JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS
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Improving Outcomes for People with Mental Illnesses Involved with New York City's Criminal Court and Correction Systems

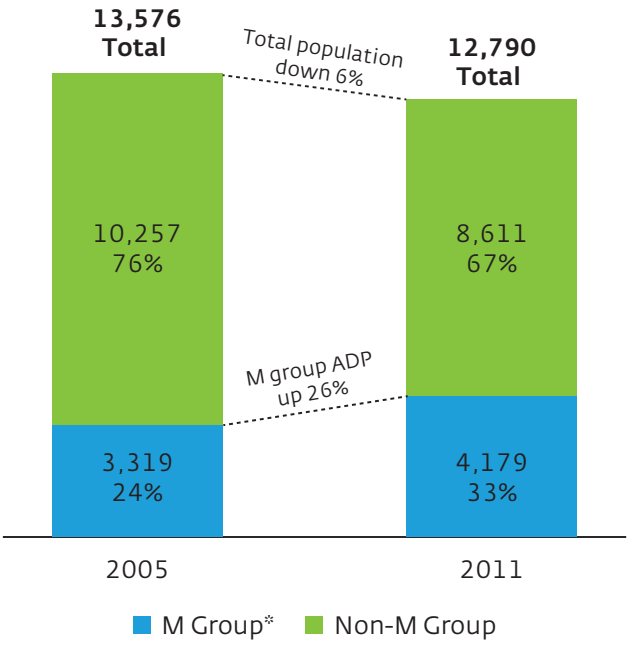
Background

In March 2011, New York City Mayor Michael R. Bloomberg sought support to develop and implement data-driven strategies to improve the City's response to people with mental illnesses who are involved in the adult criminal justice system. In particular, the City wanted to understand and address how even as crime in New York City has decreased and the jail population has declined, individuals with mental illnesses represent an increasing percentage of the City's jail population (less than 25 percent of the average daily population in 2005 vs. about 33 percent in 2011). Impressed with the high level of commitment from the Mayor and city leadership, the quality of available data, and the innovative efforts of the City's nonprofit organizations serving people with mental illnesses, the United States Department of Justice's Bureau of Justice Assistance and the Jacob & Valeria Langeloth Foundation made resources available to the Council of State Governments Justice Center (CSG Justice Center) to work with city leaders across the criminal justice and behavioral health systems to demonstrate how a large urban area could use data to increase public safety and help connect individuals with mental illnesses to effective community-based health services.

The Mayor established the Citywide Justice and Mental Health Initiative Steering Committee, co-chaired by Deputy Mayor for Health and Human Services Linda I. Gibbs and Chief Advisor to the Mayor for Policy and Strategic Planning and Criminal Justice Coordinator John Feinblatt. Department of Correction (DOC) Commissioner Dora B. Schriro and Department of Health and Mental Hygiene (DOHMH) Commissioner Thomas Farley led the Committee. Committee members included Health and Hospitals Corporation President Alan Aviles, Department of Homeless Services Commissioner Seth Diamond, Commissioner of the Administration for Children's Services Ronald Richter, and Department of Probation (DOP) Commissioner Vincent Schiraldi; members of the City Council; judges, district

Average Daily Jail Population (ADP) and ADP with Mental Health Needs (2005–2011)

*With total average population declining (-6%) and the sub-population with mental health needs (M group) increasing (+26%), a **greater proportion** of the average daily jail population has mental health needs.*



Source: The City of New York Department of Correction

*The M group consists of people identified with mental health needs and people who received mental health services while incarcerated.

attorneys' offices, and defense organizations; representatives of community-based organizations; and representatives of alternatives to detention and incarceration providers across the City's five boroughs.[1]

Over the course of eight months, the Steering Committee met four times to discuss findings and possible strategies to address the challenges associated with people with mental illnesses who are involved in the criminal justice system. The CSG Justice Center staff conducted exhaustive quantitative data analyses that drew on multiple data systems and brought together information related to mental health need, criminogenic risk,[2] and the risk of failure to appear in court for those booked into the City's jail system. In addition to these quantitative data analyses, CSG Justice Center staff conducted more than 20 focus group meetings with stakeholders in the City's justice and health systems, including judges, prosecutors, defense counsel, currently and formerly incarcerated individuals, correctional and probation officers, and behavioral health treatment providers.[3]

Based on the study's findings and with the guidance of the Mayor's Steering Committee and extensive collaboration with senior city agency officials and stakeholders, CSG Justice Center staff identified a set of policy recommendations and strategies that could improve public safety and treatment outcomes and reduce jail costs. This report describes the study's methodology, highlights key findings, and discusses those recommendations and strategies.

One City, Five Boroughs

New York is a city of five counties called "boroughs:" Brooklyn (Kings County), the Bronx, Manhattan (New York County), Queens, and Staten Island (Richmond County). While court administration and city agencies such as the Department of Correction and the Department of Health and Mental Hygiene serve all five boroughs, each borough has its own booking and court facilities and elects its own district attorney. The five boroughs also have significant demographic differences, as well as different crime patterns. As a result, although connected by short subway and ferry rides, five distinct legal cultures have emerged that must be accounted for in any citywide effort.

The availability of slots for community-based supervision and treatment through alternatives to detention and incarceration differs widely by borough. While some larger community-based treatment providers work across boroughs, most work in just one or two boroughs, and coordination among providers in different boroughs varies significantly.

Summary of Key Findings and Recommendations

In comparison to the general jail population, people with mental health needs in the DOC exhibited several distinct tendencies:

- **They had consistently longer average lengths of stay.** People with mental illnesses booked into the DOC had an average length of stay (ALOS) of 112 days, almost double that of the general jail population (61 days) even though both populations shared similar profiles in terms of criminal charge, risk of rearrest, and actual rearrest rates. Furthermore, the disparity in ALOS for people with mental illnesses and without mental illnesses existed regardless of a person's gender, race, age, or the borough where his/her case was processed.
- **They were less likely to make bail and stayed considerably longer before making bail.** Differences in ALOS between individuals with and without mental illnesses were most pronounced within the population admitted to jail pretrial (about two-thirds of the 2008 jail admissions). While minimum bail set was comparable for the two populations, individuals with mental illnesses were less likely to make bail than the general jail population, and those with mental illnesses who did make bail took five times as long as those without mental illnesses to do so (48 vs. 9 days).
- **Their average length of stay varied based on severity of mental illness.** People with Serious Mental Illnesses (SMI) had a shorter ALOS than those with identified mental illnesses who did not meet the criteria for SMI (91 vs. 128 days), but both groups had significantly longer ALOS than the general jail population (61 days).
- **They experienced delays in case processing for many reasons, including limited information available to key decision makers and limited community-based options.** Judges, prosecutors, and defense counsel reported that the availability of alternatives to detention and incarceration (ATD and ATI) is extremely limited, and even these options are unknown to many working with this population. They also reported that information about criminogenic risk and behavioral health needs is rarely available to key decision makers, making it difficult to match a person with the combination of supervision and treatment that is most likely to reduce recidivism.

