# Prisons and Jails: Hospitals of Last Resort

## The Need for Diversion and Discharge Planning for Incarcerated People with Mental Illness in New York

**By Heather Barr**

The Correctional Association of New York is a non-profit policy analysis and advocacy organization that focuses on criminal justice and prison issues. It is the only private entity in New York State with legislative authority to visit prisons and report its findings to policy makers and the public. The Urban Justice Center (formerly the Legal Action Center for the Homeless) is a not-for-profit agency which works on behalf of poor and marginalized New Yorkers through a combination of direct representation, systemic advocacy, community organizing and education. The agency houses five projects which, respectively, work for and with: the homeless and the marginally housed, poor people with mental illness, survivors of domestic violence, lesbian and gay youth, and welfare applicants and recipients. Heather Barr is a Soros Justice Fellow and an attorney with the Urban Justice Center's Mental Health Project. She advocates on behalf of people with mental illness in New York's criminal justice system. 

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Gail B. Allen, M.D., Director of Substance Abuse Services, St. Luke's Roosevelt Hospital*
Nahama Broner, Ph.D., Research Director, NYU/SAMHSA Jail Diversion Research Project
Ralph S. Brown, Jr., Esq., Chair of the Correctional Association Prison Visiting Committee*
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Constance P. Carden, Esq., Supervising Attorney, New York Legal Assistance Group*
Michelle Des Roches, CSW, Program Director, Times Square Consortium Outreach Team
Carol Bernstein Ferry, Correctional Association board member
John Gresham, Esq., Senior Litigation Counsel, New York Lawyers for the Public Interest
Patrice Kanada, Research Associate, Center on Crime, Communities and Culture
Stacy Lamon, Ph.D., Criminal Justice Consultant to the New York City Commissioner of

Mental Health
Dori Lewis, Esq., Senior Supervising Attorney, Legal Aid Society -- Prisoners' Rights Project Trish Marsik, CSW, Facility Director, Citizen's Advice Bureau -- The Living Room
Evelyn Mielke, Core Member, NAMI-NYC Metro Criminal Justice Support Group
Marjorie Rock, Dr.PH, Associate Professor, NYU School of Social Work
James D. Silbert, Esq., Silbert, Hiller & Sena, LLP*
Barbara H. Stanton, Center for Human Environments, CUNY*

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# EXECUTIVE SUMMARY

Have jails and prisons replaced hospitals for New Yorkers with mental illness? Increasingly, theanswer is yes. Deinstitutionalization and the closing of psychiatric hospitals, the rise of managed care, the growth of prisons and jails, and punishment of "quality of life" crimes have contributed to the incarceration of thousands of people with mental illness in New York City and New York State. This paper examines the scope of the problem and recommends strategies which, if implemented, would lead to a far more humane and sensible system. In such a system, seriously mentally ill minor offenders would be diverted to treatment rather than sent to jail, and prisoners requiring mental health services would be able to continue their treatment as they moved between correctional facilities and the community. These strategies have the potential to be safer and cheaper for the community while providing better care for people with mental illness.

The central premise of this paper is that people with mental illness rarely belong in jail and prison. Diversion and discharge planning are the only humane responses to illegal activity by people with serious mentall illness, and we believe that these responses have far greater potential than traditional law enforcement approaches to stop the "revolving door" and lead to real rehabilitation for mentally ill offenders. The goal of this paper is to serve as a catalyst for change.

On any given day, there are close to 8,000 people with mental illness in New York's prisons and jails. Fifteen to 20% of city jail inmates are mentally ill; 7 to 8% of state prisoners are. Some of these people are serving long sentences in the state prison system; many others spend short periods of time at Rikers Island on relatively minor misdemeanor charges. In 1997, 15,000 New York City jail inmates were treated for serious mental illness and more than 33,000 required mental health services.

People with mental illness in New York's prisons and jails are marginalized in many ways. Prior to incarceration, very few were employed; most relied on public benefits or had no income. The vast majority received Medicaid or had no insurance at all. They are predominantly poor people of color and are disproportionately female. Most people with mental illness in New York's jails and prisons, like the correctional population generally, struggle with substance use. Finally, an overwhelming number of inmates with mental illness

are homeless: On any given day, there are about 1,100 homeless mentally ill people in New York City's jails.

New York's current practices in dealing with people with mental illness in the criminal justice system are neither efficient nor humane. People with mental illness who have committed minor offenses, and desperately need treatment, are simply incarcerated. New York has no effective mechanisms, legal or informal, to divert offenders with mental illness into mental health treatment and out of the criminal justice system. While incarcerated, people with mental illness are victimized and segregated, learn institutional behaviors, lose contact with their families and community mental health treatment providers, and lose their housing, income and insurance.

During their incarceration, most people with mental illness receive basic mental health services, but when their release date arrives they are usually discharged with no referral to community treatment, no income, insurance, or housing -- none of the support they need to remain in treatment, maintain their psychiatric stability and stay out of trouble. This failure to create a continuum of care has many harmful consequences for the ex-inmate and the community. The burden of housing the person and dealing with the return of psychiatric symptoms falls on the city shelter system. The task of treating uninsured, acutely ill ex-inmates taxes the city's hospitals and emergency rooms. Finally, ex-offenders with mental illness who receive no discharge planning are likely to reoffend, thereby creating both financial and social costs for their communities.

By offering woefully insufficient diversion and discharge planning to criminal defendants and prisoners with mental illness, New York fails to stop the "revolving door" of repeated hospitalizations and incarcerations. Not only does this failure set people up to reoffend, it also squanders what may be a rare opportunity to intervene in the course of an individual's illness. Involvement in the criminal justice system offers a window of opportunity for even a treatment-resistant person with mental illness to get help. All of society benefits when we take these opportunities to assist people.

The recommendations outlined in this paper fall into three distinct areas: 1) mechanisms to divert criminal defendants with mental illness into mental health services; 2) strategies to create a continuum of care for people with mental illness as they move between the criminal justice system and the community; and 3) the components necessary to provide comprehensive discharge planning and help ex-offenders with mental illness reintegrate into the community.

This paper recommends:

**DIVERSION**

Divert people with mental illness instead of arresting them. 1) Direct 911 calls involving people with mental illness to specially trained police. Police can be taught to do crisis intervention rather than arrest. 2) Provide easier access to psychiatric hospital beds for police and courts. Acutely ill offenders can be hospitalized, not arrested, if beds are available. Divert misdemeanants with mental illness into community mental health services. 1) Make mental health screening, diversion and crisis beds available at arraignment. The arraignment process can offer a unique mental health intervention point. 2) Complete 730 (competency) exams in misdemeanor cases within 48 hours. Incompetent misdemeanants can move quickly out of the criminal justice system. Develop alternative to incarceration programs for people with mentally illness. 1) Enhance existing ATI programs with mental health services and create

new mental health ATI programs. Mentally ill felony offenders can succeed in formal mental health ATI programs.

**CONTINUUM OF CARE**

Build links between jail and community treatment providers. 1) Train community mental health workers to track clients in the criminal justice system. Community workers can learn to be advocates within the criminal justice system. 2) Create mechanisms to connect jail-based mental health services to the community. Continuity of care can be built into jail-based mental health care.

**DISCHARGE PLANNING**

Link inmates with services before release. 1) Provide pre-release discharge planning to all mentally ill jail and prison inmates. Correctional mental health staff can smooth the transition back to the community. Ensure immediate access to essential services following release. 1) Provide immediate access to medications and treatment. Releasees can be guaranteed the treatment they need to succeed. 2) Expedite benefit approval/recertification. Releasees can be insured that their immediate survival needs will be met. 3) Refer mentally ill ex-offenders to supportive housing or specialized shelter programs. Programs can provide shelter and support to ex-inmates with mental illness. 4) Create specialized mental health parole/probation programs with low caseloads. Community supervision officers can help ex-inmates avoid re-offending.

## Glossary of Abbreviations

The following terms are written in full at first mention and abbreviated thereafter throughout the paper.
ACT assertive community treatment
ADA assistant district attorney
AMI Alliance for the Mentally Ill
ATI alternative to incarceration
CIT Crisis Intervention Team
CNYPC Central New York Psychiatric Center
C-PEP Comprehensive Psychiatric Emergency Programs
CPL Criminal Procedure Law
DHS New York City Department of Homeless Services
DMH New York City Department of Mental Health, Mental Retardation, and Alcoholism Services
EDP emotionally disturbed person
FY fiscal year
HRA New York City Human Resources Administration
HHC New York City Health and Hospitals Corporation
ICP intermediate care program
MHU mental health unit
MICA mentally ill chemical abuser
MOU mental observation unit
NGRI not guilty by reason of insanity
OMH New York State Office of Mental Health
SSD Social Security Disability
SSI Supplemental Security Income
WEP Work Experience Program

# I. INTRODUCTION

## A. A Case Study

*James[1] grew up in Brooklyn in a middle class family where he was the oldest of three children. He was a junior in college studying engineering when he was hospitalized for the first time and diagnosed with paranoid schizophrenia. He has been in and out of hospitals dozens of times since then. His family took care of him for years, but eventually his parents died and his siblings left the city.*

*After James lost contact with his family, his condition deteriorated. He lived in a single room occupancy hotel for several years, paying his rent with disability benefits. In the early 1990s, James was sent to prison after breaking the window of an appliance store and injuring a police officer. While in prison, James took Thorazine every day and functioned relatively well, but when he left prison he had no way of getting his medicine and he'd lost his disability benefits and his room.*

*Today James is homeless. He sleeps in a park, eats out of garbage cans, panhandles and drinks malt liquor to help him cope with the voices he hears in his head. He does not see a psychiatrist; he has neither benefits nor insurance.*

*James hears things other people do not. He hears agents from the FBI planning to capture him, kidnap him and hurt him. He often talks back to the voices he hears.*

*One day James is standing on a busy corner arguing loudly with the voices in his head and waving his arms for emphasis. He is blocking pedestrian traffic and a police officer tells him to move along. James looks at the police officer and sees one of the FBI agents coming to get him. He flails his arms, hitting the officer and knocking him down.*

*James is arrested and charged with disorderly conduct, assaulting a police officer and resisting arrest. Assaulting an officer is a felony. James spends several hours at the nearby precinct, several more hours at Central Booking, several more hours in a pen below the courthouse, several more hours in a pen behind the courtroom, and finally, about 30 hours after hitting the police officer, James meets his lawyer.*

*The lawyer knows immediately that there is something wrong with James. Thirty hours of moving from one cage to another have not helped James collect himself. He is disheveled and smelly and detoxing from alcohol; he is barefoot, talking loudly to himself, and there is a cut and a bruise on his face where another prisoner punched him for being too noisy.*

*James's lawyer asks him what happened. The details are sketchy, but James manages to explain that he didn't mean to hit the police officer. The lawyer considers asking the judge to have a psychiatrist examine James to determine whether he is competent to assist in his own defense.[2] But the lawyer knows that getting the results of this examination could take weeks -- much longer than the sentence will be if he can get James the chance to plead guilty to disorderly conduct or even a misdemeanor assault.*

