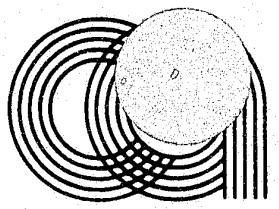
The Correctional Association of New York



INSANE AND IN JAIL

THE NEED FOR TREATMENT OPTIONS FOR THE MENTALLY ILL IN NEW YORK'S COUNTY JAILS

Prepared by the Correctional Association of New York

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October 1989

ACKNOWLEDGEMENTS

This document was prepared with the assistance of Pete Taft who worked as a writer/consultant on the project.

Work on this report was supported in part by a grant by the New York State Legislature that was channeled through the New York State Commission of Correction. Special acknowledgements are due Dan Feldman, Chair of the Assembly's Committee on Corrections, Terri Crowley, of Mr. Feldman's staff, Jim Yates, Counsel to the Assembly Speaker and to William McMahon, Chair of the State Commission of Correction and James Lawrence, who directs the Medical Review Bureau for the State Commission of Correction.

I. Introduction

Francisco Velasquez[1] was in trouble again: While in group therapy to control his alcoholism, he'd charged a halfway house attendant and was arrested for assault.

It wasn't the first time Velasquez had problems with the law. Nassau County authorities knew him, a diagnosed paranoid schizophrenic, as a chronically mentally ill offender who'd spent time in jail, prison and state hospitals on a lengthy string of charges. In fact, Velasquez was on bail awaiting sentencing for trespassing when the incident at the halfway house occurred.

In court, Velasquez squabbled with his attorney and shouted incoherently at the judge. Losing his patience, the judge ordered a psychological exam to determine if Velasquez was fit to stand trial. Though the test showed Velasquez lucid enough to participate in the proceedings, things went downhill from there. At the next hearing Velasquez continued verbally abusing both his attorney and the judge. When Velasquez finally insisted on being relieved of counsel, his exasperated court-appointed lawyer obliged. "I can't take this anymore," he told the judge.

Adjourning the hearing, the judge ordered Velasquez back to jail. There, according to his mother, Velasquez refused to bathe, eat, or take his medication; jail psychiatrists told her they legally could not force him to take his medication. Velasquez later called his mother to complain that inmates were beating him and guards were splashing him with ammonia. A few days later, he was placed in solitary confinement.

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[1]All names of offenders in this report are pseudonyms.

"Jail obviously isn't the place for him," said Velasquez's exasperated attorney. "But he can't simply be released. There's a valid concern that he'll lose his temper and hurt himself or others.

"It's an intolerable situation."

Francisco Velasquez is not an isolated case: Thousands of chronically mentally ill offenders like him are flowing into the criminal justice system across New York, frustrating police, puzzling judges, and swelling the courts with their ranks. If they're lucky, some of them will be spotted, diagnosed, and released to treatment. But the majority will end up languishing in what one warden called "society's backstop" -- jail -- where they'll prove disruptive, vulnerable to victimization, and time consuming, posing a very real danger to themselves as well as to staff and other inmates.

The situation in New York's jails reflects a larger, equally troubling, national trend. "Surpassed only by the problem of overcrowding," said former Federal Bureau of Prisons Administrator Robert Levinson, "the second highest area of concern for jail and prison administrators is coping with the increasing number of mentally disturbed offenders."

In 1987 the Correctional Association released "The Mentally Impaired in New York's Prisons," a groundbreaking analysis of the needs of mentally ill and developmentally disabled inmates held in the custody of New York State's Department of Correctional Services.[2] That report helped consolidate a statewide consensus around that issue and

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[2]A developmental disability is not a mental illness, but a physiological impairment attributable to mental retardation, cerebral palsy, epilepsy, neurological problems, autism, or other physiological complications. The disability is usually present at birth; clients are characterized as possessing low i.q.'s and experiencing difficulty with basic functioning. While developmentally disabled offenders were covered in the prison report, this document focuses solely on the mentally ill.

ultimately played a key role in expanding the number of special facilities and programs for these offenders, including a new unit at the Wende Correctional Facility reserved exclusively for mentally retarded inmates, a population that had never been serviced in the state prison system.

Purpose of this Report

While preparing that report, however, it became clear that more efforts were critically needed to divert mentally ill offenders from the criminal justice system and into treatment at the local level. There, they could receive help dealing with the pathology that has brought them -- and might ultimately bring them again -- to jail. This document was intended to both identify the needs of the mentally ill offender and describe the programs throughout New York that have been successfully diverting them from jail.

While we have achieved those goals, it has not been an easy task. Unlike the mentally ill in prison, scant research exists on the mentally ill in jail, and much of what exists is methodologically suspect.[3] As a result, an inordinate amount of time was spent identifying the characteristics and needs of this special population. Likewise, we encountered a dearth of viable programs for mentally ill offenders. After consultations with the New York State Office of Mental Heath (OMH) and the New York State Division of Probation and Correctional Alternatives, however, we were able to identify three promising programs for study: the Monroe County Clinic for Socio-Legal Services in Rochester, Treatment Alternative to Street Crime (TASC) in White Plains, and the experimental Mental Health Alternatives to Incarceration (MHATI), also headquartered in White Plains. Two site visits were made to each program.

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[3]In New York, prisons are state run institutions housing offenders sentenced to one year or more of incarceration. Jails are operated by local jurisdictions and confine minor offenders and pre-trial detainees.

What follows is, we believe, the first report of its kind in New York State. It first describes the problems of the mentally ill in New York's jails, sketches a brief profile of each of the three programs, and, finally, offers a series of recommendations intended to help legislators as well as criminal justice and mental health professionals better think about developing more programs to serve this troubled clientele.