In order to address these systemic issues, the CSG Justice Center has presented the Steering Committee with a policy framework including strategies to:

- **Determine levels of risks and needs** for individuals entering the DOC in order to identify appropriate considerations for community-based supervision and treatment.
- **Provide pretrial, plea, and sentencing options** that allow people with mental health needs to reenter the community while maintaining public safety. These options include pretrial alternatives to detention, alternatives to incarceration, and sentences that include post-incarceration supervision to ensure a safe transition to the community for those at the greatest risk of reoffense.
- **Establish centralized hubs to coordinate and communicate assessment information and community-based supervision and treatment options** to ensure that individuals are efficiently and consistently linked to appropriate community-based services, while allocating system-wide resources effectively.

Implementing this framework could improve treatment outcomes and expedite case disposition for people with mental illnesses, ensuring the most appropriate use of scarce city resources while maintaining public safety.

Methodology

The findings in this report are based on an analysis of data for just over 48,000 individuals in the adult criminal justice system admitted into the DOC in 2008 with a length of stay greater than three days.[4] A focus on the 2008 cohort ensured that researchers could follow people released from jail for at least two years and examine outcomes for those at risk of rearrest for the same period of time. Researchers at the CSG Justice Center merged data from this cohort with data from information systems maintained by the New York State Department of Criminal Justice Services (DCJS) and the Criminal Justice Agency (CJA), a non-profit charged with conducting pretrial interviews and research and providing other pretrial services for the City.

To focus on the subset of people in the adult criminal justice system with mental illnesses, CSG Justice Center researchers used the DOC/DOHMH mental health indicator ("M indicator"). Developed for discharge planning purposes, the M indicator is assigned to individuals who have been incarcerated in city jails for at least 24 hours and who, during their confinement, received treatment for mental illnesses. These individuals may receive the M designation at intake, during a more comprehensive mental health evaluation (often completed within 72 hours of admission), or at any point during their incarceration should the need for mental health services arise.[5] Conclusions in this report about individuals with mental illnesses refer to those with the M indicator ("the M group").

The M designation is not a precise measure and includes people with mental health needs of varying type and severity; diagnostic categories for the M group range from adjustment reactions with depressed mood to more serious mental illness, such as schizophrenia. The M designation may also include false positives, such as individuals without a diagnosable mental illness. In order to develop a more nuanced understanding of the mental health needs of this population, CSG Justice Center staff coordinated with DOHMH staff, who conducted analyses to identify the portion of the study cohort that met the New York State Office of Mental Health criteria for Serious Mental Illness (SMI).[6]

Findings

I. People in the M group stayed in jail considerably longer than people who were not identified as having a mental illness. The M group was similar to the general jail population in analyses looking at gender, age, criminal charges, risk of rearrest, and actual rearrest rates.

- While 21 percent of all people admitted to the DOC in 2008 were in the M group, over 25 percent of the jail's average daily population (ADP) was in the M group during the same period. This difference is a result of the M group's longer average length of stay (ALOS): 112 days for the M group vs. 61 days for people who were not in the M group.
- The prevalence of the M indicator was higher among females (40 percent female vs. 19 percent male). However, demographic factors such as gender and race did not account for longer ALOS for the M group. Regardless of the borough where a case was processed, ALOS were also longer for the M group.
- People with mental illnesses stayed longer on average in every age group, but the differences in ALOS between the M and non-M groups was most pronounced for people under 25 years of age.
- Overall, younger people were more likely than older people to be incarcerated in the DOC for more serious charges, and this trend applied to both the M and non-M groups as well.
- Neither charge severity nor risk of rearrest accounted for the longer length of stay associated with the M group. The distribution of charges among people in the M group and the non-M group was comparable. The different levels for risk of rearrests (low, low-medium, medium-high, high) were also distributed comparably between the M and non-M groups.

Risk Assessment

Validated criminogenic risk assessment instruments are effective tools to gauge the likelihood that an individual will come in contact with the criminal justice system, either through new arrest and conviction or reincarceration for violation of conditions of release. Use of these instruments allows the corrections system to prioritize supervision and treatment resources for those individuals who pose the greatest risk to public safety. At the request of the DOC, the Vera Institute of Justice developed the preliminary components of a risk of recidivism assessment tool. The DOC refined their efforts and validated the tool with DOC data.

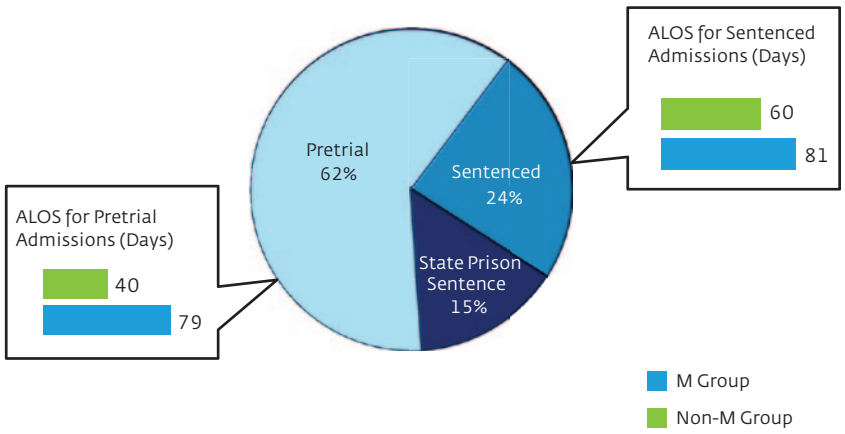
For the purposes of this study, the CSG Justice Center developed a proxy risk of recidivism score by identifying factors associated with rearrest within two years of release, assigning a score according to each factor's ability to predict rearrest for the population, and then adding together the scores for each individual. Six factors were identified as predictive of rearrest in New York City and were used to calculate an individual's criminogenic risk level: age at first arrest, age at admission, prior arrests, prior admissions, charge, and self-reported drug use. Factors associated with higher rearrest rates include: the younger a person was at first arrest and first admission to jail, the higher the person's number of prior arrests and admissions, whether the person was charged with a misdemeanor drug or larceny offense, and whether the person self-reported drug abuse. Scores based on these factors were then used to differentiate the population into groups with low, low-medium, medium-high, and high risk of recidivism. These groups were then analyzed for their actual rates of rearrest following their release. This classification differentiates people solely by their risk of rearrest, not by their risk of committing a serious offense.