*At arraignment, the assistant district attorney assigned to the case is amenable to lowering the charges. She has reviewed the paperwork and agrees with the defense attorney that James probably did not mean to hit the police officer. She, like the defense attorney, can tell just by looking at James that he has psychiatric problems.*

*James is offered the opportunity to plead guilty to misdemeanor assault and receive a sentence of 10 days of community service. The defense attorney tells James it's a good deal and he should take it. James pulls himself together enough to get through the procedure of pleading guilty. His defense attorney tells him where and when to go for the community service and, as an afterthought, suggests that James see a doctor and get some medicine.*

*James agrees to everything and walks out of the courtroom barefoot into a cold rainy night. He still has no benefits or insurance or any idea where he might find a doctor, if he wanted one. He loses the piece of paper with the information about community service almost immediately. He goes back to the park where he usually sleeps. He does not show up for community service. Three weeks later, James is found sleeping in the entrance foyer of a building on a snowy night. He is arrested for trespassing and the judge wants to send him to jail because he didn't do his community service last time.*

## B. A Case for Change

James is an example of a stigmatized and rapidly growing group of people -- people with mental illness who are or have been involved in the criminal justice system. An important threshold question is what the term "mentally ill" means. For the purposes of this paper, "mentally ill" does not include everyone who has been or could be diagnosed with a mental disorder. This paper is concerned with people who have serious mental illnesses -- illnesses (other than substance use), such as schizophrenia and bipolar disorder, which substantially impair their daily functioning -- and who require ongoing psychiatric treatment and supportive services in order to function in the community.[3]

Across the country, attention is finally being paid to the problem researchers describe as "the criminalization of mental illness" and "transinstitutionalization" -- the movement of people with serious mental illness from community psychiatric hospitals into jails and prisons.[4] The incarceration of thousands of people with serious mental illness is having tragic consequences nationwide, and nowhere more so than in New York.

On any given day, there are approximately 7,680 people with mental illness in New York State's jails and prisons.[5] At least 2,850 of those are in the New York City jail system, making Rikers Island, de facto, the state's largest psychiatric facility.[6] Fifteen to 20% of New York City jail inmates are mentally ill.[7] In 1997, 15,000 New York City jail inmates were treated for serious mental disorders.[8] Twenty-five percent of New York City jail inmates receive some sort of mental health services -- a total of about 33,325 people per year.[9] Seven to 8% of the 70,000 inmates in New York's state prisons are mentally ill, and 15,000 to 20,000 mentally ill state prisoners are released to New York City each year.[10]

Police, courts, jails and prisons are not adequately prepared to deal with a woman who stands in traffic yelling at voices she hears in her head, or a man who stalks a celebrity thinking she is his wife. Police are much more likely to arrest people with mental illness than the non-mentally ill.[11] Once arrested, mentally ill people in New York are incarcerated longer and have less access to alternative to incarceration programs than non-mentally ill offenders.[12] As a result, even mentally ill people charged with minor misdemeanors can end up spending significant time in jail. While incarcerated, they receive limited psychiatric care or none at all. Any psychiatric treatment they were receiving in the community is disrupted. When inmates with mental illness are released, they are generally not referred to mental health services or benefits or housing and are likely to end up in jail again as a result. This is the cycle that has criminalized mental illness and made jails and prisons New York's new psychiatric

institutions.

People with mental illness who are or have been incarcerated are perhaps the most marginalized people in New York. They suffer the stigma and consequences of both mental illness and criminality; they are predominantly poor and of color, and they are often battling substance use and additional problems including homelessness and illnesses such as tuberculosis and AIDS. They are cut off from mental health services available to non-offenders, and their psychiatric problems isolate them from advocates for "normal" defendants and prisoners.

The vast majority of people with mental illness in the criminal justice system are not dangerous and are not incarcerated for long. With New York City's increasing punishment of "quality of life" crimes, more people with mental illness than ever, particularly the homeless mentally ill, are charged with misdemeanors.[13] They spend days, weeks or perhaps months in jail,[14] then return to the community needing help reintegrating into society, remaining psychiatrically stable and staying out of trouble. People with mental illness sentenced to upstate prison terms are not gone forever either. Most prisoners are eventually released, and 70% of state prisoners return to New York City.

These problems are not unique to New York City or New York State. Nationwide, as many as 13% of jail inmates suffer from severe mental disabilities.[15]In many jurisdictions, jails have become the primary treatment provider for poor people with mental illnesses. In state and federal prisons, the situation is the same: An estimated 10% of the nation's prisoners, a total of about 122,000 people, are seriously mentally ill.[16] The total number of people with serious mental illness in jails and prisons nationwide is estimated at almost 200,000.[17] While this population and the problems it poses have received significant national attention recently, finding solutions remains uncharted territory.[18] Clearly, innovative treatment and intervention models are needed, and a successful local model is likely to be replicated across the nation.

There are three obvious ways to help people with mental illness who are involved in the criminal justice system. One is to divert them from the criminal justice system into mental health treatment. A second is to offer discharge planning that helps them gain access to treatment and other services they will need after they leave prison or jail.

An important third way to help people with mental illness in the criminal justice system is to improve conditions and mental health services inside jails and prisons. While addressing the changes that need to be made within correctional facilities is beyond the scope of this paper, this omission should not be seen as an endorsement of the current treatment of incarcerated people with mental illness in New York.

Another limitation of this paper is its focus on New York City. We do not intend it to be a comprehensive overview of correctional systems or mental health systems statewide. While the paper's recommendations have some general applicability, they are designed with New York City in mind, and refer in many cases to New York City government agencies.

The central premise of this paper is that people with mental illness rarely belong in jail and prison. Diversion and discharge planning are the only humane responses to illegal activity by people with serious mental illness, and we believe that these responses have far greater potential than traditional law enforcement approaches to stop the "revolving door" and lead to real rehabilitation for mentally ill offenders. The goal of this paper is to serve as a catalyst for change.

## C. Treatment Works

History and research have shown that mental health and substance use treatment works. Although we are far from being able to "cure" serious mental illness or provide universally effective treatment, the range, compassion and efficacy of mental health treatment modalities have improved dramatically in recent years. Researchers have developed new medications that offer clinicians a greater range of options and that may help patients who did not respond to or who experienced severe side effects with the previous generation of psychotropic drugs. New "client-centered" mental health programs, such as psychosocial clubhouses, have succeeded in engaging people resistant to conventional treatment. A broad array of effective programs with different levels of care have been developed in both inpatient and outpatient settings to accommodate patients' individual needs.

The majority of people with mental illness in New York's prisons and jails have substance use problems. People who suffer from both mental illness and substance use disorders pose a great challenge to the mental health community. The co-occurrence of these disorders complicates the patient's prognosis and clinical treatment planning; fragmentation of treatment programs often adds to the problem. Traditionally, the mental health and substance abuse fields have been separate and, at times, even antagonistic. The result was often that mentally ill substance users received treatment for only one of their problems or, at best, received mental health and substance use treatment from separate providers who did not work together or even communicate to create a joint treatment plan.

This gap is beginning to close as researchers and clinicians call for integrated mental health and substance use services that address both problems simultaneously.[19] Research has shown that integrated services are more effective than mental health and substance use treatment offered separately or sequentially.[20] A number of specific integrated treatment modalities have shown definite promise in treating mentally ill substance users.[21]

The movement toward integrated services, and the research showing the success of this approach, are enormously important for people with mental illness in the criminal justice system. Clearly, diverting people with mental illness out of the criminal justice system and into treatment is not an attractive option if the treatment only addresses one aspect of their problem. With integrated treatment programs available, however, we have an opportunity to create real change in the lives of offenders with mental illness by diverting them to community mental health services or referring them to community treatment following incarceration.[22]

## D. Potential Cost Savings of Diversion

An obvious question is whether effective treatment costs less than incarceration. In 1996, the cost of incarcerating an individual in the New York City jail system for one year was approximately $64,000.[23] The comparable cost of a year in state prison was $32,000.[24] This is equal to $175 per day to keep someone in jail and $88 per day in prison. These figures are for the average inmate, however, and people with mental illness are not average inmates; inmates with mental illness require far more than their "share" of jail and prison resources, in the form of treatment, suicide prevention observation and crisis intervention. As a result, inmates with mental illness substantially inflate average incarceration costs.

In comparing the costs of diversion to those of incarceration, it is important to remember that incarcerating a person with mental illness does not "save" the cost of providing health and mental health care to the individual. Health services provided in jail or prison are limited but

costly. For example, New York City pays more than $115 million a year to provide health and mental health services to jail inmates.[25]

Another important element of any comparison of the costs of diversion with those of not diverting people with mental illness is the costs of processing the case. Long before a person with mental illness is sentenced to incarceration, taxpayers begin paying the costs of the police who arrest and process the person; the court pens where the person is held; the defense attorney who represents the person; the Assistant District Attorney (ADA) who prosecutes the person; the judges the person appears before, as well as their staff and court officers; the rent, maintenance and overhead of the courthouse; the jail where the person is detained; transportation to and from the jail, et cetera. Diverting a person with mental illness out of the criminal justice system at an early stage, for example prior to arrest or at arraignment, saves not only the cost of incarceration, but many of these costs as well.

Finally, any cost comparison is incomplete if it does not consider the future fiscal consequences of the decision to divert or not divert a person with mental illness from the criminal justice system into treatment. Many of the people with mental illness in New York's criminal justice system are caught in a "revolving door" that shuffles them repeatedly through hospitals, jails and shelters at an enormous cost to taxpayers. One authoritative estimate places the annual cost of serving a seriously mentally ill homeless person caught in the revolving door of repeated hospitalizations in New York City at about $70,000.[26] An individual passing repeatedly through hospitals and the criminal justice system may cost even more. If diversion from the criminal justice system into community mental health services creates an opportunity to engage the individual and provide services that will stop the revolving door and prevent future hospitalizations and arrests, and the other costs of crime, for example, injury to victims and property damage, then diversion has the potential to save a great deal of money in the long run.

It is difficult to quantify the costs of treating a person with mental illness in the community because the individual may use a variety of mental health services. The question of how much mental health services cost, and how this cost compares to that of incarceration, has not been widely studied in the past; currently, a number of jurisdictions have begun to research the comparative costs of community treatment and incarceration.[27]

It is possible, however, to make some educated guesses about relative costs. A 1997 Wisconsin study of 1,890 severely mentally ill patients found that the average total expenditure for inpatient and outpatient mental health services per client was $10,995 per year, or $30 per day.[28] Obviously, Wisconsin is a very different setting than New York; it is also important to note that in this study outpatient services accounted for 53.5% of expenditures, and the costs of food and shelter for people in outpatient programs were not borne by the mental health system. This study still stands out as one of the few recent attempts to quantify the costs of providing a continuum of community services.

