to be a part of this important NYPD effort to train its ESU officers, sergeants, and recruits in managing situations involving emotionally disturbed persons. We ask the City Council to support the continuation and expansion of this program.

STATEMENT OF
CHIEF ROBERT GIANNELLI
CHIEF OF PATROL
NEW YORK CITY POLICE DEPARTMENT

BEFORE THE NEW YORK CITY COUNCIL
COMMITTEES ON PUBLIC SAFETY AND MENTAL HEALTH, MENTAL RETARDATION, ALCOHOLISM, DRUG ABUSE, AND DISABILITY SERVICES

FEBRUARY 28, 2008

Good morning Chairman Vallone, Chairman Koppell and members of the Council. I am Chief of Patrol Robert Giannelli, and joining me today is Assistant Commissioner Carol Ann Roberson of the NYPD's Office of the Deputy Commissioner for Training. On behalf of Police Commissioner Raymond W. Kelly, I wish to thank the City Council for this opportunity to provide an overview of the Police Department's procedures regarding our response to incidents involving a mentally ill or emotionally disturbed person.

The mission of the Police Department is to enhance the quality of life in New York City by providing a safe environment for all those who live in, work in or visit our city. Our goal is to reduce crime and fear and enforce the law in a fair and impartial manner. Encounters with mentally ill or emotionally disturbed persons are among the most difficult of all police interactions, requiring a high degree of skill and sensitivity. As law enforcement officers, our responsibility is not only to protect the life and safety of the emotionally disturbed person but also to protect the lives of others who may be at risk.

On average, patrol officers are dispatched in response to 911 calls regarding emotionally disturbed persons more than 200 times a day. Last year, the 911 operators received over ten million calls for service, and over 87,000 radio runs stemming from these calls involved incidents concerning emotionally disturbed persons. Police officers may also encounter these individuals in the normal course of patrol, or when told about an individual by a passerby. On occasion, an emotionally disturbed person will come to police attention because his or her actions are criminal and may result in injury to people or damage to property. When patrol officers encounter an emotionally disturbed person in any of these ways, in addition to the responding patrol officers, the patrol supervisor, the Emergency Service Unit and an ambulance are automatically required to respond as well.

Our officers are guided by Patrol Guide procedures, by their training and experience, and by the individual circumstances of each incident.

The first responding officers must assess the situation to determine whether there is an immediate threat of serious physical injury to anyone involved. If so, police officers are directed to take reasonable measures to end or prevent the problematic behavior and to take the person into custody, for their protection and the protection of others. In some instances, where the person is emotionally disturbed but not armed or violent, the person may be willing to leave voluntarily, and the officers will take the person into custody immediately. However, if the individual is armed or violent, no attempt is made to take the person into custody without the specific direction of a supervisor, unless there is an immediate threat of physical harm to the person or others present.

In assessing the potential violence of a situation, police officers must take a great number of factors into consideration in a short period of time and often in highly tense circumstances. They must collect as much background information as possible on the individual by speaking with the 911 complainant or anyone else who may have information about the individual. If there appears to be no immediate threat of serious physical injury, officers will take cover and wait for a supervisor while attempting to isolate and contain the individual. They will also establish a "zone of safety," defined as the distance to be maintained between the individual and the officers, which should be greater than the effective range of any weapon the individual may have (except for a firearm), but in most instances at least 20 feet. The distance will vary with the type of situation, and officers will attempt to maintain the zone of safety if the emotionally disturbed person changes location.

Depending upon the situation, specialized resources may be needed to address potentially volatile and dangerous situations. Patrol supervisors are equipped with less lethal devices such as Tasers which may assist in restraining the emotionally disturbed person, pending the arrival of the Emergency Service Unit.

The Emergency Service Unit is called upon to handle a diverse array of emergency situations, including those involving emotionally disturbed persons. Officers assigned to the unit have received specialized training and are equipped with many different types of less lethal devices, which can be used to prevent emotionally disturbed persons from harming themselves or anyone else while the officers are attempting to bring them into custody. They are also equipped with heavy tactical bullet resistant vests and helmets, which can help protect them while they are attempting to bring an armed or violent person under control.

At times, an emotionally disturbed person may hold hostages or barricade themselves within a premise. In such instances, in addition to the Emergency Service Unit, the Department's Hostage Negotiation Team and Technical Assistance Response Unit will respond. Their personnel provide specialized expertise and resources and determine the best strategy, under the circumstances, of controlling or restraining the individual, using the minimum amount of physical force necessary to prevent the individual from hurting anyone and to safely restrain the individual, so that he or she can be brought to a hospital for treatment. The goal of

the Hostage Negotiation Team is to engage the individual so that a peaceful and voluntary end to the incident can be accomplished. Their work is supported by the Technical Assistance and Response Unit, whose members use technology to obtain as much information as possible about the circumstances of the incident as it evolves, including highly specialized video, thermal imaging and communications equipment.

In a hostage situation or barricaded scenario, as in any tense confrontation, there are basic guidelines and procedures which provide general direction to the officers, such as: seeking cover; establishing inner and outer perimeters limiting who may be within a certain distance of the person; attempting to slow the pace of the incident and to establish a dialogue with the person, including requesting an interpreter if needed; and contacting others who may be helpful, including family, friends or local clergy. Especially important is to immediately establish firearms control, requiring that none of the officers on the scene will discharge a firearm unless directed by the supervisory officer in charge, unless discharging the firearm is absolutely necessary for self-defense or defense of another, and there is no alternative.

Guidelines are of course adapted to the situation at hand, but there are three constants which inform all decisionmaking during a hostage or barricaded scenario:

- **when there is time to negotiate, take all the time necessary to ensure the safety of all concerned;**
- **deadly physical force will be used only as a last resort to protect the life of persons present; and**
- **the overriding goal is the safety of everyone concerned.**

When the situation is under control and an emotionally disturbed person has been taken into custody, if the individual has not broken the law, the officers will accompany the person to a hospital facility in an ambulance and inform the hospital personnel of the circumstances which brought the person into custody. The officer will then leave the individual in the care of the hospital and prepare an aided report documenting the incident. If it is determined that the individual has committed a crime, then the person will be placed under arrest but similarly will be escorted to the hospital in police custody, where he or she will be examined and treated before entering the criminal justice system.

As you know, interaction between police officers and emotionally disturbed persons can be highly dangerous, and can escalate with no warning into deadly confrontations requiring the use of force. A key element in preparing our officers to take appropriate action and to defuse potentially explosive situations is training.

All police officers receive training in recognizing and communicating with emotionally disturbed persons while at the same time being able to assess the person's level of dangerousness.

Police recruits receive training in identifying specific mental disorders and recognizing emotionally disturbed persons, learning how to deal with them through both classroom lectures and at a full-day workshop at John Jay College. They participate in role play scenarios, focusing on assessment, safety, and communication, gaining practical training in handling persons displaying various types of emotional distress. The recruits also meet with a panel of people with different disabilities, usually including a person who has a mental illness, to give the recruits an opportunity to gain insight on each person's circumstances and their personal experiences with the police.

Newly promoted sergeants receive 14 hours of training in the handling of emotionally disturbed persons, and newly promoted lieutenants receive an additional seven hours of training in the handling of emotionally disturbed persons. For both recruit training and promotional courses, the Department's Firearms and Tactics Section provides training in the effective use of less lethal devices. In addition, our In-Service Training Unit periodically incorporates the handling of emotionally disturbed persons and the use of less lethal devices into its training modules, both through centralized In-Service Tactical, or "INTAC" Training, and through command-level, or "roll call" training.

Beyond the training delivered to patrol officers, the members of our specialized units receive extensive training in handling encounters with emotionally disturbed persons.

Officers assigned to the Emergency Service Unit receive 16 hours of specialized tactical training in dealing with emotionally disturbed persons, and an additional 40 hours of emergency psychological training, which is delivered through a five-day course given at John Jay College and funded by the Department of Health and Mental Hygiene. The curriculum includes classroom discussions and role play scenarios, and successful completion of this intensive training program results in the officer being certified as an "Emergency Psychological Technician" with two college credits awarded.

Established in 1973, the Hostage Negotiation Team represented the first unit of its kind created by any law enforcement organization, for the sole purpose of hostage negotiation. It is considered the model for all such teams, with over 100 highly trained and skilled professionals on call and available to respond at any time. Newly assigned hostage negotiators receive 11 days of training, focusing on characteristic traits for mentally ill persons most likely to come into contact with police, and including the "Emergency Psychological Technician" course at John Jay College.

In light of the complex and potentially dangerous nature of the Police Department's interactions with emotionally disturbed persons, we constantly review our procedures and training, in order to enhance the professionalism and sensitivity of our response.

For example, in 2003, our Deputy Commissioner of Training was Dr. James J. Fyfe, a nationally acclaimed expert on police matters who conducted extensive studies and published widely on police issues including excessive force, deadly force and police interaction with the emotionally disturbed. In the course of a complete review and revision of the Department's recruit training materials, Dr. Fyfe convened a symposium of more than 40 members of the NYPD and the mental health and legal communities, on "Policing the Emotionally Disturbed." The participants were provided with the Department's recruit training materials and were asked to provide their insights and suggestions regarding the training curriculum. Dr. Fyfe revised the curriculum to incorporate as many of their comments as possible, and the training developed, with the participation of these advocacy groups, to include community based interactive programs on behalf of the emotionally disturbed.