- People in the M and non-M groups had similar rearrest rates for the most common charges. The M and non-M groups both had higher rearrest rates for misdemeanor charges than for felonies (misdemeanor: 60 percent of the M group and 61 percent of the non-M group; felony: 35 percent of the M group and 36 percent of the non-M group).[7]

II. Differences in lengths of stay between the M and non-M groups were most pronounced among people admitted pretrial to the DOC (compared to those admitted after being sentenced to city jail time or awaiting transfer to state prison).

- The majority of admissions were pretrial detainees. Almost two-thirds of admissions for both the M group (62 percent) and the non-M group (64 percent) were pretrial when they were booked into jail.
- Members of the M group admitted pretrial to the DOC stayed almost twice as long on average (79 days) as members of the non-M group (40 days).
- Among the sentenced population, there was also a disparity in the length of stay between the M group and the non-M group, although it was less pronounced: 81 days for the M group as compared to 61 days for the non-M group.

Case Status at Admission and Average Length of Stay (ALOS) by Mental Health Status



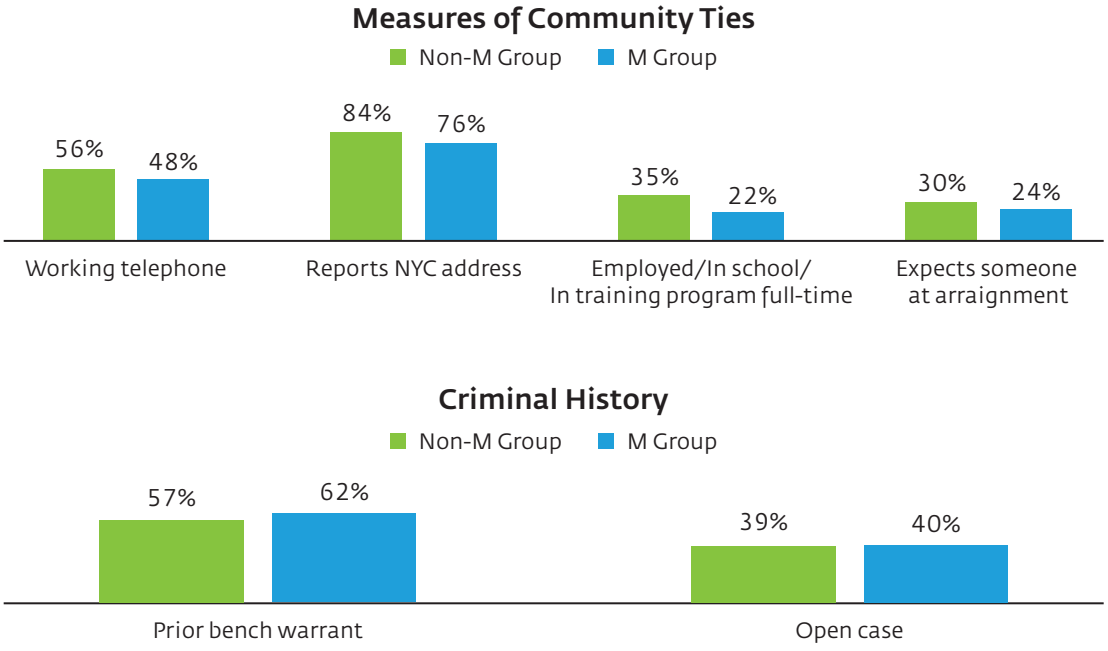
Source: The City of New York Department of Correction, 2008 Department of Correction Admission Cohort with Length of Stay > 3 Days (First 2008 Admission)

- Nine percent of the M group, compared to 15 percent of the non-M group, was assessed as presenting a low risk of failure to appear in court and recommended for release.[8]
- Members of the M group scored lower on self-reported measures of ties to the community related to future appearance in court—such as expecting someone to join them at arraignment or having a valid New York City address—than people in the non-M group.
- The vast majority of people admitted to the DOC—nearly 80 percent—had bail set but did not make bail at arraignment. This was true for people in the M group and the non-M group.
- While people in the M group had minimum bail amounts set that were comparable to the non-M group, only about 12 percent of those in the M group made bail post-admission compared to about 21 percent of those in the non-M group. Furthermore, those in the M group took five times as long to make bail as those in the non-M group (48 vs. 9 days).
- Judges, prosecutors, defense counsel, mental health service providers, and advocates for people with mental illnesses reported that, compared to people who did not have mental illnesses, those with mental illnesses were less likely to be connected to their families or have access to financial resources, which could impede a person's ability to post bail.

Competency Evaluations

Competency evaluations determine an individual's ability to communicate with his/her defense counsel to aid in his/her own defense and to understand his/her charges. Focus group participants reported that the time taken to complete competency evaluations (CPL 730 evaluations) and the time taken to restore competency contributed to delays in case-processing times for people with mental illnesses. Quantitative analyses did not support this anecdotal observation, however, as just one percent of DOC admissions received CPL 730 evaluations. The ALOS for those cases was 52 days, which is well below the ALOS of 61 days for the general jail population and the ALOS of 112 days for people in the M group.

Factors Related to Risk of Failure to Appear



Source: The Criminal Justice Agency, 2008 Department of Correction Admission Cohort with Length of Stay > 3 Days (First 2008 Admission)

Risk of Failure to Appear

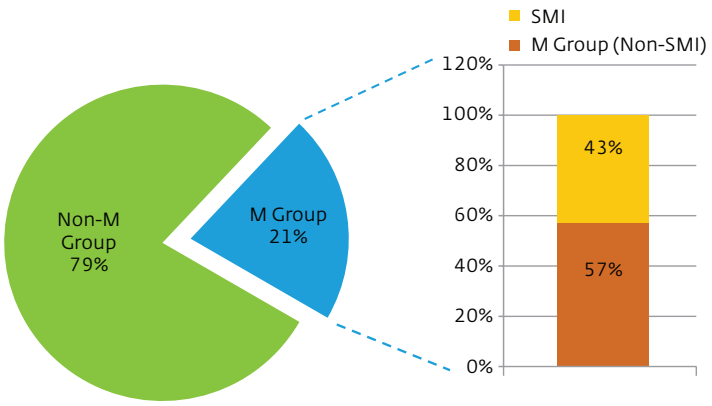
In making pretrial release decisions, under CPL 510.30, New York courts must consider factors associated with an individual's risk of failure to appear (FTA) in court. To inform pretrial release decisions made at arraignment, New York City judges use release recommendations and information provided by the Criminal Justice Agency (CJA). CJA's recommendations are informed by a statistically based assessment of the individual's risk of failing to appear in court if released on recognizance. FTA risk scores are calculated using information about an individual's criminal history and ties to the community obtained from interviews conducted at central booking facilities in the 24 hours following an individual's arrest and preceding his/her arraignment. Specifically, CJA makes assessments according to the following factors: whether the individual reports a valid New York City address; whether the individual has a working telephone or cell phone; the individual's employment status; whether there are prior bench warrants or open cases; and whether the individual expects someone to join him/her at arraignment. Based on the results of this assessment, CJA classifies individuals into one of three categories—Recommended for release on own recognizance (ROR); Moderate Risk for ROR; and Not Recommended for ROR.