Another helpful figure may be the cost of supportive housing. Supportive housing is permanent housing provided by a social service agency and designed specifically for mentally ill, often formerly homeless, people. Mental health services including case management, psychiatry, medication management and counseling are typically provided on-site. The cost of providing supportive housing to an individual in New York City is about $12,000 per year or $33 per day, considerably less than the $175 per day to incarcerate.[29]

Another model for providing intensive services to seriously mentally ill clients is the Assertive Community Treatment (ACT) team model. This model works with clients who are

housed, but who also have great service needs and are not able to access these services without assistance. An ACT team is a mobile team that works with these difficult or treatment-resistant clients by bringing psychiatric, case management, drug treatment and vocational services to the client's home. ACT teams in New York City are currently funded at approximately $10,000 per client per year.[30]

A few cautions are necessary when comparing the costs of community services such as supportive housing and ACT teams to the cost of incarceration. For example, some residents of supportive housing and ACT clients may also require mental health services such as day treatment and hospitalization in addition to a $12,000 bed in supportive housing or the $10,000 ACT team services. Supportive housing residents and ACT clients also generally create additional costs by receiving benefits which they would not be eligible for were they incarcerated. With comprehensive on-site services, however, a person with a very serious mental illness may be able to receive all of his mental health services at his residence and work toward future employment and independence.

Clearly, more research on the costs of diversion and discharge planning is needed. Any cost-benefit analyses should figure in the long-term costs of a person trapped in the revolving door. It is not adequate to examine how much money is spent or saved in the first six months or year; we need comparisons of the long-term costs of repeated contact with fragmented systems versus outcomes for people diverted or discharged to comprehensive, integrated programs.

Implementation of diversion and discharge planning strategies makes sense from both a public safety and a humanitarian perspective, even if these programs never save a penny. We believe research will show, however, that if offenders with mental illness are diverted to, or linked at discharge with, comprehensive integrated services, these services will stop the revolving door for many people and save money.

## E. Limits of Legal Mechanisms for Diversion

Two sections of the New York State Criminal Procedure Law (CPL) make provisions for diverting a mentally ill criminal defendant out of the criminal justice system and into mental health services. These two sections deal with "730 exams"[31] and verdicts or pleas of "not responsible by reason of mental disease or defect" (commonly referred to as a NGRI or "not guilty by reason of insanity" defense).[32]

Under CPL section 730, a judge who has reason to believe that a criminal defendant may be "incapacitated" must order that the defendant undergo a psychiatric examination. "Incapacitated," in this context, means that because of mental disease or defect, the defendant is unable to understand the proceedings against him or assist in his own defense. A "730 exam" can be requested by a defense attorney or an assistant district attorney, or may be ordered upon the judge's own initiative.

When a 730 exam is ordered, the case is delayed while the defendant is seen by two psychiatric examiners. Each examiner makes an independent determination as to whether the defendant is "fit" or "not fit" to proceed with the case.[33] If the defendant is found "not fit" to proceed and the case is a misdemeanor, the charges will be dismissed and the defendant hospitalized as a civil patient at a state psychiatric hospital until he is clinically ready for discharge or is released by a judge under civil commitment laws.[34] If the charges are a felony, a "not fit" defendant will be hospitalized at a state forensic hospital[35] until he becomes "fit."

The 730 process is the only special legal mechanism for dealing with a criminal defendant with a mental illness, except for the NGRI defense. A NGRI defense is rarely used, however, because it is expensive and generally requires a defendant to take the substantial risk of going to trial with little chance of avoiding conviction. Another reason for the limited use of the NGRI defense is that defendants found not guilty by reason of insanity are not set free; they are committed to secure psychiatric facilities for indeterminate periods of time. Finally, some defendants with serious mental illness refuse to permit their defense attorneys to interpose a NGRI defense, either because they do not believe they are mentally ill or because they prefer incarceration to long-term hospitalization.

Neither the 730 process nor the NGRI defense comes close to addressing the needs of criminal defendants with mental illness. Both standards ("not fit" to proceed and "not responsible") are very narrow; the majority of criminal defendants with mental illness are found organized and coherent enough to understand the proceeding against them and are, under New York's standards, legally responsible for their actions. Thousands of these "fit" and "responsible" defendants are seriously mentally ill, however, and should be dealt with differently than other criminal defendants, in ways that address their mental health needs.

Another limitation of the 730 and the NGRI provisions is that both are most often used in cases with very serious charges and neither offers much benefit to the misdemeanor or "nuisance" offender with mental illness who passes repeatedly through the doors of the criminal justice system. In misdemeanor cases, even repeat offenders are unlikely to go to jail for very long,[36] so remaining confined pending a 730 exam may constitute a greater "punishment" than the sentence available through plea bargaining.[37] This delay discourages defense attorneys from requesting 730 exams even when they know their client has serious psychiatric problems. A NGRI defense is not a realistic option for a misdemeanant either; preparing to go to trial with a NGRI defense requires time and resources that neither a defense attorney, a defendant, nor the court is likely to invest in a misdemeanor case.

There is another section of the CPL which, while not specifically concerned with mental health, can be used to facilitate diversion of criminal defendants with mental illness. CPL section 390 requires pre-sentence reports in felony cases and permits them for misdemeanors. A pre-sentence report is a report prepared after a guilty plea or conviction but prior to sentencing; the report may include a psychiatric examination.[38] Should this examination find the defendant to be mentally ill, the report may suggest treatment options to the judge, offering the judge a greater range of sentencing alternatives. The judge may sentence the defendant to treatment, or order the person to go to treatment and defer sentencing while monitoring treatment compliance. In some cases, a finding of serious mental illness during a pre-sentence examination may even serve as the basis for vacating a plea on the grounds that the defendant was not fit to plead guilty. "390 Exams" are being used creatively by advocates and judges to access treatment for defendants with mental illness, but this, too, is at best a partial solution. By the time a defendant with a mental illness is seen for a 390 exam, he may have already spent many months in jail awaiting trial.

The NGRI defense, 730 exams and 390 exams are important acknowledgments by the legislature that the psychiatric condition of a defendant is relevant to the disposition of criminal charges. All of these mechanisms, however, focus solely on legal competence and culpability, not need for treatment or public policy goals such as stopping the revolving door. As a result, for the vast majority of criminal defendants with mental illness, including virtually all mentally ill misdemeanants, there is no statutory mechanism for addressing their mental health needs.

## F. Lack of Alternatives to Incarceration

Progressive thinkers in the criminal justice community have long recognized the need for forms of punishment other than imprisonment. New York City is home to a number of well-respected "alternative to incarceration" (ATI) programs, which provide supervision and services to distinct offender populations. However, not one of these programs targets offenders with mental illness.

In fact, not only are there no ATI programs designed for this population; people with serious mental illness are often deliberately excluded from New York City's ATI programs. Lacking expertise in mental health and the resources to provide intensive services to this difficult population, ATI program staff are unable to deal with the seriously mentally ill. As a result, offenders who are otherwise appropriate for ATI programs are screened out.

Offenders with mental illness are good candidates for ATIs. They may have committed the offenses for which they are charged because of untreated mental illness. As studies have shown, they are likely to respond well to mental health treatment, so it is possible to determine what services will help them avoid future criminal behavior. New York City agencies offer a wide array of mental health services that could be woven into ATI programs. Offenders with mental illness should have at least as much access to ATIs as the rest of the offender population.

# II. THE INCARCERATED MENTALLY ILL

With diversion from the criminal justice system an option for very few criminal defendants with mental illness, multiple systems struggle to meet the needs of incarcerated mentally ill New Yorkers. These inmates not only require expensive mental health services during incarceration, they also need a great deal of assistance in making the transition back to the community at the time of their release. This section describes the mentally ill jail and prison populations and highlights gaps in the continuum of care.

## A. The Mentally Ill in New York City Jails

New York City's jail system is composed of 16 separate jails, including "borough houses" of detention in Manhattan, Brooklyn, the Bronx and Queens, and ten separate jails on Rikers Island, including facilities for women and adolescents. In 1997, the New York City Department of Correction had an average daily census of 19,205 inmates and a total of 133,300 admissions throughout the year.[39] Approximately two-thirds of city jail inmates are pretrial detainees, and 90% of the population is male.[40] The average length of stay for detainees in 1997 was 46 days; for sentenced prisoners, it was 37 days.[41] Two-thirds of sentenced inmates are recidivists.[42]

### *The structure of mental health services in New York City jails*

To serve the approximately 33,325 prisoners per year requiring mental health services,[43] including the 15,000 with serious mental disorders, the New York City jail system provides a broad spectrum of mental health services.[44] Although responsibility for supplying these services rests with the city's Department of Mental Health, Mental Retardation and Alcoholism (DMH),[45] DMH has delegated this duty to the New York City Health and Hospitals Corporation (HHC), the body that operates the city's public hospitals, to provide mental health services to jail inmates. HHC, in turn, has contracted with a private hospital, St.

Barnabas, which since January 1, 1998, has provided the vast majority of mental health services within the city jails.

Mental health services are provided both to inmates housed in general population and within segregated Mental Observation Units (MOUs), a Mental Health Center and a Behavioral Management Unit. Inmates who are not believed to present any risk to themselves or others are treated in general population. The next higher level of care, for patients who are judged to require removal from general population, is provided within the nine MOUs -- segregated mental health treatment units with the capacity to house up to 625 inmates at a time.[46]

Inmates too ill for the MOUs are sent to the 350-bed Mental Health Center at Anna M. Kross Center on Rikers Island, where 24-hour, seven-day-a-week psychiatric, medical and nursing care is provided.[47] A 24-bed Behavioral Management Unit at the Bronx House of Detention works exclusively with unusually aggressive mentally ill men.[48] This facility brings the total number of segregated mental health beds in the New York City jail system to 999. During 1997, 192,228 mental health visits were provided to inmates in the city jail system.[49] About two-thirds of mental health visits are provided within the segregated mental health units.[50]

Patients found to be too ill even for the Mental Health Center are transferred to secure psychiatric units at three community hospitals -- Bellevue, Kings County and Elmhurst.[51] Utilization of these community hospital beds has dropped in recent years, and the number of beds in these units has been reduced as a result.[52] The HHC Office of Correctional Health Services attributes the reduction in hospital transfers to new treatment initiatives at the Rikers Island Mental Health Center, including having a psychiatrist review all hospital referrals before transfer and having a psychiatrist consult with any patient refusing medications.[53] The Legal Aid Society of New York City, however, has expressed concern that the community hospital beds for jail inmates are being inappropriately underutilized in an attempt to save money.[54]

***Who are the mentally ill in New York City's jails?***

Not surprisingly, people with mental illness in the city's jails are marginalized in many ways. They are overwhelmingly people of color: 50% African-American, 35% Latino.[55] They are disproportionately female: Only 10% of the city jail population are women, but 17% of the inmates utilizing mental health services are female.[56] They are also likely to be unemployed: In a sample of seriously mentally ill inmates served by the NYC-LINK discharge planning program,[57] 28% had never been employed, and only 10% were employed at the time of incarceration.[58] Fully 39% received SSI or SSD (social security disability benefits), 25% received Public Assistance, and 16% had no income.[59] Only 2% had private insurance, while the vast majority of patients in the sample relied on Medicaid (63%) or had no insurance (30%).[60]

People with mental illness in city jails are also likely to have histories of psychiatric treatment and of substance use. In an HHC Office of Correctional Health Services study conducted in November 1997, 68% of inmates in the sample had contact with the mental health system prior to their incarceration.[61] While more than half (54%) admitted to histories of substance use,[62] this figure is almost certainly low. Prevalence of substance use among the general New York City jail population is estimated to be 75-80%,[6.3] and there is no reason to expect a lower prevalence among inmates with mental illness.