There is a compelling financial argument for the expansion of such programs: Authorities estimate that keeping a mentally ill offender in jail in New York costs around $80 per day. The cost-per-client at the two established programs included in this report -- Monroe County's Clinic and Westchester's TASC -- are 87 cents and $1.64 per day, respectively.[4] But, as TASC Director Carlos Maldonado points out, the financial argument "is not the main issue. We look at it from a moral point of view. We have people who are mentally ill.

"Is it right to keep them in jail?"

II. The Problem

No one is exactly sure how many mentally ill offenders are incarcerated in New York's 74 county and municipal jails and 200 police lockups. No agency maintains such figures; precise numbers are difficult, if not impossible, to come by.

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[4]Neither program offers long-term in- or outpatient therapy; both serve basically as referral sources for programs that offer such treatment. Nevertheless, even when the expenses of such treatment are included, the use of alternative approaches results in significant savings over the cost of jail.

Some experts have concluded that anywhere from one to seven percent of the nation's jail population may be composed of psychotic inmates (those with the most severe forms of mental illness) while less serious, but nonetheless significant, mental illnesses afflict up to 20 percent. The New York State Commission of Correction, a state agency charged with monitoring conditions in the state's prisons and jails, estimates that three to 11 percent of New York's jail inmates may be psychotic, while 15 to 20 percent may suffer other psychological maladies. Applying those percentages, as many as 7,000 mentally ill inmates may have been locked up in New York's jails in March 1989.

While it is difficult to paint a detailed demographic portrait of the mentally ill inmate, experts believe that the population possesses the same characteristics as those of inmates found in most jails: Predominantly men between the ages of 18-40 who are poorly educated, were marginally employed before their incarceration, and possessed of limited means. Women may comprise anywhere from ten to 25 percent of the mentally ill in jail; their characteristics are considered generally similar to their male counterparts. For both sexes, the racial mix depends largely on the racial makeup of the jail's service area.

The pathologies of the mentally ill inmate, however, resist such easy generalizations. They can range from mild anxiety disorders -- agoraphobia or post-traumatic stress syndrome, for instance -- to serious psychoses that may leave an inmate delusional, hallucinatory, and completely out of touch with reality. Psychologist and Monroe County Clinic Director Dr. James R. Clark has identified at least 20 "archetypal" personalities from among the clients he has seen at the clinic over the past nine years. "We see everything from the shoplifting housewife to everybody's worst nightmare: an antisocial paranoid schizophrenic who abuses alcohol," he says.[5]

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[5]Though complex clinical diagnoses appear throughout this report, the reader need not possess a sophisticated grasp of psychology to discern their meaning. Broadly speaking, they describe the organic, emotional, or psychological pathologies identified by the Diagnostic and Statistical Manual (DSM-IIIR), the handbook of diagnoses used by

Frequently, the mentally ill inmate is characterized more as a public nuisance than a serious criminal. Typically, he is portrayed as a disoriented vagrant forever shuffling between jails and clinics, usually arrested again and again for some minor crime. Both homeless persons and "bag people" are usually counted among their number.

But while it is true that a significant percentage of the mentally ill in jail are caught in an endless cycle of arrest and treatment, relatively few of them are harmless vagrants. In fact, the severity of both their pathologies and their crimes is startling.

Most mentally ill jail inmates are, in fact, what some authorities label "systems abusers" -- men and women caught in what Henry J. Steadman, former director of New York State Office of Mental Health's bureau of survey and evaluation research, calls "a Byzantine pattern of relationships" with both the criminal justice and mental health systems. One study of 102 mentally ill jail inmates in California, for example, found that 90 percent of those inmates had a history of prior hospitalization for mental illness while 92 percent had prior arrest records.

While no such detailed data exists in New York, anecdotal evidence from the three programs described in this report support such a pattern. In Rochester, for example, Jacqueline James, head of the Clinic's unsentenced prisoner program, estimates that 60 percent of her clients have spent time in mental hospitals. In White Plains, a survey of inmates conducted by MHATI caseworkers revealed that 74 percent of the mentally ill inmates confined to the Westchester County Jail's forensic unit had been in jail before.

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most clinicians. The context of the sentence should suggest the severity of the disorder.

"The folks we hospitalize forget to take their medication, and come back," says Bruce Gehring, clinical coordinator at the Clinic. "The system can't break the pattern of arrest, hospitalization, no medication, arrest, and hospitalization." Jan Feldman, former court mental health nurse and director of the sentenced prisoner project at the Clinic, characterizes the population as "a batch of regulars I'm sure everyone would love to have somewhere else."

The characterization of mentally ill inmates as harmless vagrants, however, appears largely inaccurate: Many, perhaps most, suffer serious pathologies and have committed serious, often violent, crimes. Among the 102 inmates interviewed in the California study, for example, 80 percent exhibited "severe overt psychopathology" and 75 percent were judged ill enough to be involuntarily hospitalized.

New York's mentally ill in jail appear to possess similar characteristics. TASC Director Carlos Maldonado was struck by "the depth and breadth of functional impairment" uncovered by the MHATI survey of the mentally ill in the Westchester jail. In Rochester, meanwhile, Clinic personnel say most of their clients are suffering from serious mental illnesses and are facing time on serious felony charges. Some, in fact, argue that the client pool is getting tougher. "There's a hard core lump of people who are getting worse and worse," says Clinic Director James Clark. "And over the years we find ourselves doing...more and more patchup work with sicker and more violent people."

To be sure, their violent behavior is often the result of circumstances well beyond their control. Mentally ill offenders "often receive the worst that both [the criminal justice and mental health] systems have to offer," says former OMH director of research Henry Steadman; many decompensate into violence after repeated exposure to such ineffective and destructive placements. Likewise, others commit "violent" acts that are more pathetic expression of mental illness than deliberate, premeditated crimes: When, for example, the

wrinkles on a walnut recalled the face of an ape in the local zoo, one psychotic man in Rochester -- using a pointed finger in his pocket as a "weapon" -- robbed a bank and threw the money into the zoo's seal pit, urging the animals to return home.

