CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON FIRE AND CRIMINAL JUSTICE SERVICES JOINTLY WITH COMMITTEE ON PUBLIC SAFETY, COMMITTEE ON COURTS AND LEGAL SERVICES, AND COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISAILITY,ALCOHOLISM, SUBSTANCE ABUSE, AND DISABILITY

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May 12, 2015
Start: 01:06 p.m.
Recess: 05:30 p.m.

HELD AT: Council Chambers – City Hall

B E F O R E:

ELIZABETH S. CROWLEY
Chairperson

VANESSA L. GIBSON
Co-Chairperson

RORY I. LANCMAN
Co-Chairperson

ANDREW COHEN
Co-Chairperson

COUNCIL MEMBERS:

FERNANDO CABRERA
MATHIEU EUGENE
PAUL A.VALLONE
CHAIM M. DEUTSCH

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

COUNCIL MEMBERS: (CONTINUED)

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Co-Director
Justice Committee

[gavel]

CHAIRPERSON CROWLEY: Good afternoon. My name is Elizabeth Crowley and I am the chair of the Fire and Criminal Justice Committee here at the council. I'd like to recognize my colleagues who have joined me here today. We have Council Member Rory Lancman, Council Member Helen Rosenthal, Council Member Mathew Eugene, and Council Member Fernando Cabrera. Today the committee will vote on proposed intro 579A which was introduced by Council Member Rosenthal and was heard at a committee hearing on December 10th 2014. This bill will require the fire department to share demographics of the firefighter applicant pool requiring information on applicants, gender, and race at every step of the firefighter testing process from application to written test to physical test, academy entrance, and academy graduation. The bill also requires the FDNY to report on its recruiting activity for the firefighter position including recruiting expenditures, a list of the recruiting events, and a list of the preparatory materials it creates to assist the applicants. With this data the council will be able to determine if a group is disproportionately affected at some point

along the lengthy application and training process. The information will help both the fire department and the council monitor the race and gender composition of the city's firefighters and help ensure that is a body of qualified diverse individuals reflective of the city's population. Before 1977 the fire department did not allow women into the ranks until the federal government passed a law requiring it to do so. But even then they did not allow a single woman to become a firefighter until a federal court, until a federal court forced its hand in 1982. After this court ruling the fire department had 41 women firefighters out of approximately 9,000 for a total of about .4 percent, so not even one percent of the department. Today 33 years later the percentage of women firefighters remains very low. Racial and ethnic minorities have farred [phonetic] better than women but have only achieved some degree of proportional representation after multiple successful lawsuits. The bill we will vote on today has the overwhelming support of the council what 41 members signed on as co-sponsors. I recommend a yes vote and I will ask the main sponsor Council Member Helen Rosenthal to offer her statement.

COUNCIL MEMBER ROSENTHAL: Thank you so much Chair Crowley. Thank you for being the leading advocate for bringing more women into the fire department. I'm so proud to have been able to co-sponsor this bill with you and so proud so many of our colleagues have signed on as well. The numbers just don't add up. 18 percent of New York City police officers are women. 13 percent of US combat troops are women. 13 percent of San Francisco's firefighters are women. And less than a half of a percent of New York firefighters are women. I'm eager to learn what is so unique about being a firefighter in New York City that it should exclude women. The data we will receive from this bill will shed light on how many women apply to be firefighters and where they drop off along the application process which can take several years from start to finish. We wouldn't be here today without the leadership of Chair Crowley who has been persistent in pursuing this issue for years. I' like to thank the chair for her commitment to equal treatment for all who are able to accomplish the physical task relevant for being a firefighter and for those who are willing to risk their lives and join the brave cohort of New York City firefighters.

I encourage all of my colleagues to vote yes on this bill today, to bring it before the full council. Thank you very much.

CHAIRPERSON CROWLEY: Thank you Council Member Rosenthal. I now call for a vote.

COMMITTEE CLERK MARTIN: William Martin Committee Clerk. Roll call vote Committee on Fire and Criminal Justice Services. Introduction 579-A. Chair Crowley.

CHAIRPERSON CROWLEY: I vote aye.

COMMITTEE CLERK MARTIN: Eugene.

COUNCIL MEMBER EUGENE: I vote aye and congratulation Council Member Rosenthal and thank you Madam Chair for your leadership on this issue.

COMMITTEE CLERK MARTIN: Cabrera.

COUNCIL MEMBER CABRERA: I vote aye.

COMMITTEE CLERK MARTIN: Lancman.

CO-CHAIRPERSON LANCMAN: [off mic] Aye.

COMMITTEE CLERK MARTIN: By a vote of four in the affirmative, zero in the negative, and no abstentions item has been adopted.

CHAIRPERSON CROWLEY: I'd ask the committee clerk to hold the vote open for a half an

hour. And in about 10 minutes we will reconvene for the start of the next hearing.

[break in audio]

COMMITTEE CLERK MARTIN: Continuation roll call, Committee on Fire and Criminal Justice Services. Introduction 579-A. Council Member Vallone.

COUNCIL MEMBER VALLONE: Aye.

COMMITTEE CLERK MARTIN: Final vote now stands at five in the affirmative, zero in the negative, and no abstentions. Thank you.

[break in audio]

CHAIRPERSON CROWLEY: Good afternoon again. I'm Elizabeth Crowley, the chair of the Fire and Criminal Justice Services Committee here at the council. This is a joint oversight hearing with the Committee on Public Safety chaired by Council Member Vanesa Gibson, the Committee on Courts and Legal Services chaired by Council Member Rory Lancman, and the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse, and Disability Services chaired by Council Member Andrew Cohen. At today's hearing we will examine the mayor's taskforce on behavioral health and the criminal justice system. The task force was

convened in June of 2014 a few months after the tragic death of Jerome Murdough. Mr. Murdough was a veteran with a mental health illness and a substance abuse problem who was arrested for trespassing as he slept in a stairwell of a building. While incarcerated he died in his overheated cell on Ryker's Island. He represents just the type of person that should not have ever been on Ryker's Island. It is important that this taskforce create a framework to divert individuals like Mr. Murdough away from the jail system. Today the average jail population is approximately 11 thousand. Nearly half of the population it was 20 years ago. The behavioral health and criminal justice taskforce recommendations will help to further reduce the population of Ryker's Island to a much greater extent if implemented properly. I'd like to thank my staff for helping to put this hearing together in the committee staff ad to all the council members here who are co-chairing. I would like to now recognize Council Member Vanessa Gibson chair of Public Safety for her opening statement.

CO-CHAIRPERSON GIBSON: Thank you very much Co-Chair Crowley. And good afternoon to each and every one of you. I am Council Member Vanessa Gibson of the 16th District in the Bronx ad I proudly serve here as the committee chair on Public Safety. I want to thank Council Member Liz Crowley, chair of the Committee on Fire and Criminal Justice as well as my two co-chairs Chair Rory Lancman ad Chair Andrew Cohen for holding this very important hearing this afternoon on the Mayor's taskforce on behavioral health and the criminal justice system. I'd also like to thank my staff who are here, my council Depar Ambedkar [sp?], legislative analyst Beth Golub, policy analyst Lori Wen [sp?], finance analysis Ellen Aang [sp?], and my communications director Dana Wax [sp?]. This afternoon we are examining the mayor's taskforce on behavioral health and the criminal justice system and examining the New York City's action plan. I'm pleased so far with the formation of this taskforce and its vision in putting a spotlight on many individuals with behavioral health issues and the roll of public safety. Crime has fallen to an all-time low in the city of New York and so has the

number of incarcerated individuals at Ryker's Island. However despite our city's success in reducing crime the number of people with behavioral health issues cycling through the criminal justice system has largely remained constant. We need to address the challenge of reliably assessing those individuals to may pose a public safety risk to themselves as well as the public in ensuring that we appropriately address not just arrest the behavioral health issues that have led many of those individuals in contact with the criminal justice system. A call to 911 and the police is often the first point of contact regarding many individuals with behavioral health issues. Police however have limited options other than processing these individuals through the criminal justice system. In this afternoon's hearing I am interested to learn the protocol that would be established when 9-1-1 is called and police respond to an EDP, an emotionally disturbed person. In addition I'd like to hear about the expanded training for our police officers and how we will enable them to better recognize and understand the behaviors and symptoms of mental illnesses and substance abuse

and use. I want to know the different options that are available for many of our first responders and police officers. We must focus on training our hard working police officers with techniques of de-escalation and ensuring that they have the tools for assessing the alternatives to ail and entry into the criminal justice system. With respects to alternatives to jail this taskforce is in the process of implementing what we are calling drop off and diversion centers. I am hoping to learn more about these centers and the plans of expanding these locations beyond the pilot program. The safety of our city is of paramount importance to everyone and it is essential that we strike a delicate balance between the public safety and the needs of those who live with mental illnesses and substance abuse. I know we have a lot of material to get through today so I'd like to thank all of our representatives from the city agencies who are here, everyone who is here to testify. And with that I will turn this hearing over to my co-chair, chair of Courts and Legal Services Chair Rory Lancman.

CO-CHAIRPERSON LANCMAN: Thank you. Good afternoon. I'm Councilman Rory Lancman chair of the Courts and Legal Services Committee. And I want to thank Council Members Gibson, Crowley, and Cohen for this joint hearing. We have been joined with the Committee on Courts and Legal Services Council Members Vincent Ignizio from Staten Island. The mayor's taskforce has rightfully identified the need for a more comprehensive strategy to handle people with mental illness ensnared in our city's criminal justice system. The committee on Courts and Legal Services is particularly focused on the taskforces recommendations concerning the quote from arrest to disposition phase of the legal process. Inmates with behavioral health issues do not just materialize in our city's jails. They are sent there by our courts usually on the recommendation of our district attorney's offices and with representation from our indigent defense providers. If we view the high number of mentally ill detained on Ryker's Island as a problem then reforming our courts and legal services system must be an integral par of the solution. The criminal justice landscape for mentally ill defendants is

complicated and filled with many gaps. Presently there is almost no mental health screening at the arraignment phase, a critical moment when bail decisions are made and many defendants accept a plea agreement. The criminal justice agency which evaluates all defendants prior to arraignment for bail purposes does not assess mental health nor does either the court except where defendants are evaluated to determine their competency to stand trial or the district attorney's office. And only some institutional legal defense providers have limited screening capacity through in house social workers. The taskforce makes several worthy recommendations including a pre-arraignment behavioral health screening pilot program in Manhattan revamping the risk assessment tool used by CJA in evaluating flight risk for bail consideration although importantly not necessarily incorporating mental and behavioral health status in that risk assessment tool. Requiring CJA to determine and alert the court to a defendant's veteran status and tripling existing supervisor release programs to approximately 34 hundred slots. The pre-arraignment behavioral health screening

program is particularly important because simply put courts should not be making bail decisions, accepting plea agreements, or imposing sentences without considering a defendant's mental and behavioral health status. Post arraignment New York City is blessed with a variety of specialty courts that are particularly tailored for defendants with mental and behavioral health issues including mental health, drug, and veterans courts. But the courts are dealing with challenges that the taskforce doesn't address. Not all boroughs have these courts at the misdemeanor level. Many misdemeanor defendants choose to take a plea for a sentence that is shorter than the length of an alternative treatment program. And all these courts suffered some degree or another from limited resources and support from the city. Throughout the criminal justice process legal service providers confront legal and ethical issues surrounding disclosure of a client's mental health status which in some circumstances can actually work against a client's interests when it comes to bail and sentencing. Additionally a client's mental and behavioral health issues can present a particularly

difficult barrier to providing robust and effective legal representation which legal services providers struggle to overcome for lack of resources and availability of on staff social workers. The taskforce does not address or make recommendations concerning these specialty courts or the challenges that legal service providers face in representing the mentally ill. We need to also consider issues such as whether the city is properly supporting the social services providers who serve these specialty courts, whether legal services providers have the resources necessary, necessary to effectively represent mentally ill clients, whether private attorneys and so called 18-B attorneys are aware of the opportunity for diversion of specialty courts, whether there is a good handoff process between the alternative to detention program and the alternative to incarceration program and whether the court based intervention and resource teams asCERT program is properly calibrated to identify the appropriate defendants. I look forward to learning the perspectives of the witnesses planning to testify today and to do something significant to address this very important issue. Thank you.

CHAIRPERSON CROWLEY: Thank you Council Member Lancman. Now I'd like to recognize Chair Cohen for his opening.

CO-CHAIRPERSON COHEN: Thank you. Good afternoon. My name is Andrew Cohen and I am the chair of the Committee on Mental Health, Developmental Disabilities, Alcoholism, Drug Abuse, and Disability Services. I am pleased to be joined by my colleagues Council Member Crowley chair of the Committee on Fire, Safety, and Criminal Justice, Council Member Gibson Chair of the Committee on Public Safety, and Council Member Lancman Chair of the Committee on Courts and Legal Services with whom I am co-chairing this joint hearing. Oh I want to acknowledge that we've been joined by Council Member Vallone, a member of the Mental Health Committee. I would also like to acknowledge Kimberly Williams committee council, and Michael Benjamin legislative policy analyst for their hard work in preparing for today's hearing. Of great concern to the mental health committee is the plight of persons who are released from our jails and prisons. There is much we still need to learn of how best to reintegrate this population

into society. But what we know with certainty includes the facts that, the facts that people coming out of incarceration had disproportionately high rates of chronic disease, especially mental illness and addictive disorders. These are some of the most attractable and complex disorders to manage for all members of society, certainly no less those for this population. We also know that without follow-up medical care these persons are statistically, statistically likely to be re-incarcerated or re-hospitalized. Those are, those who are uninsured leave prison with 30 days' worth of medication and then mostly left to their own devices. We know this hasn't always produced the best outcomes for many of these individuals on the past. Effective discharge programs have to be available for those released from jail or prisons because former offenders are likely to struggle with not only substance abuse but also a lack of adequate education and job skills, limited housing options, and again mental health issues. To help reduce recidivism many New York City community based organizations help inmates preparing to leave jail. And we hope to learn today both details and,

details and the effectiveness of such efforts. The committee hopes to learn more about the program called Health Home which is a care management service model whereby all of an individual's caregivers communicate with one another so that all the patients' needs are addressed in a comprehensive manner to assure that the clients receive everything necessary to stay healthy and out of the emergency an out of the hospital. Supportive housing availability for persons reentering society is a major component of successful reentry. A program named fuse for exam is an initiative that emerged as a result of ongoing interagency workgroup meetings within the New York City discharge planning collaboration. This initiative involves constant and formal information sharing coordination program monitoring and troubleshooting among agencies including DOCDHS, C, the Corporation for Supportive Housing and participating supportive housing providers. The goal is to break the cycle of repeated use of costly crisis services and involvement in shelters in the criminal justice system. I look forward to this afternoon's testimony. Thank… Oh and I'd also

like to acknowledge that we've been joined by Council Member Corey Johnson. And I still look forward to this afternoon's testimony. Thank you.

CHAIRPERSON CROWLEY: Thank you Council Member and Co-Chair Cohen. I'd like to recognize council members who may not have been recognized yet. We've been joined by Council Member Eugene, Torres, Vacca, Matteo, Rosenthal… and I believe all the other council members have been recognized. And now we would like to hear testimony from the administration and all those who are going to be giving testimony or answering any questions I would ask if you could raise your right hand. We, as part of the process here in the council, as, you to affirm that you will tell the truth. So I'm going to read the affirmation and if you do affirm to just say I do. Do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before the committee and to respond honestly to council members' questions. Thank you.

TRISH MARSIK: Good afternoon Chairperson Crowley and members of the Committee on Fire and Criminal Justice Services as well as members of the Committees on Public Safety, Courts,

and Legal Services, and Mental Health, Developmental Disability, Alcoholism, Substance Abuse, and Disability Services. My name is Trish Marsik and I am the Executive Director of the Mayor's Taskforce on Behavioral Health and the Criminal Justice System. Thank you for the opportunity to testify today. The Taskforce on Behavioral Health and the Criminal Justice System is embedded in the Mayor's Office of Criminal Justice which advises the Mayor on Public Safety Strategy and together with partners inside and outside government develops and implements policies aimed at achieving three main goals reducing crime, reducing unnecessary arrests and incarceration and promoting fairness. These three goals are at the heart of the taskforce's work. In June of 2014 Mayor de Blasio launched a robust effort to address how the criminal justice and health systems can work together better to ensure that we are reserving criminal justice resources for the appropriate cases and deploying treatment and other proven effective remedies to interrupt those needlessly cycling through the system. Under the leadership of Deputy Mayor of Health and Human

Services Lilliam Barrios-Paoli and Director of the Mayor's Office of Criminal Justice Elizabeth Glazer the taskforce's executive committee included commissioners from city and state agencies, experts from the private sector, representatives from law enforcement and behavioral health agencies, district attorneys, defenders, judges, and other court representatives, academics, and service providers. The taskforce brought together over 400 leaders and participants in this work from across the city and the nation. Over a 100 day period this group developed a comprehensive strategy to ensure that when appropriate people are diverted from the criminal justice system and that justice involved individuals with behavioral health needs are connected to care and services at every point in the criminal justice process. The result is an unprecedented 130 million dollar four year investment in targeted solutions that look not only at individual points in the system about how the system as a whole operates. In implementing this plan we are reducing the number of people with behavioral health needs cycling through the criminal justice system and connecting them instead

to interventions that could change the course of their lives. I will discuss with you today the strategic imperatives driving these reforms as well as the mechanisms we're using to ensure that reforms are being fully and effectively implemented. Over the last 20 years New York City has experienced the sharpest drop in crime anywhere in the nation. As crime has fallen so has the city's jail population. On the last day of 2014 there were fewer than ten thousand individuals detained at Ryker's for the first time since the mid-1980s. While many factors contributed to this extraordinary achievement at its heart the success was due to a focused effort to identify who was committing crimes and where and then tailoring strategies to address those specific problems. Despite our success in reducing the overall jail population. The number of people with behavioral health issues has stayed largely constant. With individuals with behavioral health issues comprised in a bigger and bigger percentage of the total number incarcerated. While in FY2010 people with mental illness where only 29 percent of the New York City jail population today they represent 38

percent of the overall jail population. Approximately seven percent of the jail population is made up of individuals with serious mental illness meaning that they suffer from diseases such as schizophrenia and bipolar disorder. In addition approximately 46 percent of inmates in the New York City jail system report that they are active substance users although we believe that actual prevalence of substance use to be much higher. Many justice involved individuals with behavioral health needs cycle through the system over and over again often for low level offences. For example a group of approximately 400 individuals has been admitted to jail more than 18 times in the last five years. This same group accounted for more than 10 thousand jail emissions and a collective 300 thousand days in jail. To address this population more effectively and efficiently the taskforce's recommendations are rooted in the recognition that these kinds of entrenched and recurring problems can only be addressed if the system is looked at as a whole. And if the strategy recognizes that each part of the system has an effect on the other the goal of these strategies is to ensure that when

there's no public safety risk that individuals with behavioral health disorders do not enter the criminal justice system in the first place. If they do enter that they are treated outside of the jail setting. If they are in jail that they receive treatment that is therapeutic rather than punitive. And that upon release they are connected to effective services. A key component of this approach involves plugging into Medicaid expansion which gives us an opportunity to expand funding from supportive programming and treatment in the community while ensuring that those3 services lead to both better health outcomes and declining justice involvement. To that end throughout the taskforce's work we are focused on increasing enrollment in Medicaid ensuring that health homes engage and retain those justice involved and that we measure the success of the range of new Medicaid initiatives not only by how they reduce reliance on health crisis services but also the crisis of justice involvement. Here are a few examples of the taskforces work today. Achieving the taskforces goals begins on the street where police and other first responders encounter those with behavioral

health issues. The NYPD is currently finalizing curriculum that will expand training for police officers to enable them to better recognize the behaviors and symptoms of mental illness and substance use. The training will ultimately be integrated into the police academy curriculum in the short term it will be a standalone 36 hour training for 55 hundred officers in the two areas where we'll pilot public health diversion centers to provide an option that is not hospitalization or jail for people who not pose a public safety threat. Additionally on April 14th Mayor Bill de Blasio and Chief Judge Jonathan Lippman announced Justice Reboot, an initiative to modernize New York City's criminal justice system so it is fairer and more efficient. Central to this first round of reforms is a robust strategy to significantly reduce case processing times, a goal of the Behavioral Health Taskforce. In developing better scheduling tools more comprehensive databases of case information and in creating borough specific and citywide workgroups the city is well poised to reduce case processing backlogs. The mayor and Chief Judge have committed to clearing half of all

cases that have been going on for more than a year within the first six months of this initiative. Behavioral health screening at arraignments will launched later this summer during selected hours in Manhattan. Nurse practitioners and other health professionals with will pilot a process to identify those with immediate behavioral health needs as well as connecting to their treating providers for care and potential diversion. Efforts are also underway to ask the questions currently used to screen veterans who enter the criminal justice system. Those identified will be flagged for veteran's affairs so case management support and linkage to care can be activated. To date the city has created two new specialized units to provide preventative services to inmates with behavioral health issues. The two sites have shown preliminary promising results and the following to which are scheduled to be open mid-2015. Additional expansions to substance use disorder treatment will launch in June providing discharge plans to an additional 4,000 individuals. The Department of Corrections has successfully implemented the eight additional hours of training for all uniformed

officer recruits in working with inmates experiencing mental health issues. Current officers will also receive this training. The city is currently engaging in extensive planning to make sure that discharge of individuals with behavioral health issues sets them up for successful reentry through linkages with appropriate public benefits and supports including public health insurance. The taskforce anticipates completion of expansions to existing discharge planning contracts I can for 41 hundred slots will occur in May 2015. Further to ensure minimal disruptions and public health insurance coverage the city is identifying the various processes by which Medicaid enrollment occurs for those leaving jail. HRA and DOHMH are in the planning phases for additional staff to be added to these efforts and to create a Medicaid implementation team. Beginning in October DOHMH is adding 120 permanent housing slots dedicated to justice involved individuals to the Department's portfolio. A similar model, the frequent user system engagement or fuse program was found to significantly decrease shelter, hospital, and jail stays, generate an an annual 15 thousand dollars

public cost savings per house participant when compared, when measured against a comparison group. Additionally the Department 0of probation is close to launching in house behavioral health teams that will provide advisory serves and the screening and assessment of behavioral health needs of individuals on probation connecting them to clinical and concrete community based services. Measuring impact and refining approaches baked directly into the DNA of the taskforce. Since the action plan was announced in December the mayor's office has been leading multi-agency teams to ensure implementation of both the projects outlined in this report as well as the ongoing planning efforts in several areas. Measurements of progress and accountability in achieving the goals laid out in the report… to ensure effective oversight and accountability the office of the deputy mayor for health and human services and the mayor's office of criminal justice will be responsible for oversight of this plan and will convene the leaders of the agencies directly charged with implementation and stake, and key stakeholders including representatives from the provider and consumer

communities to monitor the performance of the initiative. The mayor's office will publish quarterly reports on the progress of the initiatives and related efforts to ensure that we are using the right metrics to evaluate impact, implementation of all the actions in the report will include establishing measures for process and substance outcomes as well as targets. These performance measures will be published in the second progress report and systematically monitored and reviewed. And to ensure that this city is getting the greatest public safety return on its investments the city will conduct an ongoing cost benefit analysis to ensure that the lives of people with behavioral health needs are improving, that the criminal justice system becomes more efficient at diverting people out of the system and that is a result cost for unnecessary incarceration declined and benefits to public health and safety are calculated. In addition the pilot programs that are to be initiated will be evaluated to determine whether they should be adopted citywide modified or replaced with alternative approaches. The taskforce is one way in which this administration is enact,

enacting its commitment to continue to drive down crime, reduce unnecessary arrests and incarceration and promote fairness. I'm happy to take your questions.