It is impossible to talk about people with mental illness in jail and prison without also talking

about homelessness. In New York City, a 1992 study found that 20% of jail detainees were homeless.[64] In NYC-LINK's first year, 29% of their clients were homeless.[65] The higher rate of homelessness among NYC-LINK clients corroborates another finding of this study -- a strong association between homelessness and mental illness. Subjects of this study who had histories of homelessness were twice as likely as the never-homeless to show some indication of mental illness (50% v. 25%). A 1995 study in New York City found that 43% of defendants with mental disorders were homeless at the time of arrest.[66] These figures show that while jail is offering emergency shelter for thousands of New Yorkers, it is especially true for people with mental illnesses. On any given day, there are approximately 3,800 homeless people in the city jails -- more than half as many as the 7,100 in the city's shelters for homeless adults.[67] A rough estimate of the number of homeless people with mental illness in the city jail system would be over 1,000.[68]

***Few mentally ill people leaving jail receive any discharge planning***

When a person with a serious mental illness goes to Rikers Island or one of the city's other jails, she or he probably receives some form of basic mental health care, including psychotropic medications as an out-patient in general population, or in one of the segregated Mental Observation Units. However, many of these people have no insurance or income at the time of arrest. Many more lose their Medicaid while they are incarcerated. Without insurance, there is no way for a person with a mental illness to leave jail and continue getting the medications she or he needs to remain stable.

Inmates with mental illness finishing their sentences at Rikers Island are generally put on a bus with other prisoners being released that day. Most mentally ill inmates are not given medications or a prescription to take with them. They are driven to Queens Plaza and released between 2 and 4 in the morning with three subway tokens.

Even if a person with a mental illness is organized enough to go straight to the welfare office, there will still be at least a 45-day wait for benefits and, more important, Medicaid. Temporary Medicaid benefits are theoretically available to qualified applicants immediately, but in practice the red tape involved in getting a temporary Medicaid card is daunting to even the most experienced social worker and all but impossible for a disorganized person with a mental illness in a crisis situation. Finally, a person with a mental illness resourceful and persistent enough to get a temporary Medicaid card is likely to be unable to find a pharmacy willing to honor a temporary card.

Without Medicaid or other insurance there is no access to treatment, and the inevitable happens: The mentally ill ex-offender decompensates,[69] acts out, and ends up in a hospital if he is lucky, but more likely back in jail.

***The NYC-LINK Program -- a small step in the right direction***

In June 1996, the New York State Office of Mental Health and the New York City Department of Mental Health, in collaboration with the New York City Health and Hospitals Corporation, created and funded a discharge planning program for jail and prison inmates with mental illness, the NYC-LINK Program. The New York City jail component of the program is currently staffed by twelve jail-based "linkage planners" and eight community-based "transition support counselors."

The jail-based staff are employed and supervised by the Health and Hospitals Corporation, while the community-based staff work for a private social service agency, the Federation

Employment and Guidance Services. Jail-based staff screen and evaluate clients and arrange for post-release services. After the client is released, the community-based staff assist the client in obtaining the needed services and follow the client's progress for two years.

Creation of the NYC-LINK Program shows that city and state officials recognize the desperate need for discharge planning for jail and prison inmates with mental illness. Unfortunately, it is a relatively small program, which only begins to address the greater need for discharge planning for all jail inmates with mental illness. As currently funded, the NYC-LINK Program is expected to provide discharge planning services to 1,200 inmates per year.[70] With 15,000 seriously mentally ill people, and 33,325 people requiring some kind of mental health service passing through the jail system each year, this program is providing services for only about 4% of the individuals who need them -- discharge planning for one in every 25 inmates with mental illness.

## B. The Mentally Ill in New York State Prisons

New York State is home to a large and complex prison system composed of 69 facilities scattered throughout the state, holding about 70,000 inmates. Although prisons are distributed statewide, with relatively few located in the New York City area, 70% of state prisoners come from New York City.

Although a higher proportion of New York City jail inmates are seriously mentally ill than state prisoners, the prison system is also, for many New Yorkers with mental illness, the psychiatric hospital of last resort. Last year, New York State prisons treated 6,000 inmates, or 8.7% of the state prison population, for serious psychiatric disorders.[71] This figure is remarkable when compared to the fact that the entire state has only 5,800 adult patients in public psychiatric hospitals.[72] A 1987 study of the New York prison system found that 15% of inmates suffered from a significant or severe psychiatric disability.[73] In a system with approximately 70,000 inmates, this means that at any given time there are about 10,500 state prisoners with significant psychiatric service needs.

### *The structure of mental health services in New York State prisons*

The state prison system, like the city jail system, has developed a variety of services to address the mental health needs of inmates. Mental health services in the state prison system are provided directly by the state Office of Mental Health (OMH). OMH provides intensive services at its 202-bed psychiatric center for prisoners, Central New York Psychiatric Center (CNYPC), and through CNYPC's satellite units at eleven maximum-security prisons throughout the state.[74]

Satellite units are segregated units within prisons where inmates requiring short-term acute psychiatric care are housed in dormitories and solitary "observation cells." The state's eleven satellite units contain a total of 134 beds. Facilities with satellite units also have Intermediate Care Programs (ICPs), which provide long-term segregated housing to inmates who, because of mental illness, are unable to function in general population. ICPs range in size from 29 to 78 beds, and house a total of 526 inmates state-wide.

At present, the state prison system contains a total of 862 segregated beds for inmates requiring mental health services. Plans are underway, however, to build an additional satellite unit for female prisoners at Albion Correctional Facility and to expand the capacity of CNYPC.

Each of CNYPC's satellite units provides mental health services to other correctional facilities within a catchment area. CNYPC also operates Mental Health Units (MHUs), which offer mental health services but do not have segregated beds, at eight facilities.[75] Each state prison is classified by OMH according to the level of mental health services it provides. Level I facilities offer the most intensive services; Level VI denotes a facility with no direct OMH services. Inmates' mental health needs are classified according to the same system of levels.

***Who are the mentally ill in New York State's prisons?***

According to OMH, the psychiatric problems of the prisoners treated in the satellite units are becoming increasingly severe and complex. "The proportions of persons with a serious diagnosis, severe and persistent mental illness, and co-occurring alcohol or drug abuse or both" have been increasing, OMH reports.[76] Lengths of stay by prisoners/patients at CNYPC have also been increasing.[77] Ninety-three percent of the inpatients at CNYPC are male, and the patient population has increased in age over the last 10 years. In 1986, the majority of patients were under 34; today over 50% of CNYPC patients are between the ages of 35 and 45.[78]

***Mentally ill people leaving prison do not get adequate discharge planning***

Approximately 1,500 to 2,000 state prisoners with mental illness are released to New York City each year,[79] and many of these people have no access to mental health services following their release. They leave prison without employment or benefits or insurance and, very likely, without anywhere to live. The Department of Correctional Services gives releasees $40, a bus ticket home, and a list of parole conditions. OMH has a policy of providing all seriously mentally ill releasees with a two week supply of medication plus a prescription for an additional two weeks, but it is not clear that all prisoners who need medications following release are included by this policy, and even those who are will have a four-week gap between when they run out of medication and when they receive the Medicaid benefits they need to fill a prescription. For most prisoners with mental illness, this is the extent of the discharge planning they receive.

Some prisoners, particularly those receiving intensive mental health services, do receive discharge planning before they are released. OMH has a discharge planner at each satellite unit and the NYC-LINK program has four transition support counselors working with inmates leaving state prison. These services are located in Level I and Level II facilities, however, and do not reach anywhere near all the inmates who need them. Some people with serious mental illness are able to function better in a highly structured environment than in an unstructured one. The extreme regimentation of prison, while certainly not therapeutic, may actually help some inmates with mental illness to maintain a higher level of functioning than they would be able to manage in the community, thus masking their great need for discharge planning and support following release. For example, some inmates with serious mental illness are able to function in Level III or Level IV facilities as long as they get psychotropic medications. When they near release, however, they are unlikely to be the recipients of scarce discharge planning resources, because those resources are concentrated in Level I and Level II facilities.

As a result, advocates in New York City frequently encounter parolees who have been taking powerful psychotropic medications, such as Thorazine, Haldol or Lithium, for years while incarcerated, but who are released to the city shelter system without access to medication and benefits, and thus, no way to continue treatment.

Even for those inmates who receive discharge planning, there are crucial gaps in the continuum of care. For prisoners returning to New York City, a wide variety of community resources is available, including supportive housing and intensive social service programs. Unfortunately, OMH discharge planners do not seem to have much success accessing these resources for prisoners nearing release. Discharge planners are handicapped by the great distance between the facility holding the prisoner and the community he will return to. Community mental health service providers are reluctant to accept clients who do not have benefits already in place, and discharge planners at faraway facilities have a difficult time developing the personal relationships with program staff which often help smooth over such obstacles. As a result, for state prisoners who receive discharge planning, the discharge plan is often no different from that of other inmates -- release to one of New York City's Department of Homeless Services shelters.

Upon entering the shelter system after incarceration, the mentally ill releasee must spend up to three months being assessed in a general population intake shelter with few or no mental health services. No information is exchanged between the prison system and the shelter system, so if the releasee is not obviously mentally ill and does not volunteer that he is mentally ill, he will not receive mental health services. Often no one is available to assist the person with mental illness in accessing benefits, insurance and treatment. For a person with mental illness recently released from the controlled environment of a prison, city intake shelters can be chaotic and frightening places.

State prisoners usually serve indeterminate sentences, i.e., two to six years, or seven to 14 years.[80] Inmates released prior to serving their maximum sentence are supervised by parole until that maximum date arrives. The purpose of parole is to monitor the ex-prisoner's conduct in the community and ensure the person remains law-abiding. Parole officers have the power to impose any number of conditions on an ex-prisoner, such as requiring that the parolee receive psychiatric treatment or not use drugs or alcohol. For ex-prisoners with mental illness, a parole officer could be a valuable resource for help in securing benefits, housing and treatment. OMH has made efforts to train parole officers about mental health issues, but parole caseloads are high and few officers have the time or expertise to help parolees reinstate their benefits and obtain mental health services.

