

MENTAL ILLNESS POLICY ORG.
UNBIASED INFORMATION FOR POLICYMAKERS + MEDIA
50 EAST 129 ST., PH7 NEW YORK, NY 10035
OFFICE@MENTALILLNESSPOLICY.ORG
KENDRAS-LAW.ORG MENTALILLNESSPOLICY.ORG

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Ms. Elizabeth Glazer
Director of the Mayor's Office of Criminal Justice
City Hall
New York, NY 10007

Lilliam Barrios-Paoli
Deputy Mayor of Health and Human Services
City Hall
New York, NY 10007

Dear Ms. Glazer and Ms. Barrios-Paoli:

How to Reduce Incarceration and Need for Housing of People with Serious Mental Illness

Thank you for looking into how to reduce criminalization of the seriously mentally ill. Following are our recommendations. We would appreciate the opportunity to discuss them with you and the task force.

BACKGROUND

We who care for seriously mentally ill loved ones are often unable to keep our loved ones at home because we can't keep them in treatment. When untreated, the hallucinations, delusions, outbursts and anger create an untenable home situation. That puts a demand on New York to build more housing, shelters or jail cells. Our primary problem is that New York City has not supported us by making the *most seriously* mentally ill a priority, choosing instead to serve others. By focusing existing resources on evidence based programs that help improve a meaningful outcome for the most seriously ill, NYC can keep patients, the public and police safer. It can also cut the need for supportive housing and incarceration.

100% of adults can have their mental health improved. Twenty percent of adults over 18 have a diagnosable mental illness. But only 4% have a serious mental illness including the 1.1% with schizophrenia and the 2.2% with severe bipolar disorder.¹ These are the individuals most likely to become incarcerated and least likely to be welcomed into community programs. A subset of the seriously mentally ill are so sick, they don't know they are sick and therefore will not accept treatment that is offered to them. It's called anosognosia.² When you see a New Yorker eating out of dumpsters, screaming they are the Messiah, it is not because they *believe* they are the Messiah, they *know* it. John Hinckley *knew* the best way to get a date with Jodi Foster was to shoot President Ronald Reagan. When our loved ones become that ill it is virtually impossible for us families to continue to provide shelter. Unhoused, they needlessly deteriorate. Some are picked up by police for low quality of life crimes but lash out at the police or nurses who are called to intervene, causing a minor charge to suddenly escalate into a serious one. We can stop that from happening.

We have to *stop ignoring the most seriously ill*. We have to recognize unpleasant truths like *not* everyone recovers, sometimes hospitals *are* needed, sometimes involuntary treatment is needed, and when left untreated, the most seriously ill *are* more violent than others. We need focus.

¹ Three major disorders account for the bulk of people with serious mental illness, but other rare disorders can also be serious at various points in time. See NIMH Schizophrenia statistics at <http://www.nimh.nih.gov/statistics/1SCHIZ.shtml>. See NIMH, Bipolar Disorder statistics at http://www.nimh.nih.gov/statistics/1BIPOLAR_ADULT.shtml. See Severe major depression statistics at http://www.nimh.nih.gov/statistics/1MDD_ADULT.shtml.

² See anosognosia studies at <http://mentalillnesspolicy.org/medical/anosognosia-studies.html>.

Almost 100% of the programs in NYC *exclusively* serve those well enough to volunteer for treatment and specifically exclude those who are not. These are the very individuals who need help the most. Even within voluntary patients, programs cherry-pick the easiest to treat. That has to stop.

We can not continue to ignore the *most* seriously ill. They should be sent to the head of the line, rather than the jails shelters prisons and morgues. Ignoring them has resulted in the high rates of incarceration of mentally ill New Yorkers, a disproportionate number of whom are people of color.³ More money is always useful, but unless the resources are directed at the most seriously ill who refuse treatment, little progress can be made. Following are specific recommendations.