In furtherance of our commitment to training, the Department established what is known as the "Link Committee," an initiative that includes members of the Police Department, the Department of Health and Mental Hygiene, mental health advocacy groups, consumers, hospitals and the legal and academic community. The Link Committee is a working group of more than 35 members who meet on a quarterly basis, for the purpose of reviewing and discussing the present police training curriculum, and exploring new ideas in the interaction between the police and emotionally disturbed persons. Subcommittees of the group are being formed to meet more often, to examine specific issues as needed.

In addition, the Police Department takes part in citywide initiatives such as the Mobile Crisis Outreach Teams and the Assertive Community Treatment Teams, which are empowered by law to evaluate and involuntarily remove a person to a hospital. The Mobile Crisis Outreach Teams are teams that are independently operated by local hospitals or community-based mental health organizations and may sometimes be attached to New York State licensed "comprehensive emergency programs." Their goal is to assess, stabilize and rapidly refer patients to longer-term providers. Similar to the Mobile Crisis Outreach Teams, the "Assertive Community Treatment Teams" are "hospitals on wheels," staffed by mental health workers and charged with providing a wide range of ongoing services.

If either of these mental health outreach programs require the assistance of the Police Department in order to involuntarily transport an emotionally disturbed person, the responding officers will check the mental health professional's credentials and verify that the appropriate removal order is presented. The officers will then assist in the transportation of the individual to the hospital and will remain

with the individual until he or she is examined by a medical team, and is either released or admitted at the psychiatric emergency room.

Police officers may similarly be called upon to assist in safely removing a mentally ill or emotionally disturbed person who is the subject of a court-ordered or "Kendra's Law" removal order. The New York City Sheriff has the primary responsibility for executing these civil orders during certain times of day, primarily during business hours, with the Police Department taking that role during nighttime hours and weekends. However, if the Sheriff finds the subject of the order to be violent or uncooperative, they will request Police Department assistance. Police officers may also be called upon to enforce another type of civil removal order, the "Mental Health Removal Order" issued by the Department of Health and Mental Hygiene. Department personnel are assisted at the scene by a City psychiatrist, and follow the same general procedure.

Another circumstance which may bring police into contact with emotionally disturbed persons is the Department's interaction with the homeless population. These circumstances present special challenges because many of these individuals need services but are difficult to contact through traditional outreach methods. Small segments of this population also engage in unlawful activity or may present a danger to themselves or others.

The Police Department's Homeless Outreach Unit operates within the Transit Bureau. The Unit designates areas within each patrol borough to allow for a concentrated effort within a limited geographical area for a fixed period of time. The target areas are chosen after considering information provided by police personnel, the Department of Homeless Services, community boards and service providers. The Unit introduces homeless persons to the myriad of services available to them within New York City and attempts to assist them in gaining access to those services. If the Unit encounters a homeless person who appears to be emotionally disturbed, then the procedures we have described for dealing with emotionally disturbed persons will apply.

During a cold weather emergency declared by the Department of Health and Mental Hygiene, patrol officers who encounter a homeless individual will ensure that the person has shelter. If the individual has no shelter, the officers will offer transportation to the nearest shelter facility. If the individual refuses shelter and has no available means of shelter, and the patrol supervisor determines that the homeless person will be at substantial risk of harm without shelter, that person will be transported to the nearest Health and Hospitals Corporation hospital for psychiatric evaluation.

In closing, we have attempted to provide an outline of how the New York City Police Department responds to the challenges presented by our encounters with

those who are emotionally disturbed. We strive to ensure that people in crisis as well as those around them are protected from harm, and we seek to prepare our officers for potential problems so that they may bring everyone through such incidents safely.

Thank you for this opportunity to speak here today. We welcome any questions you may have.

THE CITY OF NEW YORK
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Michael R. Bloomberg
Mayor
Thomas R. Frieden, M.D., M.P.H.
Commissioner
nyc.gov/health

Testimony

of

Trish Marsik
Assistant Commissioner for Mental Health Services
New York City Department of Health and Mental Hygiene

before the

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

on

Examining the Roles of the NYPD and the Department of Health and Mental Hygiene in Responding to Calls to the Police Involving Emotionally Disturbed Persons

February 28, 2008

Council Chambers, City Hall
New York City

Good morning Chairman Koppell, Chairman Vallone and members of the Committee on Mental Health, Mental Retardation, Alcoholism, Drug Abuse and Disability Services and the Committee on Public Safety. I am Trish Marsik, Assistant Commissioner for Mental Health Services at the New York City Department of Health and Mental Hygiene.

To begin, it is important to note that the term "Emotionally Disturbed Person" is not a clinical diagnosis nor is it synonymous with, or even indicative of, a mental disorder. Emotionally disturbed persons don't necessarily have a mental illness. In fact, the vast majority of people with mental illness, and even acute mental illness, are not violent and do not represent a threat to the public safety.

While responding to emergency calls involving emotionally disturbed persons is not within the Department's purview, we do fund and monitor a broad range of programs to serve individuals with mental illness. As Dr. David Rosin described during a hearing on this topic on November 7, 2007, the Department contracts with hundreds of organizations to provide long term community based and recovery oriented mental health services. We provide people with mental illness with access to case management, psychiatric medication, counseling and therapy, substance abuse services, and peer support. Our services promote community integration, stability, and recovery with the goal of helping individuals manage their mental illness and live independently.

The Department takes a proactive approach, through our Assisted Outpatient Treatment (AOT) program, to helping individuals whose prior histories of non-compliance with treatment for mental illness resulted in either repeated hospitalizations or violent behavior. The Department also contracts with 23 Mobile Crisis Teams (MCT),

each consisting of a variety of mental health professionals, which may include nurses, social workers, psychiatrists and/or psychologists. Teams operate under the auspices of voluntary organizations and hospitals and respond to persons in the community, usually visiting them at home. I would like to stress that neither the AOT program nor the MCTs are charged with responding to calls involving emotionally disturbed persons. These programs provide mental health services; the police ensure public safety.

In closing, I would like to reiterate that not all people with mental illness are dangerous, and any increased stigmatization of mental illness or association with violence has the potential to discourage people from seeking services that could have a profoundly positive impact on their lives. Thank you for the opportunity to testify on this issue; we are happy to answer any questions at this time.

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HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc
Charlynn Goins, Chairperson
Alan D. Aviles, President

Testimony of

Ronnie Gorman Swift, M.D.

Network Chief of Psychiatry

Generations + Northern Manhattan Health Network

New York City Health and Hospitals Corporation

Before the New York City Council

Committee on Public Safety &

Committee on Mental Health, Mental Retardation,

Alcoholism, Drug Abuse and Disability Services

February 28, 2008

Good morning, Chairpersons Koppell, Vallone and members of the committees. My name is Dr. Ronnie Gorman Swift, Network Chief of Psychiatry for the Generations + Northern Manhattan Health Network of the New York City Health and Hospitals Corporation (HHC). I am here to provide testimony on HHC's behalf about what happens when someone is brought to an HHC Psychiatric Emergency Room by the New York City Police Department (NYPD) or Emergency Medical Services (EMS) labeled as an Emotionally Disturbed Person (EDP).

The eleven HHC acute care facilities operate psychiatric emergency services and six are designated as Comprehensive Psychiatric Emergency Programs or CPEP's. HHC facilities generate more than 16,260 psychiatric inpatient discharges, more than 9,094 detoxification discharges and provide more than 944,000 behavioral health outpatient visits per year.

The difference between a CPEP and a regular psychiatric emergency service is that CPEP's operate a Mobile Crisis Team, provide 72-hour extended observation for patients in a dedicated unit within the Psychiatric Emergency Room and have direct access to community crisis beds. These program

components are focused on stabilizing patients and diverting unnecessary hospitalizations.

Psychiatric emergency services are an important part of the overall continuum of care. Often, the psychiatric emergency room is where people first access behavioral health services. They may be brought in by the police, they may walk in voluntarily or may be brought to the hospital by family, friends or their community-based providers.

When an emotionally disturbed person enters an emergency room, the first step is to determine whether or not the presenting psychiatric or behavioral symptoms are due to a primary mental disorder, are substance induced or result from an underlying medical condition. Many times medical conditions can manifest as a psychiatric or behavioral disorder. Therefore, all patients are medically screened as part of the overall assessment process in the emergency room. Once the patient is medically screened and medically stabilized, staff gather additional pertinent clinical information: through talking to the patient, review of any prior medical records, talking to the patient's family, friends and outside treatment providers if the patient grants permission.

A comprehensive psychiatric evaluation includes: gathering a detailed history of the present illness, past psychiatric history, substance abuse history, medical history, developmental, criminal justice and social history; a mental status examination is also conducted. This information allows providers to make a determination of the patient's level of risk for self-harm or violence towards others.