CHAIRPERSON CROWLEY: Thank you for your testimony. My first question has to do with the population on Ryker's Island. If implemented correctly your supervisor release program will be reducing the population there. So currently there are approximately 10 to 11 thousand inmates how many fewer would there be if your plan was to be implemented the way you see it rolling out.

TRISH MARSIK: I can't answer that question specifically because there are a number of variables in play there but what I can tell you is that we're expanding our supervised release program by 23 hundred slots. Whether I, it's not a one to on relationship that there be 23 hundred fewer people on Ryker's Island but we do anticipate it reducing emissions and we'll be monitoring it closely to see what the impact of that is.

CHAIRPERSON CROWLEY: Now how quickly can you ramp up to that day when you're serving 23 hundred unsupervised release.

TRISH MARSIK: That's a great question. The process is subject to city procurement rolls so we'll be releasing an RFP for vendors to provide the supervised relief services and we anticipate that launching in the fall

CHAIRPERSON CROWLEY: So that in, in the fall you will pick the companies…

TRISH MARSIK: We'll have select…

CHAIRPERSON CROWLEY: …the nonprofits that are awarded the contract.

TRISH MARSIK: Yep.

CHAIRPERSON CROWLEY: You see it as more than one nonprofit?

TRISH MARSIK: It may be more than one. It's not clear yet how that'll shake out.

CHAIRPERSON CROWLEY: So if there's currently let's say for numbers sake ten thousand people on Ryker's Island you can't say with certainty that it would bring it down 23 percent. Like that 23 hundred?

TRISH MARSIK: No I can't say that with…

CHAIRPERSON CROWLEY: But it would make a significant impact in the average daily population.

TRISH MARSIK: We believe it's going to make an impact that we'll be able to see and measure.

CHAIRPERSON CROWLEY: When you had the report you talked about 400 inmates…

TRISH MARSIK: Mm-hmm.

CHAIRPERSON CROWLEY: …have cycled in and out and been arrested 18 times in the past five years. They make up what you're calling the significantly entail ill population that's seven percent that has bipolar or schizophrenia?

TRISH MARSIK: That, those 400 people actually represent people who have had the most frequency, the most frequent use of the jail system. So it's not necessarily people with serious mental illness although some of them did have serious mental illness but it's more related to how often and how long they spent in jail rather than the characteristics of their behavioral health needs. Now your goal would be to provide them housing, health insurance, and a job.

TRISH MARSIK: I think those… [cross-talk]

CHAIRPERSON CROWLEY: …program…

TRISH MARSIK: I'm sorry?

CHAIRPERSON CROWLEY: Through this program as it, you, you have 130 million dollars set aside to spend over the next four years.

TRISH MARSIK: Mm-hmm.

CHAIRPERSON CROWLEY: And that is a, an arch goal of the program no?

TRISH MARSIK: Yeah so I would say that it doesn't translate specifically to say those 400 people but that we do have components that are about connecting people to care at all points in the system that we are rolling out housing beds. We have 120 so launch thus far and a mini solicitation we'll be ramping that up to 267 and we are looking at further at what the employment opportunities are for this population. But there wasn't a concrete programmatic initiatives attached to the employment component.

CHAIRPERSON CROWLEY: If you were to implement the program as planned in a few months to a few years you'd need to measure the success of the program.

TRISH MARSIK: Absolutely.

CHAIRPERSON CROWLEY: And wouldn't it be a way to measure it looking at those 400 that you speak about in the report?

TRISH MARSIK: We're going to be looking at a number of things attached to the report. One is a reduction in jail days for people with behavioral health need. One is a reduction in arrests for people with behavioral health issues. And the other two are healthcare outcomes that those people spend less time in the hospital in the ER and they have a greater continently of care. We imagine that those people who are cycling in and out of jail most frequently will be part of that subgroup that we'll be looking at. So we'll be able to see if…

CHAIRPERSON CROWLEY: But you'll measure the success by the reduction of the average daily population.

TRISH MARSIK: Well that will be one of the components that we'll looking at but we'll be looking at it specifically for people with behavioral health needs as well.

CHAIRPERSON CROWLEY: Which in your report says about 85 percent of the population on Ryker's Island has substance abuse problem.

TRISH MARSIK: Those, those numbers have since been revised a little bit. We do think, as per my testimony we do think it's about 46 percent by their own report but we do believe it's much higher than that.

CHAIRPERSON CROWLEY: So your plan also reduces the time somebody would wait for a trial. And that time has grown substantially over the years.

TRISH MARSIK: Yes.

CHAIRPERSON CROWLEY: So today an average person is waiting about six months is that correct, six and a half months.

TRISH MARSIK: I don't have that number in front of me but I can get it to you.

CHAIRPERSON CROWLEY: In reducing the length of time and, and putting these programs to help the 23 hundred combined it should reduce the average daily population to a certain extent.

TRISH MARSIK: That's our plan.

CHAIRPERSON CROWLEY: That's the goal.

TRISH MARSIK: Absolutely.

CHAIRPERSON CROWLEY: But there's no goal in terms of measuring the success and the outcomes by looking at the daily population.

TRISH MARSIK: We absolutely will be looking at the day, daily population. I think if I can clarify a little bit the metrics that we're using are still somewhat in development. I've given you the larger goals. But the way that all of these different initiatives will fit together and interlock and put pressure on the population on Ryker's Island is still being developed because it's complicated. You've probably hear this when you've had other testimony that different agencies measure the population in different ways. Sometimes it's the people who are coming in. Sometimes it's the daily population. We're trying to put together an evaluation and a set of performance measures that make sure we're comparing apples to apples and that we're looking at how we're reducing arrests and jail time for this population.

CHAIRPERSON CROWLEY: Your report speaks about the adolescent issues on Ryker's Island which was Department of Justice report. And it showed

how, how significant abuses were happening with use of force and that any adolescents were in punitive segregation for extended periods of time. Now the Department of Correction has been working with the department of justice to meet the goals of, of that study and the report, the recommendations. Now how is your taskforce differing? We had a hearing last week with the Department of Correction and we saw that since the Department has been implemented the recommendations of the Department of Justice it has only seen adolescent use of force and violence decrease whereas the rest of the population continues to increase. And I want to get at the heart of your training and goals of this taskforce as it relates to the DOC because I'm not sure if they're realistic or I'm not sure that we have the infrastructure here and the city in place to do the types of training or to have the staffing ratio. Because when we look at 16 and 17 year olds they're less than 200 of the people who are on Ryker's Island, the inmates but the vast majority are not and while the goals are, are admirable and I want to help in achieving that we're not seeing any results of, of the plan. I mean look going back six

months ago when it was released we, we haven't seen changes on Ryker's and, and any realistic, you know any plan seems very difficult to, to reach because you just don't have the infrastructure there.

TRISH MARSIK: …about infrastructure?

ERIK BERLINER: Sure. Good afternoon. So one of the first things that we've done and are doing to address this through the taskforce and, and through its work is the training issue, you know the…

CHAIRPERSON CROWLEY: Have to, just…

ERIK BERLINER: I'm sorry Erik Berliner, Deputy Commissioner of Department of Correction. The issue of training. So it takes a long time to train you know a 9,000 person workforce and more importantly once they're trained they have to then use the training to build the skills necessary you know to, you know to, to put that training into practice. So we're focusing especially of course on the adolescent population who are receiving intensive, the officers who work with adolescents are receiving intensive training, the officers who are working with our young adults are receiving training, those who work with the mental

observation populations are receiving intensive trainings.

CHAIRPERSON CROWLEY: Sorry Mr. Berliner [phonetic]. Last week when we had the hearing the commissioner testified that there was nowhere to train, that they had a hard enough time filling the vacant slots of correction officers that he couldn't possibly train new correction officers in the space that they ha nor train the 9,000. When, when looking at the adolescent population it appears that you have changed the ratio to 15 to one whereas the rest of the population including those who have mental health and serious health needs that, that there's no real plan in place to, to meet them. And I bring this up because we're right about the time when the, the budget is coming out and we have to be realistic about the goals. It, it, it's good to help the 200 but we need to look at the overall 10,000. And there's nowhere to train 9,000 officers. There's nowhere even to train a new class.

ERIK BERLINER: That's certainly an issue that we're, we're dealing with. One of the things that we are focused on in terms of rolling

this training out is by training staff who work with targeted populations. We can do that on site. We don't have to necessarily use the academy for that. So when training folks who are working in mental observation units for example we can do that on Ryker's in the, in the facilities in which they're working and that way we're able to get those folks who most need the training to work with this population… the training.

CHAIRPERSON CROWLEY: Last question before I recognize Council Member Gibson for questions. It is, it is those special units, the caps units and the pace units that you need to be training, you need to fast pace that training. But there doesn't seem to be a plan with 13 hundred to 15 hundred people on a waiting list right now to get into those training facilities, into those specific areas.

ERIK BERLINER: I'm sorry are you talking about staff or inmates?

CHAIRPERSON CROWLEY: No, no, no last week you testified that there were 15 hundred people who have mental health diagnoses that been involved in violent incidents and have infractions

and need to go into an area where they can get the clinical care either an area you call caps or an area you call pace. But there's just such a waiting list that there's no realistic timeframe to have them all be served in the space that you have with the staff that you have.

ERIK BERLINER: Yeah so just to clarify the waiting list that you're talking about is about 750 folks and that's for either punitive segregation or the RHU which is a punitive segregation with a behavioral health program component. There's no waiting list for caps. And their pace is not a post adjudication issue so there's also no waiting list for pace. That's a clinical decision who goes in there and there's upon a clinician's determination that somebody belongs in the caps unit they can go in that day.

CHAIRPERSON CROWLEY: So point of clarification there is no waiting list for people who have diagnosed mental health illnesses for an area where they would be considered an alternative to punitive segregation?

ERIK BERLINER: Not for the caps unit per say. There is absolutely a waiting list of

about 750 people to go into, who, who have a diagnosed mental illness who have committed a jail based infraction and are waiting for a determination or for a punitive segregation bed. But that would be for either the central punitive segregation unit or the restricted housing units.

CHAIRPERSON CROWLEY: How often are the 750 in that, on that waiting list re-infracting?

ERIK BERLINER: We're looking at that after your, after the hearing last week and we should have an answer for you very shortly.

CHAIRPERSON CROWLEY: But when in your time frame do you have a space where you could serve that population?

ERIK BERLINER: Should somebody re-infract or commit an infraction that was particularly violent or dangerous they could be expedited to the front of the line. We do have a, a prehearing detention process that allows for that. But for others the adjudication process continues and when a bed is available they may be transferred.

CHAIRPERSON CROWLEY: But there's no timeframe to increase the number of caps or pace or restricted housing areas.

ERIK BERLINER: The timeframe for an increase… there, there is no plan to increase caps beds at this time. There are two pace units that are preparing to come online. One hopefully will be next month, the other a little later on this summer. And there is no plan at this time to increase the restricted housing unit beds.

CHAIRPERSON CROWLEY: So when you have 750 people on a, a waiting list and they're infracting and they're re-infracting you just say, you just hang out here until we get a, a spot for you or this is just an infraction that is there for show?

ERIK BERLINER: The new rules in place regarding the time one can spend in punitive segregation and the department and the health department's plans for implementing those rules. We have modeled that out and we believe that in the next eight to ten months the backlog will be completely remediated. There will be nobody left waiting for a bed of any kind. And everything we've

seen in the first two months since implementing those rules continue to give us confidence that that will in fact be the case.

CHAIRPERSON CROWLEY: Okay Council Member Gibson.

CO-CHAIRPERSON GIBSON: Thank you very much Chair Crowley. And thank you for your presence and your testimony. So I'm going to frame my questions and really focus on the diversion drop off center that we're looking to open in East Harlem this fall as well as the NYPD training. Since I chair public safety we've had extensive conversations around some of the intricate details of this diversion center. So just a couple of things. This is going to be a pilot health diversion center in East Harlem starting in the fall of 2015. So a couple of things I didn't see in your testimony in terms of the staffing that will be at this center the criteria in terms of services that the individuals will be offered I assume this is volunteer right. This is to deter them from going to Ryker's Island but it is a volunteer, a process, and in the eligibility so if it's physically in East Harlem the clients that are

going to this diversion center are they coming in with PD, with EMS, with DOC? Are they able to come in with someone else? Can you talk a little bit about that in detail?

TRISH MARSIK: Sure. The folks who are eligible for this diversion center are going to be coming exclusively from the 2-3, the 2-5, and the 2-8 precincts. They will be brought in by law enforcement. At this point the plans for the diversion center are for, that it's scheduled for law enforcement only. When they get there they'll be assessed for the types of services that they need and there's going to be a mix of both clinical staff there including some nurse practitioners as well as peers who will be able, who will be on site to help engage the individuals there and further retain them in treatment, get them excited about what we have to offer, connect them to other services. Keep in mind that it's a short term center so we want to connect, we want to get people excited about the services, help them to think about what they might need, talk to them about what's available to them and then hand them off to a next provider.

CO-CHAIRPERSON GIBSON: Okay when you say short term stay I imagine we're talking about a couple of days from…

TRISH MARSIK: Three days.

CO-CHAIRPERSON GIBSON: …the point of entry.

TRISH MARSIK: Three days.

CO-CHAIRPERSON GIBSON: And will the clients be given a discharge plan? So what if there are a series of medications or long term treatment that is identified while they're there, how will that work for many of these individuals that may be homeless, not have a place to go, some of the other social components that we deal with and we know many clients may have? How will we address that for their short term stay and then have a plan in place when they exit?

TRISH MARSIK: The same way that we would in any other setting? They're going to be assessed for the needs that they have. They're going to be you know ideally seen by a physician or a nurse practitioner who can prescribe medication if they, if in fact they need it. They'll be

connected to care and resources within the community.

CO-CHAIRPERSON GIBSON: Okay. And in terms of capacity when we had an earlier meeting in terms of the number of beds that are there are we looking at a dozen to 15 or is that dependent upon funding or other matters.

TRISH MARSIK: The plan right now is for 10 beds.

CO-CHAIRPERSON GIBSON: Okay. So do we expect at any given time to reach capacity in terms of, I mean that's a low number for those commands 2-3, 2-5, and 2-8.

TRISH MARSIK: Yeah. I mean I think that we're going to have to see how it plays out. Yeah. And not everybody's going to be staying overnight. Some people will come in, get what they need, come out. Some people will stay one night. Some people will… some people will come in and say you know this is not something that I want right now but they'll be able to come back and receive services that the next time they come in.

CO-CHAIRPERSON GIBSON: So in terms of it only, you know obviously this is only in three

commands and it's really being led through law enforcement so what I'm trying to understand is with all of the services that will be offered at the center what factors and what indicators are we going to look at to determine success s we're looking to expand beyond the ten as well as expanding to other commands in the city. What are we going to look at to define the success?

TRISH MARSIK: It's the, it's the same, roughly the same indicators that I mentioned before. It's few arrests. It's connection to care. It's continuity of services.

CO-CHAIRPERSON GIBSON: So is there any thought… I always think about some of the unintended consequences of the great work we do. And do you think that there may be any possibility that because of the services that will be provided for many of these individuals that it would entice others to to try to get services there that do not come in through law enforcement through these three commands?

TRISH MARSIK: Potentially. But the service, the part of the diversion center will be about connecting people to other, other care

providers. So they will be able to you know hand people off or give people information about other services that are available even if they don't' come in with law enforcement.

CO-CHAIRPERSON GIBSON: Okay. And in terms of…

TRISH MARSIK: And, and that would be great. You know the more people we can engage in care the better.

CO-CHAIRPERSON GIBSON: Right. No I agree. In terms of some of the data that you're going to keep the system itself how long are you going to keep the individual's information on file. So for instance if an individual's comes in the foal and then for some reason they are in another situation where they could be getting a summons an they're diverted to the center you'll be able to know because you have their information on file. How long would you keep their information on file for any repeat, repeaters that may come back to the diversion center.

TRISH MARSIK: I'm not sure that's been determined. Yeah I, I think, I mean it's, it's still in development. We'll be working with the

provider, the ven [phonetic], the successful vendor who gets awarded that to figure that out. But I think that what we're looking at is trying not to lose track of anyone. So we'll be considering how to do this best to keep, retain as many people as possible.

CO-CHAIRPERSON GIBSON: Okay. So I do recognize… I know this is still a plan in the works and that's why I'm bringing up a lot of these questions…

TRISH MARSIK: They're good questions.

CO-CHAIRPERSON GIBSON: …because I, I really want to make sure that we capture everything. I am a huge supporter of diversion and I really like this approach and I obviously want to make sure it works so I just want to make sure that we're looking at some of the other angles as well. So the NYPD and the training, and Deputy Commissioner Susan Herman during a, a previous hearing that I held talked about this revise in new training of 55 hundred officers that would be integrated into the police academy curriculum. There will be a 36 hour training. So just a couple of questions about that in terms of the curriculum

is being derived off of some of LA's practices so I guess I just wanted to understand what some of those practices are that we're going to look at. And then the length of the training itself who's going to do the training. I'm always very concerned about that. And then the cost. I know there was funds that came from our wonderful DA of Manhattan. Is that enough to cover the cost of the training for these 55 hundred officers? Oh wait you have to be sworn in. Hold on for a second.

CHAIRPERSON CROWLEY: Do you affirm to tell the whole truth and nothing but the truth in your testimony and in answering any questions.

TERRANCE RILEY: My name is Terrance Riley. I'm an inspector inside the NYPD's Training Bureau.

CHAIRPERSON CROWLEY: Okay.

TERRANCE RILEY: NYPD's Training Bureau. So you had asked how many days it's going to be. T's going to be four days in length and it's currently in development. It's going to start in June and we would certainly welcome any outsiders or advocates who want to come and view the training to give us some input on how to improve it, that

would be welcome. And this could be delivered by NYPD instructors to certain portions. But other portions for instance as it relates to mental illness we're going to bring in clinicians from outside entities.

CO-CHAIRPERSON GIBSON: Okay. So this is based on LA's practices. What did LA do that we're looking to do?

TERRANCE RILEY: Yeah it's going to be informed by crisis interventions, intervention teams aren't anything new. They've been around a long time. So we're looking at models across the, the nation. We looked at LA. We're looking at Seattle, Houston, Las Vegas metro but we want to work with providers and also families of, of the people who have these problems.

CO-CHAIRPERSON GIBSON: Mm-hmm. Now you're doing the training in, in concert, in partnership with MOCJ and the other stakeholders right?

TERRANCE RILEY: That's exactly right. Yeah.

CO-CHAIRPERSON GIBSON: Okay.

TERRANCE RILEY: Yeah.

CO-CHAIRPERSON GIBSON: As well as DOC?

TERRANCE RILEY: No we haven't worked with DOC, DOHMH.

CO-CHAIRPERSON GIBSON: Oh just DOHMH, okay.

TERRANCE RILEY: Yes.

CO-CHAIRPERSON GIBSON: And you're looking to start in June? How are you picking the officers that will begin the training?

TERRANCE RILEY: Well we're going to pick officers from the 2-3, 2-5, and 2-8. The commanding officers who know their personnel the best would choose who would attend and what we're going to do to make sure that there's no operational implications like we don't want to take too many people off of patrol and put them into training they'll be backfilled with personnel in overtime. So while these officers on straight time are in training they… have other officers cover for their open position. So while the officers are in this training they're not responding to 9-1-1 calls during that time?

TERRANCE RILEY: That is correct, for four days they'd be assigned to the police academy

at a college point. And an important point is I think a lot of the council members have seen our mock environments. There we have a subway station brownstone you know really streetscapes that look very realistic in those streetscapes we're going to have a lot of scenario based training. Small classes, not, you know not 100 200 but 30 officers at a time very small, small instructor to student ratio and we're going to have actors who have been tutored on how to show the signs and symptoms of behavioral illness, actually acting inside these scenarios.

CO-CHAIRPERSON GIBSON: Okay. So one of the things I wanted to also mention is that you know we are having conversations with the administration around different offences that are deemed summon sable [phonetic], certain violations like park rules or jumping a turnstile where they're misdemeanors and what I'd like to know is individuals that are encountered with police officers under some of the minor offences is it the individual officer's judgment on whether that individual should go to this diversion center if therein those commands how like what would the

protocol be to determine how the individuals get to the center instead of getting a summons.

TRISH MARSIK: So part of that protocol is still in development but it is going to be the officers determination. They'll be able to use some discretion about when people will be able to go to the diversion center. Do you want to answer?

CHAIRPERSON CROWLEY: Do you affirm to tell the whole truth in answering the questions the council poses today?

SUSAN HERMAN: I do. I'm Susan Herman Deputy Commissioner, Collaborative Policing. And the one thing I would add is that this is a, an idea that's similar to the diversion that we're engaged in currently in the subways so that this is someone's voluntary acceptance of the services that are offered. So it will depend on the officer recognizing a behavioral health issue. It will depend on the officer then offering these services appropriately and then the person accepting these services.

CO-CHAIRPERSON GIBSON: Okay. So and, and I'm glad I asked that question because there is different series of steps that obviously have to

happen and so the training of the officers is going to be critical in this because it's their determination on who gets the services and who doesn't. And so while I…

SUSAN HERMAN: …their determination on who's offered.

CO-CHAIRPERSON GIBSON: Right, on who's offered, right.

SUSAN HERMAN: Yep.

CO-CHAIRPERSON GIBSON: And I'm always concerned about that because every individual makes a different decision based on different perceptions and the reality of that individual situation. But as long as we have guidelines and structure that overall outweigh you know individuals I think it's, it's a good approach to have that standard in place. The other thing that I wanted to mention is a lot of the police officers I talked to that are always concerned about responding to EDPs you know the calls don't come into 9-1-1 of that nature all the time. And so you don't recognize that you're dealing with an individual that may have a mental illness until you get to the scene.

SUSAN HERMAN: Mm-hmm.

CO-CHAIRPERSON GIBSON: So is there any conversation that we're looking to have as it relates to our 9-1-1 call operators where they would understand what is happening as well? Is there any involvement of, of 9-1-1 call takers?