- Stakeholders reported that delays occur at each stage of processing for cases involving those with mental illnesses for a number of reasons:
  - Prosecutors and defense counsel agreed that people with mental illnesses often have complicated social and personal circumstances, and cases involving these individuals require caution and exploration of additional options, which can be time consuming.
  - People with mental illnesses held in the DOC reported that they often have difficulty communicating effectively with their defense counsel.
  - Defense counsel noted that they often become de facto case managers responsible for identifying community-based plans in order to resolve their clients' cases.
  - Corrections managers reported that people with mental illnesses are more likely to be involved in jail incidents and may have difficulty navigating the justice system.[9]

III. The behavioral health needs and levels of risk of rearrest varied considerably among people in the M group.

- The M group included people with serious mental illnesses (SMI), as well as people who had some indication of mental health needs but did not meet the SMI criteria (non-SMI). According to DOHMH data, 43 percent of the M group met the criteria for SMI.
- Whereas people meeting criteria for SMI made up 53 percent of the 25-and-over population in the M group, those with SMI made up just 1 percent of the 24-and-under portion of the M group. This difference is partially explained by the criteria for SMI, which requires that an individual be over 18 years of age and that qualifying conditions be met for at least 12 months.

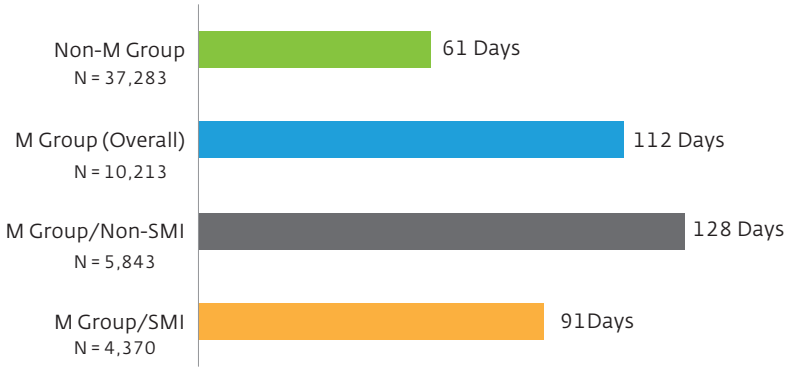
Portion of M Group Meeting Criteria for Serious Mental Illness (SMI)



Source: New York City Department of Health and Mental Hygiene, 2008 Department of Correction Admission Cohort with Length of Stay > 3 Days (First 2008 Admission)

- Within the M group, both SMI and non-SMI individuals had an average length of stay (ALOS) that considerably exceeded the ALOS for members of the non-M group. The non-SMI portion of the M group had an ALOS of 128 days while the SMI portion of the M group had an ALOS of 91 days, both significantly higher than the 61-day ALOS for people in the non-M group who did not have an indication of mental illness.

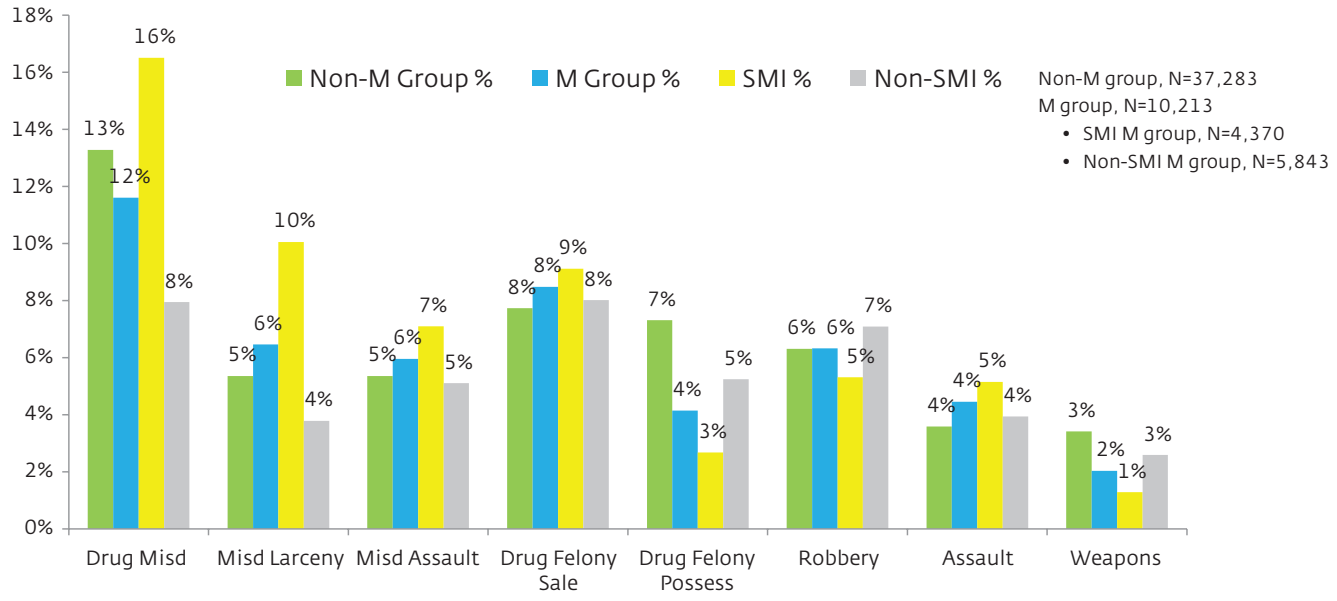
Average Length of Stay by Mental Health Status



Source: New York City Department of Health and Mental Hygiene, 2008 Department of Correction Admission Cohort with Length of Stay > 3 Days (First 2008 Admission)