Unfortunately, no psychiatric assessment of risk for dangerousness has been proven to have strong predictive power for an individual. There are certain risk factors for dangerousness such as a prior history or a recent act of violence, but regrettably, no single risk factor or combination of risk factors has been shown to predict who will commit an act of violence, be it self-harm or suicide or violence towards others. Once the comprehensive psychiatric assessment is complete, it is summarized into a biopsychosocial formulation, which supports the decision to either treat and release the person, or to hospitalize the individual.

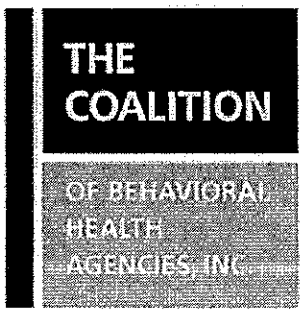
The decision to retain someone in a psychiatric emergency service, CPEP observation unit, or to admit him to an inpatient psychiatric unit is considered a deprivation of liberty – a decision that is not taken lightly. Mental health consumers have been afforded a number of legal safeguards to protect their rights in this process. New York State Mental Hygiene Law requires, in every instance

that, if a psychiatrist determines a person meets the criteria for inpatient treatment that he be first offered a voluntary admission, even if the patient is found to be a danger to himself or others. If the patient does not accept voluntary admission, but has been determined to pose a threat to himself or others, State Mental Hygiene Law provides for three ways in which the patient can be involuntarily committed – through an emergency admission called a 9.39; an admission on medical certification pursuant to Section 9.27 of the State Mental Hygiene Law (also known as a 2PC); and in instances where hospitals have a CPEP, a patient may be admitted to the extended observation bed under Section 9.40.

If an individual does not require hospitalization, an appropriate discharge plan is developed and includes a range of tailored interventions depending on the needs of the individual patient. For example, if the patient needs immediate follow-up, he may be referred to a mobile crisis team who will visit the person at his home while he is waiting for his appointment with an outpatient provider to take place. A patient with less intensive needs may be given medication and a referral for an outpatient visit.

Research has shown that, with proper treatment, medication and supports, recovery is possible for persons with mental illness. I hope that my testimony has

provided you with an outline of the psychiatric evaluation process for individuals brought to the emergency room. I would be happy to answer any questions you may have. Thank you.



Testimony of

Michael J. Polenberg, Director of Policy & Advocacy
Coalition of Behavioral Health Agencies, Inc.

At a New York City Council Oversight Hearing:

"Examining the Roles of the NYPD and the Department of Health and Mental Hygiene in Responding to Calls to the Police Involving Emotionally Disturbed People"

"Resolution 1249 by Council Members Dickens and Vann – Resolution calling on the Mayor, the NYPD and DOHMH to continually reevaluate their protocols and response to field incidents concerning the apprehension of, restraint of, and use of lethal force against emotionally disturbed persons."

The Committee on Mental Health, Mental Retardation,
Alcoholism, Drug Abuse and Disability Services
Hon. G. Oliver Koppell, Chair

The Committee on Public Safety
Hon. Peter Vallone, Jr., Chair

February 28, 2008

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INTRODUCTION

Chairman Koppell, Chairman Vallone, distinguished members of the respective Committees, thank you for inviting us to testify before you today on the topic of the dual roles of the New York City Police Department (NYPD) and the Department of Health and Mental Hygiene (DOHMH) in responding to the needs of New Yorkers who are experiencing a psychiatric crisis. My name is Michael Polenberg, and I am the Director of Policy & Advocacy for the Coalition of Behavioral Health Agencies, the umbrella advocacy organization of New York's behavioral health community, representing over 100 non-profit community-based mental health and substance abuse agencies in New York City and surrounding areas. Our members constitute a broad cross section of service providers – all sizes from very small to very large; treatment and rehabilitation-oriented; outpatient and residential; focused on linguistically and culturally specific populations and on many special-needs – serving more than 350,000 individuals in the five boroughs of New York City and its environs.

Before we begin our formal testimony, we'd like to offer our profound sympathies to the family, friends and colleagues of Kathryn Faughey, the psychologist who was tragically killed in her Manhattan office earlier in the month. The terrible murder of one of our fellow New Yorkers deeply affects us all, and we share in the grief that accompanies this kind of senseless killing.

It is important, too, to keep in mind the following: this morning, tens of thousands of New Yorkers living with schizophrenia, bi-polar disorder, major depression, and other

mental health disorders woke up, got dressed, went to school, went to work, attended day programs, sought comfort from family and friends, took medication, pursued wellness through exercise, proper diet and smoking cessation, and made plans to see a movie, join with friends and family, have dinner, or read a book. In other words, the overwhelming majority of New Yorkers living with mental illness, including major illness such as schizophrenia and bipolar disorder, do not require the kinds of emergency services which are the subject of today's hearing. Make no mistake: each of these tens of thousands of people represents a profound victory for the strength of the community mental health system, the advances in pharmacology, the adoption of the principles of rehabilitation and recovery, the commitment of government at all levels to helping those in need and the personal resilience of these individuals. In respect to the ordinariness of their days, they are very much like all of us.

We are supportive of the in-depth look that the Council is taking at how the NYPD and DOHMH respond to New Yorkers in crisis, and is calling for periodic re-examinations of training protocols related to this issue. Since the police are often the first to respond in these cases, it is critically important that they are properly trained and equipped to relate to and deal with someone with a mental illness who is potentially posing a danger to him or herself or others. It is just as important that sufficient numbers of mobile crisis teams are readily available for those instances where specialized psychiatric expertise is required. Moreover, the State should consider funding additional Assertive Community Treatment (ACT) Teams to provide the appropriate level of care to certain consumers discharged from psychiatric

hospitalization. Protocols should be developed for these teams in dealing with resistant clients and in potentially threatening situations.

One issue that the Coalition is working on with colleagues from around the State has to do with the gaps in the continuity of mental health care for some New Yorkers. The transition, for example, from inpatient to outpatient care, is not always seamless. There is tremendous pressure on hospitals to empty beds for consumers once their symptoms have subsided and the insurance will no longer pay for their inpatient stay. Depending on their level of functioning, consumers are generally referred to some form of aftercare, including intensive or supportive case management and Assertive Community Treatment (ACT) teams. In most cases, the process consists of a phone call and submission of paperwork from the hospital to a centralized referral bank (the Single Point of Access, or SPOA), which in turn refers the consumer's file to a provider who has the capacity and expertise to offer the appropriate level of care (case management or ACT team) in the neighborhood where the consumer lives. By the time the provider receives the case file, however, the consumer has likely been discharged from the hospital and is now somewhere – anywhere -- in the five boroughs of New York. An inordinate amount of time is spent by case management teams trying first to locate the consumer before even the most rudimentary elements of aftercare can be provided. This hardly strikes us as the most efficient way to deliver services. The problem is further compounded when the case managers have no central number to call to find out, for example, if the consumer has been re-admitted into any of the city's public or private hospitals.

Another problem has to do with the level of aftercare assigned to New Yorkers with serious mental illnesses. In general, patients who are preparing to be discharged from hospitalization are referred to the level of care that most appropriately meets their needs. ACT teams, which are referred to as "clinics on wheels", offer the most service-rich options for these consumers and include psychiatrists and psychiatric nurse practitioners who are authorized to call for an involuntary hospitalization if a danger exists. The next levels, Intensive Case Management (ICM) and Supportive Case Management (SCM), utilize social workers to help connect consumers to services (benefits, housing, medical care, treatment, etc.).

But the referral process depends to a certain extent on the availability of the proper aftercare slot. If a consumer requires the services of an ACT team based on his or her assessed ability to function in the community, and willingness (or unwillingness in this case) to access traditional clinic or day treatment services, but no ACT slot is available in that particular catchment area, the consumer will instead be referred to the next and lower level of care – an Intensive Case Management slot. Theoretically, that consumer will be shifted out of ICM and into an ACT slot if and when one opens up. In practice, this is not always the case. Providers report that consumers with very serious impairments are in levels of care that cannot offer the kind of services they require. We would encourage the State to consider funding additional ACT teams to ensure an appropriate level of care for those consumers whose needs are the greatest. As mentioned earlier, ACT teams can also authorize involuntary hospitalizations if a consumer presents with thoughts or actions that indicate a danger to themselves or others.

We would also like to see a level of "step-down" care for persons who are no longer in need of hospitalization but who require some level of care beyond that which can be offered in most outpatient settings. This setting could also serve as a "safe space" for persons who are acting erratically but do not necessarily meet all of the conditions that would require involuntary hospitalization.

Finally, we would like to encourage training for police officers which includes shadowing a mobile crisis unit with the goal of gaining a more comprehensive understanding of the psychiatric side of working with persons in crisis. Perhaps a cohort of these officers, could be identified as being "on call" to assist with emergencies of this nature, given that the police are more likely to be the first responder.

These are fraught and extremely complex matters and we do not pretend to have all the answers or even all the questions. We do think that the best minds in the City and State, from government, the provider world, the NYPD and a full range of healthcare professionals should be convened to examine and consider models of success and to work to develop urban-sensitive and culturally sensitive responses and modalities in New York City to better prepare us and help us avoid the preventable tragedy of the future.