Nevertheless, their mental illnesses may also play a significant factor in the violence associated with crimes. One upstate man was charged with assault with intent to murder after shooting at the mayor of his town. The man was diagnosed as having a "schizoid personality disorder with paranoid and antisocial features" -- an illness which would lead him "...to act in a very grandiose, self-centered manner, have difficulty expressing hostility and ordinary aggressive feelings...and [have a tendency] to blame others and ascribe evil motives to them," the court psychiatrist wrote.

Clearly, such a population places an enormous burden on the criminal justice system. Police officers must often wait hours after bringing a deranged person to a hospital emergency room. Once they are incarcerated, mentally ill people must be shuttled between forensic units and hospitals, causing administrative headaches for jail staff. Their cases generate a complex series of legal hearings to determine, among other things, their competency to stand trial and their mental status at the time of the offense; in court, their behavior exasperates both judges and attorneys. "It's very sad," says TASC Director Carlos Maldonado. "There's a lot of laughter and bafflement -- especially if the person exhibits odd behavior. [Courtroom personnel] just don't know what to do."

Too often, judges simply keep them in jail because, as one Westchester district attorney put it, "no one knows what to do with them." While in jail, they disrupt routine, act out, and are frequently victimized. They pose a very real threat of physical harm, not only to staff and other inmates, but to themselves: According to statewide data collected in 1982, half the inmates who committed suicide in New York's jails between 1977-82 had been previously hospitalized for treatment of a mental disorder. Sixty-four percent had

known psychiatric histories. In Monroe County, Clark was asked to interview a disturbed inmate accused of setting fire to his apartment. "Do you think about 'hanging up?'" Clark asked during the diagnostic interview. "All the time," the man replied, then broke down in tears.

What's more, some disturbing new evidence appearing in several studies suggest that once the mentally ill are in jail, they tend to remain in jail. That phenomenon was borne out, to a degree, in the data collected in the MHATI survey of the Westchester jail. "One of the most stunning findings of that research was the extraordinarily high probability that a mentally ill defendant would get an incarcerative disposition after a week in jail," said Bart Lubow, deputy director for alternatives to incarceration for the New York Division of Probation and Correctional Alternatives.

Some have argued that the mentally ill are best served by jail-based psychiatric units. But mental health experts point out that any form of institutionalization can be damaging to this troubled population. And, jail-based mental health services are, at best, substandard: The ACLU's National Prison Project once called jail mental health care in the United States "grossly inadequate to deal with the problem," while the American Medical Association has characterized jails as "second rate mental hospitals."

What is needed, experts say, is a comprehensive jail diversion system that spots the mentally ill offender early in the adjudication process -- perhaps as early as arrest or booking -- and diverts him or her to treatment as quickly as possible. "There is a substantial number of people in need [for whom] finding the appropriate treatment is the challenge," says former OMH director of research Henry Steadman. "The real question is how an individual community coordinates all those services to provide the treatment these individuals need. When they do that, the jail is 'treated' as well."

What follows are brief descriptions of three programs in two communities that have met that challenge and, as a result, provided "treatment" for both the offenders and the jails.

III. Three Program Approaches

A. The Clinical Model: The Monroe County Clinic for Socio-Legal Services

With considerable foresight, in 1963 Monroe County community leaders and representatives from the University of Rochester created a new mental health agency to address the growing number of mentally ill offenders coming into the county's criminal justice system. By offering a wide range of high-quality diagnostic, treatment, and referral services, the agency would, these leaders theorized, move the mentally ill more swiftly, effectively, and compassionately through -- and, by extension, out of -- the county criminal justice system.

To a great extent, that original mission is still being pursued at the Mental Health Clinic for Socio-Legal Services (known locally as "the Court Clinic" or simply, "the Clinic"). Clinic staff perform diagnoses, render opinions, offer treatment, administer medication, and recommend long-term treatment options for the 1,200-plus[6] mentally ill offenders referred to them yearly by judges, jailers, and other criminal justice officials in the greater Rochester area.[7] Clinic staff also serve more informally as a mental health consultants to police, probation, pre-trial service agencies and other organizations, offering occasional workshops and training sessions as well as advice.

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[6]1988 figures

[7]Fourteen police departments and 86 judges serve the county; in most cases, offenders are arraigned at the court complex in Rochester and held at the Monroe County Jail, located next door.

Though they work closely with almost every criminal justice agency in the area, Clinic staff are quick to point out that their role is to inform, not influence, the course of justice. "Criminal responsibility is not our province," insists Clinic Director James Clark. "We do not render opinions [as to whether an offender] is or is not responsible for his crime. We help the criminal justice system [get] the information to assess responsibility."

The Clinic is, in fact, a free-standing mental health clinic approved, and partially funded, by the state's Office of Mental Health.[8] Located inside the Terminal Building, a rambling, turn-of-the-century structure in the middle of downtown Rochester, the Clinic's headquarters have the look and feel of a doctor's office, not a public health agency: A roomy, cheerful and well-lit waiting area is attended by a pair of receptionists; a bank of private offices lead off from there. Clinic staff will use those offices to counsel the handful of walk-in clients who stop by each day. More likely, however, staff can be found one block away at the court and jail complex, administering treatment to inmates and conferring with judges, probation officers, jail medical staff, and attorneys.

The Clinic is staffed by a clinical psychologist/director (Clark), a psychiatrist/medical director, five consulting psychiatrists, four psychiatric nurses, and a specialist in developmental disabilities. In addition, medical students from the University of Rochester regularly serve six-month psychiatric internships at the Clinic. Clark says the rotation of new, young physicians keeps the Clinic "from going stale. How often can you hear someone say they will commit suicide and then hear the real cry for help?"