- The nature and seriousness of charges may explain to some degree why people in the M group who did not meet the criteria for SMI had a longer ALOS than people in the M group who did meet the criteria for SMI. Misdemeanor charges—misdemeanor drug, misdemeanor larceny, and misdemeanor assault—were more common within the SMI group, while a higher portion of non-SMIs were admitted to the DOC with more serious offenses such as felony drug possession, robbery, and felony weapons offenses.[10]
- Compared to the non-SMI portion of the M group, a higher percentage of those meeting the criteria for SMI were classified in the medium-high and high criminogenic risk categories.[11]

Distribution of Non-M Group, M Group, SMI, and Non-SMI Across Most Frequent Charge Categories



Source: New York City Department of Health and Mental Hygiene, 2008 Department of Correction Admission Cohort with Length of Stay > 3 Days (First 2008 Admission)

Differentiating Behavioral Health Needs

People meeting criteria for SMI have functional impairments due to their mental illness that can be expected to continue over an extended period of time and have a high level of need for treatment and support services. Meeting the criteria for SMI is required to access many intensive and comprehensive evidence-based practices (e.g., assertive community treatment) in adult public mental health treatment programs. A majority of individuals meeting the criteria for SMI in national jail populations have co-occurring substance use disorders and integrated treatment approaches are necessary to achieve optimum clinical outcomes.[12]

People in the non-SMI category have a broad range of treatment needs. For those not meeting criteria for SMI, treatment may include medication and brief or long-term psychotherapies, including cognitive behavioral interventions. For those ultimately assessed as having substance use disorders only, appropriate community-based treatment may be necessary. Most of the non-SMI group is not eligible for Medicaid on the basis of their disability.

People in both the SMI and non-SMI groups may have co-occurring Axis II diagnoses (personality disorders and intellectual disabilities). Oftentimes people with these diagnoses pose management difficulties in and out of custody.

IV. Judges, prosecutors, and defense counsel stated that they typically did not receive sufficient and timely information to determine when placement in community-based alternatives to detention and incarceration (ATDs and ATIs) would be appropriate and effective.

- Prosecutors reported that information about a person's mental health status is rarely provided as part of a formal, standardized assessment, but instead is brought to their attention by families, victims, officer statements, or defense counsel. ATD and ATI administrators reported they, too, rarely receive information about a person's mental health status.
- Judges and prosecutors indicated that they typically do not use (or have access to) the results of a validated risk assessment to inform placement into community-based ATDs and ATIs. Judges, prosecutors, and defense counsel often make decisions about a person's placement in an ATD or ATI based on their own observations or recommendations provided by supervision and treatment providers themselves.
- Judges, prosecutors, and defense counsel reported that providing defense counsel with access to social workers increases defense counsel's effectiveness in identifying placement options for clients with mental illnesses.
- Judges stated they were often unfamiliar with community-based treatment options for defendants with mental illnesses, and what programs they are aware of are not sufficient to meet the demand for services.
- ATD and ATI administrators reported that community-based mental health treatment providers are often reluctant to serve people involved in the criminal justice system.
- When judges, prosecutors, and defense counsel receive key information about an individual's behavioral health needs, significant time is still required to identify and negotiate dispositions to community-based supervision and treatment. In addition, correctional staff reported that people with mental illnesses may present management challenges while awaiting appropriate placement in the community.

Policy Framework

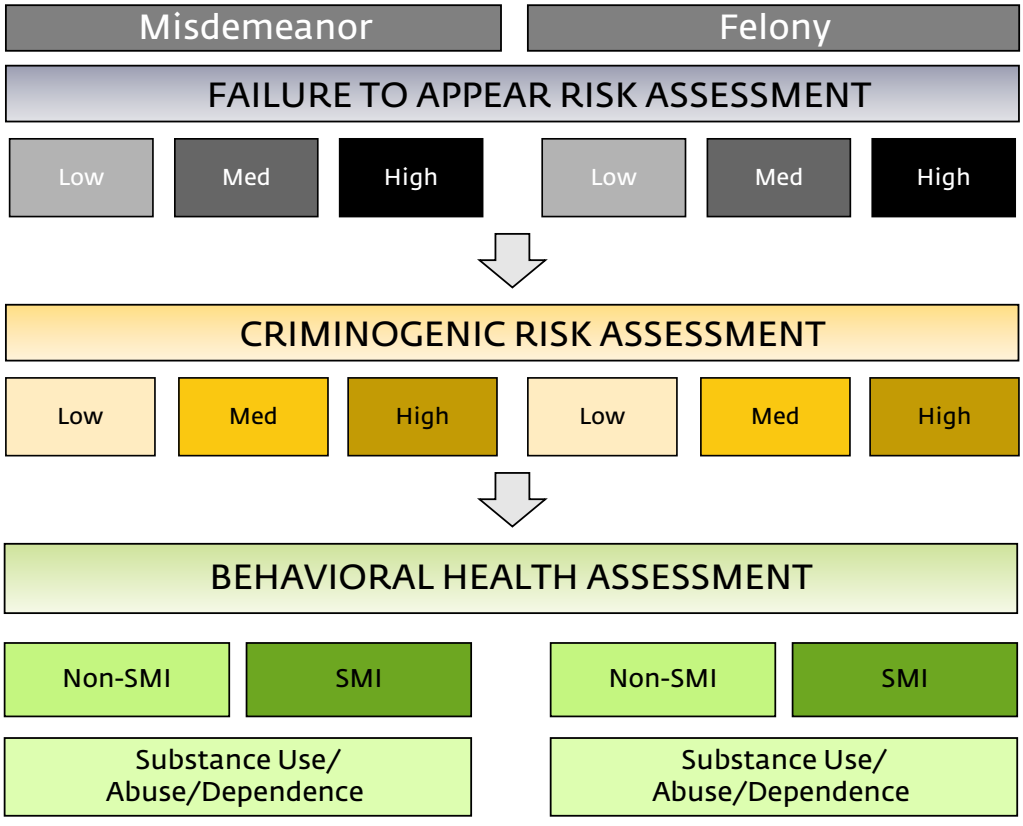
I. Determine levels of risks and needs

A growing body of research points to the importance of conducting individualized assessments to inform an appropriate combination of supervision and treatment that will be most effective in reducing recidivism and improving public health outcomes.[13] Such individualized assessments go beyond using information about the offense with which a person is charged and/or his/her criminal history to predict likelihood of reoffense. Similarly, information should not only indicate mental illness or substance abuse history, but also how acute the person's mental health and substance abuse needs are. By developing and implementing processes to get the appropriate level of information to decision makers throughout the system in a timely, user-friendly way, New York City officials can maximize the value of investments in community-based alternatives.

