6-2019

# The Treatment of People with Mental Illness in the Criminal Justice System: The Example of Oneida County, New York

Alexander Black '19
*Hamilton College*

Kylie Davis '18
*Hamilton College*

Kenneth Gray '20
*Hamilton College*

Connor O'Shea '18
*Hamilton College*

Alexander Scheuer '18
*Hamilton College*

*See next page for additional authors*

Follow this and additional works at: https://digitalcommons.hamilton.edu/student_scholarship

Part of the Criminal Law Commons, Criminology and Criminal Justice Commons, Law Enforcement and Corrections Commons, and the Psychiatric and Mental Health Commons

**Authors**

Alexander Black '19, Kylie Davis '18, Kenneth Gray '20, Connor O'Shea '18, Alexander Scheuer '18, Samantha Walther '18, Nico Yardas '18, Frank M. Anechiarico, Ralph Eannace, and Jennifer Ambrose

# The Treatment of People with Mental Illness in the Criminal Justice System: The Example of Oneida County, New York

AUTHORS

Alexander Black, '19
Kylie Davis, '18
Kenneth Gray, '20
Connor O'Shea, '18
Alexander Scheuer, '18
Samantha Walther, '18
Nico Yardas, '18


ADVISORS

Prof. Frank Anechiarico, Maynard-Knox Professor of Government and Law, Hamilton College
The Hon. Ralph Eannace, Judge, City Court of Utica, New York

EDITOR

Dr. Jennifer Ambrose, Director, Hamilton College Writing Center

PRODUCTION

Nico Yardas, '18


June, 2019

# TABLE OF CONTENTS

## CASE STUDY 3112

# EXECUTIVE SUMMARY

Nicolas Yardas
April, 2019

# Foreword

This executive summary provides a general overview of a larger report, attached to this document, of the criminalization of the mentally ill. It begins by summarizing three case studies from the report that concern the intersection of mental health issues and the criminal justice system in Oneida County in New York State. It then provides a brief historical overview of mental health issues and the criminal justice system before going on to discuss the current best practices in addressing the criminalization of the mentally ill, including law-enforcement mechanisms, mental health courts, and reintegration programs. Next, the paper identifies the shortcomings of these practices and the lack of organizational and financial capacity that hobbles concerned stakeholders from effectively tackling the issue. The paper concludes by proposing a general program for immediate action on local and national scales.

The first case study, "The Treatment of the Mentally Ill in the Criminal Justice System: Survey of the Corrections and Forensic Environments in Oneida County, New York," by Samantha Walther, surveys the current care practices and interventions at Oneida County Correctional Facility, Marcy Correctional Facility, Auburn Correctional Facility, Mid-State Correctional Facility, Mohawk Correctional Facility, Central New York Psychiatric Center (CNYPC), Hutchings Psychiatric Center, and Forensic Units (FU) in inpatient facilities. The study revealed that Oneida County has taken significant steps toward improving the treatment of the mentally ill, however, if suicide prevention is to be a priority state-wide, the authors recommend the removal of solitary housing units to decrease the exacerbation of mental health issues, self-harm, and suicides. The study also found that the most significant factor in reducing recidivism is employment upon release; therefore local and state correctional facilities should aid individuals in the reentry process through skill-development and employment programs. The study suggests several very inexpensive rehabilitation methods that may be implemented at any type of mental

health facility, many of which do not require the addition of more staff, another looming issue in the mental health world.

The second case study, "Hope and a Plan: An Evaluation of the Utica Mental Health Court, One Possible Model for Effective Management and Care," by Alexander Scheuer, explores the best practices of mental health courts across the country, as well as the effectiveness of the Utica Mental Health Hub Court, which has been operating for 11 years and has yet to be evaluated by any official means. The study notes that while there are no accepted standards of operation and practice among mental health courts nationally, they share goals: reducing recidivism for mentally ill offenders, targeting and treating the root causes of their criminal behavior, and helping them remain crime free as they reintegrate back into society. The study deploys a longitudinal analysis of the Utica Mental Health Hub Court, finding that of the 43 graduates of the program in the sample years, only 19% recidivated, compared to the national average rate of recidivism (54%) for mentally ill offenders who receive little or no treatment.