SUSAN HERMAN: This is, this will involve 9-1-1. We, we anticipate though that there'll be many calls that, many encounters that don't flow from a 9-1-1 call that are just pickup jobs here walking down the street and you observe something. So the officer has to be well trained in responding and recognizing what the officer is dealing with.

CO-CHAIRPERSON GIBSON: Okay. So we're going… do you know how many officers we're going to start training before we get to the 55 hundred? Like what the, the timeframe?

SUSAN HERMAN: We're going to train approximately half of the officers on patrol in each of these three commands.

CO-CHAIRPERSON GIBSON: Starting in June?

SUSAN HERMAN: Mm-hmm.

CO-CHAIRPERSON GIBSON: Okay.

SUSAN HERMAN: …several months.

CO-CHAIRPERSON GIBSON: Okay. Will there be any, any difference in protocol in, in responding to EDPs, that, that do come into the 9-1-1 call system, that we have identified? Will there be any difference in protocol or…

SUSAN HERMAN: If the 9-1-1 operator knows that that's what's happening the 9-1-1 operator passes along that information. And that'll, that will continue. The, the difference here is that we have a, we still have sort of a, a very specially trained elite core of people who will deal with people in extreme distress. That, that ESU response is going to continue. This is to enhance the response of the patrol officer who hasn't determined that it's necessary to call ESU.

CO-CHAIRPERSON GIBSON: Okay. Okay well thank you very much. Of course I always have lots of questions but I appreciate sharing a lot of this information. And I do know that this is still in formation but I certainly appreciate the dialogue that we have had and we will continue to have. This is very important. We're investing a lot of money in this and so we wanted to work but I think the

act that we're looking at it from a different perspective, a more holistic approach I think is good. Jail is not the answer if we can identify many of the challenges the individuals faced before they ever get to Ryker's I think we save ourselves a lot of work, a lot of money and we really can tackle the root of many of the issues and that is mental illness. So I appreciate your work and thank you so much. And now I'll turn it back over to Chair Crowley.

CHAIRPERSON CROWLEY: Thank you Chair Gibson. We've been joined by Council Member Gentile, Ferreras, Menchaca, Kallos, and just before I recognize Chair Lancman for questions how did the to training of your staff whether it be the NYPD or the DOC compare to one another? How do they differ and is it the same type of timeline? Because hearing from the NYPD it seems like they have advanced much further along in their plan to train their workforce. And what? And, and, and DOC seems to me to train the entire workforce because DOC has you know, you have many more… that's your population. You know 40 percent of your population.

TRISH MARSIK: Well I think what I'd start with saying is that the, the long term goal is that we have a fully trained police force on identifying behavioral health issues. And this is the starting place. I think what Council Member Gibson kind of underscored for us to is how, how important it is to see these initiatives as interlocking so you can see the health department's initiative and the NYPD's initiative and the NYPD's initiative are completely interlocking. The, the circumstances of the experience of police officers, particularly patrol officers and correction officers are quite differently. So you would expect their training experiences to be running quite differently.

CHAIRPERSON CROWLEY: Right but when we heard the YPD answer they were going to start their training in June. They knew exactly how any hours the training was going to be… they knew that their goal was to train 55 hundred officers. It doesn't seem like the DOC is as organized as that.

TERRANCE RILEY: We are training the entire workforce in mental health first aid which is an eight hour class. The recruits have been

receiving that training since last summer and the in-service training is rolling out slowly. We hope to have that accomplished by the end of, by the end of the next, the coming fiscal year. The are, we have not yet talked about the crisis intervention training that we'll be doing jointly with the Health Department as a part of the taskforce's initiative but that training will roll out for somewhere between 300 and 600 to a thousand DOC officers will be one week training and that will happen starting in July and going through the end of the calendar year and that will allow for crisis intervention responses inside the jails as well.

CHAIRPERSON CROWLEY: And that training will be held on Ryker's Island?

TERRANCE RILEY: We will almost assuredly hold it on Ryker's Island. There may be some scenario based training we will do elsewhere but it will be a joint training with health staff and correctional staff and… [cross-talk]

CHAIRPERSON CROWLEY: And you currently do training on Ryker's Island?

TERRANCE RILEY: We do many trainings on Ryker's Island, yes.

CHAIRPERSON CROWLEY: Okay. Council Member Lancman. Chair.

CO-CHAIRPERSON LANCMAN: Thank you. Good afternoon. First let me say the de Blasio administration and everyone who participated in taskforce absolutely has to be commended for taking on this issue and for what is a very thorough look and approach at how we address this very very serious topic. But as I mentioned in my opening statements there are some areas that I felt were not addressed. First I want to ask you though about one area that, that you did pay attention to. And that's the issue of arraignments and screening potentially mental health behavior health defendants. Now I assume that we're starting this pilot program because you and, and the taskforce would agree with me that a defendant should not be allowed to plead guilty, have bail imposed, be sentenced… Without the court having some awareness or consideration of that defendant's potential mental health or behavioral health issues.

TRISH MARSIK: Well I, I would say that it's, it's incumbent upon the defense to determine

whether the disclosure of health information is helpful or not helpful to that case.

CO-CHAIRPERSON LANCMAN: Well I would challenge that but let's talk about it. Let's talk about it. Person is brought in, they're arraigned. Presently CJA does not do any mental health assessment of that defendant correct? Person goes into the, the, the court room. We took a little field trip to arraignment part in Queens last week. They're brought before the judge. They have the, the CJA form in front of them. Perhaps the person has a record, perhaps they, they don'. But if there's nothing necessarily in their criminal record to indicate whether or not they're, what their mental health, behavioral health status is the, the legal services providers have very limited capacity, very little, limited time and very limited resources to do any kind of mental health assessment of their client which in many cases is someone that they're meeting for the first time. And the court of course has probably never seen that particular defendant so how could it be… and I, I don't want to put it to you as aggressively as it, as it might sound, just two people having a

conversation, how could it be that due process is served and, and we have a just system if a decision is going to be made by the judge if it, if an application is, is going to be, a recommendation is going to be made by the district attorney as to what bail should be or what someone should plead guilty to is in the court you know should accept that or accept bail and pose a sentence. The defense attorney should be able to properly guide his or her client. If you don't know if the person's standing there has a mental health issue that could impede his or her judgment or might lead them to violate any of the provisions that, of bail that are being sent, set or if it's a sentence if it's to, to Ryker's or, or some kind of, something that's going to let them out in the community whether or not we've missed this opportunity to intervene then break what is probably in that person's case a, a, a cycle.

TRISH MARSIK: I absolutely understand what you're saying. I think that that we want to capitalize as much as we can on addressing individuals' needs when people do touch the criminal justice systems. So there's a couple of

things in the action plan that will help do that. One is pilot of a prearrangement screening unit that's going to be doing a healths, a preliminary health screen of individuals when they come through arraignments firstly to check and see if there's an immediate health need for this person or if there's any presenting health need that will net, need to be addressed while, if they're retained in custody and that's behavioral health or health need. Secondly, and we're working through this process right now is if we can identify someone who has behavioral health needs right now what we can do with that information. One of the the things that we potentially may be able to do is contact their care provider at that time and say hey you know Trish Marsik is down here in arraignments you know if you can come down and talk to the defense attorney maybe we can work something out that's in her favor and can try and do this in a way that supports her in the community not just in her favor but keeps her, keeps her and the community safe. Secondly I think the risk assessment screening that we're rolling out in conjunction with supervised release gets it some of what you're doing. So we

want to pull apart risk assessment from the assessment of their health needs. So somebody as we develop this risk assessment screening instrument in, in alternative, supervised release program we'll be using that instrument to identify people who may be eligible for release. So the risk assessment tool is assessment for re-arrest, risk of re-arrest. They'll be communicating that information to the defense along with what that person's needs might be.

CO-CHAIRPERSON LANCMAN: The risk assessment, so let's drill down. The risk assessment instrument or the risk assessment tool that's going to be deployed by CJA in, in pre-arraignment or you're talking about if somebody who's on supervised release.

TRISH MARSIK: that's going to be deployed by a supervised release vendor which is separate from CJA. So CJA is doing a risk of flight assessment this separate risk of re-arrest assessment will be done by a supervised release program and that…

CO-CHAIRPERSON LANCMAN: So it's done once somebody's already in supervised release.

TRISH MARSIK: No it's done preliminary to them…

CO-CHAIRPERSON LANCMAN: The, the pilot programs that exist now for supervised release…

TRISH MARSIK: Mm-hmm.

CO-CHAIRPERSON LANCMAN: Is there something more than the CJA risk assessment that exists today that is used to determine whether or not someone is eligible for supervised release?

TRISH MARSIK: There is not a screening instrument that's used… [cross-talk]

CO-CHAIRPERSON LANCMAN: So this is a new screening instrument.

TRISH MARSIK: This is a new instrument.

CO-CHAIRPERSON LANCMAN: So you're doing two things. You're, you're bulking up the CJA flight risk assessment and you are introducing a separate assessment for supervised release which includes re-arrest?

TRISH MARSIK: Correct.

CO-CHAIRPERSON LANCMAN: That's interesting because…

TRISH MARSIK: Right. We're trying to, we're trying to use data to make some of these decisions.

CO-CHAIRPERSON LANCMAN: In our conversations with the District Attorney's Offices including the one in, in Queens there are concerns that the metric used to support supervised release is, is, is quote merely risk of flight which we all know is what the bail statute limits us to but there is significant re-arrest issues which courts wink wink are trying to also deal with when they set bail. So the, the risk assessment instrument that CJA is going to be used, be using going, going forward that's necessarily going to include some kind of mental health component in terms of… [cross-talk]

TRISH MARSIK: The, the, the supervised release will have to be procured so we don't know that it will be CJA who deploys that… [cross-talk]

CO-CHAIRPERSON LANCMAN: No no I'm talking about the, the, the pre-arraignment.

TRISH MARSIK: Okay.

CO-CHAIRPERSON LANCMAN: It, it…

TRISH MARSIK: I'm sorry.

CO-CHAIRPERSON LANCMAN: No that's alright. The, the prearrangement flight risk assessment, the CJA is doing and is going to be doing, is going to be, that's going to be changing right?

TRISH MARSIK: Yes.

CO-CHAIRPERSON LANCMAN: Right. Is a defendant's mental health status going to be built into the f0ormula that CJA uses to determine someone's flight risk.

TRISH MARSIK: I don't believe so now.

CO-CHAIRPERSON LANCMAN: Okay. So, so you're not, you're not contemplating giving CJA at the pre-arraignment stage any additional responsibility for evaluating someone's mental health status and reporting it to the court?

TRISH MARSIK: No.

CO-CHAIRPERSON LANCMAN: The pilot program that you're doing in, in Manhattan, that's, okay I thought that that would be performed by CJ. It's not going to, CJ it's not… Okay alright. And, and do you know who is going to be performing that? Is that going to be a private vendor? Is it going to be HHC or…

TRISH MARSIK: That's going to be done through the health department.

CO-CHAIRPERSON LANCMAN: I DIDN'T HEAR…

TRISH MARSIK: It's going to be done through the health department.

CO-CHAIRPERSON LANCMAN: Okay. And do you know if it's going to be health department employees or they're going to hire private vendors…

TRISH MARSIK: It's a, it's a mix.

DOCTOR VENTERS: Doctor Homer Venters, Assistant Commissioner of Correctional Health for DOH. So it'll be a combination of staff. We have clinical staff who will be doing… so nurse practitioners and PCAs were like med techs who will be doing the screening. They're going to be taking over one tour a day during the week from the EMS staff that you've probably seen do their quick health screen. So those staff will likely be through our vendor horizon and we're hiring up those nurse practitioners because we need to be able to backfill those positions. Also Manhattan as you know is linked to Manhattan House where we have a lot of other staff who can help them out if they need it. We also receive support for some diversion

liaison staff. And so that's really critical because when we start this process because of the, there's a quick stipulation that mandates this. The grub settlement… because we want to be attentive to the arrest to arraignment time. We want to not slow things down. We're going to be focusing on doing the health screen that happens currently but doing it with the benefit of our electronic health record and you know having a higher level provider but we're also going to be mapping out all of the diversion potential that you've been talking about.

CO-CHAIRPERSON LANCMAN: Yeah. Let me ask you something. How long do you expect the pilot program in Manhattan to last before you assess it and decide whether and how to expand it to the rest of the city?

DOCTOR VENTERS: So Trish and her office have given us… work out some very important metrics an timelines and so overall we have a six month window but it really within that six months every month we're going to be reporting back metrics about the number of people we see about our progress in working with partners around the diversion questions and she's going to be leading

the supervised release question which is really going… [cross-talk]

CO-CHAIRPERSON LANCMAN: So, so is it that you anticipate you're going to give the pilot six months, you'll feel at that point you've collected enough data potentially and then you'll decide whether and how to expand it citywide?

TRISH MARSIK: I'm sorry, yes. It might take us a little bit longer than six months to crunch through it all but we want to do this quickly. We think, we have high hopes for this.

CO-CHAIRPERSON LANCMAN: Alright. Well we do too. The, the folks from CJA are here so I'll get a chance to ask them directly later but while we're, while you're doing the pilot and doing it thoughtfully and deliberatively and, and making sure you've got the right people to do these assessment as quickly as possible because the arraignment rules of the arraignment you know speedy trial speedy trial, speedy arraignment is speedy arraignment. Wouldn't it make sense to at least admit to CJA's current questioning to at least ask people to self-report if they have a mental health illness, issue. You know are you

seeing a mental health provider, are you in a, some kind of program to do something to you know as soon as possible at least, at least get that, that information before the court to the extent that you can get it from someone self-reporting. Because right now the courts are flying blind and, and they really don't know if the person in front of them who they're going to maybe except the plea from, set bail for, maybe set a sentence for. Nobody knows if that person has a mental illness.

TRISH MARSIK: I think that we need to be mindful of, of disclosure of personal health information but it's something we can think about further.

CO-CHAIRPERSON LANCMAN: Yeah you might want to think about it and maybe just release it to the person's defense council. What's that? Well whether, wonder whether, it is suggested maybe they ask for someone to waive it but it raises a question the question of someone with a mental illness can, can, can voluntarily and consensually waive disclosure. Let me ask you about the specialty courts. I, I, unless I'm missing something it's not the specialty courts, the mental

health courts, drug courts, veterans courts, human trafficking courts, all of whom deal with people with mental health… issues. They played an incredibly important role in keeping people with behavioral issues outside of Ryker's. Did the taskforce not look at the, those specialty courts for, for, for a reason or did they look at and I, I just missed it.

TRISH MARSIK: Well it, the, the taskforce looked at a wide array of things and, and I will say that we, we do treat this action plan as just a starting point for, for jumping off from any issues. And so capturing the 24 recommendations that we did was a task in and of itself, you know trying to figure out which pieces fit together and feasibility and so on. I think that the, the problem solving courts remain an important component of how we serve people with behavioral health needs in the community and I think we'll continue to work with them and think about how to best knit them into this fabric going forward. They certainly were represent, people from those… courts were, were both co-chairs and representatives on the many different committees.

CO-CHAIRPERSON LANCMAN: So just tell me briefly about the, the, the process from here of the, the, the taskforce.

TRISH MARSIK: Yeah…

CO-CHAIRPERSON LANCMAN: …you talked, you issued a report. What, do you meet every month? I mean…

TRISH MARSIK: We're, we're reconvene…

CO-CHAIRPERSON LANCMAN: Is there, is there… you know part two of the recommendation…

TRISH MARSIK: We're reconvening quarterly at this point. We just had our, our first reconvening which was basically an update on where we are from here. We'll be… again in another couple of months and at that point I anticipate having a deeper dive into okay where do we go from here now that we've kind of kicked off everything we have metrics, we'll have metrics in place by then… what are the next steps moving forward?

CO-CHAIRPERSON LANCMAN: Good well I, so I would just close my, my questioning with, with, with a plea to in the next round and you've done terrific work so far really…

TRISH MARSIK: It's a lot of work.

CO-CHAIRPERSON LANCMAN: But in the next round if you can put some focus on these specialty courts which on a day to day basis are literally keeping people with, with behavioral and mental health issues out of the jail system. And by most reports they are successful and, and effective when you look at recidivism rates etcetera. Thank you very much.

CHAIRPERSON CROWLEY: Thank you Chair Lancman. Now I'd like to recognize Chair Cohen.

CO-CHAIRPERSON COHEN: Thank you for your testimony. One I think the administration should be applauded in all those many many people involved in just the, the, the net reduction in population at Ryker's I think that that's really a very positive step. I have to say when, when I took the tour at Ryker's I, I could see why trying to get people out of there is a good thing. I… But the, obviously the, as the population goes down the, the concentration of people with behavioral health issues is, is staying constant. I'd like to learn a little bit more about that in terms of the length of stay, the general population, the length of stay versus people with behavioral health issues

and, and, and any change that, that's in those, in those amount of time?

TRISH MARSIK: We certainly can't point to a change at this point. We're very early in the rollout of our initiatives but we do know that people with behavioral health issues tend to stay longer for a host of reasons some of which is attached to bail some of which may be a little bit about the charges that they have but it's not totally clear. We don't have all of the data that we'd like to have about looking at this population and that's one of the big components of this, of the action plan is to create a means for integrating data across the many different points in the system so that we can have a more comprehensive picture of how people travel through the system why, why the prevalence is what it is on Ryker's Island an, and what are some of the other methods we can use for driving it down.

CO-CHAIRPERSON COHEN: But, but you gave us a stat today as the percentage of the population that, that has behavioral health issues. I mean could you, could we identify those people on any given day?

TRISH MARSIK: I mean yes. I mean that's how, that's how we came up with a statistic.

CO-CHAIRPERSON COHEN: So if we know who they are do we know how long they stay there?

DOCTOR VENTERS: The general population, the, the overall system length of stay is about 54 to 55 days. For those with diagnosed mental illness it's about 112 days.

CO-CHAIRPERSON COHEN: Sorry 120?

DOCTOR VENTERS: 1-1-2.

CO-CHAIRPERSON COHEN: And, and those, and those numbers have been constant in, I say in under since…

DOCTOR VENTERS: As the percentage of our population with felonies goes up so too does the length of stay. So the numbers do drift up a little bit but they track one another. They're, they're going up at similar rates.

CO-CHAIRPERSON COHEN: Is that what we attribute to the overall reduction in population that we're trying to weed out people who are not committing serious crimes?

DOCTOR VENTERS: What, what, what it, what exactly are we doing to make that happen?

TRISH MARSIK: To reduce the number of misdemeanants in, in the courts… I mean that's been the host of efforts that we've started to roll out already. Some of which you've seen in the reduction in case processing times some of which is the supervised release that we do have in place, the 11 hundred slots. We have a number of alternative to incarceration programs across the city that are addressed in the needs of misdemeanants who might be jail bound.

CO-CHAIRPERSON COHEN: Do we, do we know on any given… I, I guess we do now, how many people enter the system every day and how many people exit the system every day?

DOCTOR VENTERS: We do. I don't want to give you bad information. We do our, we're tracking for about 70 to 72 thousand admissions for the year. So I could quickly do the math but it's about 12 hundred emissions a week so that's what about 145 150 people a day?

CO-CHAIRPERSON COHEN: And, and, and the ratio out is more or less the same? Well obviously we're, we're, we're slowly getting more people out than in…

DOCTOR VENTERS: Yes we discharge about the same number of people in a year as we admit.

CO-CHAIRPERSON COHEN: Switching to diversion is there any way when we have an EDP call that we like… but I guess is that a qualifier right away for, for diversion if we know it's an emotionally disturbed person call?

TRISH MARSIK: It's not necessarily a qualifier for diversion. It's a qualifier for how the police handle the, the situation. There's a special deployment of a emergency services unit.

CO-CHAIRPERSON COHEN: I understand that but I want it now that, in these three precincts what we're going, where we're trying diversion will that be an indicator for, for potential diversion?

TRISH MARSIK: There are, there's a wide number of people who are, who are attribute as a EDP, an emotionally disturbed person if you will. And some of those may have a, a, be engaged in a low level offense or just a behavior that people think is problematic or, or potentially threatening. And then there might be people who actually have a weapon or are engaged in something that's life threatening. And so the, the

opportunity for diversion has less to do with the equity of their mental illness and more to do with the charge that they're facing, and the danger. Thank you.

CO-CHAIRPERSON COHEN: In, in terms of… what, what do we think currently is the, I know you mentioned the ten beds but what do we think really is the capacity for diversion presently?

TRISH MARSIK: I may have that number. Just give me one moment. We've identified roughly in, you're speaking specifically about the diversion center. We've identified roughly 4,000 people who may be eligible for it. So we're estimating that some, there'll be some fraction of those who will come through and not be subject to contact with the criminal justice system formally.

CO-CHAIRPERSON COHEN: So 4,000 sort of system wide?

TRISH MARSIK: 4,000 for those three precincts.

CO-CHAIRPERSON COHEN: Oh for those three precincts. Oh that's great. Finally I, I would like to take up NYPD on their invitation to

view the training at some point. So thank you very much.

CHAIRPERSON CROWLEY: Council Member Johnson.

COUNCIL MEMBER JOHNSON: Thank you Chair Crowley. Thank you all for being here. I want to echo Council Member Lancman's praise for taking on this incredibly important task. I wish this had been done years ago. I don't think this is all of a sudden needed. I think this has been something that has been a long time in the making so I'm happy to see the collaboration between all the city agencies as part of this taskforce. I just wanted to in your testimony you said to date the city has created two new specialized units to provide preventative health services to inmates with behavioral health issues. Is that caps and pace?

TRISH MARSIK: That's pace.

COUNCIL MEMBER JOHNSON: That's pace. The two sites of… promising results schedule to open in mid-2015. Those are the two additional pace units?

TRISH MARSIK: Yes.

COUNCIL MEMBER JOHNSON: What is the capacity of each pace unit?

TRISH MARSIK: It’s roughly 26.

DOCTOR VENTERS: There are two pace units whose capacity will be 20 beds each and two pace units whose capacity will be 35 to 40 beds each.

COUNCIL MEMBER JOHNSON: So that brings a total of pace beds to just over a hundred?

DOCTOR VENTERS: Yeah that’s about a right. A, to a maximum of 120.

COUNCIL MEMBER JOHNSON: and what is the estimated need for pace?