Strategies:

- Use validated assessment tools to identify risk of failure to appear, criminogenic risk, and behavioral health needs.
- Share assessment information with defense counsel, who can then negotiate and advocate with judges and prosecutors to inform decision making.
- Provide judges, prosecutors, defense counsel, DOHMH staff, corrections staff, and community behavioral health providers with the appropriate cross-training to understand and recognize behavioral health needs, and identify community-based supervision and treatment options.

Framework for Assessing the Risks and Needs of the M Group



II. Provide pretrial, plea, and sentencing options

When making pretrial release decisions, court officials—including judges, prosecutors, and defense counsel—should have options that will ensure that defendants return to court as directed without pretrial detention when less restrictive interventions will suffice. While many defendants can continue to be released on their own recognizance, for those who cannot, there should be options other than money bail that can provide court officials confidence that defendants will have the motivation and structure to return to court. Pretrial release programs that include some form of community-based supervision, and, when appropriate, community-based treatment, should be available based on assessments that inform the decision to release pretrial. New efforts throughout New York City—such as the Criminal Justice Agency's Queens Supervised Release and the Legal Aid Society's Manhattan Arraignment Project—have begun to use supervision and mental health assessment, respectively, to provide pretrial release options for those who previously would have likely been detained. These efforts remain limited, however, to relatively small groups in specific locales and do not yet link assessment of behavioral health and criminogenic needs to supervision and treatment strategies.

For those defendants whom the court is inclined to consider for some form of community-based supervision and treatment, these placements need to be made efficiently to minimize time in detention, and effectively to ensure that the level of supervision and services corresponds to the person's assessed risks and needs. Efficient and effective decision making hinges not only on how certain information is shared and used, but also on increasing the availability of existing community-based programs, which currently do not have the capacity to serve all the referrals they could potentially receive. Existing alternatives to incarceration—from diverse mental health courts in all five boroughs to programs such as CASES' Transitional Case Management and the Nathaniel Project or TASC's mental health diversion programs—serve only a fraction of the individuals involved in this study.

There is also a subset of people with mental illnesses charged with crimes not serious enough to warrant a state prison sentence, but whose risk of reoffending is so high that the judge and prosecutor determine the person's incarceration is appropriate and necessary. This high-risk population, however, typically completes their sentences in jail, returning to the community with routine discharge planning, but no post-release supervision. Accordingly, for this high-risk population with treatment needs, judges should have options that also ensure some post-release community-based supervision, along with treatment. In exploring this concept, policymakers will want to consider strategies such as adding post-release supervision in exchange for a shorter stay in jail, which would appeal to defense counsel who might not otherwise see such an option as advantageous to their clients.

Strategies:

- Develop alternatives to detention for individuals with diverse mental health needs who can be safely released pretrial.
- Expand the availability of alternatives to incarceration for people with mental illnesses who, based on assessed risks and needs, are appropriate for release.
- Expand the use of post-release, community-based supervision and treatment for people with the greatest risk of reoffending in order to increase the likelihood of successful transition.

III. Establish centralized resource hubs to coordinate assessment information and community-based supervision and treatment options

A systematic approach is needed to ensure that assessments are conducted uniformly and that this information is used consistently to connect people to the appropriate combination of supervision and services including treatment. Periodic, timely, data-driven reports are also necessary to determine whether programs are realizing their intended outcomes. (See "Centralized Resource Hubs" on page 13.)

Strategies:

- Coordinate assessment information, using appropriate consent and privacy protections, to develop case plans for community-based supervision and treatment.
- Systematically track performance and service delivery capacity at the city and borough level to allocate resources appropriately.
- Provide community-based behavioral health care providers, case managers, and supervision officers with training to equip them to work with people with mental illnesses involved in the criminal justice system.

Centralized Resource Hubs

Criminal justice and mental health systems across the United States are recognizing the importance of conducting timely, validated risk and needs assessments to improve outcomes for people with mental illnesses. In coming to this realization, they are also appreciating a host of challenges: a) conducting criminogenic risk and behavioral health assessments uniformly and recording these results consistently, no matter which staff performs them; b) sharing these results with appropriate consent; c) ensuring that court officials interpreting these assessments use this information consistently to inform decisions about what level of supervision and types of treatment most effectively address the combination of risks and needs; and d) maintaining a system-wide knowledge of what is available in the community and ensuring that limited programming slots are prioritized for the populations who would most benefit from them.

New York City is allocating funding to establish a centralized "resource hub" in each of the City's boroughs. By using a centralized organization to connect people with mental illnesses to the combination of supervision and services that are most likely to increase public safety and improve behavioral health outcomes, this approach will help ensure consistency and facilitate the most effective use of existing resources. New York City agencies will contract with selected community-based organizations to perform the following functions: 1) ensure assessment information is collected and shared appropriately and efficiently; 2) consult with defendants, defense counsel, and the courts; 3) partner with appropriate city and community-based organizations to develop supervision and treatment plans; 4) provide case management; 5) monitor compliance with conditions of release and coordinate with court officials as appropriate; and 6) compile and analyze data to inform city officials about trends and performance.

These resource hubs will reflect a joint effort among multiple city agencies, with the Criminal Justice Coordinator's Office, the Department of Correction, and the Department of Health and Mental Hygiene playing lead roles, in coordination with the Department of Probation and other relevant agencies. Each lead agency will dedicate staff and other resources to develop approaches that ensure that the hubs have appropriate levels of access to data maintained in the city's diverse information systems. The resource hubs will not only build and bridge institutional and community-based resources, but will also serve as a way to knit together the alternatives to detention and incarceration programs currently operating in the boroughs.

Considerations for Implementation

Adopting the strategies described above in all five boroughs could have a significant impact on the City's jail population. CSG Justice Center staff identified approximately 8,700 individuals in the adult system with identified mental health needs who were admitted to the DOC in 2008 and stayed the three or more days necessary to be part of the study group. Their average length of stay was 79 days, and all returned to the community following their incarceration. This group does not include the approximately 1,500 individuals in the study cohort with identified mental health needs who were sentenced to state prison.

CSG Justice Center staff used charge severity, risk of failure to appear, and criminogenic risk to identify three groups that could be appropriate for community-based treatment and supervision at different stages of case processing: "Group A" during the pretrial period; "Group B" after accepting a plea; and "Group C" after a period of incarceration.

Analyses on demographic factors, as well as the degree of the mental health need, were performed for each of these groups. CSG Justice Center staff also worked with stakeholders in the City to determine how these new approaches could be implemented without "net widening," either by placing people under supervision who would not otherwise have been or by lengthening the period of involvement with the criminal justice system unnecessarily.