Thank you again for the opportunity to testify, and I'd be happy to take any questions you might have.

NYS OMH Single Point of Access (SPOA)
Case Management/ACT Program Application Cover Sheet

Send this cover sheet to CUCS along with the complete Universal Referral Form packet for all SPOA applicants.

Date of Submission: _____ For CM/ACT Consultation Assistance call (212) 801-3343

TO:
SPOA Case Management/ACT Program
Center for Urban Community Services
2212 Third Avenue, 6th Floor
New York, NY 10035
Fax: (212) 803-5880

ALL COMPLETE SPOA PACKETS must include:

- ☐ This Cover Sheet with Signed Consent
- ☐ The Universal Referral Form (URF)
- ☐ CM/ACT Referral Summary
- ☐ A Comprehensive Psychosocial Summary
- ☐ A Comprehensive Psychiatric Evaluation
- ☐ Physical Exam (required from inpatient referral)
- ☐ PPD Results (required from inpatient referral)

FROM:

Referring Agency/Program: _____

Referring Worker's Name: _____

Contact Phone: _____ Fax: _____

Referring Worker E-mail: _____

Borough Where Applicant Is/Will Reside (circle one): Brooklyn Manhattan Queens Bronx Staten Island

RE:

Applicant's Last Name: _____ First Name: _____

Applicant's D.O.B.: _____ / _____ / _____

Level of Service Requested (circle one): ACT ICM BCM SCM

TYPE OF REFERRAL (circle all that apply):

Priority Referral: AOT Potential AOT State PC Acute Inpatient Unit CPEP Unit Psychiatric Emergency Room Correctional Health/Prison Mental Health Unit Mobile Crisis Teams Mental Health Courts OMH Links OMH Residential Treatment Facilities

Community Referral: ACT/Case Management Transfer Continuing Day Treatment Program Psychiatric Outpatient Program Residential Program DHS/Section 8 Project
Other: _____

Specific ACT/Case Management Program Requested (If applicable): _____

CONSENT TO RELEASE INFORMATION

(Please keep original on file)

I authorize the disclosure of the New York City Case Management Application and all related supporting documents to the Center for Urban Community Services, 2212 Third Avenue, 6th Floor, New York, NY 10035 for the purposes of case management assessment and placement assistance for a period of ninety (90) days. I understand that I may revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.

Applicant's name (printed)	Signature of Applicant	Date
Witness' name (printed)	Signature of Witness	Date

THE CITY OF NEW YORK

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Michael R. Bloomberg
Mayor

Thomas R. Frieden, M.D., M.P.H.
Commissioner

nyc.gov/health

Adult Case Management and ACT Services
UNIVERSAL REFERRAL FORM

A Complete Application Must Include the Following:

- ☐ The Universal Referral Form (URF) including SPOA Coversheet. **Please answer all questions** and write legibly. If information is Unknown (U/K) or Not Applicable (N/A), please indicate.
- ☐ A Comprehensive Psychosocial Summary completed or updated within the last 6 months.
- ☐ A Comprehensive Psychiatric Evaluation signed by a Psychiatrist or a Psychiatric Nurse Practitioner and completed within the last 30 days for inpatient referrals and within 6 months for outpatient referrals.
- ☐ A Physical Exam is requested for referrals from out-patient programs and required for referrals from inpatient programs, including PPD results.
- ☐ Authorization for Release of Confidential HIV-Related Information, if any HIV-related information is disclosed.

Send or FAX Complete URF Packet to: **CUCS, SPOA Case Management/ACT Program**
2212 Third Avenue, 6th Floor
New York, NY 10035
FAX: 212-803-5880

Note: The Applicant's social security number (SSN) may be used to verify identity. Disclosure of the SSN is voluntary.

For Questions about the Universal Referral Form: **Call CUCS at 212-801-3343.**

Service Being Requested:

O Assertive Community Treatment (ACT)* O Intensive Case Management (ICM)
O Blended Case Management (BCM) __SCM __ICM O Supportive Case Management (SCM)

Section A: Demographics

1. Name:
First: _____ Last: _____

2. DOB: ☐☐/☐☐/☐☐ 3. Sex: O Male O Female

4. Medicaid # (if applicable): ☐☐☐☐☐☐☐☐ Medicaid Sequence #: ☐☐
O None O Unknown

5. Primary Language:

O 1. American Sign Language	O 6. French	O 11. Italian	O 16. Russian	O 21. No Language
O 2. Cantonese	O 7. German	O 12. Japanese	O 17. Spanish	O 22. Unknown
O 3. Chinese	O 8. Greek	O 13. Mandarin	O 18. Urdu	O 23. Other (specify):
O 4. Creole	O 9. Hindi	O 14. Polish	O 19. Vietnamese	
O 5. English	O 10. Indic	O 15. Portuguese	O 20. Yiddish	_____

6. English Proficiency: (Check one)
O Does not speak English O Poor O Fair O Good O Excellent

7. Social Security Number: ☐☐☐-☐☐-☐☐☐☐
If Not Provided, indicate reason: O Applicant declines to provide O Applicant does not have a SSN

Applicant's Last Name:_____

8. Applicant Address (If applicant is homeless note the shelter/drop in center or place he/she may be contacted): _____

_____ Tel #:(___)_____

If applicant is hospitalized and being discharged to a different address; or if the applicant is homeless and moving into housing, please indicate new address/contact information:

_____

_____ Tel #:(___) _____

9. What is the applicant's Race/Ethnicity? (Check all that apply)

O 1. White, European American
O 2. Black, African American
O 3. American Indian or Alaskan Native
O 4. Asian Indian
O 5. Chinese
O 6. Filipino
O 7. Vietnamese
O 8. Other Asian
O 9. Native Hawaiian
O 9. Guamanion/Chamorro
O 10. Samoan
O 11. Japanese
O 12. Latino/Latina
O 13. Korean
O 14. Unknown
O 15. Other Pacific Islander
O 16. Other (specify): _____

10. If the applicant is Latino/Hispanic, please complete the following:

O 1. Mexican, Mexican American or Chicano
O 2. Puerto Rican
O 3. Dominican
O 4. Cuban
O 5. Unknown
O 6. Other: _____

Section B: Family Contacts

1. Marital Status: (Check one)

O Single, never married O Cohabiting with significant other or domestic partner O Currently married
O Divorced / Separated O Widowed O Unknown O Other: _____

2. Family/Friend/Emergency contact(s): (Include name, address, telephone number and relationship)

_____

_____

_____

Section C: AOT

1. AOT: O Yes O No **If Yes:** Effective Date:____ Expiration Date:_____ O Voluntary or O Involuntary
AOT Contact Person: _____ Phone #: _____

* 2. If applying for AOT, has the AOT team been notified? : o Yes o No o Not Applicable
AOT Office Contact Person: _____ AOT Contact Phone #: _____

*Please note: The AOT office must be aware of the potential application for AOT.

Section D: Characteristics

1. Current Living Situation: (Check one)

O 1. Private residence alone
O 2. Private residence with spouse or domestic partner
O 3. Private residence with parent, child, other family
O 4. Private residence with others
O 5. MH Supported Housing (Supported Housing or Supported SRO)
O 6. MH Housing Support Program (Congregate Support or Service Enriched SRO)
O 7. MH Apartment Treatment program
O 8. MH Congregate Treatment program
O 9. MH crisis residence
O 10. Inpatient state psychiatric hospital
O 11. Inpatient, general hospital or private psychiatric
O 12. DOH adult home
O 13. Drug or alcohol abuse residence or inpatient setting
O 14. Correctional Facility
O 15. Homeless, street, parks, drop in center, or undomiciled
O 16. Shelter or emergency housing
O 17. Unknown
O 18. Other (specify): _____

Applicant's Last Name:_____

2. Has the applicant ever been homeless? O Yes O No

3. Has an HRA Supportive Housing application (HRA 2010e) been submitted within the last 6 months for this applicant?

O Yes O No O Not Applicable O Unknown

4. Does the applicant have a current housing determination/approval? O Yes O No

5a. If you answered "Yes" to Question 2, complete the following. (Include dates of present episode of homelessness, provide name of shelter, drop-in center, street, etc., under "Location". List most recent locations first.)