DOCTOR VENTERS: Sure so I think that we are not, there’s not a global need because what we’re looking, the way we approach this is the way an inpatient mental health system would which is we think about what a population, subgroups of this population need. So the hospital return unit was the first pace unit to open. We opened that with one unit. And that one unit is basically accommodating all the need for people coming back from Belleview to Ryker’s. similarly we have another unit that was opened after the first unit

for people that are decompensating but don't quite yet meet hospital emission criteria in that one unit suffices for that group. I think that there are two or three more groups, subgroups of the population that we want to think about opening new pace units for. And so that's kind of how we're approaching it as opposed to having a global number. So the third pace unit for instance will be a diagnostic unit. So in our system like any, every other system there's a group of patients for whom we're not confident about our diagnosis. They have a complex mix of you know what you might know as access one, access two and, and, and other issues. And so the diagnostic unit will be the third unit to open actually in June. And we think that that unit will be sufficient in size. I think that there are a couple more groups that we're concerned about. So we think that the fourth unit, the fourth pace unit that'll open a little bit later in the summer will be for people who are coming back from the OMH system so these are the 730 returns that you hear about coming back, you know going to get restored in the… So we're thinking about it in terms of what are the actual needs of the patients.

We think that we have a couple three more, four more of these subgroups of populations that we need to do a better job for.

COUNCIL MEMBER JOHNSON: Thank you. So Doctor Venters since I have you an since you're up there and since you have been so great at all of these hearings I want to just come back to the use of solitary confinement for people who do have a serious mental health diagnosis or people who may not be categorized as having an SMI but do have mental health issues. The American Psychiatric Association said prolonged isolation may produce harmful psychological effects including anxiety, anger, cognitive disturbance, perpetual distortion, obsessive thoughts, paranoia, and psychosis. For persons with serious mental illness these effects may exacerbate underlying psychiatric conditions such as schizophrenia, bipolar disorder, and major depressive disorder. A district court found that placing people with mental illness and developmental disabilities in the shoe is the mental equivalent of putting an asthmatic in a place with little air to breathe. I know that DOC has eliminated punitive segregation, solitary

confinement for 16 and 17 year olds an there's imminent action being taken on 18 to 21 year olds. Could you tell us a little bit about what the epidemiology says on using punitive segregation for people who have mental health problems?

DOCTOR VENTERS: Sure. And I appreciate the, you referencing the APA statement. I think for us because we're a data driven agency we don't actually, we support those statements but we don't need to look any further than our own data, our own patients. And what we see is that patients who are in restrictive settings fair worse than patients who are in treatment settings. So I'm presenting this distinction that's really important in the jails when somebody has a behavioral problem do we engage them with a treatment response or do we engage them with with a punishment response. And obviously it's the job of the correction department to assess the, the primary obligation of the agency which is security, which is making sure that people aren't hurting others. However when we look at our patients whether they have a diagnosed behavioral health problem or not those whoever have exposure to solitary confinement are the seven times higher

risk of harming themselves. We certainly see that specific subgroups and who have extra risk are those who are adolescents, those with mental health problems definitely. But we, you know I think that our success is actually the best indicator of where we need to go. So in the caps units we have low rates of self-harm. We have low rates, relatively low rates of violence. There's a cohort of patients that have been both in a caps unit and in a restrictive housing unit. And what we see is that those patients who have been in both types of settings that you've seen very well yourself they do much better when they're in the cap setting. They have very low rates of self-harm compared to when they're in the restrictive housing unit. So that's why both departments are engaged in figuring out how we can together meet the security mandates of, of DOC but also broaden the benefit of a treatment response to people with behavioral problems.

COUNCIL MEMBER JOHNSON: Thank you for that answer. I know my time is up. I think we should stop calling RHU or restrictive housing unit. It's solitary confinement. It's punitive

segregation. It's being in the shoe. It's being in the box. And it's bad for peoples' mental health. It is cruel and unusual punishment and I think that we should work our best to expand caps and pace to everyone that needs it. The first answer is they shouldn't end up there in the first place which is why you all are doing this important work. And I look forward to supporting it and I appreciate you being here for this hearing today. And I appreciate the mayor's leadership on this. Thank you very much. Yeah I just have one more question. It's not about this. It's about the crisis intervention teams that were discussed before. I know that there is a pilot project I believe that's happening in Manhattan, is that right? Yeah. And I just wanted to ask I know these teams have been, are being formed in the training that was talked about that's going to happen at the police academy which I think is very exciting. The NYPD of course are the folks that are going to be responding when an incident takes place when there is what's deemed to be an emotionally disturbed person. And the hope is to divert them away from the criminal justice system and get them the treatment that they need before

they end up at Ryker's or in any type of detention facility. But I wanted to ask how much have mental health professionals, how much has DOHMH been involved in working with the NYPD on determining best practices as it relates to the CITs

TRISH MARSIK: They've been working hand in glove on this the entire time. They've traveled on site visits together. They've been… They're inseparable. And so…

CHAIRPERSON CROWLEY: Do you swear to tell the whole truth and nothing but the truth in answering the questions to the committee today?

JOHN VULPE: John Vulpe from the health department. So yeah the answer to your question is we've been working with NYPD for over a year on both the diversion center and more recently on the training and in particular the, in April we convened a, a, in order to include the community consumers advocacy groups, Commissioner Herman and Doctor Venters the, the EDC and Health Department convened a broad ranged group to start advising us and will meet regularly on how the CIT police roll out happens as well as the July meeting will focus

on the soon to opened diversion center in Manhattan.

COUNCIL MEMBER JOHNSON: Thank you very much and I'll just end with this. I'm sure Council Member Crowley's going to think I'm a broken record for saying it but there is an opportunity before December 31st of this year to get rid of Corazon [sp?]. They are not doing a good job at Ryker's. Washington D.C. just did not reapprove their contract. I believe that HHC if possible should take over the care of our inmates here in our city jail system. And I look forward to the administration, to DOC, to DOHMH, to HHC, to the NYPD, to everyone coming up with a viable solution that is not Corazon, they are unacceptable. There have been too many preventable deaths happening under their watch. Thank you Madam Chair.

CHAIRPERSON CROWLEY: Thank you Council Member Johnson. We've been joined by Council Member Cornegy, Council Member Williams, Deutsch, and Wills, and Espinal. And with us today in the balcony is a class from Borough of Manhattan Community College. We'd like to welcome the law

class. And I'd like to recognize Council Member Vallone for questions.

COUNCIL MEMBER VALLONE: Thank you Madam Chair. Good afternoon everyone. A lot of great things here and there's so many different topics so you almost need days to go through it but well just a couple of quick things. I mean there's the health diversion center, the supervised release program. We haven't even touched on the expansion of the discharge programs which on my days at the Board of Correction was always something we envisioned on doing. There's no greater way of tackling recidivism then to have a proper discharge plan and, and guiding the folks leaving the island to, to make sure they don't come back. So I applaud you on that. I guess the council's been pretty unified in their call for a thousand additional police officers and I, I think the underlying belief on that is that because we need more officers to keep our city safe. So when I, when I questions on the health diversion center is my concern on the burden on the police officers and the eight million people that here in the city and the decision they're going to have to make on the street regarding a

decision whether to bring someone into a health diversion center or bring someone into the precinct for arraignment concerns me. So have we thought of possibly removing that situation and maybe bringing those services into the department so that it's not done on the street of the cities of New York and that the police officers have some backup that the services maybe could be ascertained at the police department rather than at a police car?

TRISH MARSIK: I, I'm not sure I'm totally understanding your question. But if I could I, I would clarify that the, the process for diversion is ideally faster than any other option that the police would engage in. If in fact somebody who voluntarily accepts going to the diversion center.

COUNCIL MEMBER VALLONE: How would that person… let's go… how is that person going voluntary. So where would the police officer in what situation be to offer that voluntary service would be… because I heard testimony before about officers walking down the street and seeing someone which is not realistic or officers responding actual to a call for a crime or an incident

occurring and now is confronted with someone saying I see Satan and that's why I created this crime and now they have to make a decision so…

TRISH MARSIK: We actually, we actually do anticipate that it will be a patrol officers who identify in persons particularly in the 2-3, 2-5, and 2-8 areas who do see a street presence of folks who may be in some sort of behavioral distress and that they would identify those individuals for potential diversion. And at that point the officers…

COUNCIL MEMBER VALLONE: So we're just talking about folks who visibly look like they need mental help? Not somebody who's committed a possible violation or a crime?

TRISH MARSIK: There's two…

COUNCIL MEMBER VALLONE: There's a big difference.

TRISH MARSIK: There's two populations that we're looking at here. One is people who are, who are potentially have or would receive a violation and the second is people who are at risk which I know as, as lighter definition. But you could imagine perhaps somebody that officers see

repeatedly engaged in behavior that they think could be problematic or could be leading to something problematic.

COUNCIL MEMBER VALLONE: Yes. But I'm also seeing a vision where someone's going to try to get out of a situation of being arrested because they're claiming they have mental health issues. So I, I want to be able to make sure that when I go home at night with my children that I'm, I'm safe. So there's a balance here that we have to, to weigh. And I'm very concerned about someone being able to make a judgment call and, and may not be right. So let's, let's take the scenario that someone has brought to the health diversion center. And it's determined the person doesn't have a mental health issue. What happens if that person was brought there because there was a crime committed or a violation that should have been issued. What happens at that point to that person? Are they just let go or do they come back through the police department for arraignment?

TRISH MARSIK: Now once the police drop somebody off at the diversion center that's the end of the police interaction with that individual.

COUNCIL MEMBER VALLONE: So then how do we track… so, so that means they got a free pass. So if someone's brought to a health diversion center and they were not now given a ticket or arrested that person goes home that's not a scenario for me that works.

TRISH MARSIK: And that's why the, the police training is so important that they be able to identify people who were actually had behavioral health issues.

COUNCIL MEMBER VALLONE: Well that, that's just such a huge, I mean our police force now has to become mental health professionals. We could spend the entire day debating whether I'm sane or not because there's certain days I'm not. So it, there's, there's a very fine line here that we're giving our officers a huge amount of taskforce. A three hour course is not going to do it to, to decide if someone should get a pass or not. Right now is there any, going to be records kept for someone who's got received numerous passes or now is coming back for the second or the third thing will the health diversion center keeps records of those who report through and are let go.

TRISH MARSIK: The training that the officers will receive is not a three hour training, it's a 36 hour training. The records that will be kept on the individuals there will be kept for health purposes.

COUNCIL MEMBER VALLONE: So there's nothing. So I, I think there is. I mean I guess that we could talk all day on… I think there needs to be serious help given to our police officers in making this determination. And I also take odds that the, the previous comment in one of my colleagues at the courts are flying blind. I've been an attorney for 20 years trying cases. The courts are certainly not flying blind. So the, you, to, to be… means you're just ignoring the fact that people have defense attorney's prosecutors, district attorneys, and have months and months and months and adjournments at hand before any decision has made. So increasing the services available for defense council in the judges is a wonderful thing that I completely disagree with the fact that courts are flying blind. That's not the case. I think giving additional instruments for those to seek if they have mental health. But there's a big

decision if you're the attorney for that person whether you're the attorney for that person whether you're going to seek that defense or not. And it's not our place to take, make that defense for people now but to provide additional services. So I thank you for that.

TRISH MARSIK: Thank you.

COUNCIL MEMBER VALLONE: Thank you chairs.

CHAIRPERSON CROWLEY: Thank you Council Member Vallone. Next we have Council Member Cornegy.

COUNCIL MEMBER CORNEGY: Good afternoon. So I have more of a, a statement than a question. I think that this hearing, I want to thank the chairs because this is long overdue. As somebody who represents one of the seven communities that's responsible for 90 percent of the incarcerated individuals in the city and in the state who knows that there's a lack of resources as it relates, as it relates to mental health on the ground I know that without looking at this in totality we can't continue to function in the way that we do. And also as someone who in a prior life worked on

Ryker's Island as the assistant director of substance abuse there got to witness the shortage of care in the MO Units or in the entail observation units or throughout that entire facility and who somebody who saw the main way of getting treatment was through self-reporting. And so obviously that didn't work at all times so really having to get, a look at this system and the way it's failing the individuals that it's supposed to serve today I'm just really pleased that this is happening. So again I won't to thank the chairs for thinking enough of those individuals who may be diagnosed or undiagnosed throughout this city who occur, who find themselves in the criminal, criminal justice system with no recourse.

CHAIRPERSON CROWLEY: Okay. We're almost finished with our questions. I would like to understand how you're, you and this taskforce will evaluate the success of the taskforce and what point in time where you stop an measure the reduction of, recidivism the number of participants how will you know that the money is well spent?

TRISH MARSIK: So that's a really important and complicated question because there

are a lot of initiatives being thrown at, at not just a behavioral health population but a justice involved population right now. So you know folks talk about the noise so you're never totally sure which intervention is making the change but we have money dedicated in our budget to doing an evaluation of these efforts. We're going to be looking at each of the initiatives in setting in, as I, as I indicated earlier setting progress indicators for each of those. We will be making them public so that people can see the movement on various initiatives that we have anticipated here. The, the question of timing is, is tricky because the rollout of all of these different action steps is not simultaneous you know. Some will roll out at different times than others. I would anticipate that in the next 18 months to two years we'll be able to, to say something more, more definitive, perhaps not conclusive but more definitive about how we've been doing and where we need to go from here.

CHAIRPERSON CROWLEY: So in two years you think would be a, a good time for us to come back to ensure the success of the program?

TRISH MARSIK: We'll be measuring, we'll be measuring our progress all along. My point about 18 months to two years is we'd actually be able to, to see a longer term effect. So you know if you want to look at repeated, or something like repeated arrests we would need some, some months out to see that happen. And if we're not launching some of these initiatives due to their procurement till the fall that's, puts us into 2016.

CHAIRPERSON CROWLEY: Was one of your initiatives to build a home for 300 participants?

TRISH MARSIK: One of our initiatives is to provide 267 units of scatter site supportive housing for people who are justice involved and chronically homeless.

CHAIRPERSON CROWLEY: Is that amongst other housing units or it's specific? When, because when you say supportive you'll, they'll need specific support for their type of diagnosis?

TRISH MARSIK: Yeah so this is not, this is, this won't be in a single building. All the units won't be in a single building. It's a scatter-site program. We've done this you know through the health department on a number of

occasions even particularly with this population. Those units will probably start coming online in the fall. And we'll have service, we'll include both a rent subsidy for the people who move into it and supportive services. For some people that will be a, a place where they can live for, for a long time. In other cases it might be a stepping stone to something even more permanent.

CHAIRPERSON CROWLEY: The 130 million dollars that is the budget for the program, is that still the same amount? And how does that get divided up in years? Is that over two years or four years…

TRISH MARSIK: That's over four years. I can give you. I can put together the breakdown…

CHAIRPERSON CROWLEY: And is that money in the budget right now, the budget that we are…

TRISH MARSIK: Yes it is.

CHAIRPERSON CROWLEY: …analyzing. And and… Okay. I have no further questions. We'll stay in touch. I want to thank you for being here today for your testimony and your leadership on this issue.

[pause]

CHAIRPERSON CROWLEY: Next up we have New York City Independent Budget Office. We have Paul Lopatto and Nashla Rivas-Salas.

[pause]

NASHLA RIVAS-SALAS: Good afternoon Chairpersons Crowley, Gibson, Lancman, Cohen, and members of the committee. My name is Nashla Rivas-Salas and I'm a Senior Budget and Policy Analyst for the New York City Independent Budget Office. I'm joined by Paul Lapatto. Supervising Analyst for Social and Community Services. Thank you for the opportunity to testify today on behavioral health and criminal justice system. My testimony will not directly address the city's action plan but rather highlights some of the findings from a report our office released yesterday that bears directly on the subject of this hearing. Our report looked at correctional mental health spending since 2009 and the city's progress towards meeting its obligations to provide mental health and discharge planning services in jails. More than a decade ago the city reached a legal settlement with plaintiffs in a case that became known as Brad H.. The city agreed to provide inmates who are convinced in its jails

for at least 24 hours and who receive treatment for mental illness join their time there with a plan for accessing ongoing services upon release. Although the average daily population in city jails continues to decrease the number and share of inmates for the mental health diagnosis is growing. In response to the recent turmoil in the city's jail system the de Blasio administration has adopted a number of new initiatives for addressing mental health services and other needs in the jails including the action plan recommendations announced in December. As the city moves forward with these new efforts it is worth looking back at how well the Department of Corrections and Health and Mental Hygiene met the obligations of the Brad H.. Settlement. IBO has compared spending in fiscal years 2009, the earliest year the Health Department could provide data for and, and 2012 the latest year data was available at the time IBO made its request. Some of the service provision data analyzed was through 2013. Among our findings from 2009 through 2012 Health Department Spending on Mental Health Services in the city's jails remain flat at about 35million a year. Over that same

period the number of inmates with mental health diagnoses increase by nearly ten percent to more than 20,200 admissions in 2012 and comprise a larger share of the inmate population. Because health department spending on correctional mental health services have not kept pace with the increasing number of inmates with mental health diagnoses per inmate spending on mental health services declined. The decline was particularly notable in spending on administrative and support areas, purchase of psychotropic medication and to a lesser extent discharge planning. But the de Blasio administration's new initiatives though per inmate spending is likely to rise. In terms of the absolute number of services provided to inmates eligible under the brad age settlement the health department delivered more services in 2013 than in 2009 including an increase of over 56 percent in the number of discharge plans completed to 8,492 in 2013. But some of the ten different types of discharge services identified under Brad H. were reaching a smaller share of eligible inmates in 2013 than in 2009 including referrals made, appointments scheduled for post release care and

Medicaid, and public assistance applications submitted. It is not possible to assess the effectiveness of the discharge services because neither the correction department nor the health department tracks inmates with entail health issues post release. The report also compares data on demographics, length of stay, and reasons for arrest for the inmates covered by the Brad H. Settlement compared to the general inmate population. Thank you for the opportunity to testify today. I'm glad to answer any questions you may have.

CHAIRPERSON CROWLEY: Your testimony states that in a given year between 2012 and 2013 there was a substantial jump or sometime in comparing some number before 2013 there was 56 percent increase in the number of Brad H. discharge plans. Can you state why you think that there was such a jump in that one year?

PAUL LOPATTO: 2009. And we get, we had spending data for as late as 2012. In some cases…

CHAIRPERSON CROWLEY: Sorry can you just identify your name for the record?

PAUL LOPATTO: I'm Paul Lopatto Supervising Analyst for Social Services at the IBM. In the case of discharge planning data we had data for as recently as 2013. What they show is that in a few cases some of the discharge planning services went up between 2009 and 2013. For most of them they actually declined as, as it… a percentage of the eligible inmates were being discharged at the time… description.

CHAIRPERSON CROWLEY: And that says something about the previous administration.

PAUL LOPATTO: It's not surprising considering that when, prior to that we had examined spending date and we found out that spending per inmate with a mental health diagnosis was actually going down between 2009 and 2012. So the outcome date is not surprising giving that, giving the spending date.

CHAIRPERSON CROWLEY: Do you believe that everybody who is in the category of Brad H. today at Ryker's Island is leaving with a Brad H. plan that is eligible for it?

PAUL LOPATTO: Well there are, in our report we have a table that, that shows, the,

breaks out the various kinds of, there are actually 10 services which Brad H. clients are guaranteed depending on their specific circumstances. And for some of the categories comprehensive treatment plans compete at which is the most basic thing. And by 2013 all of them are going to be receiving it. For other categories such as things like walk-in medications provided for those who are eligible was only 96 percent for referrals made to outside help when they… was only 83 percent of those eligible. So it really depended on the category.

CHAIRPERSON CROWLEY: So the referral for outside help is at 83 percent?

PAUL LOPATTO: As of 2013 yes.

CHAIRPERSON CROWLEY: Which is not so, that's not such a bad statistic.

PAUL LOPATTO: Well it should be…

CHAIRPERSON CROWLEY: Not a, it should be 100 percent.

PAUL LOPATTO: Should be 100 percent according to the, the court agreement yes.

CHAIRPERSON CROWLEY: And can you give an explanation as to why you think they didn't meet that 100 percent?

PAUL LOPATTO: Oh we, we don't have the specifics but it, it likely was just a lack of resources being that that the actual spending per inmate during that time was actually going down.

CHAIRPERSON CROWLEY: Okay we have no further questions. Thank you for your report.

PAUL LOPATTO: Thank you.

CHAIRPERSON CROWLEY: Next up we have Queens District Attorney's Office Douglas Knight from DA Richard Brown's Office.

DOUGLAS KNIGHT: [off mic] Good afternoon my name… Good afternoon… [on mic] Better? Good afternoon. I would like to thank Council Member Elizabeth Crowley chair of the Committee on Fire and Criminal Justice Services, Vanessa Gibson chair of the Committee on Public Safety, Rory Lancman Chair of the Committee on Courts and Legal Services, and Andrew Cohen Chair of the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse, and Disability Services for giving me the opportunity to testify at this hearing on behalf of Queens District Attorney Richard A Brown. My name is Douglas Knight. I'm the Director of Alternative Sentencing

at the District Attorney's Office. I have a Master's degree in criminal justice and I am a credentialed alcoholism and substance abuse counsellor with over 25 years of alternative sentencing experience. Our office has had both a misdemeanor and felony mental health court for many years and we offer a variety of alternative sentencing options to individuals whose criminal activity is motivated by mental health issues. These include programs targeted to assist young offenders, veterans, those who are duly diagnosed with substance abuse and mental health problems and trafficking victims. At present we seek to identify at the earliest time possible defendants who may in a need, who may be in need of mental health services. It is our view that the earliest someone enters treatment the more likely they will be successful. Identifying those in need of mental health services however is not always easy. There is currently no mechanism in place to conduct an independent professional and comprehensive mental health assessment of all defendants entering the criminal justice system. Consequently, consequently aside from those cases where the defendant's mental

health issues are so substantial that they are immediately obvious to all we have surprisingly little information at the time of a defendant's arraignment about his or her mental health needs. Such information might be provided by the defendant's family or defense council but it is equally likely that no one present at arraignment will have access to any information about whether the defendant has been hospitalized in the past, whether he or she is currently on medication, well whether he or she has been diagnosed with a particular mental illness. As a result it may not be until the defendant is assessed at Ryker's Island or speaks with a defense attorney after arraignment if he or she is ROR that a mental health assessment may occur. Our office will affirmatively reach out to defendants who are nonviolent and whom we believe may safely participate in community based treatment programs. If a defendant is interested in participating in a diversion program he or she will undergo a comprehensive mental health assessment conducted by mental health task, a well-known, and well respected not for profit organization. Task will

then facilitate a thorough and objective psychological assessment. This will include not only a, a, a clinical interview with the defendant but it will also include a review of the defendant's psychiatric history, medical records, school records, medications, conversations with relevant persons who can provide information about the defendant's clinical history, behavior, and ability to obtain stable housing including family members, treating doctors, and correctional personnel. Task will then help investigate a defendant's eligibility for various benefits including SSI, SSD, Medicaid, and health insurance. At the end of the assessment Task will make a recommendation as to whether the defendant is in need of treatment and what type of treatment would be most beneficial for his or her individual needs. Once a defendant is recommended for an appropriate level of treatment we attempt to place them in a specific treatment program which may be outpatient or residential depending upon the need. However this can sometimes be a slow and difficult process for a variety of reasons. Treatment programs may be wary of accepting defendants with serious criminal

histories or prior arson or sex crime convictions. It may take some time for homeless defendants to obtain documentation necessary for various entitlements. Defendants' whose mental health status deteriorate while waiting for a treatment place, placement may wind up in a psychiatric hospital or for stabilization or Mid-Hudson for a competency assessment. Defendants who do not speak English may have difficulties finding a treatment program that they can, that will meet their needs. Young offenders may be delayed in obtaining treatment when parental consent for both assessment and treatment purposes cannot be obtained promptly. And defendants who are undocumented may have difficulty accessing services because they cannot obtain insurance coverage. Defendants who enter treatment through the criminal justice system will enter into a plea agreement that permits the judge and the attorneys in the treatment court an opportunity to monitor their progress in treatment. Upon successful completion the criminal charges against the defendant are either reduced or in some cases dismissed. We believe that our ability to provide mental health services to those in need in

Queens County could be improved in a number of ways. In many of our treatment courts it has been extraordinarily helpful to have a trained clinician available in the courtroom who can work with defense council to identify those in need of treatment and begin the assessment process quickly enabling task an other agencies to have representatives at arraignment for those interested in assistance could greatly facilitate our ability to identify mental health clients early. It would also be an… it would also be enormously helpful to expand the pool of treatment providers available, particularly programs that provide residential care to individuals with serious and chronic mental illness. Additional options would also be welcome for young offenders. There are simply not enough residential treatment slots available for seriously ill high risk youth under the age of 18. In Queens County, the most diverse county in the nation, there are few mental health programs available for non-English speaking defendants and it is very difficult to find appropriate treatment for many others with special needs including pregnant women, individuals with developmental disabilities, or

those who are in need in medical accommodations. Accommodating criminal justice involved defendants with behavioral health issues is extremely challenging. However we continue in Queens County to work tirelessly to assist them in accessing appropriate clinical services which, which best meet their needs. I want to thank, I want to thank you for the opportunity to speak before you today and I'm happy to answer any questions that you may have.