Though most of the Clinic's referrals come from city judges, probation officers, and the jail medical staff, referrals also come from other sources within the criminal justice system and from 'agents' of the mental health system -- district attorneys, public defenders,

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[8]Monroe County and OMH share half the Clinic's $409,000 budget.

probation and parole officers, physicians, emergency room nurses, hospital administrators, and police officers. Referrals generally occur early in the adjudication process -- at booking, arraignment, or after an inmate has spent a short time in jail.

Clinic staff spend the bulk of their time administering jail-based treatment (both counseling and psychotropic medication) to inmates and doing informal evaluations for judges who want a quick "snapshot" of a subject's mental status. That kind of assessment takes about 24 hours. "The judge doesn't need a long, meandering discussion of who this guy is," says Clark. "He needs the basics." In recent years, however, the number of requests has increased for longer, more complex, legally-mandated examinations to determine a subject's fitness to stand trial.[9]

While most cases are dispatched within a few days, some cases can drag on for weeks, even months. But even in the longer cases, Clinic staff don't see themselves as "long-term case managers," says Clark. "We don't pick up cases and stay with them forever. Gatekeeping, triage -- that's primarily what we have to offer."

When a case warrants more -- or different -- treatment than the Clinic can provide, staff can refer these clients to any number of treatment resources in the Monroe County area that offer everything from once-a-week outpatient therapy or family counseling to 24-hour sheltered workshops and intensive inpatient psychiatric care. They include four community mental health centers (including one at Strong Memorial Hospital, the University of Rochester's teaching hospital), two large private clinics, OMH's Regional Forensic Unit at Rochester Psychiatric Center for those in custody who require more

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[9]As per Criminal Procedure Law 730.30(1). Examiners must determine whether the subject can: (1) orient himself to time, place and person; (2) perceive, recall, and relate; (3) understand the charge(s) lodged against him; (4) work with an attorney; (5) appreciate, but not necessarily follow, an attorney's advice; and (6) withstand the rigors of a trial.

intensive treatment, and hundreds of private psychologists, social workers and physicians, many of whom know the Clinic well.

"It's an affluent uptown community," says Clark. "And the bottom line is that the service is surprisingly uniform. What is the best [agency]? I don't know that there is one."

But even in this resource-rich area there exists a need for more and better services. For the last several years clinic staff have been promoting the concept of a "forensic half way house", a small, 10-bed facility that would provide a 24-hour structured routine for the chronically mentally ill who are persistent offenders. Yet while the Clinic's formal proposal has won the support of Rochester's criminal justice and mental health communities and has been greeted favorably by county political leaders, it has yet to secure the necessary $300,000 it needs to begin operating.

Though it has fought its share of inter-agency battles, the Clinic is enormously popular among criminal justice and mental health officials in Monroe County. A few years ago an informal, Clinic-administered survey sent to those officials revealed a solid base of support.

While the popularity of the Clinic is apparent, its true performance is more difficult to gauge. Clark points to the absence of both lawsuits and negative press as an indication of the program's success. "People aren't jumping up and down and saying, 'Look at the problem with the mentally ill.' There are no newspaper stories, no unidentified dead bodies, no letters to the editor about mentally ill people."

Nevertheless, no objective study of the Clinic has been conducted. But in numerous interviews, officials in both the criminal justice and mental health systems in Monroe County unanimously expressed the belief that the Clinic is successfully diverting the

mentally ill from jail by applying its clinical expertise and serving as a mental health "consultant" to the criminal justice system. "The Clinic really helps," says Monroe County Public Defender Ed Nowak. "We absolutely use what they recommend."

Jail Warden Christian deBruyn may have put it best. "A lot of jails can identify mentally ill people," he says. "But in some cases, even our own medical staff doesn't have the expertise to work with them. But the Clinic does.

"I can't overemphasize the role the Clinic plays."

B. The Referral Model: Treatment Alternatives to Street Crime (TASC)

Not long ago a Westchester County judge, faced with a mentally ill defendant awaiting sentencing, brought a telephone book into court and began thumbing through the Yellow Pages in search of a treatment agency. After several minutes, he slammed it shut in disgust. "He just didn't know what to do with the guy, or where to send him," recalls Paul Scharf, chief of the Yonkers bureau of the Westchester district attorney's office.

During the early 1980s mentally ill offenders had, in fact, become a persistent problem in the Westchester courts. They were clogging the docket, confronting judges with difficult questions of disposition. What's more, representatives of treatment agencies were crowding the courtrooms, "fishing" for clients, then failing to report their progress. Rather than create an entirely new agency to end the logjam, Westchester officials instead turned to Treatment Alternatives to Street Crime (TASC), an program that had been in operation locally since 1978.

Developed from a national model created by the federal Law Enforcement Assistance Administration (LEAA), Westchester TASC, like other TASC programs around the country, was originally designed with one objective in mind: To efficiently refer offenders to, and monitor their progress in, drug and alcohol treatment. TASC was not to provide therapy, medication, or evaluation. It was to be, as Scharf puts it, "the middle of a spoked wheel" of agencies, referring clients to appropriate treatment, then following their progress. In 1982, to the delight of both judges and the prosecutor's office (which originally sponsored the program), Westchester TASC assumed responsibility for mentally ill offenders as well.

Today, mentally ill cases comprise roughly ten to 15 percent of TASC's annual caseload of about 800 clients (roughly 65 clients for each caseworker); drug and alcohol cases still make up the vast majority of referrals.[10]

TASC is a small, efficient operation consisting of 12 caseworkers, two supervisors and one administrator working out of three regional offices (White Plains, Yonkers and Mount Vernon) located close to or within the region's municipal (or, in the case of White Plains, county and superior) courts. TASC caseworkers divide their time between the courts and jails -- where they screen clients and make appearances at hearings -- and their offices, where they arrange treatment services by telephone.