Dates	Location

5b. Where did applicant reside prior to current episode of homelessness? (Indicate name of facility if applicable)

O 1. Own apartment/house
O 2. Single room occupancy
O 3. With family
O 4. Community residence
O 5. With friends
O 6. Jail/Prison
O 7. Adult home
O 8. Inpatient psychiatric facility
O 9. Unknown
O 10. Other (specify) _____

Facility Name: _____

Address: _____

5c. Length of occupancy (in months): ☐

5d. Reason for leaving: _____

6. Current Employment Status: (Check one)

O 1. No employment of any kind
O 2. Competitive employment (employer paid) with no formal supports
O 3. Competitive employment (employer paid) with no ongoing supports
O 4. Sporadic or casual employment for pay (includes odd jobs)
O 5. Non-paid work experience (includes volunteer positions)
O 6. Community-integrated employment run by a state, local or non- government agency or organization
O 7. Employment in sheltered (non-integrated) workshop run by State or local agency
O 8. Unknown
O 9. Other_____

7a. Income or benefits currently receiving: (Check all that apply)

O 1. Wages, salary or self employed
O 2. Supplemental Security Income (SSI)
O 3. Social Security Disability Income (SSD)
O 4. Soc. Sec. retirement, survivor's, dependents (SSA)
O 5. Veteran benefits
O 6. Worker's Compensation or disability insurance
O 7. Medicaid
O 8. Hospital-based Medicaid
O 9. Medicaid Pending
O 10. Medication Grant Program
O 11. Unemployment or union benefits
O 12. Railroad, retirement pension (excluding SSA)
O 13. Medicare
O 14. Public assistance cash program, TANF, Safety, temporary disability
O 15. Private insurance, employer coverage, no fault or third party insurance
O 16. None
O 17. Other: _____

Applicant's Last Name:_____

7b. For any current benefits checked in Question 7, indicate the type and amount per month:

Type of benefit	Amount per month	Type of benefit	Amount per month

7c. Describe any special payee arrangements and the name and address of Representative Payee:

_____

_____

8. Current Criminal Justice Status: (Check all that apply)

- O 1. Applicant is not under Criminal Justice Supervision
- O 2. CPL 330.20 order of conditions and order of release
- O 3. In NYS Dept. of Correctional Services (State Prison)
- O 4. On bail, released on own recognizance (ROR) conditional discharge, or other alternative to incarceration
- O 5. Under probation supervision
- O 6. Under parole supervision
- O 7. Under arrest in jail, lockup or court detention
- O 8. Released from jail or prison within the last 30 days
- O 9. Unknown
- O 10. Other (specify): _____

Section E: Clinical

1. Axis I: Clinical Disorders and other conditions that may be focus of clinical attention.

Diagnosis (if none, please indicate)	DSM-IVR Code

2. Axis II: Personality Disorders and/or Mental Retardation.

Diagnosis (if none, please indicate)	DSM-IVR Code

3. Axis III: General Medical Disorders, including Significant Communicable Diseases.

Diagnosis (if none, please indicate)

_____

_____

_____

4. Axis IV: Psychosocial and Environmental Problems. (Check all that apply)

- O 1. Problems with primary support group
- O 2. Problems related to the social environment
- O 3. Educational problems
- O 4. Occupational problems
- O 5. Housing problems
- O 6. Economic problems
- O 7. Problems with access to health care facilities
- O 8. Problems related to access with legal system/crime
- O 9. Unknown
- O 10. Other (specify) _____

5. Axis V: Global Assessment of Functioning (GAF), current :_____

Applicant's Last Name:_____

6. Current Psychotropic Medications: If none prescribed, please check ○

Name	Dosage	Schedule

7. Current Medications for Physical Illness: If none prescribed, please check ○

Name	Dosage	Schedule

8. Applicant Adherence to Medication Regimen: (Check one)
   - ○ 1. Takes medication as prescribed
   - ○ 2. Takes medication as prescribed most of the time
   - ○ 3. Sometimes takes medication as prescribed
   - ○ 4. Rarely or never takes medication as prescribed
   - ○ 5. Applicant refuses medication
   - ○ 6. Medication not prescribed
   - ○ 7. Unknown
   - ○ 8. Other (specify) _____

9. What level of support is required for compliance with medication regimen? (Check one)
   ○ None, Independent ○ Reminders ○ Supervision ○ Dispensing ○ Not applicable ○ Unknown

10. Does applicant have a medical condition that requires special services such as special medical equipment, medical supplies, ongoing physician support and/or a therapeutic diet?
    ○ Yes ○ No If Yes, please describe: _____

11. Name of Treating Medical MD or facility: _____ Phone #: _____

12. Medical Tests:
    Has applicant been tested for TB in the past year? ○ Yes ○ No **If Yes, attach results.**

13. Physical Functioning Level:

	Yes	No		Yes	No
Fully ambulatory	○	○	Can bathe self	○	○
Needs help with toileting	○	○	Can feed self	○	○
Climbs one flight of stairs	○	○	Can dress self	○	○

Section F: Utilization

1. Applicant Services within the last 12 months: (Check all that apply)
   - ○ 1. None
   - ○ 2. State psychiatric center inpatient unit
   - ○ 3. General hospital unit or certified psychiatric hospital
   - ○ 4. Mental health housing and housing support
   - ○ 5. MH outpatient clinic, continuing day treatment, partial hospital, IPRT
   - ○ 6. Alcohol / Drug abuse inpatient treatment (e.g. clubhouse, vocational services)
   - ○ 7. Alcohol / Drug abuse outpatient treatment
   - ○ 8. ACT, ICM, SCM or other case management
     Name of Program:_____
   - ○ 9. Emergency mental health (non-residential)
   - ○ 10. Prison, jail or other court mental health service
   - ○ 11. Local MH practitioner
   - ○ 12. Assisted Outpatient Treatment (AOT)
   - ○ 13. Self help / Peer support services
   - ○ 14. Community Support Program non-residential mental health program
   - ○ 15. Unknown
   - ○ 16. Other (specify) _____

Applicant's Last Name:_____

2. Psychiatric Services utilization including current hospitalization if applicable. (Indicate the number of utilizations for each. Include "O" if none. "UK" if unknown.)

Psychiatric hospitalizations in the last 12 months: ☐ Psychiatric hospitalizations in the last 24 months: ☐ Arrests in the last 12 months: ☐

Emergency room/mobile crisis visits for psychiatric conditions in the last 12 months*: ☐ Emergency room/mobile crisis visits for psychiatric conditions in the last 24 months: ☐

Note only those ER/Mobile Crisis visits that did **NOT result in a psychiatric admission.*

3. To degree known, list all psychiatric hospitalizations (including current), psychiatric emergency room visits and mobile crisis visits within the last two years. OMH Residential Treatment Facilities are considered inpatient. (This information is required to determine eligibility for service).

Hospital/ER/Mobile Crisis	**Admission Date**	**Discharge Date** (If currently hospitalized, expected Discharge Date)	**Source of Data**

4a. Indicate any mental health or substance abuse program the applicant attends, had previously attended in the last 24 months, and/or if program is part of the discharge plan: (e.g., mental health clinic, substance abuse treatment program, day treatment, vocational services program). Indicate whether program is: **C** = **C**urrently attending or **P** = **P**reviously attended

Dates	Program Name	Contact Name	Telephone Number	C or P

4b. For inpatient and RTF (Residential Treatment Facility) referrals, the discharge plan for outpatient **medical** and **mental health** services must be listed below:

Purpose	Program/Clinic Name	Contact Name	Telephone Number	Appointment Date

Applicant's Last Name:_____

Section G: Well Being

1. **High Risk Behavior:** (Check one response for each)

0=no known history
1=not at all in the past 6 months
2=one or more times in the past 6 months, but not in the past 3 months
3=one or more times in the past 3 months but not in the past month
4=one or more times in the past month but not in the past week
5=one or more times in the past week
U=unknown

	0	1	2	3	4	5	U
a. How often did applicant do physical harm to self?	○	○	○	○	○	○	○
b. How often did applicant attempt suicide?	○	○	○	○	○	○	○
c. How frequently did applicant physically abuse another?	○	○	○	○	○	○	○
d. How frequently did applicant assault another?	○	○	○	○	○	○	○
e. How frequently was applicant a victim of sexual abuse?	○	○	○	○	○	○	○
f. How frequently was applicant a victim of physical abuse?	○	○	○	○	○	○	○
g. How frequently did applicant engage in arson?	○	○	○	○	○	○	○
h. How frequently did applicant engage in accidental fire-setting?	○	○	○	○	○	○	○
i. How often did applicant exhibit the following symptoms?:							
Homicidal attempts	○	○	○	○	○	○	○
Delusions	○	○	○	○	○	○	○
Hallucinations	○	○	○	○	○	○	○
Disruptive behavior	○	○	○	○	○	○	○
Severe thought disorder	○	○	○	○	○	○	○
Other (specify below):	○	○	○	○	○	○	○

_____

2. **Does applicant have current or history of substance abuse?** ○ Yes ○ No

If yes, complete the questions below.
0=no known history
1=not at all in the past 6 months
2=one or more times in the past 6 months, but not in the past 3 months
3=one or more times in the past 3 months but not in the past month
4=one or more times in the past month but not in the past week
5=one or more times in the past week
6=daily
U=unknown

	0	1	2	3	4	5	6	U
a. Alcohol	○	○	○	○	○	○	○	○
b. Cocaine	○	○	○	○	○	○	○	○
c. Amphetamines	○	○	○	○	○	○	○	○
d. Crack	○	○	○	○	○	○	○	○
e. PCP	○	○	○	○	○	○	○	○
f. Inhalants	○	○	○	○	○	○	○	○
g. Heroin/Opiates	○	○	○	○	○	○	○	○
h. Marijuana/Cannabis	○	○	○	○	○	○	○	○
i. Hallucinogens	○	○	○	○	○	○	○	○
j. Sedatives/hypnotics/anxiolytics	○	○	○	○	○	○	○	○
k. Other prescription drug abuse	○	○	○	○	○	○	○	○
l. Tobacco	○	○	○	○	○	○	○	○
m.Other (specify)_____	○	○	○	○	○	○	○	○