CHAIRPERSON CROWLEY: Thank you Mr. Knight. I appreciate you being here and giving testimony. Your testimony states that if you had a clinician, right now you don't have a clinician, is that correct?

DOUGLAS KNIGHT: We, we don't have dedicated clinicians. We have multiple agencies who are working in, in some cases collaboratively. We have the supervised release program and, and, and many cases they will do the preliminary work and then they'll hand the case off over to an organization like Task who will facilitate a, a placement and, and do the case management post-plea.

CHAIRPERSON CROWLEY: Seems like Queens County has a pretty good handle on those that, who would have mental health needs because you have a mental health court.

DOUGLAS KNIGHT: Correct.

CHAIRPERSON CROWLEY: You had one for many years. Do you know how you compare to other boroughs?

DOUGLAS KNIGHT: I'm not sure statistically how we, we, we fair but I do know that we have successful completion rates that are in the 75 percent range and I know that CCI has historically done a recidivism studies and we've always faired very well.

CHAIRPERSON CROWLEY: Do you know how many people you divert from having to go to Ryker's Island through your program?

DOUGLAS KNIGHT: We divert hundreds of individuals per month in the various ATI and ATD programs that we have in Queens County.

CHAIRPERSON CROWLEY: Okay. Council Member Lancman has questions, Co-chair.

CO-CHAIRPERSON LANCMAN: Thank you. Good afternoon. It's good to see you again.

DOUGLAS KNIGHT: Likewise.

CO-CHAIRPERSON LANCMAN: Very happy to have your, your testimony both because it raises some interesting points but also we know Judge Brown's long commitment to, to these issues and his view of his responsibilities beyond the, the four corners of, of an indictment or, or an information… Let's talk a little bit about the arraignment process. And just to, to emphasize you, you know the offices believe that it's very important at that stage where somebody is potentially accepting a plea to guilt, pleading guilty, somebody who is going to have bail set and may or may not be going home that day. Or if they are accepting a plea, being sentenced, that to a large extent the court, your office, the defense attorney's unless as you put it the defendant's mental health issues are so substantial that they are immediately obvious to everyone that person's mental health, health issues may not be considered in those important decisions. How do your assistant district attorneys who are staffing arraignment court told to, to, to, to deal with those kinds of situations.

DOUGLAS KNIGHT: Well the first thing that I would, I would say and one thing that I'm very very proud of is that Judge Brown has a director alternative sentencing and I think we're the only office in the city that does have a director of alternative sentencing. The, one of the other things that we do with all of the new incoming assistant district attorneys is that we provide them a full day training with respect to alternative sentencing. We provide them the basic information with respect to and access one diagnosis. We review with them all of the many different ATI and ATD programs that are available and we also take them on a field trip to a therapeutic community so that they become very familiar with the treatment process. So as you know arraignments is a very fast moving process and I do believe that many of the young assistants that are in that capacity when presented with those facts and circumstances would exercise the appropriate judgment and on a case by case basis respond appropriately if, in the event that an alternative to detention was, was presented.

CO-CHAIRPERSON LANCMAN: I understand that one of the challenges that, that your office has is the proliferation of organizations all doing good work, all well-intentioned, who are in a situation of more or less vying for clients to do the, the assessments particularly as I understand it the assessments for which defendants are eligible for specialty court and which court. Could, could you tell us a little bit about some of those challenges and, and whether or not you think it might make sense to narrow the number of organizations that are doing the, proving those services both, both for uniformities sake but also you know just to, for everyone's sanity?

DOUGLAS KNIGHT: I believe in trying to be as efficient as possible and one of the benefits of me being in the capacity that I am with the district attorney's office is that we convey one message. And one of the things that I try to do on a consistent basis is to coordinate ATI and ATD services so that we can be as efficient as possible. We have numerous organizations, ATI organizations, the fortune society cases, we have the Osborne Associate, we have Task, we have

supervised release, and one of my primary goals is to try to streamline the services as best we can. One of the frustrating things that we deal with on a, on occasion is that there are individuals that are trying to undercut one another for a, a statistic if you will. It doesn't happen that often but in the world of performance based contracts there is a desire to accommodate paper eligible and clinically eligible clients into appropriate treatment services. So one of the things that I tried to do is work collaboratively with all the ATI and ATD programs in Queens County so that we have one message that's being conveyed. And again with the goal of trying to be as efficient as possible one of the other things that I tried to do in facilitating my role as Director of Alternative sentencing is to treat the, the clients that are represented by QLA, legal aid, the private bar, as equally as possible. Nobody gets better treatment or worse treatment because of whoever's representing them. And I think that we do a very very good job in achieving that goal.

CO-CHAIRPERSON LANCMAN: Well I think the office definitely has a, an excellent

reputation in, in the legal community on those issues as well as, as all others. Let me just ask you about the testimony you gave regarding the treatment programs and the challenges that you have finding placement for people have maybe less traditional backgrounds; undocumented immigrants, people with, who might be US Citizens but have, have language issues, who if anyone in, in the city administration, because a lot of these programs are funded by the, by the city whether specifically for that treatment option or somewhere else. I mean is there somewhere… the city that, that, that you can go to and say listen they've got a defendant who meets these criteria, no one's taking him or her, you can either spend whatever it is a year to, housing them in Ryker's or, or we can try to make this, make this work. Who in the city is making sure that, that there are these options available?

DOUGLAS KNIGHT: I'm not exactly sure who's making sure that these options are available but we do utilize the resources at our disposal if in fat somebody is incarcerated and they have a major depressive disorder and we are in need of residential treatment services we will access

depending upon their housing process if in fact somebody requires an HRA 2010 application you know we'll use the… process which sometimes can be a frustrating. But we, we try to collaborate with community based resources. One of the things that I'm most proud of is that in Queens County for the most part we are treatment rich and we try to collaborate with existing resources to overcome those obstacles so that we can again be very efficient in individualized treatment plans so that the, the defendants are getting the best chance at success.

CO-CHAIRPERSON LANCMAN: Well just again I mean, I mean if you look at the work that the Queens DAs office is doing from the establishment of your position to all the different programs that you run and, and operate, and the operations, options that you you know are willing to take the risks because there are risks involved is really something the rest of city should look at. So I appreciate your testimony and, and definitely some of the issues that you raised are going to guide some of the follow-up that we're going to have with the taskforce and, and others. Thank you.

DOUGLAS KNIGHT: Thank you.

CHAIRPERSON CROWLEY: Thank you Co-Chair Lancman. And thank you Mr. Knight for your testimony and…

DOUGLAS KNIGHT: Thank you.

CHAIRPERSON CROWLEY: …for all that you and the district attorney do. We're going to call up the next panel which is a New York City Criminal Justice Agency Jerome McElroy and we'll also hear from the Center for Court Innovation Carol Fisher, Fisler. Please begin Mr.…

JEROME MCELROY: McElroy.

CHAIRPERSON CROWLEY: McElroy.

JEROME MCELROY: Mm-hmm. I'd like to introduce also Murry Cabello [sp?] who is our Associate Director and who is the Principal Architect of the supervised release programs that we've been providing now for little over five years. I didn't have a prepared statement. I was really responding to the invitation to join a panel and to ask, answer whatever questions you might put to us. I did distribute or are distributing a couple of pages that just kind of outline the various things which CJA is charged with doing in

the city. But I understood that your principal concern was with the supervised release program. So I would be… In that regard let me just say we started, designed and started with the assistance of the coordinator's office five and a half years ago a supervised release program in Queens. It was specifically for non-violent felonies and it had a variety of other criteria which were eligibility criteria for people coming into the program. It works at criminal court arraignment that is the court reps that we have employed are looking to identify cases that would appear to be eligible. And to clear that with the defense attorney, the defense attorney is essentially the gatekeeper in, in these cases. If the defense attorney believes that this is not necessary or appropriate in his case then we back off. If the defense attorney agrees we go forward to interview, re-interview I should say the defendant, figure out whether or not he understands the program, he's willing to go into it, and he has sufficient community ties that we'll be able to, we'll be able to supervise him in the community. And if that's the case… go back to the defense attorney, the defense attorney will then

include that in his bail application. And it's up to the court obviously as to whether or not they will put the defendant in supervision. If so that there is a contract signed that becomes part of the court papers the defendant, or the client as we now call him now goes to the program office. He will undergo a fairly extensive assessment which is among other things designed to identify either substance abuse problems or mental health problems or a combination of both. He is required to appear in person at least twice a week and with one phone conversation. The case managers whom we apply are… social workers and so they are attempting to engage him seriously in the process. We report to the court each time the defendant has a scheduled court appearance and in exceptional circumstances that is if the person is re-arrested and arraigned we will give a special report to the court about that fact or if in the rare instances we actually lose contact with the defendant that will also prompt another special report. In Queens we have so far served I think I have 17, 18 hundred people over the last five and half years. A couple of years ago the city impressed with the performance in Queens

asked us to extend the program in Manhattan which we did, we've been operating there for a little over, just over two years. We have served 775 defendants through that period of time. We believe our failure to appear rates are rather low and our re-arrest rate although may be somewhere in the neighborhood of 22 to 24 percent in the two boroughs. I think it's important to note that between 65 and 75 percent of those re-arrests are for quality of life type misdemeanors, lesser severity charges. The vast majority of those cases that are of that type when brought to the attention of the court are continued under our supervision and ultimately are successfully completing the program. Maybe that's enough for the moment and I'll be happy to answer any questions you may have.

CHAIRPERSON CROWLEY: Okay. Thank you. Is anyone else providing testimony?

CAROL FISLER: Yes I am.

CHAIRPERSON CROWLEY: Okay thank you. You may begin.

CAROL FISLER: Okay. Good afternoon Chair Lancman, Chair Crowley, Chair Gibson, Chair Cohen, and the other members of the council. My

name's Carol Fisler. I'm the Director of Mental Health Court Programs at the Center for Court Innovation and for somewhat to apologize that I just realized as I was walking up here that you only have three pages worth of five page testimony. We didn't get the double sided copying right. I will email the full testimony to you later this afternoon but this will help me stay very focused on the important points most of which do fall on pages three and five. Just wanted to say the Center for Court Innovation has been deeply involved in initiatives involving offenders with mental illness in the court system through the specialty courts, mental health courts and drug courts through our community justice centers like the midtown community court, Bronx Community Solutions, Red hook Community Justice, Justice Center. And also through some of the newer programs, the Brooklyn Justice Initiatives which includes a supervised release component in Brooklyn and we're involved in the CERT program in, in the Bronx and Brooklyn. What I wanted to do with my testimony was just highlight a few of the things that the research in the field, both local and national field has taught

us in recent years much of which is counterintuitive, comes as a surprise even to people who've been deeply involved in the field. First of all the very good news is that the emerging body of research on mental health courts is really across the board quite positive. The mental health courts that have been studied rigorously with a comparison group of people going through the traditional courts shows that participants in specialized mental health courts have significantly lower rates of recidivism, fewer days of incarceration, and that these gains can be sustained for at least up to a year after people exit the court. So that's, that's very good news. Mental health court participants also show greater engagement in community based services than people who go through more traditional pathways. Some of the things that the research has shown us that are not necessarily obvious, the seriousness of a defendant's charges or a defendant's most serious prior offense typically is not associated with higher rates of reoffending. In fact we see better results, lower rates of recidivism in a number of the studies among defendants who have been charged

with violent felonies compared to defendants whose charges were property crimes or drug related crimes. And so I think the lesson there is that there really is an opportunity for jurisdictions to consider you know expanding their, their programs to include violent felony offenders that with appropriate supports and supervision people who have committed violent offenses can do well in the community. Second really important point I wanted to make is the national research that has been published in recent years shows quite surprisingly that there is really not the correlation between how symptomatic people are and what kind of treatment they're getting and how deeply involved they are in mental health treatment and whether or not they reoffend. The factors most associated with reoffending among mental health court participants are the same risk factors that we see in the general population of justice involved people. And so the field has really shifted its focus here to looking at criminogenic risk factors and trying to understand the interplay of those factors with, with mental illness. And I think the mayor's taskforce report the action steps reflect a lot of

that very appropriate focus on criminogenic risk factors. And just a final point on the research one of the things that we think really is an important explanation for the positive results that we see in mental health courts is the importance of procedural justice, the connections that are made between the judge and the participants, the prosecutors and the participants, the, the whole court team. There's, there's all growing body of research not only in the court system but with police, probation, parole that shows that when people are treated with dignity, given a voice in proceedings, made to feel like the, the justice system cares what happens to them they're more likely to comply with judicial orders and follow the law and, and those dynamics in the courtroom are perhaps more important than the treatment people get. I'm honored to make a big pitch for expansion of supervised release programs and I am about to run out of time so I will stop it there and you'll see some of the concerns that I wanted to highlight in the written testimony that I will email you after this.

CHAIRPERSON CROWLEY: Thank you to both agencies, well one agency sort of, the other provider. Councilmember Lancman, I'd like to recognize the co-chair for question…

CO-CHAIRPERSON LANCMAN: Thank you. Good afternoon. Thank you for coming in today. Very much appreciate it. We're going to have a bail hearing next month so I don't want to have to do this twice. So we're going to put some questions aside that we're really interested in and try to focus on the behavioral health aspect of it all. So right now, this is for the CJA folks, right now just to, to clarify I mean I've, I've seen it, I've got the, the forms that, that you fill out and, and what is handed over to the court. There's no mental health examination, behavioral health examination that you conduct prearrangement to give to the court district attorneys defense, defense council for their use during arraignment, correct?

DOUGLAS KNIGHT: That is correct as, as part of our pre-arraignment interview and where it goes forward to the arraignment court there is nothing on that that has anything to do with mental health.

CO-CHAIRPERSON LANCMAN: Now it's the taskforce recommendation that that change. There's going to be a pilot program whereby someone is doing that mental health assessment but it's not going to be CJA. Now I don't have a, an opinion whether that's…

DOUGLAS KNIGHT: No I believe the, I believe that is correct. There is a project or a demonstration project going on right now I think to design the tool that would be used to identify somebody with a mental health… [cross-talk]

CO-CHAIRPERSON LANCMAN: So, so one of the challenges we have in government and we heard testimony to this effect somewhat from the district attorney's office is we institute programs and then you wake up a few years later and there are you know 53 different providers of the services that you, you want to achieve. Is, is CJA not capable of, of performing this assessment if, if you were given the resources?

DOUGLAS KNIGHT: Well I'd have to say that we are not now capable of it. We don't know what tool we would use to do it. We are constrained as you know by the serious time constraints on the

pre-arraignment process. So this is, and I think the, the other question that we would be concerned with and I'm sure you are as well is the legitimacy of collecting personal information of that sort and simply passing it on. I'm not quite sure where it should go. I would think the defense bar would have serious questions about passing on that information without the approval of the defense bar.

CO-CHAIRPERSON LANCMAN: Well they're here and we'll ask them. It would seem to me pretty straight forward if at least there was something that was passed on to the, to the defense bar.

DOUGLAS KNIGHT: Mm-hmm.

CO-CHAIRPERSON LANCMAN: But defendants have to be assessed for bail purposes, potentially sentencing purposes. I just wanted to know or give you the opportunity if you had a strong objection or any objection to that service being provided by some entity other than CJA which is already in the business of interviewing defendants pre-arraignment. And if you don't that's, that's fine as well.

DOUGLAS KNIGHT: I would not have any objection to some other organization or some other entity doing that.

CO-CHAIRPERSON LANCMAN: Mm…

DOUGLAS KNIGHT: I should add and I think I pointed this out before. We're talking about the pre-arraignment interview that CJA performs. But in the supervised release programs there we look fairly extensively at a person's mental health needs and we make referrals where they are appropriate.

CO-CHAIRPERSON LANCMAN: Okay. And I understand that and, and there are lots of good questions that need to be asked about the supervised release programs and, and just in the general bail context. But maybe you could tell us a little bit about the collaboration or coordination or maybe lack thereof between the alternative to detention program which is the supervised release and, and the alternative to incarceration programs which is the, the, the specialty course, courts. Any observations on how that handoff is, is done, whether or not things get lost in the cracks?

DOUGLAS KNIGHT: When we began the program in Queens we had extensive discussions with the district attorney's office and others and we provided the in, the assurance that we would in no way try to interfere with the handoff that you're talking about. And I think I would say that in Queens particularly that has worked very effectively. I think perhaps maybe as much as 30 percent of our cases. A little bit less than that but a substantial portion of the cases that we have been supervising ultimately wind up in the drug court or the mental health court in Queens. I think that that relationship has been a little less successful so far in Manhattan but we are working obviously with the District Attorney's Office to accomplish what is needed.

CO-CHAIRPERSON LANCMAN: So… to preview the, the bail hearing just a little bit, but am, am I correct that the supervised release programs terminate at the, the centers for… disposition.

DOUGLAS KNIGHT: At the plate.

CO-CHAIRPERSON LANCMAN: At the plate?

DOUGLAS KNIGHT: Yep. … excuse me. That's generally true and that is what we desire

for among other things resource issues. There are instances in which a judge may specifically ask us to continue somebody under supervision. This has happened in at least, well some number of cases in Queens. Whenever we are asked to do that we agreed to do it and we will continue the person until the judge imposes sentence.

CO-CHAIRPERSON LANCMAN: And would you have any opinion particularly in, in this context where we're expanding supervised release and, and, and particularly for, for folks with mental health issues whether or not it should just as a matter of course continue through to, to sentencing. It seemed to me intuitively that there's a greater risk of, of flight once a person you know knows what's coming.

DOUGLAS KNIGHT: Well let me say that although this is a felony program the vast majority of the cases that are exposed are in fact disposed as misdemeanors. And in fact the, in the vast majority of those cases the sentences imposed at that point in time that's particularly true in Queens. The issue of whether or not the person should be continued under supervision is ultimately

I think up to the court and in some instances the, the defense bar may have an objection to that. But if the court as I indicated earlier if the court thinks it is appropriate and asks us to do so we will do so. If we were to assume that this was to become a matter of course then I think we would among other things need more resources than we currently have to continue that.

CO-CHAIRPERSON LANCMAN: Hi, from, from CCI, by the way your, your, thank you very much. Your reports were very informative and, and very very helpful.

DOUGLAS KNIGHT: Could I, could I just make one point I should have made earlier that in many of these cases that end where our supervision ends because a person has gone on to a drug court or mental health court or whatever those courts of course have their own supervision capacity. And so it isn't as if it's, it's over and there is no supervision.

CO-CHAIRPERSON LANCMAN: Right. But I assume, I, my understanding is those courts… and it's not a criticism but those courts will use the, the program providers that are providing the mental

health or drug treatment services as a proxy for, as providing the supervision. They 're the ones who are reporting back to the court… so and so you know attending their treatment or, or, or not their treatment, not that there's anything wrong with that but, but let me ask, ask you if I can you are a, a student of the specialty courts, the mental health courts, the drug courts, etcetera. I think two months ago we had a hearing here where we had folks from the human trafficking court in Queens including Judge Serita pleading with us for the city to provide additional resources so that those courts can do their, their job. They didn't not more court officers, they didn't need you know bigger court rooms, they needed the social services providers that make those courts what they are to provide mental health, psychological, educational, employment counselling etcetera etcetera etcetera to, to their clients. I mean we have the human trafficking court folks saying that one of the, the providers had to cease accepting clients for 30 days just to deal with the backlog. Were, were you surprised that the, the taskforce doesn't make any recommendations for the city's additional support

of these courts so we can serve the people who, who are being kept out of Ryker's Island by being in those courts.

CAROL FISLER: …you'd raised the question earlier about why the taskforce report was silence on the specialty court and I know my own answer to that as Trish Marsik was responding to that question was I think people feel like the specialty courts are by in large doing a very good jo and so the taskforce didn't really have to be dealing with him. I do think the human trafficking courts have not been as resourced as, as the mental health courts and the drug treatment courts. And that is an issue. You know those are much newer courts and providers like the center for court innovations are… stepped up and provide some services without full payment for them and so now the others are struggling to, to be able to institutionalize those. I'll say there are really two separate categories of services we have to think about when we think about the specialty courts. One is the, the staff of the courts themselves. And we have an incredible patchwork in New York City. Every single one of the courts has

and I'm seeing the attorneys here you know nodding their heads to this. It's, it's different funding sources and different providers in each of the different counties. And each of the providers has the responsibility of going out year after year and figuring out where the funding is going to come from to sustain what they're doing. That is a big challenge. I would say the, the upside, the virtue to that from the, from the providers perspective is that it allows us to keep defining what it is that we think is important to do as opposed to having a, say a single payer saying for all the specialty courts, all the treatment courts here's what we want, here's what you're going to have to do. So there's a, you know a bit of a tension there between scrambling for resources but that scramble also keeping us a bit nimble and, and innovative. So I, I would love to have more resources for all of the treatment focused courts but we don't want those to come at the expense of you know sort of bureaucracy and, and over standardization. There's a separate issue about what the services are that the courts are linking people to. And I don't think in the hearing today so far that that question has

been addressed as much as it might have been. We've talked a little bit about the expansion of you know some, some housing. But you know there are, there are a few categories of services on the mental health court side that are extremely difficult act to access. Especially supportive housing or affordable housing generally and that many potential participants in the courts are kept waiting in Ryker's Island for months and months and months until those resources become available. I'm not as familiar with the human trafficking services and the providers and, and where the gaps are on that on the mental health side. You know generally speaking there's easy rapid access to outpatient treatment to good mental health outpatient treatment, you know serious shortages of housing and we're in a changing landscape right now with care coordination services. We used to rely on intensive case management as an important resource and now we're in the world of health homes and that's a, you know a different service. So we're, we're adjusting to that. So I just want to be clear and maybe ask you if you wanted to re-ask the question with a specific focus on this, the

resources to support the operations of the court versus the resources to provide the, the treatment services.