Most TASC referrals come from prosecutors and judges. A TASC caseworker screens the referral and, provided the offender meets TASC's selection criteria, makes a treatment recommendation to the court. Should both the judge and prosecutor agree to that recommendation, the offender is either given a conditional discharge -- the discharge

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[10]In 1988, for example, 12 percent of TASC's total caseload was made up of mentally ill offenders (102 of 852). Drug and alcohol cases, on the other hand, accounted for 83.9 percent of the total (715 cases).

pending completion of the TASC-recommended treatment -- or sentenced to probation, with completion of treatment as part of the probation package.

Participation in TASC is limited to offenders who have committed misdemeanors or low-grade felonies (class D or E felonies such as forgery, larceny, or third degree burglary). In addition, an offender must be at least 16 years old, be lucid enough to understand the charges against him or her, and agree to participate in treatment for up to one year. Those criteria automatically preclude offenders with more serious forms of mental illness. TASC Director Carlos Maldonado describes TASC clients as people who have "a combination of involvement with drugs and alcohol and a mental illness [who haven't] gone so far as to have committed a heinous crime."

Martin is a good example: A homeless Vietnam veteran with a bipolar disorder[11], Martin was found wandering White Plains and was arrested for trespassing and criminal possession of a controlled substance. In jail, a TASC caseworker assessed his clinical and criminal history, then recommended to the court that Martin attend outpatient treatment at a local veterans' hospital. Martin was released on a conditional discharge, with the TASC caseworker charged with monitoring his progress in treatment. From that point on, the TASC caseworkers sole responsibility was to track Martin's attendance at treatment.

"It's screening but not diagnosis, referral but not treatment, then monitoring," observes Westchester County Criminal Justice Director Robert Maccarone, who has supported TASC since its inception. "Those distinctions are important."

Maccarone is right: TASC's approach to the diversion of mentally ill from jail is based on the ability to speedily refer, not diagnose, clients. Caseworkers are not expected

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[11]"Bipolar disorder" is a comparatively new term for manic depression.

to be skilled or knowledgeable about treatment methods, only about treatment options. "I expect of them almost a triage -- to know enough about the case to handle it efficiently," Maldonado says of his caseworkers. Adds TASC supervisor Andrea Leighton, "We're not involved in their day-to-day treatment. We're involved in finding them help."

Most times, that is not difficult in Westchester County, an affluent area with substantial mental health resources. TASC caseworkers have perhaps 50 to 60 programs, both inpatient and outpatient, to which to refer their mentally ill clientele -- resources ranging from major hospitals to private practitioners. But placing more seriously disturbed patients can be more difficult. "The problem is when a client needs more than [treatment that involves] one or two visits a week -- when they need more all-around services," says Andrea Leighton. "That kind of client really flounders."

Nevertheless, according to TASC's own limited statistics, the agency is doing a good job at matching client to resource. TASC measures its performance by gauging how far its clients progress in treatment: A "successful" client, according to TASC, "completes treatment with significant improvement"; "partially successful" clients finish treatment but "show marginal progress"; clients who fail to complete treatment or show no signs of improvement after completion are given "negative" or "neutral" designations. From January to September 1988, 36 percent of TASC's clients successfully completed treatment. From October to December, completion rates jumped to 47 percent.[12]

Overall, TASC enjoys an excellent reputation among Westchester County leaders. "We've had a number of experiences [including informal surveys] to indicate that district attorneys and judges are extremely supportive of TASC," says Bart Lubow, deputy director for alternatives to incarceration for the New York Division of Probation and Correctional

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[12]Figures are for all offenders. No separate statistics were available for mentally ill offenders only.

Alternatives, which funds half of TASC's $600,000 annual budget (Westchester County funds the other half; federal funding ended in 1981). "Lots of judges say it's a great resource -- and it is. If you're confronted with a guy who is drunk and out of his mind, TASC is a great resource."

TASC is not without its problems, however. Staff turnover historically has plagued the agency. A TASC caseworker position is a lower-grade county employee position that promises little in the way of career advancement. As a result, many TASC caseworkers have been transitional employees who, for the most part, are en route to a better-paying job elsewhere ("And if there is a better job, I encourage them to get them," says Maldonado).

Additionally, TASC has also only recently settled a longstanding turf war with probation over client supervision, a conflict that often left judges confused about which agency had control of the client. "There was the general feeling that TASC was a duplicitous agency," says Anthony De Angelo, then assistant director of probation for Westchester County. For a time, some probation officers refused to work with TASC. A written protocol, developed in 1988, appears to have established a tentative rapprochement.

Most important, there are those who criticize TASC for not being a true diversion program for the mentally ill. Lubow and others contend that TASC's narrow selection criteria limit them to working with a pool of inmates who, even without TASC intervention, would normally do little or no jail time. "While TASC may do an excellent job of identifying people with substance abuse or mental health problems and referring them to treatment agencies, they aren't necessarily targeting individuals who, absent that, would be incarcerated," says Lubow. "I don't think it's unfair to say that TASC is not a true alternative."

Last year, however, funding and political pressures forced TASC to drop its work with clients charged with violations[13] and add the new low-grade felony criterion (one veteran caseworker is now assigned fulltime to felony cases). Pointing to a TASC list of excluded charges, Maldonado notes that there is a "growing grey area" of charges the agency is coming in contact with -- robbery, burglary, assault -- "charges that we never took before."

These changes, Maccarone and others argue, make TASC more of an alternative. "I recently spent several hours talking with TASC caseworkers and it confirmed my gut impression that 50 to 55 percent of their cases are true alternatives," says Maccarone. "I think TASC is an alternative. Is it in every case? No."

C. The Intensive Case Management Model: Mental Health Alternatives to Incarceration (MHATI)

The "pure" diversion program that TASC's critics seek may be found in the Mental Health Alternatives to Incarceration (MHATI, pronounced "ma-ha-tee"), a three-year experimental program funded by OMH that is, as of this writing, in various stages of development in Westchester County, the Bronx, and Oswego County.