Applicant's Last Name:_____

3. Co-occurring disabilities: (Check all that apply)

O 1. None	O 5. Impaired ability to walk	O 11. Deaf
O 2. Drug or alcohol abuse	O 6. Tobacco	O 12. Bedridden
O 2. Cognitive disorder	O 7. Wheelchair required	O 13. Amputee
O 3. Mental retardation or developmental disorder	O 8. Hearing impairment	O 14. Incontinence
	O 9. Speech impairment	O 15. Other (specify): _____
O 4. Blindness	O 10. Visual impairment	

Section H: Referral Source

1. **Referral Source:**

O 1. family/legal guardian	O 13. private psychiatric inpatient hospital
O 2. self	O 14. residential treatment facility
O 3. school/education system	O 15. community residence
O 4. state-operated inpatient program	O 16. ACT
O 5. local hospital acute inpatient program	O 17. Mobile Crisis Team
O 6. criminal justice system	O 18. AOT
O 7. social services	O 19. Blended Case Management
O 8. other mental health program	O 20. Supportive Case Management
O 9. physician	O 21. Intensive Case Management
O 10. emergency room (psychiatric & general hospital)	O 22. OMRDD
O 11. hospital medical unit	O 23. shelter
O 12. outpatient mental health service	O 24. Other (specify) _____

2. **Referring Agency Information:**

Agency Name:_____

Program/Unit Name:_____

Primary Contact: _____

Primary Contact phone number: _____ Fax number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Date: _____

NOTICE REGARDING DISCLOSURE OF CONFIDENTIAL INFORMATION

This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure.

Applicant's Last Name:_____

Referral Summary for ACT/Case Management

To be completed for an application for all referrals. Use additional pages if necessary.

1. Reason for the referral :

_____

_____

_____

2. Community Mental Health Services tried in the past 2 years: *Type of services* (Outpatient Clinic, Community Day Treatment, Partial Hospitalization Program, Assertive Community Treatment, Case Management, etc.) *and outcome,* i.e. rarely attended, never attended, refused services.

_____

_____

_____

3. What community based supports and interventions/strategies (e.g. ICM, ACT, Mobile Crisis Team, AOT, etc.) have been attempted within the last 12 months to engage and/or link applicant to community mental health services?

_____

_____

_____

4. Medication compliance/non-compliance and consequences:

_____

_____

_____

5. Brief statement regarding applicant's current level of functioning including mental status, relationship with family, community supports, etc.:

_____

_____

_____

_____

6. Health/Medical Status, including impact on applicant's overall functioning:

_____

_____

_____

Worker: _____ _____

Print Name **Signature** **Date**

Title: _____ **Phone #:** _____

Applicant's Last Name:_____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HIV RELATED INFORMATION

Confidential HIV (Human Immunodeficiency Virus) related is any information indicating that a person had an HIV related test or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV related information without a release by calling the HIV Confidentiality Law Hotline at (800) 962-5065.

If you sign this form, HIV related information can be given to the people or organizations listed on the form. You do not have to sign the form, and you can change your mind at any time. If you experience discrimination because of release of HIV related information, you can contact the New York State Division of Human Rights at (212)961-8624 or the New York City Commission of Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights.

Name of person whose HIV related information will be released:	**Reason for release of HIV related information:** To provide appropriate medical, case management and/or ACT services
Name and address of facility/provider obtaining release:	**Extent or nature of information to be released:** Universal Referral Form, Psychosocial Summary, Medical and Psychiatric Reports, Treatment Plans, Progress Notes and other related information as required.
Name and address of person signing this form (if other than the person whose HIV related info will be released): **Relationship to person whose HIV info will be released:**	
Time during which release is authorized: **From:**	**To:**

I authorize the provider/facility listed above to release HIV related information to the people/agencies listed below. I also authorize the agencies listed below to release such records back to the named provider and to share necessary HIV related information among and between themselves for the purpose of providing assistance in receiving needed services. I understand that these records, including the HIV related information, cannot be shared with persons or organizations not named or identified on this release form.

Note: Unused boxes **MUST** be crossed out prior to authorizing signature.

Agency Name:	Agency Name:
Address:	Address:
Staff member name (if known):	Staff member name (if known):
Staff member title (if known):	Staff member title (if known):

Agency Name:	Agency Name:
Address:	Address:
Staff member name (if known):	Staff member name (if known):
Staff member title (if known):	Staff member title (if known):

My questions about this form have been answered. I know that I do not have to allow release of HIV related information and that I can change my mind at any time. I have received a copy of this release.

Signature: _____ **Date:** ____/____/____

Signature of parent or guardian if required: _____ **Date:** ____/____/____

Applicant's Last Name:_____

NEW YORK STATE OFFICE OF MENTAL HEALTH
CRITERIA FOR SEVERE AND PERSISTENT MENTAL ILLNESS AMONG ADULTS

To be considered an adult diagnosed with severe and persistent mental illness, Criteria A must be met. In addition, Criteria B or C or D must be met.

A. **Designated Mental Illness Diagnosis**

The individual is 18 years of age or older and currently meets the criteria for a DSM IV psychiatric diagnosis other than alcohol or drug disorders (291.xx-292.xx, 303.xx), organic brain syndromes (290.xx, 293.xx-294.xx), developmental disabilities (299.xx, 315.xx-319.xx), or social conditions (Vxx.xx). ICD-9-CM categories and codes that do not have an equivalent in DSM IV are also not included as designated mental illness diagnoses.

AND

B. **SSI or SSDI Enrollment due to Mental Illness**

The individual is currently enrolled in SSI or SSDI due to a designated mental illness.

OR

C. **Extended Impairment in Functioning due to Mental Illness**

The individual must meet 1 or 2 below:

1. The individual has experienced two of the following four functional limitations due to a designated mental illness over the past 12 months on a continuous or intermittent basis:

   a. Marked difficulties in self-care (personal hygiene; diet; clothing. avoiding injuries; securing health care or complying with medical advice).
   b. Marked restriction of activities of daily living (maintaining a residence; using transportation; day-to-day money management; accessing community services).
   c. Marked difficulties in maintaining social functioning (establishing and maintaining social relationships; interpersonal interactions with primary partner, children, other family members, friends, neighbors; social skills; compliance with social norms; appropriate use of leisure time.)
   d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home, or school settings (ability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings; individuals may exhibit limitations in these areas when they repeatedly are unable to complete simple tasks within an established time period, make frequent errors in tasks, or require assistance in the completion of tasks).

2. The individual has met criteria for ratings of 50 or less on the Global Assessment of Functioning Scale (Axis V of DSM IV) due to a designated mental illness over the past twelve months on a continuous or intermittent basis.

OR

D. **Reliance on Psychiatric Treatment, Rehabilitation, and Supports**

A documented history shows that the individual, at some prior time, met the threshold for C (above), but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder, e.g., hallucinations, but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings which may greatly reduce the demands placed on the individual and, thereby, minimize overt symptoms and signs of the underlying mental disorder.

My name is LaVerne D. Miller and I am the Director of the Howie the Harp Peer Advocacy Center in Harlem. The Center is a program of Community Access, Inc. and is a consumer run and driven employment program. In 2001, the Center in collaboration with the New York State Office of Mental Health developed the Center's nationally recognized STARR (Steps to a Renewed Reality) Program. This program trains mental health consumers with a history of incarceration to work in human services. Our graduates work as Forensic Peer Specialists, Discharge Planners, Case Managers and other positions working with individuals with similar backgrounds.

All of our graduates have had hundreds of formal and informal contacts with police during their adult lives and virtually all report that many of these contacts with law enforcement were sometimes abusive, disrespectful and/or intimidating and virtually always missed opportunities for engagement and treatment. I can say with confidence that we all want change and we hope that a change is going to come.

I want to thank the Committees for holding this hearing today. We are at a time in the life of our city where we can no longer approach the criminalization of mental illness in the reactive piecemeal way that we have done it in the past. We must find the political will to create real alternatives to incarceration that go beyond the cosmetic and semantic and really make a clear and significant break with the past. The Crisis Intervention Team Model currently being used in such cities as Los Angeles, California, Portland, Oregon and Memphis, Tennessee creates a unique opportunity to break with our past and move to the future.

New Yorkers often feel that other cities have little to offer us because we are bigger, more diverse and complicated than other cities in the United States. I firmly believe that our sister cities have a lot to offer us in this area and I would encourage the members of this council to visit these cities to witness firsthand the impact that CIT has upon law enforcement and consumers and their families and its impact on the criminal justice system.

The Memphis CIT Program describes itself as a "community effort enjoining both the police and the community together for the common goals of safety, understanding, and service to the mentally ill and their families...CIT is about doing the right thing for the right reasons". Let us do the right thing.