The third case study, "Policing & Mental Illness in Oneida County, New York: Best Practices, Shortcomings, and Proposed Reforms," by Connor O'Shea, examines the interactions between law enforcement and individuals with mental health issues. The study revealed that Oneida County (and New York State more generally) is both a participant in and progenitor of the deinstitutionalization problem, which has hamstrung law enforcement by insisting on 'square- peg-round-holing' mental illness into the criminal justice system. The author recommends that Oneida County de-emphasize law enforcement's role in mental health care while aggressively expanding alternatives in the community and re-expanding institutional care. The County should also exhaust every possible mechanism of improving law enforcement's ability to safely and effectively interact with people with mental illness. Most notably, the study argues that all police departments in Oneida County become Crisis Intervention Team departments, and that the County should pioneer a hybrid model of policing in which a CIT department also utilizes a Jail Diversion Program (see pages 7-8, below) by which psychiatric professionals co-respond with police officers in the same squad car to psychiatric emergency service calls.

Each study takes pains to point out that the criminalization of the mentally ill has become a chronic issue in American society for which there are no easy answers. The cost of such criminalization handicaps our ability to progress as a nation and weighs heavy upon our moral conscience. We can no longer afford to turn a blind eye. We can no longer afford to turn away because it is easier. When America's roads and bridges are crumbling, when our public school districts continue to decline, we can no longer afford to spend billions of taxpayer dollars on jail and prison maintenance. Years of research and study have pointed the way for local initiatives that have found some success: now is the time for national action. The following pages illustrate just how critical that action is.

## A Modern Crisis

A grossly disproportionate number of individuals with serious or severe mental health issues who are unable to access adequate care often end up in the criminal justice system.[1] These are people who are too often homeless, jobless, and hopeless; they have nowhere else to go. They languish across the nation's jails, and those most in need of help – the 2.5% of the population who suffer from severe mental health issues such as schizophrenia[2] – are the most likely to be locked away in local jails or state prisons that were never designed to accommodate individuals with mental health issues (MHI). Worsening of their initial condition, self-mutilation, and suicide are commonplace results for these individuals.

This problem has not gone unnoticed, nor have concerned stakeholders failed to make their voices heard. Judges, police officers, psychiatric professionals, general care practitioners, and community leaders have joined forces to address this problem with laudable and creative initiatives. Despite this, stakeholders simply do not have the capacity to adequately address mental health issues in either the healthcare system or the criminal justice system. The deinstitutionalization movement of the 1960s reduced the capacity of the healthcare system to accommodate individuals with MHI: U.S. psychiatric institutional capacity plummeted from 559,000 beds in 1955 to 35,000 beds in 2017.[3] The major federal funds for the local outpatient treatment facilities that were supposed to take place of psychiatric

institutions were appropriated instead for use in the Vietnam War. In one stroke, deinstitutionalization outstripped the capacity of community-based organizations to help individuals with MHI resolve the problems that they faced. It demanded that these organizations help people that they were not designed or organized to care for. And it hamstrung the ability of psychiatric facilities to provide adequate inpatient care for individuals with severe MHI.

For those individuals with severe mental health issues, this was the start of the long road to carceral re-institutionalization over the following decades. The mass influx of individuals with MHI into the criminal justice system – from 1955 to 1994, the number of inmates with mental health issues rose by over 600%[4] – created a 'revolving carceral door' that does not accomplish the goals of the criminal justice system. Correctional facilities, prisons, and jails are now the primary mental health institutions in the U.S.[5] while the criminal justice system runs a "shadow mental health system" with the only cards it has left in its deck: detention, arrest, incarceration, and prosecution.[6] Local jails and state and federal prisons were never designed to function as psych wards, yet individuals with MHI, despite representing only 1.24% of the total U.S. population (approx. 4 million people)[7], are involved in one-tenth of all law enforcement service calls and occupy over one-fifth of all jail and prison inmate beds.[8] A 2017 report by the Federal Bureau of Justice estimated that 14% of state and federal inmates and 26% of jail inmates suffer from some form of mental illness.[9] Yet no strategic organizational model exists for resolving such a persistent and pervasive problem.