Because their parole conditions generally require them to get mental health treatment and to remain in the shelter, people with mental illness recently released from prison are in an even worse situation than those released from jail. When they decompensate because they have not received mental health services, or when they leave the shelter because their mental state is too fragile for such a difficult environment, they have violated parole and are often sent back to prison shortly thereafter.

## C. Effects of Incarceration on the Mentally Ill

People with mental illness entering the criminal justice system have complex service needs that incarceration does little to alleviate. In fact, by the time most people with mental illness leave the criminal justice system, their problems have been exacerbated.

### *Victimization*

People with mental illnesses have difficulty protecting themselves while incarcerated. Jails and prisons are often harsh, dangerous environments for inmates, and are especially so for the mentally ill. Common symptoms of mental illness include bizarre and disorganized behavior; these behaviors make mentally ill prisoners vulnerable. Bizarre behavior often annoys

correction staff and other inmates and leads to victimization. Disorganization makes prisoners with mental illness easy prey for aggressive fellow prisoners. Finally, untreated mental illness may make inmates' behavior erratic, alarming others and at times provoking violent responses from guards and other inmates.

### *Institutionalization*

Like all prisoners, inmates with mental illness learn institutional behaviors that help them cope with incarceration but that compromise their successful transition back to the community. Some of these behaviors may include aggressiveness and intimidation of others or, conversely, extreme passivity, manipulative behavior and reluctance to discuss problems with (or "rat" to) authority figures.[81] These behaviors create barriers to engagement in mental health services and treatment. Former prisoners may associate the structure of mental health treatment facilities, such as hospitals and supportive residences, with prison, and behave accordingly toward staff and fellow patients.

### *Segregation*

Inmates with mental illness may be punished for disruptive behavior in ways that exacerbate their illnesses. The standard punishment for disobeying prison or jail rules is "punitive segregation" -- locking inmates in small single (or occasionally double) cells for 23 hours a day. Better known as solitary confinement, the punishment prevents contact with the general population, prohibits participation in programs or prison work, and often denies the inmate access to reading materials or hygiene products. A person with mental illness who has not violated rules, but whose presence in general population is deemed by correction officials to "pose a threat to the safety and security of the facility,"[82] will be sentenced to administrative segregation. Despite the kinder-sounding name, administrative segregation is just as isolating as punitive segregation and often as restrictive in terms of movement and privileges. New York correction officials have been known to sentence inmates to punitive or administrative segregation for years at a time.

People with mental illness are particularly likely to find themselves in punitive or administrative segregation due to behavior that is symptomatic of their illness.[83] For example, studies in Ohio in the early 1990s found that hundreds of inmates had been placed in disciplinary cells for no reason other than mental illness.[84] "Acting out" psychotic behavior and even suicide attempts by inmates with mental illness are sometimes treated as discipline problems; several days after his death, one inmate in a California prison received a disciplinary write-up for committing suicide.[85]

The conditions in punitive and administrative segregation create great psychological stress and can cause symptoms of mental illness to appear even in inmates with no prior psychiatric problems. Segregated inmates are also at risk for suicide. A recent study examined nine suicides that occurred within 24 months at an unnamed large metropolitan jail; the author found that of the nine suicides, eight were segregated from the general population of the jail at the time of their death.[86]

The dangers of segregation have been recognized by courts in many prisoners' rights cases. For example, in 1995 a federal court held that, "Social science and clinical literature have consistently reported that when human beings are subjected to social isolation and reduced environmental stimulation, they may deteriorate mentally and in some cases develop psychiatric disturbances."[87] Another federal court, presented with allegations regarding the misuse of administrative segregation in New York State prisons held that, "A conclusion

...that prolonged isolation from social and environmental stimulation increases the risk of developing mental illness does not strike this Court as rocket science."[88]

Too often, psychotropic medication is the only form of treatment available to prisoners with mental illness confined in punitive or administrative segregation units. Even though the Department of Correctional Services requires that a mental health counselor make daily rounds in special housing (segregation) units, actual contact with individual prisoners, in the form of conversation or counseling, is infrequent. The cumulative effect of isolation, reduced supportive services and sensory deprivation will typically leave the inmate with mental illness functioning at a lower level than before incarceration.

### *Alienation from family and friends*

While incarcerated, people with mental illness lose many of the community contacts that are essential to their success following release. It is difficult for even the most supportive family members or friends to maintain contact with an incarcerated person. Rikers Island, where the vast majority of city jail inmates are housed, is very inconvenient to visit. A trip to Rikers is likely to take an entire day; when the visitor finally arrives, the inmate may have been taken to court for the day or transferred to another facility. Visiting state prisoners also poses challenges. Most state prisons are located hours from New York City, with some as far away as the Canadian border. To reach these facilities, families take buses from Manhattan on Friday night, spend Saturday at the prison, then Saturday night on the bus returning to the city. Under these difficult circumstances, as years of incarceration go by, a prisoner's connections with family and friends often wither and die. When a released prisoner returns to the community, with neither discharge planning, transitional services, nor the support of family and friends, he is likely to reoffend or violate parole, and be returned to prison.

### *Disconnection from community mental health services*

Another vital source of support for people with mental illness is community mental health services. New York City is home to a broad spectrum of mental health services, ranging from simple outpatient clinics to 24-hour supportive residences. Many people with mental illness who are arrested have some connection with a community mental health service provider prior to incarceration. These people are likely to be receiving treatment, including psychiatric medication, which is disrupted when they are arrested and incarcerated. Staff at these programs often wish to maintain contact with the client to ensure that the client is getting appropriate mental health services or to offer support to the person following release. But a number of barriers make it difficult for community mental health providers to maintain contact with incarcerated clients.

When jail-based mental health professionals evaluate a newly arrested defendant at intake, it is often as if the patient has never before received mental health services. Members of the jail's mental health staff interview the patient and make informed guesses about the person's diagnosis and which medications may be helpful; no system exists to facilitate or even encourage the exchange of information between community treatment providers and jail staff. Having to "reinvent the wheel" with each incoming patient is frustratingly inefficient and clinically unsound. Many inmates have a psychiatrist or case manager in the community who can tell the workers in jail, for example, that the patient's last diagnosis was schizoaffective disorder and that he has had bad side effect reactions to Haldol and Mellaril and Lithium and Zoloft, but recently has been doing well on a dose of 15 mg. of Stelazine and 1200 mg. of Depakote at night plus 1 mg. of Cogentin two times a day.

As any community mental health worker can attest, it can be exceedingly difficult for an outsider to locate a client in the city's criminal justice system. The process of finding out which jail an individual is in is a complicated on requiring multiple phone calls. Once an inmate is located, it is difficult to even find the names and numbers of whom to talk to in the individual jails, much less get information regarding an inmate's treatment status. Community mental health workers who manage to contact a facility where a client is being held often find that no one staff person is responsible for gathering or relaying information about what medication the client has been taking or what diagnoses have been made. Defense attorneys, who could act as liaisons between a community program and the jail, often do not see this as part of their job or understand the advantages of involving a community mental health worker in their client's defense. Finally, when an inmate with a mental illness goes to court or is released it is rare that anyone will notify his community worker -- although it might be useful for the worker to come to court and essential for the worker to know when the client is being released and returning to the community program.

All of these barriers lessen the effectiveness of community mental health programs. By necessitating the duplication of each others' work, these barriers also waste the resources of both community and jail-based mental health programs. They also jeopardize the mental health of inmate patients by interrupting their continuum of care.

### *Loss of housing*

Incarceration costs inmates their homes; many mentally ill people are homeless at the time of their arrest, but far more are homeless by the time they leave jail or prison. Even people detained for only a few weeks may be evicted during their incarceration; those who are incarcerated for a year or more will inevitably leave prison homeless unless they have family or friends who will take them in. Homelessness is a problem for everyone leaving jail or prison, but people with mental illness are worse equipped than most to take on New York City's daunting housing market or to navigate the city's shelter system. Stable and supportive housing is an essential key to successful reintegration into the community for ex-offenders with mental illness.[89]

### *Loss of income and insurance*

Most city jail inmates with mental illness depend on Social Security or Public Assistance benefits for income, and Medicaid for insurance. The longer the period of incarceration, the more likely it is that these benefits will be terminated; even a short incarceration may lead to loss of benefits. For example, under New York City's Work Experience Program (WEP), Public Assistance recipients are required to report to work assignments in order to maintain their benefits. Missing even a single day of work without a documented excuse leads to loss of Public Assistance, Food Stamps and Medicaid.[90] Additionally, a graduated series of sanctions that require waiting periods of up to 180 days before the former recipient may reapply are imposed as penalties for failure to comply with WEP requirements. Therefore, as a result of these policies, a person with a mental illness who is arrested for a misdemeanor, such as jumping a subway turnstile, and spends a day or two in the system prior to arraignment can lose his benefits, insurance, access to mental health treatment and housing.

People incarcerated for months or years always lose their benefits, and they cannot reapply for benefits prior to release. On the outside, the application process is bewildering even for people who are not dealing with mental illness and the upheaval of having recently left jail or prison. For example, to apply for Public Assistance, Food Stamps and Medicaid, an applicant must first figure out which Income Support Center to go to. The closest Income Support

Center is not necessarily the right one; Income Support Centers are down-sizing and merging, and Income Support Centers' overworked staff sometimes tell new applicants that the Center is not taking any more applications. Once the appropriate center is located, the applicant must arrive before 9 a.m., complete a complicated application form, present identification and documentation of rent expenses and/or lack of cooking facilities, and be interviewed by a caseworker.

The applicant will then be directed to the Eligibility Verification Review office in Brooklyn Heights for a painstaking interview intended to detect fraud. Then, Eligibility Verification Review will send the Front End Detection System workers, who carry badges and announce themselves as "the FEDS,"[91] to visit the applicant's house and verify residence. If, after three visits, the FEDS have not found the applicant at home, the case will be closed.

Under the new welfare-to-work initiatives, many Income Support Centers have become Job Centers. An applicant who goes to a Job Center will be turned away the first time and sent to look for a job or other resources.[92] Once applicants return to the center and prove that they have been actively seeking work, cannot find work and have no other resources, they are permitted to apply for benefits. They must comply with finger-imaging in order to begin the process. Next they are sent to a center where they must report promptly five days a week and spend the day looking for a job for 50 days (35 if they have children to take care of) before they will receive benefits. If a caseworker believes the applicant has a substance abuse problem, the applicant must undergo substance abuse assessment at a center in Long Island City. Applicants who indicate that physical or mental health problems limit their ability to work must report for examination at Health Service Systems in midtown Manhattan.

An applicant who complies with all of these conditions and is deemed eligible for benefits will, after about 45 working days, receive up to $352 per month in rent and cash monies plus $120 in Food Stamps and a Medicaid card. People living in shelters, however, will receive only a "shelter allowance" of $22.50 every two weeks.