CO-CHAIRPERSON LANCMAN: Well I think it's definitely the resources to provide that the treatment services… in terms of the operations of the court as I said they don't… for court officers and, and…

CAROL FISLER: No I'm talking about the clinical services, the people who are doing the evaluations, the treatment planning. It served two layers of services. There are the, the people who are the… the, the… [cross-talk]

CO-CHAIRPERSON LANCMAN: The gatekeepers?

CAROL FISLER: The, the boundary spanners.

CO-CHAIRPERSON LANCMAN: Okay.

CAROL FISLER: The clinical people who staffed the court, the people doing what, what Doug Knight was referring to in Queens. You've got Task, you've got the social workers of the legal aid society, the center for court innovation provides the clinical support… [cross-talk]

CO-CHAIRPERSON LANCMAN: So the folks who were providing the support information to the court as opposed to the defendant slash client.

CAROL FISLER: Or they're doing the initial work of the, the assessments, the treatment planning, and making the initial linkages to services.

CO-CHAIRPERSON LANCMAN: So let me ask you in, in, in the plan, in the taskforce recommendations which I know you're very familiar with in the plan going forward which is good if not complete but as it was told it was a first step where do you think that our attention should be? For example the, I think and we've heard testimony that the, and, and it was one of the commission's taskforce recommendations that the lack of mental health assessment at the very earliest stage for the benefit of the, the court council, district attorney's office is a very very serious problem. So as, as we look to, to, we're about to finish the city budget hopefully in you know six weeks where should we and the taskforce be putting the taxpayers money right, right now. I wouldn't be shocked or, or verse if, if we were to hear that

right now we need to get the courts and the, the people in the, in the, in the process better information, more timely information than right now we need all of our money to go to more services directly to the, to the clients of the defendants. Like where do you, give us some guidance.

CAROL FISLER: I do think that expansion of supervised release opportunities starting prearrangement, at arraignment, but also in the days and weeks immediately following arraignment, kind of a whole web of, of resources for assessing people ad connecting them to services is an important step and I think the taskforce recommendations include of, you know substantial expansion and capacity for that area. I do want to caution and I know you're going to hear this point from the, the defense bar. First of all there are real concerns about who's going to have access to the information, who's going to be the gatekeeper, when is it appropriate to introduce that information. There I think is a very wide array among the judges and among prosecutors as to the openness and interest in using clinical information to expand community based opportunities or

responding to it in a very negative stigmatizing way. There are certainly judges who are much more likely to detain a defendant as soon as they hear that there's a mental health issue.

CO-CHAIRPERSON LANCMAN: Right and we've, we've heard that.

CAROL FISLER: And, and, and that, that is a, that is a real concern. So, so I think again we don't necessarily want to be focusing too much on expanding all the resources at the moment of arraignments partly because you want time for the defendant and the defense attorney to take a look at what's going on in the case but also it takes time to do a good mental health assessment and to really figure out what other services somebody needs. So again I think if we think in terms of resources that support kept a web of assessments, treatment planning, connections to services during the early days and weeks there's only so much that you can really accomplish well if you try to pack it in at arraignment. But expanding the services along the lines of what was contemplated in, in the CERT program but a more flexible set of models would be a very wise use of city funds.

CO-CHAIRPERSON LANCMAN: Last question. Since you mentioned CERT…

CAROL FISLER: Mm-hmm.

CO-CHAIRPERSON LANCMAN: …I don't know if you have an opinion on this but we've heard concerns from both the defense bar and from the district attorneys that how shall I put it the, the calibration of who is eligible for the program is either too lax or, or too stringent.

CAROL FISLER: Mm-hmm.

CO-CHAIRPERSON LANCMAN: You have any opinion on that as a, as a…

CAROL FISLER: I would say that sort of speaks to the point I was just trying to make that we're talking about people who present complicated issues and being set up with an array of resources that allow the parties that take the time to do good assessments. One of the challenges with CERT is that it's very driven by you know a handful of proxies for complex issues. So there are a few factors that trigger a, an assessment as to whether someone is at high, medium, or low risk of reoffending. The assessment is to their mental health needs is based on the M designation that

they get at Ryker's Island. Those pieces of information in and of themselves are not enough to really understand what somebody needs to put together a meaningful service plan. So it's a good jumping off point for saying here's someone who merits a closer look. So I think CERT is making progress towards figuring out you know how to use these different screening mechanisms, these different proxies for risks and needs to identify a body of people who merit more attention. And when I talk about kind of a web of resources for supervised release it would be again a ross you know from arraignment through early days of incarceration at Ryker's Island or even for people who are released in the pretrial context for defense attorneys have more opportunities to access services for their clients, even who are out in the community, I think we could do a lot more to expedite long term connections to appropriate services with a greater investment in pretrial services CERT is in the right direction but it's, it's trying to like thread a, a needle and maybe we need a, a bigger set of needles to play with let me put it that way.

CO-CHAIRPERSON LANCMAN: Got it. Thank you very much.

CHAIRPERSON CROWLEY: Thank you Co-Chair Lancman. Next, thank you providers for being here today, next we have Queens Law Associates Lori Zeno, the Bronx Defenders Justine Olderman, William Gibney from LAS, also from Legal Aid Society Reena, Regina Schaefer and Sarah Kerr.

REGINA SCHAEFER: Hi.

CHAIRPERSON CROWLEY: Please begin once you're ready.

LORI ZENO: Okay thank you. Good afternoon. My name is Lori Zeno. I am the Deputy Director of Queens Law Associates. I think members of council for asking us to come and testify on this issue. My organization as a public defender office located in Queens we represent 25 thousand people a year in criminal and family court as well as providing advice and representation on immigration matters. And I will say we welcome this administration's commitment to reforming the criminal justice system. The much needed reforms outlined in the mayor's action plan will benefit our most vulnerable population; those in need of

mental health and behavioral services rather than being incarcerated. These reforms are a clear acknowledgement that the old criminal justice system just did not work. This proposed 130 million dollar four year investment plan does have the potential to reduce unnecessary arrests ad incarceration to redirect criminal justice resources to where they will have the greatest public impact and finally make our city's criminal just system more fair. In the long run this plan will benefit many people. While this plan is comprehensive I do have some concerns. First the projected timeline of the roll out of the number of these reforms I believe are going to take too long. What I mean by that is what about all the people that need these services right now. I believe that there are immediate steps that can be taken to serve the people to, to make programs accessible to them to make them more affordable to those people who are in the need of services by giving more resources to existing public defender offices, diversion courts, diversion programs. And rather than you know taking a large amount of this 130 million dollars to trained police officers to

figure out you know if they're going to bring somebody to a drop off center you know rather than arrest them or if the, you know, and training corrections officers to decide you know whether or not somebody should be housed in a mental observation war. You know I'm, I'm all for training people but I would think that we have a, that's, there's a better use of that money it, you know we have 10 thousand people in jail today and 40 percent of those people are facing behavioral health issues on some level. That's 4,000 people. And only seven percent which is less than 300 people are facing serious mental illness at, which means the overwhelming majority of these people, 40 percent of the people that are housed in jail right now are, are currently not getting services that they need. And of, they remain incarcerated and they remain incarcerated when 85 percent of them are charged with low level offenses, violations, and misdemeanors. And, and, but they can't get out because they can't get a program. So that also, that brings me to my second, my second concern which is the plan relies heavily on, on the fact that court involved individuals should have access

and qualification or Medicaid, well they do not. Treatment courts are consequently finding a program for somebody who does not have health insurance or does not qualify for Medicaid is almost impossible. Treatment courts and the diversion courts, many of them only take clients who are already eligible for Medicaid. So even the treatment courts which have a great success in which I'm, I'm here saying that you, you know they should be given more funding. They're the ones that you know like, like Councilman Lancman says keeps our, you know keeps these people out of jail. But even they only take people who qualify for, for Medicaid. And applying for Medicaid itself is very lengthy, very complicated, and you know also is a, you know a cause of delay. And of course people who are incarcerated are staying in jail during all of that time. You know it's on average 90 days to get approved for your Medicaid which is interesting considering when we were talk, when one of the speakers was, or was asked about how long do these people stay incarcerated when there's the general population staying for only 54 days you have a mental health population staying for 112 days. You

know not much above that 90 day waiting period. Now…

CHAIRPERSON CROWLEY: Are you…

LORI ZENO: Even the people…

CHAIRPERSON CROWLEY: You're going to have to… your, your time ran out, I'm sorry.

LORI ZENO: Oh you know what I'll just make one comment about…

CHAIRPERSON CROWLEY: Mm-hmm.

LORI ZENO: …the people that's, are, are covered by Medicaid. Even Medicaid does not cover the types of programs that these people need and the types of programs that are offered to dispose of these cases which are the anger management programs, batterers intervention programs, and likewise. And the intake fees and the cost of the clients are not feasible which means that even though there are programs there they can't use them. So my, my request is that these programs be made available to, to people free of cost, something that the taskforce plan doesn't mention anything about and that they get in family court. If they're, if they're supposed to go to a program

in family court they get it for free. We need to have that as well.

CHAIRPERSON CROWLEY: Okay…

LORI ZENO: …court. Thank you.

JUSTINE OLDERMAN: Good afternoon. My name's Justine Olderman. I'm the Managing Director of the Criminal Defense Practice at the Bronx Defenders. Thank you so much for inviting me to be here this afternoon. I'm just going to skip ahead since I know my time is short. You know sitting here through the testimony and reading through the memos that were distributed to the council members it's clear that the members of the council and the various committees have done a tremendous amount of research already into the problems that our clients who suffer from mental illness face in the criminal justice system. And you've identified three areas for further discussion, arraignment, specialty courts, and client representation. While I will speak to these three areas in my written testimony and I'm happy to answer any questions that you have when the panel is done giving their initial comments I do want to draw attention to one issue that was just very briefly touched on in the last

panel, that we have to address if the city's efforts at reform are to be successful. And that is the problem of stigma, stigma. Our mentally ill clients are as unique and varied as our other clients are. There're mothers, there're fathers, there're children, there're elderly, there're people with graduate degrees and people who dropped out of school. There are people who have been stabilized on treatment their entire lives and people who have been self-medicating their whole lives. There are people with co-occurring disorders and people who are only struggling with their mental illness. There are people who have suffered unspeakable trauma in their lives and then there are other people for whom their mental illness is the trauma in their life. And their mental health issues that they face are just as diverse. They suffer from depression and anxiety and schizophrenia and bipolar disorder, and the list goes on and on. And what is especially important to recognize is that the exact same diagnosis means very different things to very different people. And that's because each one of our clients is unique. Yet one of the biggest problems that we see day in

and day out as public defenders in the criminal justice system is that there's actually very little differentiation. People with mental health issues are labeled and stigmatized. Regardless of their individual diagnoses successes and struggles. They are feared. Now obviously there's been mention about specialty courts and I representative from the Queens DAs Offices here. Those aren't' the people that I'm talking about within every criminal justice system in every borough there' a handful of people, people that are well trained, people that understand. But then there's the rest of the people in the criminal justice system. These people, judges, prosecutors, other criminal justice stakeholders sometimes I will admit it even defense councils. They fear those that are mentally ill. The mentally ill in the criminal justice system are viewed not only as the ones that everybody fears won't come back to court but they are viewed as the people that will go out and, and commit unspeakable crimes. They are the ones that truth be told that judges and prosecutors will cause them to land on the front page of the New York Post. And as with most fears the fears in the criminal justice system

of the mentally ill is not born out of knowledge and it's not born out of experience, ignorance of what it means to be mentally ill, ignorance of what mental illness means in terms of behavior, ignorance of how mental ill, mental health treatment works. And that ignorance leads many people in the criminal justice system to simply assume the worst about our clients. It's easier that way for people. It's safety that way for people. And so we treat everybody as a anger. If we do that nobody can criticize us, no one can blame us when they go out and commit another crime when they reoffend. So what ends up happening is that once somebody is labeled with that M designation is more often set than not, jail and prison is more often offered than not. And we end up repeating the pattern of feeding the criminal justice system with the most vulnerable of New Yorkers. And there is a tendency to address the problem currently with a one size fits all approach and that is exactly why we are where we are today in a society that essential treats its criminal justice system as one big psych ward. The only way to begin to address the problem identified here today is to start

chipping away that ignorance and roll back this fog of fear. We have been talking about educating Department of Corrections Officers and we've been talking about educating the NYPD. But we need to educate everybody in the criminal justice system, not just the one judge that provides over a specialty part and not just… the one prosecutor who filters through these cases. Everybody, all prosecutors, judges, institutional providers, 18-B attorneys, people who interact with our clients in the criminal justice system, the DOC officers that work in the courts, the court officers that work there, the clerks who interact with our clients, and I do mean educate in the traditional sense. We all need to be trained, formally trained in who our clients are, what they need, and how they can help. We need to recognize it's, a couple of other things, that we need to be as mindful on the programmatic level as on the cultural level. We have to create a culture in our courts of compassion. We need to message that it's okay to take chances on people. We need to bring in some of the, what I think would be very startling information to many people in the criminal justice

system that was highlighted in the last panel about what risk factors are and what they are not. And we need to also help people understand that mental illness is not something to be cured but it's something to be managed. And we need to recognize the successful management of mental illness does not come in a one size fits all package that can be easily handed out by supervised release programs or specialty courts or other criminal justice based programs. The recommendations we've heard about I think are great ones but they are only going to work if we learn to treat people with mental illness in the criminal justice system as individuals with their own histories, their own diagnosis, and their own… [cross-talk]

CHAIRPERSON CROWLEY: Okay I appreciate your testimony. Thank you.

JUSTINE OLDERMAN: Thank you.

WILLIAM GIBNEY: Chairpersons Crowley, Gibson, Lancman, members of the council, thank you for this invitation to testify. I'm William Gibney. I'm the Director of the Special Litigation Unit, Criminal Practice Special Litigation Unit at the Legal Aid Society. We appreciate the Difficulty of

the situation where we are now for over 20 years the NYPD engaged in an aggressive stop, frisk, and arrest, practice that incarcerated disproportionate numbers of, of mentally ill for low level crimes. We're trying to work out of a system that has existed for generations. And we appreciate the policy change that the city is attempting to make now and, and also the difficulty of that policy change. Chairperson Crowley mentioned a victim of this policy Jerome Murdough. Our testimony focuses on, mentions the, the two tourists who were shot in Times Square in 2013 because a, a person with mental illness was weaving in and out of traffic and two NYPD officers shot at him and missed him but hit the two bystanders. There are story after story that can be told about improper interactions between the police and the mentally ill. The incarceration policy and it, it was a deliberate policy, it was a designed policy was an incredibly expensive one. It cost over 167 thousand dollars each year to incarcerate an individual at Ryker's Island. We applaud the formation of a taskforce, of Seymour James, the, the attorney and chief of the Legal Aid Society, was a member of the taskforce,

many members of the legal aid society including those on the panel today participated in some of the working groups. We applaud the, the general direction of, of some other recommendations; expanded training, hospital drop off centers, risk, detailed risk assessment instruments, supervised release screening for fiscal and mental health problems at arraignments, identification of veterans, reform of bail, reduction of case processing times. I will mention it's good to hear that there's a bail hearing coming up. We think bail, bail reform has great potential for helping not only those with behavioral health issues but, but making the criminal justice system really a more jut system, the bail is as being used today punishes only those who don't have money and therefore can't get out. It has nothing to do with dangers as it has nothing to do with the seriousness of the offense. It, it punishes only the poor who, who cannot afford to post bail. And it, it makes all the difference in the world in terms of the disposition of the, of the criminal case itself. CJA reports that there's about a 50 percent conviction rate for those who can't post

bail. There's over 92 percent conviction rate for those who are stuck in Ryker's Island because it changes the entire dynamic of the case that, that a primary goal often becomes just get me out of Ryker's Island whether I'm guilty or not becomes a, a secondary factor. It was mentioned earlier by the city, the legal aid society worked with the city to modify a court order, class action court order that we entered into in the case of grubs versus saffer [phonetic]. That modification was done by the federal court about a month ago. And that expands the use of people who can be used to screen people at arraignments, nurse practitioner… the old order required EMTs but the, we now have an expanded range of people who can do those assessments. What is missing from what we're hearing from the city right now. I have some confusion on, on this point. We didn't see the inclusion of CIT partnerships in the written proposals, written proposals coming from the, the taskforce. I did hear this morning, this afternoon that CIT partnerships are actually part of the planning with the NYPD. If that is the case I think that's a significant step but our concern was we didn't see it in the written plans

and we think that is vitally important. Council Member Vallone expressed concern about the resources that are available to the police officers and their obligation even with training to make individual assessments if they were trained professionals who could partner with the police officers that would make that assessment I think much, much more accurate and useful interaction. And we've seen those interactions work well in other areas of the city, of the country. Thank you.

REGINA SCHAEFER: Good afternoon. My name is Regina Shafer. I'm the Director of Social Work for the Criminal and Civil Practices of the Legal Aid Society. Thank you for having me here today. We've discussed a lot of pieces to the Mayor's taskforce and their report while my testimony includes a lot of information I'm going to hone in specifically on the diversion options that the council is looking at as well as the roll of the social work department at the Legal Aid Society and how we are, might believe uniquely situated to address these issues with an expansion of resources in the current programs that we have. Three of the programs I'm going to speak to very

quickly I begin with our misdemeanor arraignment project that program is up and running in four of the five boroughs that began in 2010. It was piloted through grant funding. It's, it has since been expanded to, to the our boroughs excluding Richmond County although it will up and running in Richmond County shortly. Misdemeanor arraignment project puts social workers, licensed clinical social workers in the arraignment parts to partner with the defense council to identify and assess folks who come through the system who may have mental health issues, may have history of hospitalizations, there's a number of different ways in which we can identify or attempt to screen those that come through the arraignment process who may benefit from our early intervention services through the use of the licensed clinical social workers. We do do a screening and assessments while it not a thorough mental health assessment we do an assessment that does include clinical measures to determine if the clients that we are, come in contact with can benefit from early intervention if they've been, they can be reconnected to service they've had previously or if there are services

that we can identify in the community and can then present to the courts as an option to avoid going into Ryker's Island where we know they are not serviced appropriately. The second program that the legal aid society utilizes that address system, the issues the council has, has looked at and the task force also addresses is our mental illness and chemically addicted project, our MICA project which is an interdisciplinary team of the licensed clinical social worker and an attorney who identify and work with those clients of the legal aid society who are dealing with mental illness and chemical addiction. We, we work with them throughout the course of their case. We provide connections to community based programs. We often work with alternatives to, to incarceration programs to identify appropriate housing. We tried to connect, reconnect them if they've connected before to services in the community and we also are able to provide an 18 to 24 month case management follow-up which is key to, has been mentioned earlier this afternoon key to avoiding folks and getting re-arrested and falling through the cracks, losing connections with services, etcetera. On both

of those, both of those programs we have done some preliminary recidivism data that we've collected and assessed around particularly with our map program which for the figures that we have for the most recent 2013 through the 2014 fiscal year we've identified in Manhattan only a 27 percent decrease in the number of arrests post map intervention services. So for those clients who have been arrested and we have met them through arraignment projects. They're a decrease in rearrests from a year out from when we first began with them. And so that while is, is a small window we do feel that that's a promising statistic. Finally the third program that I want to talk about very briefly is our defender services program which again is social workers in the legal aid society we have that pair with attorneys. They're referred cases of clients who we feel we can, we do interview them at Ryker's. Our social workers go to Ryker's regularly. We meet with them in their homes. We mate, meet with them in court at any other location where they are in residents and do an assessment with the goal of identifying those services or circumstances that we may utilize to inform the

courts and court staff of opportunities and possibilities for diversion, not diversion but identify opportunities for treatment and services that perhaps they have not been connected to before. Thank you.

SARAH KERR: My name is Sarah Kerr. I'm a Staff Attorney with the Prisoner's Rights Project at the Legal Aid Society. Thank you Chairs Lancman, Crowley, Gibson, and Cohen and I'm afraid I left two of you off our testimony. Apologize for that oversight. I along with others at the legal aid society was involved in the taskforce work group on the jails. Many of the taskforce initiatives are being implemented in the fails now and will benefit individuals with behavioral health, health issues through reduction and violence and improvement in treatment opportunities. I want to talk about the crisis intervention team in particular it's not just about treatment. It's about reducing the violence in the jails. I think that the training of the DOC staff and the, also the idea of using steady staff in particular places particularly in places where we house people with behavioral health issues is going to be a huge reduction, help with

the reduction in the violence in our city jails. So the idea that we were looking at reducing punitive segregation, how to make our jails therapeutic and have a therapeutic response to people with behavioral health issues rather than the punitive response, CIT training, and the CIT teams are a big part of that. This will be fully integrated clinical insecurity staff members who are assigned by a facility, you know are facility based so they will have familiarity with the people who they are responding to and that's different than the ESU, the emergency services unit which we are sorry to see is now part of the antiviolence project because the ESU isn't like that. It's not based in a facility. The people will not have knowledge of the people that they're responding to in that way that steady officers can have. The ESU is also, does not have that duel clinical staff as part of it. Reduction in the use of punitive segregation clearly a very important issue. The board of correction passed new standards in January after an overwhelming need for reform was demonstrated including numerous studies and a number of tragic and avoidable deaths. Prior to these change… the

revisions to the Department of Correction used to force policy that's clearly part of the Department of Justice and Legal Aid Society Nunez litigation that is going to address other ways of reducing violence in the jails. But that avoiding force training in de-escalation is all part not just of responding better to people with behavioral health needs and having a more therapeutic environment but also in reduction of violence in our jails. The creation of the program, I'm going to call it pace instead of going through the name which I can never remember is a wonderful change where instead of the caps unit that only provided this need for treatment to people who had already run afoul of the department rules we create units where people can be identified before they go through the disciplinary process and be, can be given that kind of enhanced treatment opportunity. I do think that one of the thing's it's missing from the taskforce plan is a need to improve all of the mental observation housing units not just these four special units but to recognize that we need a larger range of treatment available in the jails and that the MO units that are going to continue to

exist should have higher clinical staffing. I'm going to skip ahead to just other needs that I think are not necessarily addressed by the taskforce; improve clinical space throughout the jails is important for safe and confidential treatment to be available in the jails, integrated mental health and substance abuse treatment that's not really the model within the jails and it should be, most of the people we're talking about have multiple needs. Trauma informed care and treatment is something that needs to be emphasized in this population as well. There's a great deal of people in our jails who have substantial trauma histories. I also want to address a couple of things that there's push back on right now in particular… I'll just do the one… There's a move being considered about changing visiting procedures as part of the anti-violence agenda. And if we're talking about improving our jails and improving treatment an improving outcomes. We can't at the same time make it even harder for people to maintain their family contacts and their community contacts. The evidence is clear that those are the most important things to keep recidivism down. If anything we should be

looking at making it easier to visit, more pleasant to visit, and not so time consuming. And I'll end there and be happy to answer any questions.