Civil society as a whole remains unresponsive to the cruel treatment of defendants with MHI, even as it suffers from a waste of taxpayer resources on inefficient responses that have negative impacts on criminal or mental health crisis recidivism, e.g. the safety and well-being in the individuals and their communities. For example, upon completion of their time, mentally ill inmates – many of whom were homeless to begin with – are usually sent back out on the streets, often with no job, no contacts, and little to no support from the community around them. Unable to access healthcare or adequate treatment, they turn to self-medication, often returning to or developing drug abuse and alcohol issues. This tendency exacerbates existing mental health issues through a well-documented rise in comorbidity. Comorbidity

and self-medication are different but important factors to overcome, but individuals with MHI are seldom capable of making that jump on their own. Yet prisons, psychiatric facilities, courts, jails, and police forces all lack the organizational and financial capacity to deal with drug and alcohol abuse themselves, let alone these same problems when compounded by MHI. Worse yet, the historical stigma around and a general misunderstanding of serious MHI tends to inhibit effective co-operation between stakeholders and the community that are necessary for individuals with MHI to receive the help they need.

## Best Practices and Commonalities

The operational complexity and emotional intensity required to successfully address MHI in the criminal justice system cannot be overstated. The detrimental effects of incarceration on individuals with MHI have been well-documented by a number of books, documentaries, and articles: it is clear that living a sustainable, let alone a productive, life becomes much harder for individuals with MHI once they have been incarcerated. Increased investment in the community and in inpatient and correctional mental health facilities promotes a more accepting environment for individuals with MHI. Furthermore, preventing individuals with MHI from becoming involved with the criminal justice system in the first place, or diverting those who become so involved from incarceration, are two avenues that offer significant promise. Developing all of these responses will be at once the most humane and efficient way to respond.

Diversion and prevention are tricky issues, however, as the criminal justice system has to regard community needs, penal and procedural legal requirements, and communicating without underestimating the problems that mentally ill individuals' face due to their surrounding environs. These add a range of criminogenic risk factors including neighbors or contacts with antisocial personalities, criminal thinking, social support for crime, and substance abuse. Pre-existing psychiatric issues such as psychosis, paranoia, cognitive impairment, and trauma (to name but a few) exacerbate and are exacerbated by criminogenic risk factors, making people with MHI "more vulnerable and less responsive to standard

correctional intervention."[10] Creative and heterodox approaches that account for these criminogenic risk factors are vital to achieving any sort of forward progress.

Out of the many programs deployed over the years, the most successful approaches occur on two levels, and both fall into the category of rehabilitative justice rather than punitive justice. The first level is during initial police contact, using local law enforcement to the benefit, rather than to the detriment, of mentally ill individuals. The second level occurs post-arrest but pre-trial through mental health courts that offer another chance to prevent individuals with MHI from entering the revolving carceral door.

On the first level, the two most promising approaches are Crisis Intervention Team models and Jail Diversion Programs (see O'Shea, 2018, for a more detailed analysis). The Crisis Intervention Team (CIT) model is "internationally recognized as one of the leading police-based models to help individuals with mental illness that come into police contact."[11] The model itself calls for 40 hours of extensive, specialized training to a select group of volunteer officers to qualify them as CIT officers. The CIT model does not merely focus on police officers, rather, it demands systemic intervention through both operational changes in police department procedures and collaboration with the community at large through mental health providers and relevant stakeholders.[12] This results in improving officers' attitudes and knowledge about mental illness, increasing officers' confidence in dealing with individuals with MHI, and increasing the utilization of mental health services through police referrals.[13]