Needless to say, this complicated process jeopardizes the chances of a successful transition for a person with a mental illness returning to the community from jail or prison. Public Assistance is the only option for a recently released person with a mental illness in need of money for food and medication. Given the 45-day wait, many are forced to finance their needs through illegal means. While focused on such basic concerns as how to pay for their next meal, ex-prisoners with mental illness are not likely to be thinking about how to get a new Thorazine prescription. The barriers to obtaining benefits and insurance following release from incarceration may be the single greatest cause of decompensation and recidivism among mentally ill ex-offenders.

### D. Costs and Consequences of Inadequate Discharge Planning

The lack of discharge planning has tragic consequences for ex-offenders with mental illness, who end up psychotic, homeless and destitute. But it also has serious consequences, financial and otherwise, for the communities and agencies that are left to pick up the pieces.

#### *The burden on city shelters*

New York City's Department of Homeless Services (DHS) is the shelter provider for up to 7,584 single adults on any given night. By default, DHS shelters have become the "discharge plan" for thousands of homeless mentally ill ex-offenders. A recent survey by the Coalition for the Homeless found that one-third of a sample of men at the Atlantic Avenue Armory had

gone directly to the shelter from prison.[93] Obviously, adequate discharge planning for the mentally ill, including housing referral, would relieve the shelter system of a great burden. Short of finding housing for every person in need, however, easier ways exist to create some continuum of care for ex-offenders with mental illness going to DHS shelters.

Currently, even when mental health workers in jails and prisons know that a soon-to-be-released inmate with mental illness is going to a city shelter, no mechanism exists to convey treatment information or to make a formal referral to that shelter. No one at the shelter is notified that the client will be arriving, and no mental health information is sent to the shelter prior to the client's release. During intake into the shelter system, each person is asked questions about psychiatric history. But those who are not obviously ill, if they withhold information about their psychiatric history and do not identify themselves as needing psychiatric services, will be put in a general population shelter and will not receive mental health services.

Many of these shelter clients, having been released from jail or prison with little or no medication, soon decompensate. They proceed to disrupt the shelter or endanger themselves until they are hospitalized or rearrested. New York City's shelters are not merely full of people with mental illness who recently left jail or prison; they are full of acutely psychotic people who recently left jail or prison.

***The costs of over-utilization of hospitals***

The other main entity that bears the impact of the lack of discharge planning is hospitals, particularly public hospitals. With the rise of managed care, health care delivery has changed drastically in recent years. Health care providers, responding to financial incentives in the managed care environment, are downsizing inpatient units and attempting to provide the majority of services through outpatient programs. The New York City Health and Hospitals Corporation (HHC), the corporation that operates the city's public hospitals, has downsized from 9,902 psychiatric inpatient beds in 1995 to a projected 8,029 in 1999 -- a 19% decrease.[94]

The needs of the 25,000 people with mental illness returning to New York City from the criminal justice system each year create a serious obstacle to health care administrators' goals of saving money and promoting outpatient services. People with mental illness released without medications or discharge planning find that the emergency room is the only place they will not be turned away for inability to pay. HHC hospitals are particularly affected because they are required to serve patients regardless of their ability to pay. The result is that many ex-prisoners with mental illness use costly emergency room services to create their own continuum of care when they could be better and much less expensively served by referral and access to outpatient services.

The other great cost to hospitals generated by the lack of discharge planning is that of preventable hospitalizations. When people with mental illness who require psychotropic medications to maintain stability are released with no means to continue those medications, their symptoms inevitably return. As anyone who has encountered a psychotic person on the street or subway knows, these symptoms can be severe. They may include disorganization, delusions, hallucinations, an inability to manage such tasks as eating and bathing, and aggressive or suicidal impulses. For many of these people, decompensation means a return to the criminal justice system. For the less unfortunate, the result is hospitalization, where symptoms may be addressed and medications resumed. These hospitalizations, however, carry considerable costs for taxpayers.

Many releasees with mental illness who end up hospitalized were psychiatrically stable just weeks earlier when they left prison or jail. Had they received access to Medicaid, referral to a community outpatient mental health provider and a sufficient supply of medication to see them through the transition, many would never have needed hospitalization. They would have been spared the traumas of decompensation and hospitalization, and hospitals and taxpayers[95] would have been spared the cost of expensive inpatient and emergency services.

***The social and financial costs of recidivism***

Releasees with mental illness on probation or parole are often required to obtain mental health services as a condition of maintaining their freedom. When prisoners are released without access to treatment, they violate this condition the first day by not taking the medications they have no means to obtain. While most mentally ill probationers and parolees are not returned to jail or prison simply for not taking medication, a more common scenario is that they gradually decompensate. Within a week or two, an array of symptoms that had been controlled by medications during their incarceration resurface. They become disorganized, delusional, agitated, and/or paranoid. In this state, the mentally ill person is unable to comply with orders of protection or keep track of appointments with probation or parole officers, court dates or community service schedules. A new arrest is the result, and the person is on his way back to jail or prison.

A psychotic and disorganized person is also likely to have difficulty conforming to social norms. Offenses committed by the mentally ill range from the very minor to the far more serious. On the minor end of the spectrum are the sort of quality of life offenses that, for mentally ill homeless people, are the inevitable result of life on the streets. Activities that non-homeless people perform legally all the time -- drinking a beer, changing clothes, urinating -- become crimes when they are done on the street. Other activities that are not legal, but which people with homes do without detection, such as drug use, are far more likely to lead to arrest when done on city sidewalks. Arrests for these types of offenses may lead to violations of probation or parole and serve as the sole basis for reincarcerating an ex-offender with mental illness.

Other people with mental illness released from incarceration without access to treatment commit more serious crimes. Although a substantial body of research has shown that people with mental illness are no more dangerous than the general population,[96] a number of recent studies suggest that there is a relationship between untreated mental illness (especially when combined with substance use) and violent crime.[97] The lesson of these studies is not that people with mental illness are dangerous and should be confined; the lesson is that all of society has a stake in ensuring that ex-offenders with mental illness have access to the services they need. By linking ex-offenders with treatment and services, we can save taxpayers the cost of processing the same person through the criminal justice system over and over again. We can save government the cost of treating mental illness in jail.[98] We can save communities financial costs and individuals emotional costs by preventing crime. And, finally, we can prevent the trauma people with mental illness suffer as they cycle repeatedly through jails, prisons, hospitals and the streets.

## E. Lost Opportunity for Intervention

Mental health clinicians have long recognized that the effectiveness of treatment largely depends on when it is offered. For example, intervening when someone is young is more likely to have a long-term impact than intervening later in the course of a mental illness. Even

for individuals who have been very ill for a long time, who have a co-occurring substance use disorder or are resistant to accepting treatment, specific occurrences in the person's life create opportunities for intervention. Hospitalization is one: A stay in a psychiatric hospital gives the patient the chance to be stabilized, and to work with hospital staff to develop a discharge plan including services that will facilitate future psychiatric stability.[99] The period following transition from a shelter to permanent housing is another important time for treatment intervention.[100]

Similarly, arrest and incarceration present opportunities to break cycles of self-destructive behavior. Unpleasant as jail and prison are, it is not terribly unusual to hear ex-inmates talk about jail or prison as having "saved their life." In fact, for some people with serious mental illness living on the streets, jail- or prison-based services may be the only mental health treatment they have received in years.

Both diversion and discharge planning can be used as treatment interventions for people with mental illness in the criminal justice system. When a person with a mental illness is diverted to mental health treatment rather than to incarceration or community service, the patient may be more willing to accept needed services because of the knowledge that a judge is monitoring the treatment and noncompliance will have consequences.[101]

Discharge planning is an essential follow-up to the mental health services received during incarceration. If correctional mental health services prescribe medications that control psychiatric symptoms, it may be the person's first period of psychiatric stability in a long time. Once stable, the patient may have far better insight about his or her need for treatment and support services and may be better able to plan for the future. It is a terrible waste to treat, stabilize and counsel a person with a serious mental illness only to send that person back to the streets with no way to capitalize on the progress that has been made.

# RECOMMENDATIONS

## A. Overview

Let us revisit James for a moment and consider how things might have worked out for him in a more humane system. When the police officer saw James standing on the corner waving his arms and yelling, the officer could tell James was mentally ill. Imagine if he had training and experience in dealing with mental illness or had the ability to get a mental health professional to respond to the scene quickly. The situation could have been defused, James might not have hit the officer, and there would have been no felony assault charge. If there had been an agreement between the precinct and a neighborhood hospital, James might have been hospitalized, not arrested -- a better arrangement for all concerned: James, the police officer, and society.

Sometimes it is difficult to prevent an arrest, but the mentally ill defendant can still be diverted out of the criminal justice system. Imagine if James were arrested. Once he arrived at the court pens, he would have caught the eye of a mental health professional assigned to screen arrestees. The mental health professional would have spoken to James, taken his psychiatric history, concluded that he was seriously mentally ill, assessed his service needs, and discussed these findings with James' attorney and the ADA. With everyone in agreement, the mental health professional would either have had James transferred to a hospital or, if appropriate, arranged for James to have a bed that night in a safe shelter. There, backed up by supportive mental health services, staff could begin working with him the next day to arrange

ongoing treatment, benefits and permanent supportive housing.

When a person with a mental illness commits a more serious crime, such as burglary, the range of options is limited by the need to hold the person accountable for his actions. However, there are still practical ways to accommodate the person's need for mental health treatment. Imagine James had broken into an appliance store, and imagine that the judge had the option of sending him to an ATI program where the staff had the expertise and resources to provide James with day treatment, counseling, supportive services and hands-on supervision to make sure that he took his medications and stayed out of trouble.

In the absence of an ATI program, imagine if James were sent to prison, but prison mental health workers were able to have James transferred to a prison in New York City six months prior to release. There, a discharge planner, familiar with community services providers, could arrange housing and services that would help James stay out of trouble after his release. The discharge planner could apply for supportive housing and begin the paperwork to get James benefits. Using contacts in the community, the discharge planner could arrange for housing providers to come to the prison to meet James and interview him. Being psychiatrically stable and having played an active role in developing his discharge plan, James would be prepared for the interviews and would present himself well and be accepted for supportive housing.

On the day of his release, James would be met by his new case manager, who would take him to his new residence. At the residence, he would be able to see a psychiatrist regularly, receive counseling, have social service staff available 24 hours a day, be assisted in applying for and maintaining his benefits, participate in therapeutic and recreational group activities, and get referrals to other services such as day treatment or vocational training.

The following recommendations would make the above scenario a reality. These recommendations overlap in some areas. For example, if misdemeanants with mental illness were not arrested, then we would not need to expedite misdemeanor 730 exams. This overlap is intentional; since no system will work perfectly, the goal of the recommendations is to provide a road map, or starting points, for designing a truly comprehensive system informed by what works in other jurisdictions.

Clearly, before implementation of these recommendations, a careful needs assessment should be conducted to determine how many people need which types of services. Prioritizing needs and creating demonstration and pilot projects are also critical steps before implementing sweeping changes. It is encouraging to note that some of the recommendations suggested, such as expediting 730 exams and providing court-based mental health services, are projects the city and state have already begun to implement or explore.