Officers from cities with CIT programs report that they feel that they are highly effective in meeting needs of consumers in crisis, keeping mentally ill people out of jail, minimizing the amount of time that officers spend on these calls and maintaining

community safety. Similarly, consumers report more positive experiences with police in cities with CIT programs. Isn't this what we all want; police officers who are confident and prepared to handle crises and consumers and families who are not fearful and distrustful of law enforcement. A parent or a loved one should not have to hesitate in calling the police because he or she is fearful that a situation will escalate and may result in harm to their loved one. In many communities, particularly where people of color reside, this formulation is part of the decision making process.

Similarly, CIT should not be viewed in a vacuum and must be part of an overall strategy on the part of policy makers to decriminalize mental illness and fund genuine alternatives to incarceration. For example, in New London, Connecticut, the emphasis is on pre-booking diversion. Here, consumers are not arrested but transported with their consent to treatment providers. What is needed is a coordinated and comprehensive approach that starts from street encounters to the reentry of consumers with histories of incarceration back into their communities. You cannot successfully implement a CIT program without adequately funding providers to increase the hours of operation and hire additional staff. Services that are recovery oriented and promote resiliency and recovery such as Peer Support Services and Peer Specialists must be funded also.

In closing, advocates are ready to stand with you as we begin this journey together. I strongly recommend that advocates and consumers assist the New York City Police Department in designing and implementing a CIT Program. Most importantly, this Council must show courage and adequately fund this initiative. This is the only way that real change and transformation will take place. We are all tired of dancing in place.

Rights for Imprisoned People with Psychiatric Disabilities
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WHAT IS PRE-BOOKING JAIL DIVERSION?

The term "jail diversion" refers to programs that divert individuals with serious mental illness (and often co-occurring substance use disorders) in contact with the justice system from jail and provide linkages to community-based treatment and support services. The individual thus avoids or spends a significantly reduced time period in jail/prison

WHO IS USING PRE-BOOKING JAIL DIVERSION?

80 law enforcement agencies across the country are currently using specialized responses when dealing with mental illness including Los Angeles, CA, Memphis, TN, and Rochester, NY.

CORE ELEMENTS OF PRE-BOOKING JAIL DIVERSION

Pre-booking diversion occurs at the point of contact with law enforcement officers and relies heavily on effective interactions between police and community mental health and substance abuse services. Most pre-booking programs are characterized by specialized training for police officers and a 24-hour crisis drop-off center with a no-refusal policy for that is available to receive persons brought in by the police. Other models of pre-booking diversion involve collaboration between police and specially-trained mental health service providers who co-respond to calls involving a potential mental health crisis.

PRE-BOOKING JAIL DIVERSION IN PRACTICE

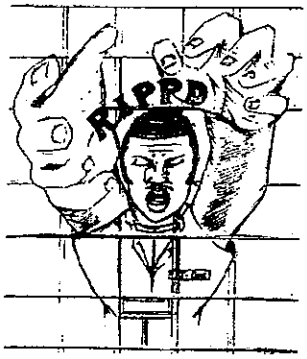
- Ensure that dispatcher/call taker appropriately assesses the nature of the call received. Dispatchers should be trained to recognize calls that involve person with mental illness.
- The dispatcher, after assessing the call, should be able to dispatch directly to appropriate police/mental health team.
- Develop tracking system to record data of each call. With this information the dispatchers can provide important historical information to the responding officers, enabling them to arrive better prepared. In addition, the agency will be able to evaluate how effective the crisis intervention really is.
- Based on previous training, officer should be able to conduct an assessment of the mental illness involvement at the scene. Officer should use de-escalation techniques when necessary
- Once an assessment has been made, police officers must have access to mental health resources. This requires knowledge of what mental health services are available and which would be appropriate for the person(s)

AVOIDING MISTAKES WITH PRE-BOOKING JAIL DIVERSION

Training is essential to a successful diversion program. It's best that all officers be trained on basic issues related to mental illness and ways to de-escalate crisis situations.

Partnership is the key. Law enforcement can handle cases more efficiently and provide a better service to the community if they work together with service providers.

There needs to be an agreed commitment from all the stakeholders, including department chiefs, mental health service providers, people with mental illness and their family members and the community at large.



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PRE-BOOKING JAIL DIVERSION
CRISIS INTERVENTION TEAMS

Testimony for New York City Council Hearing

Mental Health, Mental Retardation, Alcoholism, Drug Abuse & Disability Services Committee

Public Safety Committee

February 28, 2008

Matthew Canuteson, Policy Specialist
New York Association of Psychiatric Rehabilitation Services

Good morning. I want to thank Chairmen Koppell and Vallone, and the members of the respective committees for this opportunity to provide comment and recommendations in response to the reevaluation of the New York City Police Department's protocols and response to incidents concerning the apprehension, restraint, and use of lethal force against people with psychiatric disabilities. While police response to people with psychiatric disabilities has always been a very important concern, this issue has taken on critical importance in the wake of several recent tragedies here in New York City.

I speak today on behalf of the thousands of New York State and City residents with psychiatric disabilities and the mental health professionals who support them who, together, form the unique partnership that is the New York Association of Psychiatric Rehabilitation Services. Over the past 26 years, NYAPRS members and staff have been dedicated to efforts to improve services and social conditions in order to advance the recovery, the rehabilitation, and the rights of New Yorkers with psychiatric disabilities.

Towards these ends, we have engaged in considerable grassroots education, empowerment and advocacy; education, training and consultation to community providers, local and state governments and probation departments and the development of a nationally replicated peer bridger model that has helped thousands to successfully transition from state and local hospitals to the community.

Our commitment to these goals if very personal at NYAPRS, as most of our staff, including myself, are ourselves people with psychiatric disabilities and so, we offer a very personal understanding of what it takes and is needed to support recovery from even the most challenging conditions and circumstances.

Before I offer comment on today's focus on improving the interface of our police with City residents with psychiatric disabilities, I would first like to present some important findings that we believe are fundamental to approaching the issues at hand. While these issues are indeed very personal to us, I'd like to respond not with feelings but facts.

1. Thanks to advances in our understanding and response to the various psychiatric disabilities (especially those affecting thinking, judgment and mood), we now know that ***even the most severely disabled individual can achieve significant levels of recovery***, when they are offered the choice of the right kind and mix of modern services, supports and medications. (1997 Harding et al British Journal of Psychiatry). http://akmhcweb.org/ncarticles/Vocational%20Rehab.htm

2. However, prestigious national studies like the 1998 Patient Outcomes Research Team (PORT) Study conducted by the Agency for Health Care Policy and Research and the National Institute of Mental Health (NIMH) found that "***Fewer than Half of Schizophrenia Patients Get Proper Treatment.***" www.ahrq.gov/news/press/schizpr4.htm

3. The 1998 McArthur Study conducted by a former top OMH researcher who has gone on to be one of the nation's experts in criminal justice issues relating to those with psychiatric disabilities found that ***"there was no significant difference between the prevalence of violence by (mental) patients" and their neighbors*** unless, like those neighbors, they were engaged in patterns of substance abuse. http://archpsyc.ama-assn.org/cgi/content/abstract/55/5/393?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=Steadman&searchid=1139212828284_30&FIRSTINDEX=0&journalcode=archpsyc

4. In fact, a 2005 study recently found that, contrary to public opinion fanned by tabloid exploitation, ***"more than one quarter of persons with serious mental illnesses had been victims of a violent crime in the past year, a rate more than 11 times higher than the general population rates."***
"Crime Victimization in Adults With Severe Mental Illness" study Teplin et al Archives of General Psychiatry. http://archpsyc.ama-assn.org/cgi/content/abstract/62/8/911

5. Finally, to bring this issue particularly home, a recent Daily News editorial estimated that "four to six times a year" in New York City, a murder is committed by a person with a psychiatric disability. While every murder is a terrible tragedy, I feel it is important to note that, **given the 494 murders committed in New York City last year, apparently only 1% are committed by people with psychiatric disabilities.**

Making Policy Based on Facts Not Fear and Discrimination

Given these findings, I hope you can fully appreciate our community's reaction when New York City tabloid headlines repeatedly play up rare, tragic incidents of violence involving people with psychiatric disabilities and frighten and anger the public against us with messages like "Deadly Madmen, Mental Health System still lets them Roam" in the New York Post.

Our community abhors violence, especially given our greater vulnerability to it as mentioned before. We suffer every time one of us is victimized, and then suffer again at how little that suffering is recognized. And we particularly suffer every time a person with a psychiatric disability commits a violent crime, because we know that that crime will be reported with meticulous detail, in sensationalistic ways that will typically play up public fears and misunderstandings about us, fanning public calls to have us all locked up or sent back to state hospitals, or closely monitored like criminals or forced into often flawed treatments that have failed us so often in the past.

Our movement is akin to many civil rights movement of the past and our struggles are similar to groups that have often had to combat similar discrimination and unjust stereotypes, like African Americans, Jews, women or gays and lesbians. It was not long ago that it was common to see African Americans portrayed in the media only when they were engaged in crime or drugs. Each group has had to speak up and fight back and, in that spirit, I ask you to reject these false

stereotypes and approach our community with respect for our resilience and commitment to recovery and peaceful and productive citizenship.

These false and misleading reports in our papers are devastating and detrimental to people in our community. Our community is made up of people who want to work, to have meaningful relationships, and to demonstrate every day the courageous capacity to recover and to live peacefully in our communities.