Jail Diversion Programs (JDP), in comparison, rely on mental health professionals to co-respond (i.e. in the same squad car as the police officers) to psychiatric crises calls. The co-response model recognizes that police officers simply cannot receive sufficient training to identify and manage every unique psychiatric emergency situations, nor do police departments have sufficient resources (i.e. psychiatric professionals) to adequately address the complex problems of distressed individuals with MHI.[14] Co-response provides the benefit of 'dual diversion' from both arrest and emergency departments; trained clinicians can "facilitate arrest diversions and reduce costly and unnecessary referrals to hospital emergency departments."[15] For individuals who are arrested, co-response has the added benefit of providing them with immediate "receive support, resources, and referrals while in police custody."[16]

On the second level (post-arrest but pre-trial), the emergence of mental health courts (MHCs) offers another chance to prevent these individuals from entering the revolving carceral door (see Scheuer, 2018, for a complete overview of MHCs). MHCs, as a rule, are voluntary criminal diversion programs that remove mentally ill individuals from the traditional sentencing system and place them in court-supervised outpatient treatment programs to address the issues at the root of their criminal behavior.[17] These courts are similar to other specialty courts as an effective and efficient means of solving persistent criminal conduct and diverting those with treatable clinical conditions from the traditional punitive sentencing system.

MHCs go beyond the boundaries of jail or prison sentencing, forging multifaceted partnerships of administrative and treatment teams composed of lawyers, case managers, judges, and treatment providers. These teams work on behalf of participants throughout their criminal process, and individuals can be referred for MHC qualification by police officers, jail staff, defense lawyers, judges, and sometimes even family or community members. The success of MHCs is dependent on each individual court, however, the most successful appear to have access to community treatment services and mental health resources; utilize an outcome-driven approach through setting specific and empirical goals and benchmarks; use a clinical evaluation survey pre- and post-enrollment; analyze Judge-Participant interaction; and effectively communicate both internally and externally.[18]

The ultimate goal of CIT, JDP, and MHCs – indeed, of every attempt to ameliorate the criminalization of the mentally ill – is to rehabilitate individuals with MHI through mitigating criminogenic risk factors so that they might reintegrate with society. There remains a backlog of incarcerated individuals with MHI, however, who also must be reintegrated into society. The process of reintegration is similar for both incarcerated and non-incarcerated individuals, however, diversion programs are critically important because of the detrimental effects of incarceration on individuals with MHI. That said, successful reintegration is achievable through a mix of psychiatric therapy, appropriate medication, engagement from peers and the community, and holistic support in matters such as housing and employment.

These metrics are what many MHCs want to see before a participant is allowed to graduate, but they are also the most effective way for incarcerated individuals to reintegrate into society upon release from prison or jail. Several programmatic approaches that can provide reintegration support for both incarcerated and non-incarcerated individuals include widely-recognized programs such as the Risk/Need/ Responsivity (RNR) and Illness Management and Recovery (IMR) models for rehabilitation. Other programs, such as New York State's Self-Management and Recovery Training (SMART) Recovery Program, can provide additional support.[19]

The success rates of diversion programs and reintegration efforts, while unique to each locality and each situation, do share several commonalities critical to their success which are absolutely vital to keep in mind. The first is a wide-spread comprehension of the challenges that individuals with MHI face, as well as empathy towards those individuals, by community and criminal justice system stakeholders, as well by the community at large. The second is effective communication and coordination among engaged stakeholders including but not limited to police departments, mental health professionals and hospitals, judges and court staff, jails, prisons, and political departments and office. Third, and perhaps most important, is active and engaged community support for individuals with MHI: these are people who have most often been outcast from society. Only with society's acceptance of them as people, regardless of their criminal background, will we begin to carve away the mountain of injustices that have been put upon them.

## Where We Fall Short

In order to begin this process, we must understand just how monumental the tasks at hand are. Current efforts can only do so much with the resources available to them. In the data-driven world we live in, the scale and magnitude of results determine whether a program should be funded. But when dealing with MHI, it is important to remember that each individual requires individualized treatment, and providing individualized treatment is necessarily expensive. Limited funding for diversion

or reintegration programs thus limits the scale and magnitude of their results, thereby raising questions of their effectiveness. Lack of financial resources breeds a lack of capacity. Lack of capacity results in a lack of financial resources. This vicious cycle of inefficacy ensures that the people who need help the most are the least likely to receive it.