CHAIRPERSON CROWLEY: Chair Lancman.

CO-CHAIRPERSON LANCMAN: Thank you. Good afternoon everyone. Thank you for coming. Thank you for sticking around and, and I know him from any of you listening to all the testimony that they proceeded you. I have some questions that each of you could answer… want to chime in and then, and then a question maybe for some of their, your particular organizations. So let's start with an issue that, that has come up with the other witnesses. And that has to do with the appropriate level of disclosure for a health assessment. So in an ideal world and, and part of the pilot project is the defendant prearrangement will get screened and have his or her mental health status assessed. What should happen with that information. Should it just go, well first of all should, should, should the defendant be asked whether or not it should be released to anyone that doesn't sound sensible. Should it be released just to the defense attorney? Should it be released to, to the courts and to the

district attorney's offices? They've got to figure this out so whatever guidance you can provide we'd love to hear it.

WILLIAM GIBNEY: We participate in… some of the recommendations here. We think defense council has a crucial role to play. Justine spoke eloquently about stigma. And it's, it's not a kind and supportive criminal justice system that we are all too often participating in. And a concern of the defense would be if, if there were just a broadly done screen that applied to everybody and then the often confidential mental health information was disclosed to all the players at the initial court appearance which after all is about release on ROR or bail that you're actually going to have worse consequences as a result of people being identified as having a mental illness in the, in the bail context.

CO-CHAIRPERSON LANCMAN: But don't you think that whether or not someone has a mental illness should be considered and whether or not bail is, is, is granted and, and there are people who… [cross-talk]

WILLIAM GIBNEY: …information here that because someone has a mental illness doesn't necessarily make them more dangerous. And I think that is the association that is the improper association that would be applied by some people. And we see that. I mean it's, it's, it's not like we're making this up. I mean I, we, in, in, I'm very familiar with the parole release process. I can tell you the stigma in that parole release process for the mentally ill. It's just incredible that their release times are so much more difficult and, and we see you know that the difficulty in, in releasing the mentally ill out of Ryker's Island that… stigma… [cross-talk]

CO-CHAIRPERSON LANCMAN: Well, well let me, let me put it in two ways. And I, I want to hear, maybe you can respond to this and whatever you wanted to say. It would seem to me as a lay person that whether or not a person has a mental illness or not would in some circumstances appropriately bear on whether or not they are a flight risk or risk to, to not return as well as an opportunity to give the, the court information that might be helpful in directing the defendant into a,

into an appropriate program. And, and then of course you have people who take pleas at arraignment.

REGINA SCHAEFER: Honestly with regard to whether or not, whether somebody has a, a mental health issue should have anything to do with bail that's set, I mean there are statutory guidelines that require you know what, what things somebody, you know you have to take into consideration when you're sitting bail. And you know the main point or the main purpose of bail is to determine if somebody's going to come back to court, period.

CO-CHAIRPERSON LANCMAN: Right.

REGINA SCHAEFER: You know yes they take into consideration the nature of the charges and the safety of the public.

CO-CHAIRPERSON LANCMAN: But only in so far as they bear on whether or not the person is going to return to court.

REGINA SCHAEFER: Exactly.

CO-CHAIRPERSON LANCMAN: So is a person's mental health status something that might bear on whether a person's going to return to court or not?

REGINA SCHAEFER: No.

CO-CHAIRPERSON LANCMAN: Okay. Why not?

REGINA SCHAEFER: You know, why not? Well first of all a person's mental health status is their own business. It's their, they're entitled to confidentiality of whatever… Let me just finish. Whatever they're… oh sorry. You know not, not whether or not they're going to come back to court. They, you could have a mental illness and you could have a lot of support at home. You could be in a facility already or you could have you know your supervised release. There's plenty of ways in which you can ensure somebody comes back to court even if they have a mental health issue. So, so for, you know and what we've said already is just…

CO-CHAIRPERSON LANCMAN: But you, but you need…

REGINA SCHAEFER: …the stigma involved.

CO-CHAIRPERSON LANCMAN: …to know that they have a mental health… If…

REGINA SCHAEFER: Well…

CO-CHAIRPERSON LANCMAN: …if someone who has a mental health issue needs some additional service…

REGINA SCHAEFER: That's why they have a lawyer. That's why we're there. We talk to the client, we meet the client, we, we know…

CO-CHAIRPERSON LANCMAN: So you would limit the disclosure to…

REGINA SCHAEFER: Absolutely.

CO-CHAIRPERSON LANCMAN: …defense council.

REGINA SCHAEFER: Yes.

CO-CHAIRPERSON LANCMAN: Okay. So now let me get, ask my second general question. And, and I ask this as, as, as a lawyer who's represented clients or their, in, in the civil setting. How do you navigate the ethical issues? Are there clear guidelines? You have a client who your, you're informed has a mental health issue. However you, you have come to learn at this point weighing you know the client's desire to get out as soon as he can knowing that if you say that there's a mental health issue the, the judge may direct some kind of, of treatment which may be in the client's best interest both as a human being as, and as someone who you know is jurying through the, the… [cross-talk] the criminal… That seems like

you've got some tough issues to, to, to think through which I don't, I don't envy.

REGINA SCHAEFER: I think the truth is is that we are all very comfortable and very used to playing that roll. It's kind of inherent in what we do. So what we have to recognize as a jumping off point is that there are, that somebody's mental health, behavioral health needs sometimes have no bearing once so ever on what brought them into the criminal justice system or what's going to happen to them once they're there. That doesn't mean that they don't necessarily need services. The truth is the vast majority of our clients who come into the criminal justice system could use something. They need connection to education services. They need connection to you know services to address addiction issues or alcohol issues, or mental health issues, or they've been evicted from their homes. And that is a much more likely factor that will lead somebody to come into the criminal justice system than some of the other ones that we've been talking about. And our job as defense attorneys and in some ways we actually discussed this a little bit at the hearing that was held on

how should we evaluate the efficacy of indigent defense services right. And we talked about housing a lot of that within an institutional provider and with the lawyer because the lawyer is not only able to, one develop relationships of trust with the client, get access to information about where they are at that moment in time, what did or did not bring them into the criminal justice system. We have access to their families and to their network of support people to get even more information to help us identify what their needs are, what their goals are, what they're capable of. And so we are constantly in the process of trying to stabilize our clients' lives. I think that the tension is that the, the, all of this focus on wanting to help people comes from such a great place. And there is a real need for the criminal justice system to shift. But there's a danger in it shifting too much and for us to get into a net widening where we look at the criminal justice system as the focal point for resolving all of the things that you know our clients struggle with when really the best place to do that is in services in the community and allow the criminal defense function to play out in that

way so that we can identify where the intersection is so where people do need to know about it, where the criminal justice system is an appropriate place to address these issues and where really the defense function can expand along with civil service providers to try to address those needs outside of the criminal justice system.

WILLIAM GIBNEY: Right. And I do think there are some…

CO-CHAIRPERSON LANCMAN: Yes.

GIBNEY issues here about getting a system that, that works. And we think a system that is non-threatening to the criminal defendant that can encourage the, the, the, the accused cooperation with a treatment system that, that, that gets the voluntary consent to, to participate in the treatment is much more likely to work, much more likely together the essential information that you're looking for at those initial assessments. But if, if, if the word is out that you know if I cooperate here I'm going to [phonetic] get punished in some way. That, that word will circulate through the defense system and I think undercut a lot of

the alternative placements that we're trying to make early on.

CO-CHAIRPERSON LANCMAN: If, have you had experiences and… I'm sure that you have and I think it came up in the, in that hearing that we had where there was a lot of conversation about wrap around services etcetera. But one of the things that was missing from the taskforce and again the first step so it's not a criticism. But how mental health issues, behavioral health issues of your clients interferes with your ability to represent them as criminal defense attorneys and whether or not the, the, the contracts that you have with, with the city provide for whatever resources would be necessary to break through that, that barrier. I mean forget helping so and so with his or her mental health problems, as mental health problems, like how do you represent someone who you know you may not be able to communicate with or to get information from etcetera etcetera.

REGINA SCHAEFER: I think that's very often the situation that arises when an attorney in the legal aid society refers a case to the defender

services program which is comprised of licensed social workers who very often are brought in to…

CO-CHAIRPERSON LANCMAN: That's the my, the NYCAP?

REGINA SCHAEFER: But, no we have map, we have NYCAP but then we have about 100 social workers, defense, defender services program. So they, and they can be brought in at any point during the case and very often that is our role is to help the attorney to navigate how to talk to their clients or to, to assess what exactly is going on with their client to contact collateral contacts family, employers, community based services that the client may be familiar with but certainly in the court setting very often we're called upon to, to, you know the client may be, may have some behavior that's of concern to the attorney and they're not really sure what to do with it or what it is because very often behavior can look like many different things. Sometimes mental health issues, sometimes not. And to be able to make that distinction so as to best represent the client when they go into court. So that is one area where we have been able to address that

although on a small scale because our, the number of attorneys that we have versus the number of social workers we have could greatly be expanded.

CO-CHAIRPERSON LANCMAN: Practical question. The map program, the misdemeanor arraignment project. How, how long does it take to, to do that assessment through your, you've got a social worker there in the court…

REGINA SCHAEFER: Right.

CO-CHAIRPERSON LANCMAN: And, and they do the assessment. How long does that, does that take , does that interfere with the, with the flow of the…

REGINA SCHAEFER: Sometimes it infers with the flow very often a judge will give us a second call if they know the social worker's there to, to assess the situation and, and try to get enough information to explain and provide the court with information or the attorney with information about what things can be done at that particular moment.

CO-CHAIRPERSON LANCMAN: And how does the social worker know, does the social worker talk to every single defendant or the social worker you

know kind of has an instinct that so this, this person, I need a close look.

REGINA SCHAEFER: So our social workers are physically in the court house for their entries, for the entire shift, the arraignment shift. We've trained our attorneys pretty extensively on what information or what they see may be a, you know red flags for them that they should bring the social worker in. There are other scenarios where the social worker will go through the cases that we're about to arraign to see what kind of information. When we have clients who are repeatedly arrested for jumping a turnstile or for urinating in you know housing complexes and, and there's a number of, a high number of misdemeanor arrests over a short period of time or maybe they just came from the hospital or maybe we know they're on medication or maybe they're behavior just warrants based on the attorney's gut or sometimes other court personnel's gut that can we have somebody take a look at him or her.

CO-CHAIRPERSON LANCMAN: So you find, you find some things there, the social worker finds something's there. What are they, they don't just

sit on that information. They share it with the, the, the attorneys who's there.

REGINA SCHAEFER: Right.

CO-CHAIRPERSON LANCMAN: And, and, and then, and then that turns into what, what you're asking for in terms of a bail decision or what you're willing to accept or not accept in terms of a plea decision?

REGINA SCHAEFER: If I could give you an example…

CO-CHAIRPERSON LANCMAN: Sure.

REGINA SCHAEFER: …we may have a, a person who comes into court and is being arraigned for a low level misdemeanor offense, being charged with that and there is something that alerts the attorney whether it be behavior or something in the, in the file. And he has the, he or she has the social worker come and meet with the clients. And the social worker may learn that the client was living in supportive housing in the community because he or she has a long history of mental health issues that, but he, he or she has that connection and we want to get the client back to that supportive housing situation. And so the

social worker will call the supportive housing facility or agency and call it, you know make the connection with an individual to confirm that information. Sometimes we have them come to court in the hopes that they can you know present to the court that this person has a connection to the community and that he or she may be a, you know a low risk flight, risk of flight because they do have connections to the community, who may have family members and make connections to the vis-a-vi phone calls at that moment right in the middle of arraignments you know based either on a second call or before the case was called so that we can present to the court those connections that the individual has and speak to the application to, to…

CO-CHAIRPERSON LANCMAN: Yeah… but that, that's not really a mental health issue or mental health assessment. I mean you might as well just have someone in the court who can ask where do you live, what's your housing situation…

REGINA SCHAEFER: Mm-hmm.

CO-CHAIRPERSON LANCMAN: Alright that's not a, you, you…

REGINA SCHAEFER: …certainly are…

CO-CHAIRPERSON LANCMAN: …found out about their housing situation and their connection to community.

REGINA SCHAEFER: Right.

CO-CHAIRPERSON LANCMAN: …an inquiry about their, their mental health.

REGINA SCHAEFER: But we do more than just an inquiry on mental health…

CO-CHAIRPERSON LANCMAN: Yeah… you know you're assessment right…

REGINA SCHAEFER: …I mean sometimes we use tools and you know to, to identify if there is, is, have they, do they have any substance abuse history? Have they ever been, do they see a psychiatrist? Do they have medications? What are the names of the medications. But sometimes you'll have somebody who'll have medication in their pocket. I mean it's, there's a number of different questions that are asked. Is, it's certainly not a as was indicated earlier that a real, really quality extensive mental health assessment is going to take a significant amount of time. But we touch on the mental health piece to identify what may be

going on. And that may include questions about their functioning and their history etcetera.

CO-CHAIRPERSON LANCMAN: At, at, at some point shouldn't this be made known to the, to, to the judge?

REGINA SCHAEFER: Sometimes it, it should be and sometimes it shouldn't be right? If it's going to affect the outcome of the disposition in some way you know many many times you know we'll get the information regarding our clients and regarding whether there's a mental health issue or not or to what extent there's a mental health issue. You know we will then you know go an use our resources to find or connect them with some kind of a program on the outside or whatever it is right. And you know there, there's also the use of the treatment courts already in play right in the courthouse. So you know if you identify that your client is suffering from a particular issue you know you'll go to the district attorney's office so you'll go to the judge and say look you know I, I'd, I'd like to have this case get put into the diversion part. And then you'll specify whatever part you want right? Then when you get there you'll

say you know listen my client doesn't really need to be in jail. My client really needs this kind of a service or whatever it is and then a lot of times that's how you dispose of a case where they'll be a, an identified program of some kind right where they'll be an identified part, courtroom, you know the treatment part. You'll go there. Sometimes the client will take a plea that's conditioned on their completing this program or getting this service or whatever it is. And then the case is monitored. The client will come back to court a couple of times depending on what it is, how long it is. And then once they successfully complete then you come back into court and you as the attorney say they completed, they this, they that, and then you know however it was that you've bargained. You know they'll either reduce the case from a felony to a misdemeanor or a misdemeanor to a violation or they'll dismiss the case outright but you know I think that you know you, these are very very sensitive issues for personally right, the person who actually suffers from the mental disorder. There are also while it's wonderful that everybody wants to help. You know the reality is though

they're there in court charged with a crime. So you know… And sometimes that, you know the crime that has them facing a lot of time in jail right. And so you know they get a lawyer for a reason. And it's to help them navigate you know through the criminal justice system as a lawyer you know you're of course the first thing you're thinking about is their case and their legal issues and how you know to deal with that. But then at the same time you know as, as my you know colleagues are saying as part of our job as public defenders and with the, with the population that we work with on a day to day basis. You know part of your job is to not only try to keep them out of the system or get them out of jail or get them out of their, you know the court you know calendar or whatever right but it's to prevent them from coming back. So you know that's part of what we do every day. You know we try to you know get them into whatever services in the community. We also have social workers. That's why we all have…

CHAIRPERSON CROWLEY: I just, sorry don't want to cut you off but we have four more panels. Co-chair?

CO-CHAIRPERSON LANCMAN: Thank you very much.

REGINA SCHAEFER: Can we just… one other…

UNIDENTIFIED FEMALE: I just, can I just respond to it very, just very briefly to your last question? I think that it, it's totally understandable. There are all these categories of information that people want to know. The question is whether or not that category of information is over inclusive in a way that is not indicative of rights of return. And the CJA studies show that 93 percent of all people return to court either on their court date or within 30 days on their own voluntarily of their court dates. So the slice we're talking about is a really small slice of people who don't come back to court. And the CJA sheet is very well tailored to the predictive qualities of what makes somebody come back to court. Wouldn't we like to know along the same vain whether or not somebody is an alcoholic. Wouldn't we like to know whether or not they suffer from drug addiction because maybe in our minds we think that, that sends a message that they might not be

stable enough to come back to court. But what you're in danger of is incredible over inclusiveness and net widening where we assume because somebody has an addiction, because somebody has a mental illness that therefore they are unstable and won't come back to court and that's just not a correlation I think we can be making in the criminal justice system.

CHAIRPERSON CROWLEY: Thank you co-chair.

CO-CHAIRPERSON LANCMAN: Thank you.

CHAIRPERSON CROWLEY: Thank you to the panel.

[cross-talk]

CHAIRPERSON CROWLEY: Next we have from the Fortune Society Barry Campbell, Greenburger Center Cheryl Roberts, Day One Andrew Santana, Lynn Kaplan from LifeNet, Jamin Sewell from the Coalition of Behavioral Health, and Mary Beth Anderson from the Urban Justice Center. If you could… order that you were called please.

BARRY CAMPBELL: My name is Barry Campbell. I'm here testifying today on behalf of the Fortune Society but first I would like to thank

the various members of the committee for allowing us to testify today. I have about five pages of testimony but I'm not even going to begin to go through all of them. A lot of the points have already been made. I just want to pint out one very important part. Someone sitting on one of the previous panels mentioned something about stigma. There's also subcultures thriving in the Department of Corrections and the police department and the mental health field that a lot of the individuals that when they come into these social service agencies or when they come in contact with these criminal justice agencies they don't divulge a lot of the information that they have because of the way that they're going to be treated once that information comes out I will say this that there's a culture that needs to be addressed in each one of these departments on how they handle the formerly incarcerated the individuals with mental health and the way that they deal with these individuals from the police department to the Department of Corrections even from the DOHMH. A lot of these individuals when you have a conversation with them let me just say that I've been with fortune society

well over 20 some odd years and I've been working with this population ever since then. What happens is is when a lot of these individuals come in contact with these agencies that are supposed to support them or provide them with service. They're literally treated like dirt or gum on the bottom of somebody's shoe. That within itself is discouraging to an individual who's supposed to be reaching out for help to one of these agencies whether it's a criminal justice agency or a mental health agency it really doesn't matter what agency it is if you don't start out from the subset of, of thinking about the individuals that come through your door as human beings, not as somebody's who's formerly incarcerate, not as somebody who's a convict, not as somebody who's, who has behavioral health issues. You need to look at them as a human being so there's a culture that needs to be changed first of all. I understand that it's great that we want to put all of these policies in place but if you still have the same culture that's delivering all of these policies that you're changing you're going to pretty much get the same results. People don't want to walk into a place where they're treated

like the gum on the bottom of somebody's shoe. Nobody wants to be treated that way. Nobody wants to extend themselves and say I need help if they have to deal with stigma or a way that a certain individual feels about their population or the way a certain individual feels about the way this person has conducted themselves in the past. I myself am formerly incarcerated. I did two and a half to five in state prison. I've changed my life completely around. But if you ask somebody how was Barry Campbell in 1989 they'll tell you I was the gum at the bottom of their shoe. Thank you for your time.

CHERYL ROBERTS: Thank you for this opportunity to testify today. I'm Sheryl Roberts. I'm the Executive Director of the Greenburger Center for Social and Criminal Justice. For the last 18 months the Greenburger Center has been developing a, an alternative to incarceration for those with serious mental illness who have committed felony level crimes and are not otherwise eligible for community based ATIs because they present a risk to themselves or society such that a DA or a judge would be unwilling to divert them to

community based ATI. We've been developing this model because of an experience Mr. Greenburger had with his oldest son who has suffered from mental illness since he was about four years old. While he was involved with his felony level cases within the Manhattan DA's office one of the ADAs said if you could find a secure locked facility where your son could receive treatment we would consider diverting him. Mr. Greenburger searched for this facility and found that it didn't exist or New York City or the state or the country. And so unfortunately his son took a plead of five years as upstate in prison and Mr. Greenburger decided to create an alternative so that other New Yorkers would have an option who found themselves in a similar situation. Our alternative would provide residential treatment for up to two years and a therapeutic like environment which would provide restorative justice, balance reduction, and other programs. It would be supplemented by a clinic to provide a therapeutic Medicaid like reimbursable services. All of this will be provided in a secure environment maintained by the Greenburger Center. We've gotten a lot of support for this proposal. You'll see in your

packet letters from DA Vance, DA Thomson, DA Brown, Judge Marks, Judge Demmick, Obis, Isias, Serita, and others. So a lot of folks who are dealing with these, this population think that a secure facility is needed. Unfortunately the taskforce did not include this population nor did they support or at least include this option in it. We hold out hope that the administration will come around. Ms. Marsik has indicated that this is only a start and is open to our ATI. We have also a letter from Liz Glazer in our packet for you. We're looking to the council to, to follow the tradition of supporting pilots and innovative programs. So we're hoping that you will fund us along with our fiscal partner, the Fortune Society to Develop this much needed and one of a kind ATI. Thank you.