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[13]Violations are infractions of the law punishable by fines, but not imprisonment.

MHATI is the third of a three-part effort by OMH's Bureau of Forensic Services to get local mental health and criminal justice systems working more closely together statewide. The first project consisted of a multifaceted education and awareness program to help jailers better identify suicide-prone inmates; that project ultimately produced a suicide prevention screening checklist that is now standard issue in almost every jail. A second program, the Police-Mental Health Coordination Project, is currently developing training materials and working with local police to teach them how best to deal with mentally ill offenders.

MHATI, begun in 1987, aims to divert mentally ill offenders destined for jail into appropriate treatment programs. By OMH's design, each MHATI site will approach that task differently. By bringing mental health and probation officials together for during presentence investigations, for example, Oswego MHATI hopes to make therapeutic services more readily available to mentally ill inmates bound for probation. Westchester MHATI, the most fully developed of the three (and, as of this writing, the only one in operation), meanwhile, is trying to keep mentally ill offenders out of jail by employing what OMH officials call "an intensive case management" approach.

"Intensive case management" is just what its name implies: intensive, almost constant supervision of mentally ill clients. A caseworker is placed on 24-hour call to help a client secure housing, buy food, find work, collect welfare checks, meet clinic appointments, take medication, find a bus -- anything he or she might need to bring structure, and thereby reduce stress, in his or her life. "The idea is if you can react immediately to psychological stressors, the chances for decompensation [and re-arrest] will decrease," explains TASC Director Carlos Maldonado, who also serves as administrator of Westchester MHATI.

The MHATI program in general -- and Westchester MHATI in particular -- relies heavily on research. Maldonado and others associated with the program spent the first

year conducting a literature review, collecting data on the mentally ill in jail and studying how other programs around the country had addressed their needs. The group then conducted a survey of the Westchester County Jail's forensic unit, gathering information on the characteristics of prospective clients.

Now, every Monday, MHATI's two caseworkers[14] comb computer printouts from the jail's forensic unit looking for offenders who fit MHATI's criteria: Westchester residents who are over 16 and possess both a criminal history as well as a chronic mental illness. Maldonado calls them "chronic and workable."

Once the district attorney approves an offender's MHATI involvement, he or she is released from jail and placed in the custody of a caseworker, who carries a beeper so the client can stay in constant touch. "TASC would say to a client, 'Be at your appointment,'" says Maldonado. "MHATI grabs the client by the hand and takes him there."

As of this writing, MHATI's two caseworkers carry caseloads of two clients each, and are looking to add more. Maldonado had originally hoped his caseworkers would carry a relatively light caseload of 20; when the demands of the case management approach became apparent, he reduced that number to 10 to 12. The progress of at least one of the four cases suggests that intensive case management can be effective with mentally ill offenders.

When MHATI caseworker Marilyn Gittens first encountered Diana, she was a homeless drifter who had been in and out of jail on a series of minor charges. Every day for two weeks, Gittens helped Diana with routine chores -- obtaining medication, coordinating welfare payments and veterans' benefits, finding her a place to stay. Slowly,

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[14]The entire MHATI staff consists of Maldonado and two caseworkers.

Diana became healthier and better groomed -- and stayed out of jail. "It's consistency," explains Gittens. "I know where she is, she knows where I am. She gets what she needs, when she wants it. Two to three weeks is too much wait for these people." As of this writing, Gittens is slowly distancing herself from Diana so she can learn to live on her own.

As of this writing, however, none of the other three MHATI cases have met with equal success. Two were re-arrested and another began drifting again after the MHATI caseworker found him housing and social services. But Maldonado is not discouraged by what appears to be the limited success of the $65,000-per-year program[15]. "It's a 25 percent success rate, and that's significant," he says. "Usually with this population, you'd get zero percent."

Maldonado argues further that MHATI is a good model for a diversion program for mentally ill offenders, since "unlike TASC, which gets referrals [from all parts of the criminal justice system], MHATI gets referrals strictly from the forensic unit in the jail." Bart Lubow agrees. "[MHATI's research suggests that] if you are mentally ill, charged with a crime, and in detention after a week, the odds that you will be sent to serve time upon conviction are extremely high," he says. "If MHATI identifies its population from among those people, it will be likely to be [a true] alternative to jail."

IV. Recommendations: Steps to Establish Programs that Work

[15]That budget pays for two caseworkers' salaries, Maldonado's supervisory time, and administrative costs, many of which are shared with TASC.

Though no objective studies have been conducted on their performance, our field research has convinced us that well-run local programs can effectively divert mentally ill people from jail and provide them with therapeutically beneficial support services. In addition, such programs offer valuable information and direction to beleaguered criminal justice officials who daily must deal with this difficult population. Accordingly, we strongly urge state and county officials to set aside the necessary resources to expand such efforts at the local level.

As they move toward this goal, policymakers should consider the following important question: Do any of the three programs described in this report offer a viable model for replication?

In our view, each program's methodology clearly warrants consideration. The clinical approach used by the Clinic provides a sophisticated level of service rarely made available to local criminal justice officials. The speed with which TASC refers clients to treatment is the primary reason for its continued support among officials in Westchester County. And, while still in the experimental stage, the intensive case management approach employed by MHATI is slowly gaining respect: In 1988 both OMH Commissioner Richard Surles and Gov. Cuomo publicly stated their support for the intensive case management of non-criminal mentally ill clients.

But while each approach merits study, it would be unwise to select any one as the foundation for a statewide model. Each program was created under a unique set of circumstances in an effort to address a specific problem; no attempt was made to fashion a comprehensive diversion program. A more valuable approach might be to analyze the critical elements from each program that would, taken together, help build an effective statewide model.