The programs mentioned above are, in many cases, underfunded and understaffed because of this very reason. The Utica Mental Health Hub Court (UMHHC), for example, which now receives cases referred from the over 40 local criminal courts across Oneida County, has seen its enrollment double in the past few years, but it still only has one Case Manager and no funding to expand its staff, making a further increase in enrollment impossible. The UMHHC serves as an example of a court that usually only takes cases where the individual in question is likely to get back on their feet without extensive and ongoing inpatient care, proving the efficacy of the Court. This means that people with more severe mental health issues – bipolar disorder, psychosis, personality disorders, those with untreated developmental disabilities, etc. – are usually disqualified because of the severity of their mental health issues. These same individuals are also the most likely to react violently to police intervention, which can result in a more severe sentencing. However, MHCs can only do so much given limited funding and staffing, and there are environmental factors that can handicap their effectiveness as well. One of the most glaring and most common is the lack of availability of mental health resources in the community.

This is a problem that not only limits the success of MHCs but also of CIT and JDP programs. Local and regional treatment centers serve as the primary providers of treatment and support for individuals with MHI, and their involvement is crucial for the success of any diversion or reintegration program. CIT programs have the potential to mitigate stigmatization and misunderstanding of MHI within local law enforcement, but police officers cannot be expected to serve as health-care givers or therapists. That is not their role, nor should it be. The JDP model offers promise, in areas where co- response is a feasible option, but in places where psychiatric services are limited or geographically distant, it falls seriously short. The same is true for MHCs: if an individual enrolled in an MHC program does not have easy access to a treatment facility, whether through lack of transportation, geographic

distance, or a backlog of patients at available treatment centers, their road to recovery will be severely limited.

Nationally, this is a stark reality for individuals with MHI who do not live in affluent coastal hubs where state-of-the-art psychiatric facilities and mental health awareness is much less of an issue. For these individuals, who live in the Rust Belt, in the Heartland, and the more rural areas of the country, any psychiatric facilities that do exist are likely to be in poor condition and are themselves usually understaffed as the best and brightest emigrate to the coast. The sub-standard condition of inpatient psychiatric facilities, due to deinstitutionalization and capital flight, means that there are not nearly enough beds or psych wards to house, let alone care for, all individuals with severe mental health issues. The lack of therapists, psychiatrists, and psychologists in the areas where they are needed most limits the capacity and effectiveness of even the most well-meaning diversion and reintegration programs. The sad truth is that most areas in this country simply lack the capacity and resources to mount fully-funded reintegration programs.[20] For incarcerated individuals with MHI, this is a double bind as state and federal prisons are usually located in geographically remote locations, economically depressed areas, or both.

State and federal prisons also feel the capacity-reducing effects of deinstitutionalization and capital flight, and as a result they do their own part in worsening the condition of incarcerated individuals with MHI, either through solitary confinement or through overmedication. In NYS, for example, prisons can be compensated based on decreases in the number of physical constraints used on inmates, which are reviewed each quarter (see Walther, 2018, for a comprehensive overview of this issue). Individuals with MHI are often overmedicated to the point of sedation due to financial incentives, creating incredibly unhealthy dependencies and preventing the development of healthy habits crucial to reintegration. Not only does their condition worsen due to solitary confinement, overmedication, and other abuses suffered in prison, but if they are released from prison, they then find themselves in areas where reintegration programs are backlogged, if they exist at all.[21] These individuals not only tend to recidivate but are disproportionately represented in the prison population: in the general population, 5%

have a serious mental disorder and 16% have a diagnosable mental disorder; in the prison population, these numbers swell to 17% and 50%, respectively.[22]

The sad irony of this situation is that the financial resources that could be invested in alleviating the problem are otherwise dedicated to the maintenance of jails and prisons. In 2017-2018, U.S. counties alone spent $80 billion on maintaining and expanding local jails.[23] Meanwhile, in state and federal prisons, solitary confinement – often resorted to by a witlessly overwhelmed prison staff to get individuals with MHI to 'behave'– costs a staggering $75,000 per inmate per year, compared to $25,000 in a general housing unit. There are roughly 80,000 inmates in solitary at any given time, many with MHI, costing the U.S. $60 billion per year.