## B. Diversion

Many of the people with mental illness currently passing through New York's criminal justice system are appropriate for diversion into community mental health treatment or formal ATI programs. In the current system, however, mechanisms to divert them do not exist. The following recommendations show how such measures could be created.

### *Avoid Arresting People with Mental Illness*[102]

**Divert the mentally ill into community mental health services rather than arresting them.**

People who commit offenses are often identified as being mentally ill at a very early stage in their movement into the criminal justice system. Currently, however, the identification of an offender as mentally ill does not trigger specialized mechanisms for dealing with the situation. Police and 911 operators do not have access to mental health experts able to respond to emergencies, and police who would like to hospitalize an offender rather than making an arrest do not have easy access to hospital emergency rooms. The following strategies can be used to facilitate the diversion of offenders with mental illness before an arrest is made.

***1. Direct all "EDP" 911 calls to specially trained police officers.***

As a standard procedure, 911 operators inquire about the type of emergency when answering emergency calls. One of the categories they look for is "EDP" or "emotionally disturbed person" calls -- police lingo for a person with a mental illness. Unfortunately, once a call has been identified as involving an EDP, no special effort is made to accommodate that fact. Police are dispatched and the EDP is dealt with by whichever officer happens to be in the area -- perhaps with great sensitivity, but perhaps not.[103]

A far better alternative would be to divert these calls to specially trained units of the police department that have the ability to respond immediately and the training and expertise to defuse the situation, assess the EDP and effect a hospitalization, if necessary. The model of a police crisis intervention team (CIT) was developed in Memphis, Tennessee, in 1988. This model has been replicated in other jurisdictions[104] and could easily be adapted to New York City.

The Memphis model was developed through a partnership between the police department and the local chapter of the Alliance for the Mentally Ill (AMI), an organization that offers support groups and advocacy for people with mental illnesses and their families. Officers from each precinct, a total of about 15% of the force, join the program voluntarily and receive 40 hours of multidisciplinary training designed to teach them that mental illness is a disease, not a crime.[105] AMI developed the training and offers it at no charge to the city. The training brings together police, people with mental illness and families of the mentally ill, and gives officers the opportunity to role-play how they would respond to specific situations. Officers learn about mental illness and are exposed first-hand to the viewpoints of people with mental illness. Special emphasis is placed on verbal de-escalation techniques designed to avoid physical conflict. In addition to the initial 40 hours, CIT officers also receive ongoing training.

Once trained, CIT officers provide 24-hour, seven-day-a-week coverage in every precinct while also performing their regular patrol duties. There are currently about 165 CIT officers. They respond immediately to all crisis calls involving a person with mental illness; the number of these calls has increased in Memphis by 97% since 1987.[106] In 1996, the CIT received 6,825 calls and transported 3,284 people.[107] Since 1989, Memphis police have not been responsible for the death of any people with mental illness.[108] The goal of the program is to "offer a more humane and calm approach" to these calls and to take most patients to medical facilities without injury or charges.[109] The Memphis CIT program has not only improved police response to crisis situations involving people with mental illness, but has also fostered broader sensitivity to mental health issues within the police department, enhanced trust between families of the mentally ill and the police, and helped forge relationships between the police department and community mental health service providers.

New York City has many mental health organizations, including chapters of AMI, which

could be valuable resources in training a special unit of police. This strategy would not only be an inexpensive way to divert a significant number of people with mental illnesses out of the criminal justice system, it would also be a significant step toward improving police relations with the community.

***2. Provide easier access to community psychiatric hospital beds for police and courts.***

A serious obstacle to the pre-booking diversion of people with mental illness is the perception by the police that if they try to hospitalize a person with a mental illness rather than arrest her, they will have to spend many hours sitting in an emergency room only to have the hospital refuse to admit the patient. This problem can be solved by creating agreements between police and psychiatric hospitals that make it easier for police to bring a person with mental illness to the hospital rather than putting the person "through the system." These agreements would also facilitate the diversion and hospitalization of defendants who display serious psychiatric symptoms prior to arraignment.

Police/hospital agreements have proven successful as diversion mechanisms in several jurisdictions. For example, as an adjunct to the Memphis CIT program, the police department has developed an agreement with a psychiatric emergency room at a local hospital, whereby officers bringing a person with mental illness to the hospital are ensured a waiting time of no more than 20 minutes. New York City has, through the C-PEP (Comprehensive Psychiatric Emergency Programs), made some effort to streamline access to emergency psychiatric services, but this program needs to be expanded and restructured.

We recommend that C-PEP sites be developed in every public (HHC) hospital in New York City and that both new and existing C-PEP programs make working with the police a priority. Police should be guaranteed a "no refusal" policy and a half-hour turn-around time when they bring a person with mental illness to the C-PEP program as an alternative to arrest. Each C-PEP program should be responsible for a catchment area of precincts; every precinct in the city should belong to a catchment area. C-PEP staff should do frequent outreach to precincts in their catchment area, explaining the program to police, building relationships, and sensitizing officers to mental health issues.

***Divert Misdemeanants into Community Mental Health Services[110]***

**Existing community mental health programs can act as alternatives to incarceration.**

Many mentally ill defendants are charged with misdemeanors. It is essential that diversion to community mental health services be an option for these people. If diversion to treatment is not available to misdemeanants, many people with mental illness will pass through the criminal justice system repeatedly without receiving help; others will go on to commit serious crimes before any attempt is made to offer them treatment.

Because of the pressure to move cases quickly, a large number of misdemeanors in New York City are "disposed of" at arraignment. The defendant receives an Adjournment in Contemplation of Dismissal or a Conditional Discharge, or a plea is entered and the arraignment judge imposes a jail sentence, community service or probation, and the case is over. As a result, mentally ill people charged with misdemeanors must be diverted quickly; for this large group of cases, slow diversion mechanisms that require the defendant to return to court repeatedly will not be effective. The only effective way to divert most misdemeanants with mental illness is to have screening procedures and diversion mechanisms integrated into the earliest stages of the criminal justice process. Following are several

suggestions on how to do this.

***1. Make mental health screening, diversion and crisis beds available at arraignment.***

A substantial number of criminal defendants appear obviously mentally ill at arraignment.[111] Anecdotal evidence suggests that judges and lawyers doing arraignments may see as many as three to five defendants with serious mental illness each shift.[112] Many of these people are charged with misdemeanors and should be diverted from the criminal justice system at arraignment. A prevalence study would be an essential first step in integrating mental health services into arraignment courts, but it is clear that a great need exists. The New York City Department of Mental Health, Mental Retardation, and Alcoholism Services has made beginning steps toward planning arraignment-based mental health services; this project needs to move forward.

Diversion of people with mental illness could be effected at arraignment by placement of mental health professionals in court to assess people believed to be mentally ill. The mental health professionals would need to be skilled in quick, accurate assessment and knowledgeable about how to access community services. Such professionals would be valuable consultants to the court and could facilitate agreements between the ADA and the defense to substitute treatment for prosecution or create alternative dispositions. The mental health worker could arrange for hospitalization when necessary and, in cases where the defendant is mentally ill but does not require inpatient care, develop a plan utilizing community mental health resources.

Pre-arraignment mental health screening raises some concerns about confidentiality issues, but these problems could be solved by creating a formal relationship between the mental health professionals and the defense counsel which would protect confidentiality. To avoid "net-widening" -- the referral of individuals who need help but whose charges do not justify continuing court supervision -- court-based mental health staff would also make their services available on a strictly voluntary basis to individuals being released by the court.

For court-based mental health professionals to divert misdemeanants efficiently, the court would need to have access to a small number of "crisis beds" -- beds in a supportive environment that homeless people with mental illnesses could be taken to directly from the court and where they could remain for a day or two while longer-term services were being located. The court-based mental health services should have enough staffing so that the workers can follow up with people who have been diverted, implement the alternative to incarceration plan, and provide the support services necessary to enforce compliance with the plan.

Integrating mental health experts into arraignment courts should be a first step toward comprehensive court-based mental health services. These services should have adequate personnel and resources to respond quickly and provide assessments and referral assistance to any court part dealing with a defendant with mental illness, not only in Criminal Court, but in Supreme Court as well.[113] These services would be particularly valuable to the city's numerous specialized drug treatment and domestic violence court parts that frequently encounter defendants with mental illness but lack the resources and expertise to fully address defendants' mental health needs.

***2. Complete 730 exams in misdemeanor cases within 48 hours.***

As noted, one reason the 730 exam is not an effective diversion tool is that it is underutilized.

Defense attorneys avoid requesting 730 exams because getting the results may take longer than the sentence available through a plea bargain. This problem could be alleviated if 730 examinations for misdemeanants were expedited and completed within two business days. This way, 730 examinations would be requested more frequently, and "not fit" misdemeanants would be diverted from the criminal justice system to the hospital, with the charges against them dismissed -- all within a few days. Implementing this recommendation might require spending more money on 730 exams than is currently allocated; however, it would be money efficiently spent because it would save the cost of extended incarceration and repeated court dates.

### *Make ATI Programs an Option for People with Mental Illness[114]*

**Formal ATI programs can, and should, include the mentally ill.**

People with mental illness have less access to formal ATI programs than other offenders. This is not the result of any intentional policy, but merely the product of a great gap between the ATI community and the mental health community. This gap can be bridged by integrating mental health services into existing ATI programs and using the expertise of both communities to create new programs that understand both how to provide services to the mentally ill and how to create successful alternatives to incarceration.

#### *1. Develop ATI programs for the mentally ill.*

The staff of New York City's existing ATI programs have many years of expertise in supervising and serving people diverted from the criminal justice system. However, they do not know very much about mental health or how to supervise and serve offenders with mental illness. One cost-effective approach to diverting defendants with mental illness, including those charged with felonies, would be to expand the expertise of existing ATI programs into the area of mental health. This could be done by funding specialized mental health training and staff to enhance established ATI programs and permit them to develop specialized services for offenders with mental illness.

Given the large numbers of people with serious mental illness being sentenced to jail and prison, and the unique needs of this population, it may also be necessary to establish one or more new ATI programs specifically for people with serious mental illness. Such programs could draw upon and combine the expertise of New York City's mental health treatment and ATI communities.

## C. Continuum of Care

### *Build Links Between Jail and Community Treatment Providers*

The lack of information-sharing between jail-based and community-based mental health services should be remedied by development of a comprehensive management information system linking community- and jail-based treatment providers. Early negotiations to develop such a system in New York City are underway. We support this effort, with the caveat that such a system must be conservative in how much information it shares and who has access to the information. It must, under no circumstances, be used to disseminate information detrimental to defendants' rights. If implemented with scrupulous attention to confidentiality and the rights of the accused, this system could bridge many of the gaps in the continuum of care.