ANDREW SANTANA: Hi, good afternoon. My name is Andrew Santana. I'm the Supervising Attorney at Day One. I wanted to thank everyone here for holding this really important hearing. Day One is the only organization in New York that devotes all its resources towards ending the issue of dating violence for young people age 24 and under through a combination of services that

include prevention, direct services, and innovation we seek to create a world without dating violence. So that's things like workshops in schools, direct legal services for young people and community organizing services. So why are we here at this panel. It' because through these lenses we recognize that the end of dating violence requires a critical analysis of the role that the criminal justice system plays in the lives of the survivors we serve, their abusive partners and within their communities particularly as this applies to mental illness. While we believe that abusive behavior is a choice we appreciate and must understand that the context, motivation, and impact of that behavior particularly through analysis of behavioral health and mental health plays an important role. To be clear our clients are often the young survivors who are calling the police and they're often the complaining witness in criminal cases. They may call the police to file a police report. And although their primary goal is often for the violence to stop they believe often that their partners need help and that the resources that they tried prior haven't worked. And while that, they

keep that in mind because these are people with whom they've had intimate relationships they don't want their partners to be treated disrespectfully, unfairly through that, through that system. For our survivors who believe that their partners have behavioral health and mental health issues we recognize that if we want a long term solution proper resources need to be in place. And so for example for a young person who is being stalked relentlessly despite court involvement that young person will remain at risk if the system doesn't incorporate possible mental health analysis and treatment. And we know that this is hard because we know that suspicion and scrutiny about mental health and the stigma attached to it make young people particularly reluctant to disclose mental health issues as they arise. We know that for our clients even with an order of protection we know that these resources for both survivors and abusive partners cannot be only punitive in nature. And so for example a survivor seeking child support knows that her family's needs aren't met when her abusive long term partner's, an abusive partner's capacity of financial aid support his child is compromised

by untreated mental illness or incarceration. Her family's needs are not met when she fears that her ex partner's experience of mental health will reduce his ability to build a healthy emotional relationship with his child during parenting time or visitation. We believe that these, this issue requires a bigger broader and long term solution that requires appropriate institutional and creative responses and we hope that folks who are doing this work recognize that for adolescents the criminal justice system might not be the appropriate response when mental health issues are important. Thank you.

LYNN KAPLAN: Chair Crowley, distinguished committee chairs, and members of the committee thank you for giving me the opportunity to testify before you today on the behavioral health and criminal justice system, the New York City's action plan. My name is Lynn Kaplan and I'm the Life Net Project Director at the Mental Health Association of NYC. LifeNet operated by MHA of NYC since 1996 through a contract with the New York City Department of Health and Mental Hygiene is New York's only 24/7/365 nationally accredited

multilingual mental health information and referral support and crisis and suicide prevention hotline. Life Net is a single point of access for New York City's mobile crisis teams. Life Net also responds to calls from call boxes and all major bridges in the New York City metropolitan area to allow people contemplating suicide on area bridges to connect directly with the council in their hour of need. Life Net recognizes one of our nation's leading crisis hotlines and has helped shape the national model for crisis hotline collaboration with 9-1-1 and emergency services. New Yorkers culling life net are connected with culturally sensitive multi-lingual trained behavioral health professionals who provide person centered culturally competent service and connect callers to appropriate mental health interventions within the broad continuum of care including crisis services and suicide prevention resources. MHANYC commends NYC for developing a comprehensive ambitious strategy to divert people with behavioral health issues into treatment when appropriate and to ensure that justice involved individuals with behavioral health needs are connected to carrot every point in the

criminal justice process. MHANYC is supportive of the recommendations that have been set forth in the action plan which will help to ensure that we appropriately address the behavioral health issues that have led many into contact with the criminal justice system in the first place. MHANYC is eager to serve as a collaborative partner as NYC continues to put these recommendations into action. Through Life et as well as through various policy and public education initiatives MHANYC has maintained a long history of collaborating with public and private partners including the New York police department in connecting community members to the level of care that most appropriately meets their need. To this end Life Net has remained continually involved in training NYC Sergeants and cadets on mental health crisis and management of emotionally disturbed persons. These training initiatives reinforce the use of life net as a free resource that the police can offer when responding to individuals in need of mental healthcare. MHANYC and Life Net are also committed to collaborating with key partners on newly formed strategies such as crisis intervention teams. We also look forward

to integrating newly developed resources including the community based drop off centers into the continuum of services to which we're able to connect individuals in order to help ensure every New Yorker is able to access the most appropriate level of care which best promotes his or her health, wellness, and recovery. On behalf of my colleagues at the mental health association I would like to thank you all for your attention to the intersection of behavioral health issues with the criminal justice system and for the opportunity to speak before you today.

JAMIN SEWELL: Good afternoon Chairs Crowley, Cohen, and Lancman. Thank you for the opportunity to testify here today. I'm Jaymen Sewell. I'm the Council Managing Director for Policy and Advocacy for the Coalition of Behavioral Health Agencies. The coalition is the umbrella advocacy organization of New York's behavioral health community representing 130 nonprofit community based behavioral health and when we say behavioral health we mean mental health and substance abuse disorder treatment agencies and we serve, our agencies serve more than 350 thousand

clients consumers throughout New York. Our member agencies are the on the ground frontline safety net providers retreat some of the most needy individuals including those with duel diagnosis of mental health and substance abuse problems. Our providers serve the homeless and the formerly incarcerated as well as victims of trauma and abuse. The agencies we represent are in every council district and neighborhood in the city. On behalf of our CEO Phillip Superior who regrets that he cannot attend today and the coalition board I'd like to thank you for the opportunity to speak on the mayor's behavioral health and criminal justice plan. In full disclosure Mr. Superior and I both served on work groups that were charged with developing recommendations for the action plan. The process was fairly inclusive with many different stakeholders in the government and provider sectors represented. It could have benefitted from more participation from formerly incarcerated individuals with mental health injuries, histories, although my work group did have a family member of an individual, of an individual participating. The coalition firmly supports the recommendations of

the taskforce that are presented in the action plan. Specifically we strongly advocate for the following approaches recommended in order to reduce the number of incarcerated people with behavioral health issues from the jail population including diversion to appropriate care settings for people with mental illness that commit low level nonviolent crimes, proving therapeutic treatment rather than punitive treatment if such individuals are in fact incarcerated, and ensuring that individuals are connected to services upon release. It appears that the mayor's executive budget begins to fund the implementation of the action planned. For example there's 1.7 million for mental health and substance abuse programming for all youth at Ryker's Island. The process of treating individuals… [beeping] Okay. I just wanted to say last year Council Member Debbie Rose promoted a new funding initiative providing mental health services to you, to court involved youth. That has been very successful. And I, we would like you to consider restoring that initiative at the, in the coming budget. Thank you.

MARY BETH ANDERSON: Good afternoon. And thank you to the chairs and the council members that are still here. I wish that Council Member Lancman was still here because he would probably get better answers on the defense oriented questions from me. I was 23 years a defense lawyer, spent most of that time working with people with serious mental illness and have advised hundreds and hundreds of lawyers on how to deal with the very difficult ethical issues but he's my council member so I'll write him a letter. I'm Mary Beth Anderson. I'm the Director of the Urban Justice Center Mental Health Project. We are a legal services organization. We monitor the Brad H. litigation as we were one of the lead plaintiff's council. I think one of the things that has been missing from today's hearing is the opportunity that the pre-diversion element of the work plan has to send a true recovery message to people with mental health issues. People access mental health treatment better and more effectively in the community than they do in jail or prison setting. And the pre diversion option is a great opportunity for people to be able to get that community leg up

and, and I find that in my practice when I've met people who are just developing a mental health problem and I'm able to get them out of the criminal justice system and into community based treatment they do far better. We at the Urban Justice Center are really thrilled about the developments of the pre-diversion, pre-booking diversion programs. We're also exceedingly grateful of that crisis intervention teams are going to take place both t the NYPD as a pilot and then also in, within the corrections environment. We hope that the training includes cross disciplinary training where law enforcement and mental health providers have the opportunity to learn from each other especially because law enforcement needs to know about mental health and mental health providers need to know about the concerns of law enforcement. We agree with Sarah Kerr of the legal aid society that there need to be more mental health units, pace units should be available for anyone with a mental health issue. And, and we encourage the city to create more of those units. We must say that it, the city still is, we're very sad to say not complying in any significant way with the Brad H.

litigation it, this settlement happened in 2003 and the, it's been, monitoring has been extended over and over and over. Reforms have to be made in different processes to better help people with their… could I just have one more minute to better help people with their discharge planning. People leave without active Medicaid, the suspension of Medicaid has made the problem worse. People leave without essential identity documents and then don't have the wherewithal to get them often or to ashamed to ask for help. People who are homeless upon entry into the jails generally leave homeless and people have a very difficult time accessing supportive housing 120 plus 267 beds is like a drop of water in the ocean for people with mental illness who end up with criminal justice involvement. There need to be more beds put together for this population. And I really encourage people to try to send a recovery message, not a management message. We really want people with mental illness can and do recover. Some people have greater measures of recover, of recovery than others. And we should be working to try to maximize that recovery message. Thank you very much.

CHAIRPERSON CROWLEY: Okay we're going to call up the next panel. Thank you for your testimony everyone who has just testified. Sandra Mitchell from the Community Access and National Action Center, Carla Rabinowitz [sp?] Community Action, Community Access, we have Matsey Richard, and from M, MFY legal services we have Diana Luck.

SANDRA MITCHELL: Good afternoon City Council Members Crowley, Gibson, Lancman, and Cohen. Good afternoon to all council persons still in attendance and to all those present in the audience. I want to thank you for the opportunity to testify in reference to the importance of the CCIT in New York City. My name is Sandra Mitchell. I am a Peer Service Provider of Mental Health Behavior Substance Abuse Services and also trained in crisis and trauma informed care. I'm also trained by the state for safety for mental health service providers in the community and I'm the chairperson of the Disability Committee at the National Action Network. I'm also a member of the Community Crisis Intervention Team Spearheaded by Community Access where Steve Coh [sp?] is the Director and Carla Rabinowitz at my right is the

community organizer. I want to just give you a personal testimony of it, something that I witnessed in the spring of 2014 I was returning from warship services and it was about 2:30 p.m. and I was waiting for the northbound Lennox avenue bus on 125th street near Starbucks I witnessed a police officer engaged with an African American Male who was seemingly demonstrating signs of mental health disorder, the individuals cursing, talking to himself, and responding to internal stimulation perhaps hearing voices and was spitting on the ground. The police officer ordered the individual to move on, leave the area, and the individual continued to curse, spit, but slowly started to move on. The officer then pepper sprayed the man. The man then stepped, faced the officer, wiped the pepper spray from his eyes, and ask what did you do that for. I think the officer panicked and so he'll, he asked for backup. More than 12 officers came in police cars and swat team vans and the police captain arrived, ordered everyone to clear the area and tapered the man, and tapered the man. Before the taser-ing the man did step away, he clutched his hands in prayer and was sinking to the

ground but he was tapered and handcuffed and dragged away like a piece of meat. The bystanders in the community were incensed. Two people were filming with their cell phones, they were ordered to get away and it was just pandemonium then. I want to say that if a specially trained CCI team would have been deployed and, and a peer provider of the CCI team would have been riding with the backup that responded to the original officer's called I'm certain that the outcome would have been much more helpful to this man than him being traumatized, pepper sprayed, tapered, and handcuffed, and dragged away with creation of the volunteer diversion drop off centers a person like this particular man could receive immediate and mental health assessment counselling, health screening, referral to community based services like housing, public assistance, food stamps, you know it. In closing if I could just have a few seconds the pre-diversion option with more people would want to voluntarily say I do need help, I do need mental health services, I am homeless, and New York City would be a safer place to live. Thank you.

CARLA RABINOWITZ: Can you hear me? Yeah? Okay. Hi, I'm Carla. I'm the organizer at Community Access. Community Access is a 40 year old non-profit that empowers mental health recipients by providing quality housing, employment training, and other stuff. I also coordinate CCITNYC which is Communities for Crisis Intervention Teams. We're excited about the mayor's plan. We support it. We've been on the taskforce. CCITNYC seeks to implement training so police who have a tough job can identify a mental health recipient and respond in a way that the escalades crisis and keeps the mental health recipients at a prison. We're thankful the mayor has embraced our vision. Basically a CIT is just a method of policing that provides officers with the tools they need to respond to incidents involving people in emotional crisis. CCIT does require coordination between the police, the public health system, and the mental health community. Why do we need CITs? Because NYPD responds to 150 thousand calls, EDP calls per year. And today according to the NYPD the ordinary officers receive not one hour of training on how to respond to these calls. There's 300 specially

trained officers that gets one day of training but the regular officers get not one hour of training. So what happens? A family member or a housing agency like us calls 9-1-1 if the person is in crisis. Police show up and go into what they're taught which is command and control proving police are in control. Police may start shouting commands at people. So right away the encounter escalates and the person who is in crisis becomes more upset. Sometimes these encounters result in serious injuries or earth of EDPs or officers and sometimes they just result in unnecessary arrests. There are also financial cost of not having a CIT. If you think about it last year New York City set aside 674 million for claims against New York City. Do you know a third of all those claims were against NYPD for police misconduct, civil rights, it's a lot of money. Just one killing could cost a lot of money. We're the benefits of CIT. For the officers less time in between calls. So Chicago reduced their time from eight hour to 30 minutes picking up the person and dropping them off. Fewer injuries to police and mental health recipients and police improve perception of police by mental health

recipients and staff at mental health agencies we really need to know we can call 9-1-1. Law enforcement will have a better view of mental health leaders and they will have better confidence when working with a person who's an EDP. It'll be much better positive media relations for the NYPD and the mayor. We're only, we're the only one of the seven largest cities in the USA without a CIT program. They'll be few arrests and more diversions. CITs are a win win for police, mental health community, and the general public. I'm so excited that Mayor de Blasio and Commissioner Bratton have embraced training of police and interactions with the mental health community leaders and we hope you do fund their plan. Thank you.

Hello. I didn't prepare a speech. I'm speaking from the heart. I'm mentally ill. I'm the story of recovery. We need services for the people. We need programs for the people. We need CITs. We need, I can't stress enough the port is a proper… of new, NYCPD for CITs so they know when a consumers decompensated. They know how to properly act when that person calls 9-1-1. If he picks up a

brush it doesn't mean a cop's going to pull out his gun. We need proper training for the police and for the CITs. I'm not going to speak that long because I, like I said I… say more than please help us. …been fighting a long time for this situation for the CITs. I, it's what an organization call… ability to… to the lack of funding we don't exist anymore. But… Carla Rabinowitz and the community access gives me the position and the platform to get back on and speak once again about the CITs. Thank you.

DIANA LUCK: Hi. My name is Diana Luck. I'm a senior staff attorney at MFY's Mental Health Law Project. The Mental Health Law Project works with New Yorkers with severe and persistent mental illness primarily to keep them stably housed in the community by preventing eviction from housing that they are already living in. Since we're not a criminal legal services provider I'm going to speak just briefly on a civil issue which is the crisis in safe and affordable housing for people with entail illness. The task, the action plan speaks briefly about housing in the return to community section and talks about the provision of 267 beds

which as urban justice center said is a drop in the bucket. Housing is central for stability and recovery for people with mental illness and unnecessary arrest and pretrial detainment greatly increases the risk of the loss of housing for people who are currently living in stabile housing because incarceration interrupts employment and benefits and tenants are not able to defend themselves in housing court if they are in jail. But more importantly for the significant number of people with mental illness who are homeless or in transient forms of housing their precarious housing situation contributes to instability which in turn increases interaction with the criminal justice system. So while MFY support the action plan we're concerned that the proposal such as diverting people from incarceration and ensuring Medicaid coverage are insufficient to prevent further criminal justice interactions if they simply remain homeless or in unstable housing once they're discharged from jail or prison. To that end we propose a few recommendations that are, are not included in the action plan around housing, first to create a rental subsidy through the human

resources administration that would be similar to FEPS [phonetic] and HASSA [phonetic] for people with mental illness in order to increase their ability to obtain and maintain housing and, in the community, to continue to lobby the state to increase its commitment to New York, New York Four Agreement to provide, to build additional supportive housing units in the city. And finally to lift the ban on single room occupancy construction which can provide stabile housing to low income single adults. The city has lost about 150 thousand SRO units since the ban on SRO housing was passed. And that's housing that hasn't been replaced by another affordable stabile model. Thank you.

CHAIRPERSON CROWLEY: Our last panel Richard Matsey, Randolph McGlocklin Esquire, Yul-San Liem, and Howa Bah. Alright if you could begin your testimony in the order in which you were called up that would be helpful.

RICHARD MATSEY: Thank you. Thanks for having me. My name is Richard Matsey. I came here not representing any organization and not representing any group that' going to ask you for

funding. Oddly enough I, I came to offer my help. The papers that I brought I'm not going to go through them. I'm going to leave them with you for you to go over. Because you've got a problem, you've got a crisis in New York. I spent 22 years working on Ryker's Island as Counsellor for the inmates. Now you can't see my Ryker's Island from here. As a matter of fact you can go there on a tour and you still won't see Ryker's Island because we were very skillful at hiding it from you. That was our job. It was you, when you came it was called the dog and pony show and it was our job to prepare everything so that it would look good for your appearance and your approval. You don't know what's going on on Ryker's Island because they won't tell you. The commissioner that you have there now, Mr.… I believe is a good man. But they're going to hide it from him too. There's a culture there that's got to be hidden. And what I'm going to offer you is, is, is the contact with me… we can have, start running a CIA. You get in touch of me… question and I'll let you know what's really going on. Now here's where the problem really is. Whatever you have on Ryker's Island you're going to

get on the streets of New York. Eventually they all come back. And they go all over the place. Don't just think that they're going to be in, in those seven zip codes that we get most of them from. They're going to be everywhere. And what happens while they're on Ryker's Island is very significant as to how they're going to be when they come back here to live with you. You know I've been sending you promotional material for my, my reentry program and you recognize it because it has the logo of the twin towers and I'm sure you've seen it. You'll get some more.

CHAIRPERSON CROWLEY: Thank you sir. I'm sorry to cut you off there but we're finished with the three minutes that we allotted you.

RICHARD MATSEY: Oh. Can I touch on the mental health? It's very important.

CHAIRPERSON CROWLEY: How long are you going to…

RICHARD MATSEY: Just a second. The lady who was here who was referring to ignorance about mental health… let me tell you where it starts. It starts with the mental health practitioners. It starts with the DSM five. The diagnosis and

statistical manual that they are using to diagnose the problems of the inmates on Ryker's Island isn't working. Because when you are incarcerated you could have the same malady… [cross-talk]

CHAIRPERSON CROWLEY: Sir is that in your testimony, the written testimony…

RICHARD MATSEY: Yes it…

CHAIRPERSON CROWLEY: …will, it will be submitted for the record.

RICHARD MATSEY: There's a page here for mental health.

CHAIRPERSON CROWLEY: Good.

RICHARD MATSEY: Yes, okay. Thank you very much but…

CHAIRPERSON CROWLEY: Alright and we have your contact information so…

RICHARD MATSEY: Contact me if you have any questions about what, what's going on and what's not…

CHAIRPERSON CROWLEY: Thank you.

RICHARD MATSEY: …going on on Ryker's Island I'll let you know.

CHAIRPERSON CROWLEY: Okay thank you.

RICHARD MATSEY: Okay.

HOWA BAH: Good afternoon. My name is Howa Bah. I am the… who give me a great pair. He was, he was a student in Bronx Community college. He was, he had never committed a crime in him life. NYPD officer took him from me on September 25th, 2012. Mohamad was sick and I know he need help. I call 9-1-1 to get him an ambulance to take him to the hospital. The police came and he stand standing of… they… to him like a criminal… [speaking foreign language]

RANDOLPH MCGLOCKLIN: She's asking me to finish her testimony if I may. I'm, My name is Randolph McGlocklin and I represent Ms. Bah and the state of Mahammad… the police knew that Mahammad was not well when they responded to the call. Instead of addressing Mohamad with care the police violently escalated the situation. They should have allowed Mrs. Bah to speak with her son and help her to get him to open his apartment door. Instead they refused her help, broke down his door, and hot and killed him in his own arm. None of the officers responsible for Mrs. Bah's son's death have ever been held accountable by the NY, by the DA's Office, by NYPD, or by the federal prosecutors.

There are far too many other family members and, mothers who have lost their loved ones and there's almost never been an accountability for the injustices that have been done to these families. And there's a conflict of interest with respect to criminal prosecutions when district attorneys are asked to prosecute the very police departments that we work with on a daily basis. That's why we've been asking for an independent prosecutor to handle these cases. Interestingly in Baltimore the police are now asking for that when they've been edited by the local DA. But that's a side issue. There's another pressing issue that Mrs. Bah's story raises. And that is the NYPD's failure to institute policies and practices designed at helping emotionally distressed persons when they're confronted with them in the streets. We're pleased to see or hear today that the Mayor's Office has opted and Commissioner Bratton a pilot EDP CIT program. If that program had been in place when the police came to Mr. Ba's door maybe he would be alive today. And there are too many instances, I won't go over them where this situation has happened. So we strongly urge the council to back

the CIT program and not just a pilot but across the board for more lives aren't lost because of ignorance and fear.

YUL-SAN LIAM: Thank you for the opportunity to testify today. My name is Yosan Liam. I'm the co-director of the Justice Committee which is an organization that does a lot of work to support families and mothers who have lost loved ones to the police. My comments will focus also on the NYPD's interactions with people with psychological disabilities or people who are in distress. I want to begin by telling you a story of another person Imam Morales who was a 35 year old Porta Rican man. He was a loving son who helped his low income mother secure an apartment on Roosevelt Island. He was a caring brother who helped his younger siblings with school and job applications and was a human being who struggled on a daily basis and overcame the challenges of his mental illness. On November 24th 2008 Imam was having a bad reaction to new medication. His mother like Ms. Bah wanted to get him help. She called 9-1-1. The NYPD responded and they escalated the situation. Eventually Imam fled out his window. He was tapered

by NYPD Officer Nicholas Marchasona [sp?] while he was elevated on an awning. This is against NYPD protocol. There are, protocol states there should be airbags below. He was tapered anyway. He fell on his head. He was immobilized. He fell on his head and died. Some other names Louise Bias [sp?], Eleanor Bumpers [sp?], Gideon Bush [sp?], Callao Coppin [sp?], Shades Francis [sp?], Mohammad Bah [sp?], Rexford Daswreth [sp?]. These are all names of human beings who like Yemon needed care and instead were killed by the NYPD. Addressing the NYPD's use of excessive and too often deadly force should be an overall priority and in particular attention should be paid to the department's long history of disrespect and blatant dehumanization of those with disability and those who are in distress. We must treat and emotional and mental health concerns correctly. Disability should not be criminalized. It's extremely problematic to assume that the NYPD with its tendency to shoot first and ask questions later will respond appropriately in these situations. For this reason we also support the CIT model. The other piece I want to touch on though is that there has to be accountability for

police officers when there is misconduct and abuse particularly when it targets those who have increased vulnerability. For example with people with psychological disabilities. Lack of accountability contributes to a culture within the NYPD that allows officers to act as though they are above the law. What that means for some New Yorkers, low income people of color and EDPs for example is that the presence of NYPD officers does not mean greater safety. It means danger. In, internally the department must develop a comprehensive accountability system that includes clear consequences for misconduct and excessive, excessive force especially when interacting with emotionally disturbed persons and to rectify this systemic conflict of interest when, that district attorneys have we ned a special prosecutor to handle these cases and for this reason we're asking the council to support families who have lost loved ones in calling on the governor to sign an executive order for a special prosecutor. Thank you.

CHAIRPERSON CROWLEY: Thank you for your testimony. This concludes the hearing of Fire

Criminal Justice, Public Safety, Mental Health, and Courts hearing of May 12th, 2015.

[gavel]

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date May 21, 2015