What follows, then, are six key recommendations gleaned from our research and site visits. They represent a consolidation of the most current thinking in New York about what constitutes an effective and comprehensive diversion program for the mentally ill in jail. They do not address all the issues: Local constituencies such as counties and municipalities must fashion their own response to the unique problems and needs of their mentally ill population[16]. But, taken together, the following suggestions go a long way toward establishing programs that work.

1. Sound research -- Any effort to build an effective diversion program must begin with thorough research. MHATI officials, for instance, carried out an extensive literature and program review before giving shape to their program. That data helped the program target its clients and avoid the pitfalls suffered by others.

Unfortunately, for the most part, research into the subject of the mentally ill in jail "stinks," says former OMH research director Henry Steadman. "It's been done by caring and competent people, but most of the time the samples are ones of convenience. They don't allow you to generalize to all inmates in all jails." As Clinic Director James Clark puts it, "differing communities have differing problems. Some questions are useful only to an immediate locality. Some questions do not transfer."

More thorough and well-designed research is needed on all aspects of the mentally ill in jail -- including independent assessments of the effectiveness of diversion programs.

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[16]Court Clinic Director James Clark and others believe that community standards are a critical element to consider when setting up an diversion programs: Police in rural and semi-rural jurisdictions are more likely to know -- and know how to deal with -- a mentally ill offender. "If I know Uncle Fred and he is running around raising hell, I might take him for a cup coffee, take him to the doctor, and take him home," says Clark. "In a community where no one knows him, they're going to take him to jail."

To that end, substantial funds should be allocated, both statewide and within individual program budgets, to hire skilled outside evaluators.

Most authorities agree, however, that the primary focus of research should be on the inmates themselves. "We need to know about the prevalence of different disorders, the course of disorders once (they) get in jail, and the careers of the mentally disordered offender through the criminal justice and mental health systems," says Steadman. "Not enough has been done."

2. Better training for police -- Little is said about the police's role in diverting the mentally ill from jail, yet it can be a significant one. In New York, police have the power to transport a person to an emergency medical facility when he or she appears mentally ill and on the verge of causing "serious harm to himself and others."[17] Unfortunately, most officers are reluctant to exercise that power: Experience has taught them that they'll end up waiting long hours at the hospital being ignored by doctors, only to watch as their detainee is released back out onto the street. Those kind of experiences, says Terry McCormick, program specialist with OMH's Bureau of Forensic Services, have created an "antagonistic and irritated" relationship between police and the mental health community in New York.[18]

In Rochester, Clinic staff have tried to improve that relationship by offering workshops and training sessions for police and other major players in the criminal justice

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[17]Section 9.41 of the Mental Hygiene Law

[18]In more recent times, many also have come to fear lawsuits, even though New York law protects police against frivolous legal action provided they have followed, in good faith, the guidelines set out in section 9.41 of the Mental Hygiene Law.

system. "The word is out there," says Clinic Director James Clark. "As a result, the level of sophistication and awareness may be higher here than other communities."

Educating police statewide will require a similar kind of outreach. At a minimum, they need to learn how to identify and to handle mentally ill offenders, and how to negotiate the local mental health services network.

Those objectives represent the foci of the Police-Mental Health Coordination Project, a joint venture of OMH and the New York State Division of Criminal Justice Services' Bureau for Municipal Police. The project hopes to both train police officers in working with the mentally ill and establish formal relationships between local police and mental health service providers.

So far, the project has developed three videos and a training manual for police academies upstate and on Long Island; an in-service training program for veteran officers will soon follow. The project has also organized five "executive forums" for police chiefs and mental health executives, and distributed "mini-grants" for projects in eight counties.

3. Effective and immediate screening -- While there is some debate over what point in the adjudication process to screen offenders for signs of mental illness -- at booking or arraignment, during the jail admissions process, or early in the jail stay -- staff at all three programs unanimously agree that screening must be effective, immediate, efficient and comprehensive.

"Every single person coming [into the system] needs to be screened for mental health problems," says Henry Steadman. "But not by a mental health professional. There

has to be a mechanism that the front line officer can use as a 'first stage screen' for those who need further help. There will never be enough money to afford a professional evaluation."

Can such a mechanism be developed? Five years ago, New York's Office of Mental Health developed a suicide prevention checklist to help jail officers identify high-risk inmates coming into jail. The questions on the checklist took about five minutes to administer. Yet that simple procedure has helped drastically reduce the number of suicides in New York's jails and made the state a leader in jail suicide prevention nationwide. A similar, simple screening device can -- and must -- be developed for the mentally ill entering the criminal justice system.

4. A skilled and flexible staff -- The value of talented and committed caseworkers and clinicians cannot be overestimated. In fact, federal officials reviewing various TASC programs around the country found that "the quality of the staff was more important to program success than organization and other factors...[and] staff training is..a critical program element..." In order to attract -- and, in the case of TASC, maintain -- high quality personnel, jail diversion programs must start by paying good salaries, offering meaningful training, and providing opportunities for career advancement.

Both TASC Director Carlos Maldonado and Clinic Director James Clark attach a high value not only to the calibre and dedication of their personnel, but to their ability to establish smooth working relationships with both criminal justice and mental health personnel. One OMH official characterized staff at both programs as using "good will to effectively combat the same problem."

TASC's felony caseworker Fabriola Piperis, for example, moves in and out of the Westchester county courts with ease thanks to more than ten years experience working with district attorneys and judges who, like her, have moved there from the local courts. "Personal relations [like that] are paramount," says Maldonado. "We have to develop trust between the district attorneys and the judges. Our credibility depends on it."

In Rochester, meanwhile, Clark says that the "open door" policy his staff enjoys with many judges is in part due to the staff's ability to speak the language of criminal justice. Judges, attorneys and courtroom personnel respect clinicians who can understand the system, says Clark. "We're fast --and we know the criminal justice system," he states.