Improving Engagement and Diversion Services to Individuals with Psychiatric Disabilities

As a community who is all too often failed by what the President's New Freedom Commission termed a fragmented mental health service system that is in "shambles," we strongly welcome your interest in strengthening our local service systems. Accordingly, we recommend the following:

- **Outreach and Engagement**
  - We need to step up efforts to better **publicize the services and supports** that are currently available, in ways that overcome barriers such as culture, language and stigma.
  - Given our poor success rate in engaging people of diverse cultural and linguistic backgrounds (as evidenced by their vastly disproportionate involvement with the criminal justice and Assisted Outpatient Treatment systems), we must **step up our training and new service development in areas of cultural and linguistic competence.**
  - Enhance voluntary models of engagement and service like New York City's nationally acclaimed Pathways to Housing's **'harm reduction' housing and support program.** Pathways has been able to achieve an 88% service retention rate and general stability among a group of primarily young men of color with psychotic disorders and previous histories of homelessness and non-participation with services...the very same group that many believe can only be served via court order. This is achieved without mandating_treatment adherence or abstinence but by offering 'housing first' via a model that merges supported housing and Assertive Community Treatment services. http://ps.psychiatryonline.org/cgi/content/abstract/51/4/487
  - The research is clear that the components of Kendra's Law that are most effective are a strong focus on **individualized follow up, coordination and priority access to housing, treatment and rehabilitation**. New York City is unique in its reliance on 'force first' approaches; most other counties have used their Kendra's Law funding to boost their coordination and outreach efforts without reliance on court orders: New York should do the same!
- **Crisis Diversion:** New York City should be a national leader in this area, but it is not. We urge the City to replicate a very innovative approach that is achieving impressive results in upstate Ulster County. That model makes available trained and supportive 'peers,' staff who are themselves in recovery from a psychiatric disability and who are especially effective in helping to engage and support people at their most distressing moments. PEOPLe, Inc makes those peers available at 4 critical intervention points:

- A peer 'warm line' offering phone support before the crisis erupts
- Peer 'in home companions' who can provide mobile assistance
- Peer staff in local hospital emergency room to help shorten and maximize ER visits and, if needed,
- Stays at a Peer crisis respite program, a home-like alternative to hospitalization that has helped hundreds to destabilize and prevent relapses and avoidable tragedies.

We urge the City to adopt such a model in association with one or more HHC facilities.

- **Intensive Family Support:** Lee Coleman's uncle and David Tarloff's father didn't get the help they needed in figuring out how best to get help for their loved ones. Family members need a specialized service they can reliably call and reach at any time and a team that can go out and provide the assessment and responsive services that are often needed to achieve a positive outcome.

Improving Police Responses to People in Psychiatric Crisis

In response to today's primary focus, we offer the following recommendations:

- It is crucial to foster much closer collaborations between the New York Police Department, the Department of Health and Mental Health and the community mental health provider system. Neither the mental health system nor the law enforcement system can manage mental health crises in the community effectively without help from the other.
- We need to ensure that individuals who voluntarily search out treatment are treated with the highest levels of respect and dignity including the use of non-police vehicles for transports as well as refraining from the use of the degrading and criminalizing act of putting handcuffs on people who are voluntarily and peacefully seeking out help.
- We understand that Suffolk County mental health and police officials have been engaged in a series of discussions which are poised to overhaul that community's emergency police response, maximize the use of ambulance transport and offer crisis diversion beds in association with the area state psychiatric center. We encourage City officials to closely follow their progress.
- We are encouraged by the start of LINK Committee meetings, of which I am a member, that are looking collaboratively at improving police training and responses to people in psychiatric crisis. I'd like to emphasize that no police skill is more critical than the ability to defuse, rather than to escalate, potentially dangerous situations.

We'd like to recommend several models for your consideration including

The Memphis Police Crisis Intervention Teams (CIT)

The Memphis Police Department's Crisis Intervention Team (CIT) is a police-based pre-booking jail diversion program. CIT has over 100 patrol officers that cover four overlapping shifts in each precinct in addition to their regular patrol duties. The CIT officers respond to calls when there is indication of a crisis. After arriving on the scene the CIT officer is the designated officer in charge.

Officers receive 40 hours of training in psychiatric disorders, substance abuse, de-escalation techniques, legal issues related to mental health and substance abuse, empathy for people with psychiatric disabilities and their family members.
CIT officers make an immediate response 24 hours a day, seven days a week. Approximately half of all calls are resolved at the scene with the individual's being referred directly to community-based services. The program creates a seamless link between law enforcement and emergency mental health services providing an efficient single point of entry into the mental health system.
The Memphis Police CIT program has decreased officer-injury rates and reduced arrests to 2% of EDP calls. Individual outcomes are lower arrest rates, decreased symptoms, and increased quality of life.
http://www.memphispolice.org/Crisis%20Intervention.htm

Birmingham Police, Community Services Officers, Birmingham, Alabama
Birmingham Police Department employs civilian social workers as Community Services Officers (CSOs) who are civilian police employees with professional training in social work or related fields. They dress in plainclothes, drive unmarked cars, carry police radios and assist police officers in mental health emergencies by providing crisis intervention and follow-up assistance. CSOs do not carry weapons; do not have the authority of arrest.
CSOs participate in a six-week classroom and field training program and are based in all four major city police precincts. Twenty-four hour coverage are provided by CSOs rotating on-call duty even during weekends, holidays and off-shift hours. CSOs also attend to other social service types of calls such as domestic violence calls.
A survey of Birmingham police officers found that many thought the CSO program was effective in meeting the needs of people with psychiatric disabilities who were in crisis; half thought the program helped keep individuals out of jail and maintained community safety. Arrest rates of offenders with psychiatric disabilities were reduced to 13%. The program saved $2,200 per case in reduced jail and officer time.
http://www.bazelon.org/issues/criminalization/factsheets/criminal6

Thank you again for this opportunity to speak before you today. I hope my comments have been helpful.

Rights for Imprisoned People with Psychiatric Disabilities
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Mary Dougherty Testimony

Hello. My Name is Mary Dougherty and I am a member of Rights for Imprisoned People with Psychiatric Disabilities. I am here today to urge the City of New York, to take action against the New York City Police Department. For too long, this agency has contributed to the criminalization of mental illness. Their policies and procedures show a lack of concern and care for people with mental illness.

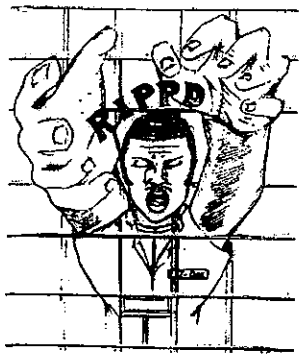
It is alarming to note that according to the Bureau of Justice Statistics more than half of all prison and state inmates report mental health problems, including symptoms of major depression, mania and psychotic disorders. More alarming are the numbers of people with mental illness in our own city jail, Riker's Island....4000 on any given day.

The NYPD is not trained to understand mental illness. Officers are trained to use aggressive techniques that only further escalate situations. This results in the unnecessary arrest of people with mental illness and unfortunately in some case, such as Kheil Coppin, Gideon Busch, and Blondel Lassegue, death.

In order to bring about positive interactions between police and people with psychiatric disabilities and to ensure the safety of all, we feel it is necessary for the New York City Police Department to make changes to its current policies and procedures

Many police departments throughout the country are taking pro-active steps in building relationships with the mental health community and are preventing the criminalization of mental illness by implementing Crisis Intervention Teams (CITs). CITs allow police officers, with specialized training, to better respond to mental health emergency calls.

People with mental illness are in need of treatment, not jail time. It is time for the City to take action against the agencies that enable the criminalization of mental illness. RIPPD will continue to fight until justice is brought about.



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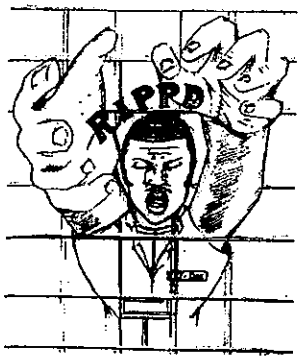
CIT Testimony

My name is David Newton and I am a member of Rights for Imprisoned People with Psychiatric Disabilities (RIPPD). It is shocking and alarming to be attending this public hearing so late in the game. People with mental illness have been abused and killed by the NYPD for many years. Why is this only being taken seriously now? And why is it that an administration that for far to long stood silent, gets to speak first, for as long as they want. It seems to me that the real experts, people directly affected, who have been voicing this issue for years should be allowed to speak first.

There are so many different models of Crisis Intervention Teams that are being successfully used in Chicago, LA, Memphis and Rochester. It's bewildering that NYC is so far behind, when it prides itself on being progressive and at the cutting edge of legislation. Our membership often wonders how affective these public hearings really are.

The government needs to recognize that we the community, those directly affected, do have the solution. Our voices and ideas need to be taken seriously in order to stop the injustice and abuse.

As members of RIPPD, we pride ourselves in always being head of game. We are aggressive in our tactics and always see through campaigns to the end. This is no exception. We will not rest until justice is seen.



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