Group A—Pretrial release for those who can be safely supervised and provided treatment in the community based on assessed risks and needs

Profile: Nearly 1,300 people with mental health needs were assessed as having a low or medium risk of failure to appear in court.

Approach: Collecting critical information about behavioral health needs and criminogenic risk as early as possible would provide the opportunity to develop alternatives to detention plans that would give judges plausible options besides money bail to ensure that defendants will return to court for trial. Developing processes to get this information to decision makers as quickly as possible—ideally by the first post-arraignment hearings—will maximize potential savings and reduce the number of days spent in pretrial detention.

Size of Target Group A	1,300 people
Criminogenic Risk	Low: 71% Medium: 24% High: 5%
Behavioral Health Needs	SMI: 25%
Age	Younger than 25 years of age: 42% 25+: 58%
Charge Levels	Misdemeanor: 55% Felony: 45%
Average Length of Stay	84 days

Group B—Expedited disposition to appropriate community-based supervision and treatment

Profile: About 4,600 individuals with mental health needs presented a high risk of failure to appear in court but only a low to medium risk of reoffending.

Approach: These individuals could be suitable for expedited disposition to community-based supervision and treatment. New York City already has a significant set of alternatives to incarceration that provide community-based supervision and treatment. These options are often available to individuals through a plea with a deferred sentenced to allow for treatment and program completion. Expanding resources to provide community-based services matched to an individual's risks and needs can reduce the time that people appropriate for diversion spend in costly DOC custody awaiting the opening of an appropriate treatment spot. A centralized resource hub could also facilitate the timely direction of individuals to the appropriate ATIs in each borough based on

Size of Target Group B	4,600 people
Criminogenic Risk	Low: 63% Medium: 36%* High: Not included
Behavioral Health Needs	SMI: 46%
Age	Younger than 25 years of age: 18% 25+: 82%
Charge Levels	Misdemeanor: 58% Felony: 42%
Average Length of Stay	79 days

*Numbers do not add to 100% due to rounding.

assessed needs, thereby both improving the accuracy of the referrals and reducing the time spent identifying appropriate ATIs and brokering case plans. The centralized resource hub could also provide the courts with updates on an individual's progress and suggest any needed amendments to conditions.

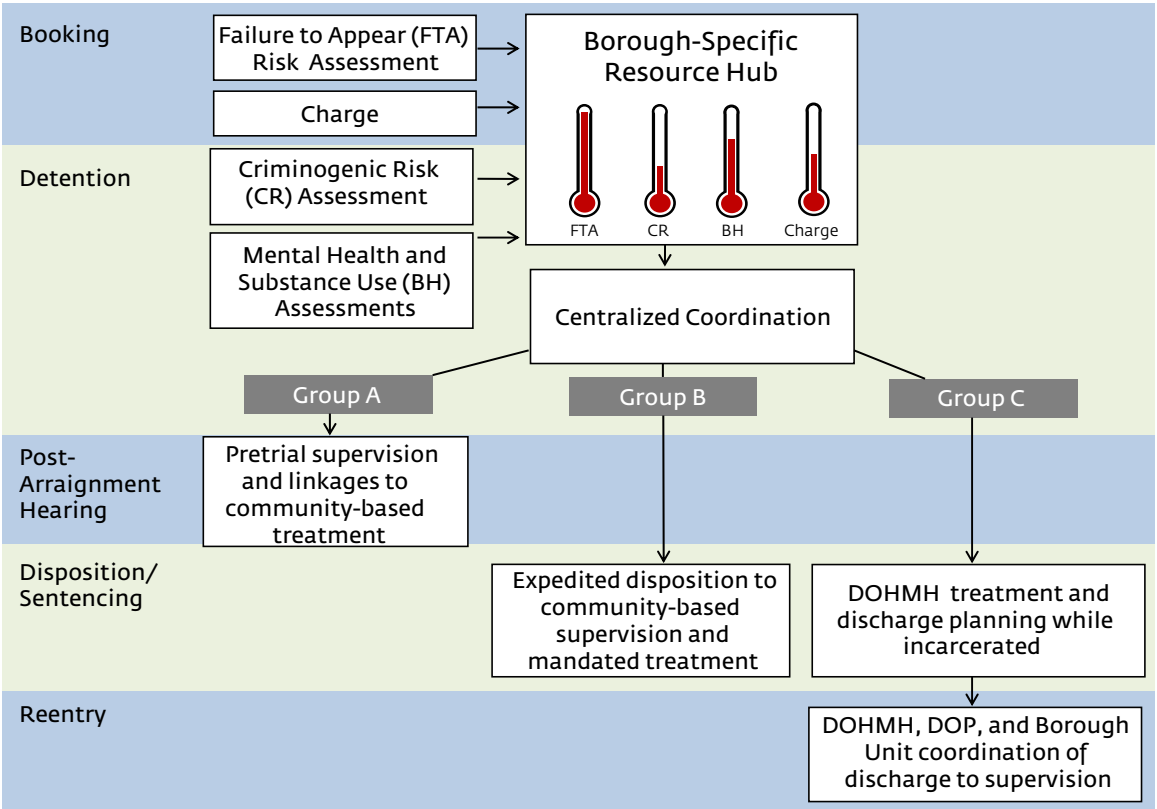
Group C—Post-release supervision and treatment for people who have been incarcerated in jail

Size of Target Group C	2,800 people
Criminogenic Risk	Low: Not included Medium: 36% High: 64%
Behavioral Health Needs	SMI: 51%
Age	Younger than 25 years of age: 11% 25+: 89%
Charge Levels	Misdemeanor: 63% Felony: 37%
Average Length of Stay	70 days

Profile: About 2,800 people with mental health needs presented both a high risk of failure to appear in court and a medium to high risk of rearrest but did not face charges serious enough to warrant a state prison sentence.

Approach: While the assessment and case planning described above are relevant here, implementation of this strategy will require additional discussion between judges, prosecutors, and defense counsel about the sentencing approaches and target populations appropriate for post-release supervision (e.g., split sentence or conditional discharge). It will also require close coordination between the DOC, the DOHMH, and the DOP to ensure appropriate pre-release planning, the development of the appropriate range of programming, and a smooth transition back to the community. There are significant challenges in program design for a population facing misdemeanor charges that is nonetheless at high risk for rearrest. However, the number of people in this category and the potential impact of targeted interventions are compelling reasons to continue working to identify additional dispositional options that will provide sufficient time and incentives for appropriate supervision and treatment.