RECOMMENDATIONS

More robustly implement Kendra's Law

Kendra's Law is exclusively for a subset of the most seriously ill and reduces homelessness, 74%; psychiatric hospitalization, 77%; arrest, 83%; incarceration 87%.⁴ **No other program does that. Kendra's Law expansion must be on the menu.** By replacing inhumane and expensive involuntary inpatient hospitalization and incarceration with less expensive outpatient care, it cuts costs in half.⁵ The only incremental cost beyond the services these individuals should already receive is the court cost. Kendra's Law is not an alternative to community services, it is a way to see that those services get used by the most seriously ill.⁶ The court order also does what community mental health programs won't do voluntarily: prioritize the most seriously ill. The court not only orders the individual into treatment, it orders the system to provide it. While approximately 4,000 NYC residents over 18 could benefit from it, NYC only has 1,800 in it⁷. Greater use will enable families like mine to keep loved ones at home, rather than forcing them onto the streets where NYC would have to build housing, shelters or jails to accommodate them.

- *Put a Kendra's Law evaluator in all city hospitals.* NYC moved those who evaluate individuals for inclusion in Kendra's Law out of hospitals and to a central office making it harder for hospital administrators who want to file a petition to do so. There were never coordinators in all hospitals. There should be.
- *Establish a procedure to ensure that reports of persons who may be in need of Kendra's Law that are made by family and community members are, if warranted, investigated and that if appropriate, Kendra's Law petitions are filed.* Because filing a petition is beyond the ability of most families, we need officials to do it. But DOHMH has not set up a mechanism that allows them to receive and investigate

³ 55% of African Americans in state prisons and 63% of those in jails have mental health problems. Bureau of Justice Statistics, Mental Health Problems of Prison and Jail Inmates. September 2006, Available at <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>.

⁴ Summary of studies and link to actual studies available at <http://mentalillnesspolicy.org/kendras-law/research/kendras-law-studies.pdf>.

⁵ Swanson, Jeffery. The Cost of Assisted Outpatient Treatment. Can it Save States Money? American Journal of Psychiatry July 2013. Available at <http://mentalillnesspolicy.org/kendras-law/research/2013-duke-aot-cost-study.pdf>. While Kendra's Law cuts costs in half much of the savings accrues to criminal justice through reduced arrest, trial and incarceration, not to the mental health system. This is why the mental health system has been reluctant to use it.

⁶ A 2005 study found Kendra's Law helped the most seriously ill. "AOT has been instrumental in increasing accountability at all system levels regarding delivery of *services to high need individuals*." "AOT has resulted in increased outreach to individuals who had previously presented engagement challenges to mental health service providers". **Improved Collaboration between Mental Health and Court Systems.** As AOT processes have matured, professionals from the two systems have improved their working relationships, resulting in greater efficiencies, and ultimately, the conservation of judicial, clinical, and administrative resources." "There is now an organized process to prioritize and monitor individuals *with the greatest need*; AOT ensures greater access to services for individuals whom providers have previously been reluctant to serve." Source: March 2005 N.Y. State Office of Mental Health "Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment.

⁷ Calculation of number of state residents eligible is at <http://mentalillnesspolicy.org/national-studies/aotbystatecosts.html>. We estimated 50% are in New York City. Number of residents in NYC under court orders is at <http://bi.omh.ny.gov/aot/statistics?p=under-court-order>

reports from family members. NYSCLMHD argued that this process would be onerous. Even if true, that is not a reason not to do it. Focusing on the seriously ill should be the core function of the department. However, it would not be onerous. It would be very easy for officials to triage phone calls simply by asking callers to show that the individual had been “in a hospital, prison or jail at least twice within the last thirty-six months” or was involved in “one or more acts, attempts or threats of serious violent behavior toward self or others within the last forty-eight months.” Records for those are generally (not always) accessible, and hence provide a good triage methodology. Only the few meeting those criteria would need further investigation.