Following are two simple and quick ways to ameliorate the breakdown in the continuum of care that currently occurs when a mentally ill person involved in community mental health services is arrested. One involves community mental health workers "reaching in" to the criminal justice system; the other is for jail-based mental health workers to "reach out" to community providers. Ideally, these strategies should happen simultaneously.

***1. Teach community mental health workers to track clients in the criminal justice system.***

Community mental health workers trying to provide a continuum of care for their arrested clients encounter great difficulty in navigating the criminal justice system and understanding its complexities. Many of these workers are inexperienced and have no professional training; most jobs working with the homeless or the mentally ill in New York City require only a bachelor's degree and pay in the low 20s. These workers have an essential role in creating a continuum of care for people with mental illness moving in and out of the criminal justice system, but they lack the tools needed to play this role effectively. At a time when people with mental illness, particularly the homeless mentally ill, are increasingly likely to encounter the criminal justice system, it makes sense to offer training about this system, especially about how to contact jail-based treatment providers, to all workers serving people with mental illness.

***2. Create mechanisms to connect jail-based mental health services to the community.***

It should be easy for a community mental health service provider to make contact with a client's jail-based mental health worker. Instead, it is often a frustrating process, where the jail-based workers very rarely instigate the contact, and do not necessarily respond when the community program contacts them. This could be changed by an adjustment in the policies of jail-based mental health services. Jail mental health staff should ask every new patient for a detailed treatment history and should have the patient sign a limited release of information form permitting community programs to release information about the patient's diagnosis and medications.

The jail-based mental health provider should contact every known recent treatment provider, fax the release and make every effort to obtain this information. Jail-based mental health services should also make communicating with outside treatment providers an integral part of both treatment and discharge planning procedures. Implementing this recommendation would be a nearly cost-free way of ensuring a continuum of care and improving the efficacy of jail-based treatment.

## D. Discharge Planning

Both inpatient and outpatient mental health service providers in the community are required by New York statutes or regulations, and by professional standards, to provide discharge planning to every patient leaving their program. The reasons for this are clear: Severe and chronic mental illness is rarely "cured," and a patient leaving a hospital or outpatient program needs assistance in accessing ongoing services. As jail and prison staff take on the role of mental health treatment provider, they should offer the same discharge planning services patients would receive from community service providers. The following are recommendations about how effective discharge planning practices can be incorporated into New York's corrections systems.

***Link Inmates with Services Before Release***

**People with mental illness should leave jail/prison with essential services already in place.**

The goal of discharge planning is to create a smooth transition into the community. The days and weeks immediately following the release of a person with mental illness from jail or prison are critical: The ex-inmate's actions and access to resources during this time are likely to determine whether the individual will succeed or fail in the community. The following recommendations illustrate how pre-release planning can help guide vulnerable people with mental illness through this difficult transition.

***1. Provide pre-discharge discharge planning to all mentally ill jail and prison inmates.***

All jail and prison inmates with mental illness should receive comprehensive pre-release counseling including referral and aggressive linkage with mental health services, benefits, shelter and housing. Because of the complex and demanding nature of discharge planning tasks, the ratio of discharge planners to clients should be low, with no worker having more than 20 active cases at one time. There should be enough discharge planners in every jail and prison to serve every inmate receiving on-going psychiatric treatment. Discharge planners should have professional qualifications, adequate supervision and resources, and should receive extensive initial and on-going training in engaging clients and accessing community resources.

Every person with mental illness leaving jail or prison should have safe housing (or at least shelter) arranged, a clear plan for how to get on-going psychiatric treatment including a supply of medication and an upcoming appointment, and an application for benefits at least pending. Inmates with mental illness should also, by the time of their release, have been referred to and accepted by a social service provider able to meet their need for case management and crisis intervention services. Many people with mental illness leaving jail or prison fall through the cracks without ever reaching the program to which they may have worked hard to be admitted; all seriously mentally ill people leaving jail or prison and going to a shelter or supportive housing should be physically transported to their destination. *Discharge planners, and the goverment agencies they work for, should view the successful reintegration of their clients into the community following release as their responsibility.*

**Jail detainees released from court.** Pre-trial detainees with mental illness are often released directly from court because of changes in bail status or as a result of a dismissal or other disposition of their case. They leave the courtroom with neither medications nor discharge planning, without even the few possessions they had with them when they were arrested. For this population, there should be a "drop-in" office at the court where they can receive on-the-spot advice about how to obtain mental health services, benefits, shelter and housing. Such a service, while no substitute for real discharge planning, would be far better than what the current system offers: nothing at all.

**State prisoners.** The physical remoteness of many state prisons from New York City creates a huge barrier to adequate discharge planning for state prisoners with mental illness who are returning to the city. Community supportive housing programs, which may be reluctant to accept ex-offenders, are far less likely to do so without the benefit of a face-to-face interview. Prisoners being released from state prisons have no way to develop relationships with New York City mental health service providers prior to their release.

This barrier to adequate discharge planning could be removed by the Department of

Correctional Services transferring state prisoners with serious mental illness who are from the city to state prisons which are in or near the city six months prior to release for discharge planning purposes. There are two prisons and a number of work-release facilities with access to mental health services in New York City where these inmates could be housed. An even better idea would be to develop one or more specialized pre-release centers for state prisoners with mental illness on the grounds of down-sized state psychiatric hospitals. New York City houses several state psychiatric hospitals, all of which have been significantly down-sized in recent years. Down-sizing has left vacant former hospital buildings which, with little capital investment, could provide adequate security for inmates nearing release.

Discharge planners at city-based facilities could help inmates with mental illness apply for housing, benefits and supportive services. An interim measure could be to use video conferencing to facilitate interviews, but this is no replacement for in-person interviews and the greater efficacy of a discharge planner who is local. Transferring prisoners with mental illness to New York City would also permit a community service provider to escort the releasee directly to housing.

***Ensure Immediate Access to Essential Services Following Release***

**45 days without access to medication and services is a recipe for disaster.**

If offenders with mental illness are to leave jail or prison and be successful in the community, we must find ways to provide them with treatment and shelter immediately. An individual who is sleeping under a bridge or lost in the shuffle of a city intake shelter, facing a 45-day wait to get benefits and insurance, has no chance of success.

***1. Provide immediate access to medications and treatment.***

Every person receiving mental health services while incarcerated should leave jail or prison with a scheduled appointment to see a community mental health service provider. The provider should be fully apprised, by the corrections-based mental health service provider, of all relevant information about the patient's treatment needs.

Every person receiving psychiatric medications while incarcerated should receive a one-month supply of the needed medication at the time of release, except in cases where the corrections-based mental health service provider has good reason to think that the patient may endanger himself by mis-administering the medication. In such a case, the patient and the medication should be sent to a shelter or housing provider with the capacity to dispense the medication.

For recent releasees who find themselves without necessary medications before they have the benefits to pay for a new supply, there must be another payer. Expansion of the Prescription Medication Service already developed to support the NYC-LINK program could solve this problem.

***2. Expedite benefit approval/recertification.***

One of the greatest obstacles to mentally ill releasees maintaining their psychiatric stability and staying out of trouble is the 45-day delay in benefit eligibility following release from incarceration. In order for people with mental illness leaving jail and prison to have any real chance of successfully reintegrating into society, this gap must be closed. The New York City Human Resources Administration (HRA) has the power to provide on-the-spot

Medicaid and cash assistance to applicants with "immediate needs," but under the current system these requests are dealt with in an informal and cumbersome manner. Nearly all seriously mentally ill people leaving jail or prison have "immediate needs"; these needs could be addressed through creation of HRA post-release "emergency" centers where released inmates could go with a referral from a jail or prison discharge planner and get cash and a temporary Medicaid card on the spot.

***3. Refer ex-offenders with mental illness to supportive housing or shelter programs.***

Homeless mentally ill people leaving jail and prison and returning to New York City generally go to the city's Department of Homeless Services (DHS) shelter system. Jail- and prison-based discharge planning staff should work with every inmate with a mental illness to try to find the person permanent supportive housing prior to release. Where this effort is unsuccessful, however, there needs to be a connection between jails and prisons and the shelter system. Unfortunate as it is to discharge anyone to a shelter, where such a discharge is unavoidable, it should be handled in a way that creates some continuum of care.

This continuum could be created by DHS providing specialized shelter beds that offer intensive mental health services to people with mental illness recently released from correctional facilities. These beds should be in settings that provide structure and support without replicating the experience of being incarcerated. In the absence of such specialized services, however, it should be possible for jail- or prison-based discharge planners to refer clients with mental illness directly to one of DHS's mental health "program shelters." Program shelters are specialized shelters for mentally ill homeless people where supportive case management services are provided and the goal is to move clients to permanent supportive housing. Referral from jail or prison to a DHS shelter should include the correctional facility sending all relevant information regarding the inmate's treatment needs to the shelter-based mental health service provider prior to the inmate's release.

***4. Create specialized mental health parole/probation programs with low caseloads.***

People with mental illnesses create specific challenges for parole and probation officers. These challenges could be much better met by designating specialized officers who are trained in mental health and assigned smaller caseloads. Specialized probation and parole officers could play a key role in helping people with mental illness access the services necessary to succeed in the community and avoid re-offending.

New York City-based parole offices have recently agreed to create specialized caseloads for parolees with mental illness. This is a very promising step toward assisting ex-offenders with mental illness. It is essential, however, in order to improve the current system, that "mental health parole officers" receive specialized training in mental health services, a mandate to assist parolees in accessing those services, and small enough caseloads so that they have time to assist individuals in a comprehensive and compassionate manner. New York City's Department of Probation currently has no specialized officers with mental health caseloads.

# IV. CONCLUSION

People with mental illness in the criminal justice system are a large and growing population with enormous, complex needs. Instead of treating them, we prosecute them. We must reverse this trend now not only because it is the right and humanitarian thing to do, but also because our current practices spin people ever faster through the revolving door -- from the

community to jail to the community to the hospital, out again and then back to jail -- and needlessly waste precious taxpayer dollars. We need to stop serving this population reluctantly and haphazardly, in precincts, court pens, emergency rooms, jails and prisons, and offer them, instead, comprehensive community-based services that will stop the revolving door.

The solutions to these problems are clear. They are not necessarily expensive or difficult to implement. Many merely require a recognition of the inefficiencies of the current system, the programs and services that are available, and a desire to integrate our criminal justice and mental health systems in sensible ways. We need mechanisms to divert people with mental illness at every stage of the criminal justice system. We need ATI and enhanced community mental health programs that can accommodate people with mental illness diverted from the criminal justice system. We need discharge planning for all jail and prison inmates with mental illness and programs that will assist people as they return to the community.

People with mental illness caught up in the criminal justice system are part of our communities. Our present system is failing to retrieve these many desperate lives and failing equally to spend available money judiciously. Decency and fiscal responsibility call for the changes outlined here. New York City and State could become leaders in addressing this growing national problem and assisting society's most vulnerable citizens. It is our hope that this report and these recommendations will persuade policymakers to follow this sensible and humane path.

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