Coordinating Assessment, Case Processing, and Community-Based Services



Additional Recommendations

There are other considerations that support effective implementation of this policy framework that would require additional strategic planning by city leadership and stakeholders in this process, including efforts to:

- Improve outreach and coordination with substance abuse treatment providers in the community to facilitate the provision of the coordinated and integrated care that is most effective in supporting recovery for individuals with co-occurring disorders;
- Improve coordination of the City's housing resources to address those in the criminal justice system with mental illnesses who are also homeless;
- Develop information technology to facilitate information sharing, as well as data collection to measure the impact of the new initiative;
- Cross-train criminal justice and behavioral health practitioners to dispel misconceptions about this population and provide information about available options under the new policy framework.

A number of other significant opportunities to improve outcomes for this population exist that were not within the scope of this study, including at the time of initial contacts with law enforcement, at arraignment, and while in jail. Building on this data-driven collaborative planning process will help to identify creative approaches that will improve outcomes for this population.

Endnotes

1. Steering Committee members included: **Honorable Jeffrion L. Aubry,** Assemblyman, District 35, Chair, Committee on Correction; **Alan D. Aviles,** President and CEO, Health and Hospitals Corporation; **Steven Banks,** Attorney-in-Chief, Legal Aid Society; **Greg Berman,** Director, Center for Court Innovation; **Honorable Richard A. Brown,** District Attorney, Queens County; **Joel Copperman,** CEO/President, CASES; **Honorable Elizabeth S. Crowley,** City Council Member, District 30, Chair, Committee on Fire and Criminal Justice Services; **Honorable Matthew J. D'Emic,** Presiding Judge, Brooklyn Mental Health Court; **Seth Diamond,** Commissioner, Department of Homeless Services; **Robert Doar,** Administrator/Commissioner, Human Resources Administration/Department of Social Services; **Honorable Daniel M. Donovan, Jr.,** District Attorney, Richmond County; **Thomas A. Farley,** Commissioner, Department of Health and Mental Hygiene; **John Feinblatt,** Chief Advisor to the Mayor for Policy and Strategic Planning and Criminal Justice Coordinator; **Linda I. Gibbs,** Deputy Mayor for Health and Human Services; **Elizabeth Glazer,** Deputy Secretary for Public Safety, Office of the Governor; **Michael F. Hogan,** Commissioner, NYS Office of Mental Health; **Honorable Robert T. Johnson,** District Attorney, Bronx County; **Rick Jones,** Executive Director, Neighborhood Defender Service of Harlem; **Raymond W. Kelly,** Commissioner, Police Department; **Honorable Judy Harris Kluger,** Chief of Policy and Planning, NYS Unified Court System; **G. Oliver Koppell,** Council Member, District 11, Chair, Committee on Mental Health, Mental Retardation, Alcoholism, Drug Abuse & Disability Services; **Scott Moyer,** President, The Jacob and Valeria Langeloth Foundation; **Denise E. O'Donnell,** Director, Bureau of Justice Assistance; **Ronald E. Richter,** Commissioner, Administration for Children's Services; **Vincent N. Schiraldi,** Commissioner, Department of Probation; **Lisa Schreibersdorf,** Executive Director, Brooklyn Defender Services; **Dora B. Schriro,** Commissioner, Department of Correction; **Robin Steinberg,** Executive Director, The Bronx Defenders; **Joseph Vaccarino,** Principal, Queens Law Associates; **Honorable Cyrus R. Vance, Jr.,** District Attorney, New York County; **Carolyn P. Wilson,** Director, New York County Defender Services.

2. Throughout this report, the term "criminogenic risk" refers to the risk of rearrest. (See "Risk Assessment" on page 5.)

3. Focus groups were held with staff and representatives from the following stakeholder groups: DOC, DOHMH, DOP, judges, prosecutors, members of the City's defense organizations, currently and formerly incarcerated individuals, forensic evaluation service providers, correctional health providers, researchers and members of academia, alternatives to detention or incarceration providers, advocates, housing service providers, social service providers, behavioral health providers, and crime victim advocates.

4. Each individual was counted only for his or her first admission to the DOC in 2008. People who stayed fewer than three days typically were not in jail long enough to receive the M indicator designation. The study cohort includes individuals sixteen years of age and older. All individuals sixteen years of age and older in the New York State criminal justice system are charged as adults. (The New York State Family Court Act § 301.2 defines individuals committing crimes who are over the age of seven and under the age of sixteen as "juvenile delinquents.")

5. The "M" designation expires at discharge and may be expunged if an individual is assessed as having no further need for treatment.

6. The term "Serious Mental Illness" as used in this report is synonymous with the New York State Office of Mental Health's definition of "Serious and Persistent Mental Illness," which can be found at http://www.omh.ny.gov/omhweb/guidance/serious_persistent_mental_illness.html.

7. This includes individuals charged with drug misdemeanors, misdemeanor larceny, and other misdemeanors.

8. Because the study focused on a cohort of admissions to the DOC, these analyses do not reflect the full population arraigned in New York City's criminal and supreme courts. The following analyses are based on pretrial interview information collected before the pretrial release decisions made at arraignment and only for those individuals who eventually became detainees or were sentenced and admitted to the DOC.

9. An independent analysis conducted by DOHMH found that, among M group individuals (both SMI and non-SMI), those with clinic visits for injury or involvement in jail incidents had significantly longer periods of incarceration than those without clinic visits. Andrea Lewis to Homer Venters, Memorandum, March 14, 2012, Medical Informatics, New York City Department of Health and Mental Hygiene and Correctional Health Services.

10. The DOHMH provided CSG Justice Center staff with the number of individuals with SMI by charge category. CSG Justice Center staff derived the number of non-SMI individuals by charge category assuming all SMIs had the M designation.

11. Difference in risk scores may be explained in part by age and charge differences, which are factors affecting an individual's risk score classification. (See "Risk Assessment" on page 5.)

12. While data on substance use was not directly analyzed in this study, in national samples, almost three-quarters of people incarcerated in jail meeting the criteria for SMI have co-occurring substance use disorders. The non-SMI portion of the M group in the DOC is also likely to have high rates of substance use disorders, both as co-occurring conditions and as the only current behavioral health disorder.

Abram, Karen M., and Linda A. Teplin, "Co-occurring Disorders Among Mentally Ill Jail Detainees," *American Psychologist* 46, no. 10 (1991): 1036-1045.

13. Council of State Governments Justice Center, 2012. *Adults with Behavioral Health Needs Under Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery*, by Fred C. Osher, David A. D'Amora, Martha Plotkin, Nicole Jarrett, and Alexa Eggleston. New York, NY.

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