5. The availability of appropriate treatment -- Diverting the mentally ill from jail accomplishes little without the availability of appropriate treatment programs to support them upon release. But while a reasonable number of options exist for the mildly disturbed -- individual counseling, marital and family therapy, medication and other forms of outpatient treatment -- few treatment programs address the needs of the chronically disturbed who make up the core of the jail's mentally ill population. "There's a severe limitation of resources for this population," says TASC supervisor Andrea Leighton. "Some can be served well in an outpatient program. But services for someone who needs more than that are difficult to find."

Why? The mentally ill are notoriously poor clients. They miss appointments, forget to take medication, and are disruptive in the clinics. As a result, treatment agencies resist accepting them. "A lot of mentally ill don't follow through with their services," explains Morris Black, director of community services at the Jewish Board of Family and Children's Services in New York City. "Most have poor impulse control and serious character

disorders. They're alienated people with marginal personalities -- not the kind of people who are highly motivated."

Treatment agencies are doubly concerned when a client has a criminal record. "There continues to be a reluctance on the community agencies' part to take someone who is wrapped up in the criminal justice process," says Dr. Andreas Pederson, former director of mental health in Monroe County. "They don't understand them, they are afraid of them, and they think something terrible is going to happen." One halfway house supervisor in Manhattan offered that mentally ill offenders "scare" his staff. "Frankly, they would rather they didn't exist," he said.

The chronically mentally ill may be poor clients in some settings, but studies have shown that they can make significant improvements when involved in programs that assist them with everyday survival skills -- shopping, grooming, finding transportation, getting work, obtaining medication, etc. Such social controls "...are important...to these patients, for whom life without structure and controls is chaotic and characterized by intense anxiety, depression, fear and deprivation."[19]

MHATI'S intensive case management approach is modeled along the same principles; so, too, is the Clinic's proposed "forensic halfway house." But MHATI is experimental, and the forensic halfway house has yet to secure funding. Many more such programs must be both funded and developed statewide.

6. An ongoing dialogue between the criminal justice and mental health communities -- In 1983 delegates to the first -- and only -- national symposium on the mentally ill in jail

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[19]H. Richard Lamb and Robert W. Grant, "The Mentally Ill in an Urban County Jail," Archives of General Psychiatry, Vol. 39, January 1982, pp. 17-21.

(sponsored by the now-defunct National Coalition for Jail Reform) concluded that the first and most important element in establishing an effective jail diversion program for the mentally ill is a vigorous and ongoing dialogue between officials in the criminal justice and mental health communities.

We agree. Specific recommendations about staffing, treatment, and other matters relating to jail diversion programs will accomplish little unless officials in local criminal justice and mental health systems agree to work together to learn each other's language, problems, policies, and procedures.

It isn't difficult to understand why such a relationship is critical. Though they both deal with the mentally ill, the two systems approach that group from widely divergent points of view: To the mental health system, a woman who sets fire to her son's former home on the anniversary of his death is a client suffering from paranoid delusions who requires treatment; to the criminal justice system, she is an offender guilty of arson who requires sanction. While on the surface they may appear to work in concert, the deeper, philosophical gulf between the two systems is wide.

That was clear in 1988, when OMH convened a conference of several MHATI advisory boards, which are composed of officials from both criminal justice and mental health systems. The first day's discussion focused on the "seriously mentally ill." By the second day, however, Bureau of Forensic Services program specialist Terry McCormick and other OMH officials realized "that when we were saying 'serious,' the criminal justice personnel were hearing 'violent.'"

"There's a good example of [officials] applying criminal justice terms to a new population," says McCormick. "Some sort of dialogue has to occur. That's the bottom line."

To that end, Andreas Pederson, former director of mental health in Monroe County, has proposed a criminal justice/mental health "coordinating committee" composed of prosecutors, public defenders, judges and mental health professionals. Such a committee would meet regularly to "surface the various issues, increase communication, and influence decision making and help lobby for mental health issues in the criminal justice system," says Pederson. Other counties around the state should also seriously consider establishing similar committees.

The best statewide jail diversion model will accomplish little without such a dialogue between professionals from both fields. "People have to deal with the issues first before they can talk about the client," says Terry McCormick. "Once that happens, it's easy. It takes all the mystery out of both the mentally ill and the criminal court process."

V. Conclusion

Both TASC and the Court Clinic are facing unprecedented periods of organizational stress. TASC's total caseload has almost doubled in the last three years due mostly to what Director Carlos Maldonado calls "an explosion of drug cases" that are not only increasing TASC's workload, but forcing the agency to put mentally ill cases on the back burner. In Rochester, meanwhile, Clinic staff have seen a steady increase in referrals, a doubling of cases requiring hospitalization, and an almost tripling of requests for competency exams over the past four years. "Potential treatment time [is being] wasted" by officials who make well-meaning but unnecessary requests for Clinic services, Clark says.

At the same time, tight budgets are forcing many treatment providers to trim services to the mentally ill. In 1988, for example, the Rochester Psychiatric Center (RPC) stopped providing acute psychiatric care to the community; in 1990, the institution plans to reduce its number of available in-patient beds. RPC's cutbacks have forced the Clinic

into the position of "trying to sell highly undesirable patients to organizations unwilling to receive them," Clark wrote in the Clinic's 1988 annual report.

These trends must be reversed. Now more than ever, there exists a critical need to establish new treatment programs statewide for the mentally ill offenders. Given the complexity of the problem, many of these new efforts will no doubt struggle, even fail: Officials at one new diversion program in Oneida County, for example, have found local treatment providers resistant to accepting the program's referrals, fearing they will "be deluged with 'criminal types.'[20]"

But in an era of diminishing resources and increased inmate populations, there is no other choice. For jail is, as Monroe County Jail Warden H. Christian deBruyn says, too "bizarre and unnatural an environment" for the mentally ill offender. "Saying you're going to rehabilitate [such a person] in jail," says deBruyn, "is almost a double negative."

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[20]From Westchester MHATI's program review material.

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