- *Set up a mechanism so that expiring court orders are proactively reviewed to see if they need renewing.* Right now, NYC allows court orders to expire without reviewing the appropriateness of doing so. People who need continuing AOT to be kept safe in the community are not receiving it. Research shows that those under court order for one year or more continue to do better even after the court order expires.⁸

Validate hospital discharge plans

Hospitals are under intense pressure to discharge patients, often before they are stabilized. To make sure the paperwork is in order, the hospitals ask the patient where they will live and accept whatever is said without validation. Often, to secure release, patients will say they are going to live with their mom or some generic ‘cousin’. Their mom may be dead or may be too elderly to care for a psychotic individual or be afraid of their own child. Discharge planners should validate discharge plans.

Hire special caseworkers assigned to help the seriously over the crack between hospitalization and community care.

The hospitals responsibility for the patient ends at discharge and the community program’s responsibility doesn’t start until intake. Many patients don’t make it from one to the other, they fall in the crack between the two. Special mobile social workers should be assigned to this crack in the system and help persons with mental illness over it.

Provide greater scrutiny and evaluation of patients involuntarily admitted to hospitals before they are discharged.

If someone has been involuntarily admitted to a hospital, they have already been adjudicated ‘danger to self or others’. These individuals should be provided greater evaluation prior to release to see what services they need to stay safe in the community—including Kendra’s Law if needed. This is the most high risk population. Hospitals should be required to document what services are being put in place for these discharged individuals and which of the criteria for Kendra’s Law the patient failed to meet if discharging an involuntarily committed patient without it. By providing added scrutiny for the involuntarily committed, and case managers to help them over the crack in the system, we can reduce the chance of repeat danger.

Make greater use of Conditional Discharge from hospital

Require physicians to make a reasonable effort to gather relevant information from the family of admitted patients.

HIPAA prevents physicians from disclosing information to families but does not prohibit them from receiving it. Many doctors hide behind HIPAA and refuse to accept information from families. This results on them relying on the often inaccurate representations of the ill. They may try medications that have failed in the past, be unaware of substance abuse, and oblivious to what has worked and hasn’t and the challenges the patient faces. Only by receiving info from loved ones can doctors deliver the best treatment.

Provide greater scrutiny and evaluation of inmates who received mental health services while

⁸ Van Dorn, Richard A. Continuing Involuntary Outpatient Treatment: Medication and Hospitalization: Outcomes in New York. Psychiatric Services. October 2010. Available at <http://mentalillnesspolicy.org/kendras-law/research/long-term-benefits-aot.html>.

incarcerated before they are let go from incarceration.

Every day jails and prisons release known mentally ill individuals without provision for continued treatment. They discharge to the crack in the system. Mentally ill prisoners should be evaluated to see what services they need to stay safe before they are discharged. This should include assignment to hospitalization, involuntary hospitalization, Kendra's Law or Psychiatric Parole if appropriate and arrangements made for it. There should be special officers or caseworkers to see that the discharged inmates make it over the crack in the system: that there is a program willing to receive them and they do go. Corrections officials may petition for AOT, but we are unaware of any doing so. They should be trained and encouraged to do so.

Support and expand Fountain House

Fountain House is one of New York City's few programs willing to accept the most seriously ill and see they receive treatment. Due to lack of support, Fountain House has to raise some of its own funds. New York should expand this program.

Support and expand Assertive Community Treatment Teams

Oppose closing of state psychiatric hospitals and expand psychiatric capacity of city hospitals.

As Chief Michael Biasotti, past president of the New York State Association of Chiefs of Police wrote, "When psychiatric beds go down, incarceration goes up."⁹ NYC should oppose state plans to close psychiatric hospitals which causes a back up in ERs, which causes denial of admission, which causes increased incarceration.

We would appreciate the opportunity to discuss these ideas with the task force. Thank you.

Sincerely yours,

DJ Jaffe
Executive Director



⁹ Biasotti, Michael. State's mentally ill need treatment, not incarceration. Albany Times Union. October 14, 2013. Available at <http://www.timesunion.com/opinion/article/State-s-mentally-ill-need-treatment-not-4894707.php>