The revolving carceral door exposes just how broken this system is. A well-known study, commissioned by the Mental Health Court Project of Miami-Dade County, found that over a five year period, 97 people (primarily homeless men diagnosed with schizoaffective or schizophrenia disorder) were arrested 2,200 times. They collectively spent 27,000 days in county jail and 13,00 days at either a psychiatric facility or in an emergency room, costing the county $13.7 million…with nothing to show for it.[24] Those 97 individuals do not even account for one-tenth of one percent of the County's population, yet they recidivated an astonishing number of times. This disproportionate impact illustrates the problem in simple terms: we annually spend billions of taxpayer dollars on repeatedly incarcerating a small segment of our country's population, subjecting them to human rights abuses and mental degradation. Not only common sense but also our moral duty as American citizens, demands that we do more.

## The Road Ahead

The problems illustrated above will not be solved overnight. Given the cycle of inefficacy, maintained by the dual handcuffs on program capacity and funding, resolution will only come with a comprehensive investment in mental health programs; including programs designed to prevent individuals with MHI from entering the revolving carceral door, inpatient and community-

based care, and programs to help reintegrate individuals with MHI into society as citizens. Significant attention must also be paid to those individuals whose conditions are too severe to function outside of inpatient care, many of whom find themselves awaiting transfer from correctional facilities to inpatient care centers.[25] The only answer to this specific problem is to re-open enough inpatient psychiatric facilities to cope with the backlog.

Beyond the urgent need for investment, there are three specific initiatives which should be undertaken in order to accomplish prevention, reintegration, and inpatient and community-based care. First, the creation of a national standard by which to measure the success of mental health programs, whether diversionary, rehabilitative, or inpatient care. This will provide a solid basis of comparison that relevant stakeholders can use to make informed decisions about their own community. It will also give legitimacy to the second initiative: a national publicity campaign, run by an independent 501(c)3. Such an organization would lend actionable heft and serve as a useful tool for distributing funding to programs that need it most. The publicity campaign itself should focus on the human rights abuses that incarcerated individuals with MHI suffer, what interested individuals and parties can do to get involved, and provide information on the various types of mental health programs that are successful.

The last two are critical for promoting the third initiative: increase community outreach and engagement efforts with local populations in the economically depressed areas that bear the brunt of rehabilitating individuals with MHI. Efforts should include awareness campaigns of the issues that people with MHI face, developing meaningful relations with important community stakeholders and thought-leaders, and organizing broad community support for individuals with MHI. Without wholesale support from the community around them, individuals with MHI will continue to be outcasts, relegated to living on the worst fringes of our society. Such a reality is far from inevitable; if it does occur, it will be because we let it happen.

# INTRODUCTION

HISTORY OF THE TREATMENT OF PEOPLE WITH MENTAL HEALTH ISSUES IN THE
CRIMINAL JUSTIC SYSTEM

Dr. Jennifer Ambrose, Director, Hamilton College Writing Center
September, 2018

Overview

In the U.S., approximately 4 million people live with 'severe mental illness.'[1] Despite representing only 1.24% of the total U.S. population,[2] these people are involved in one-tenth of all law enforcement service calls; occupy over one-fifth of all jail and prison inmate beds; and represent a full one-fourth of people killed in deadly police encounters. A 2017 report by the Federal Bureau of Justice estimated that 14% of state and federal inmates and 26% of jail inmates suffer from some form of mental health issue (MHI).[3]

The disproportionate rate at which the criminal justice system responds to, arrests, jails, and kills people with MHI is part of a larger trend in the deinstitutionalization and criminalization of mental illness, in which the federal government and most states took, on average, 50% of their inpatient psychiatric beds out of service. For many of those involved in the deinstitutionalization of the 1990's and beyond, a better life opened up in their communities with the help of advanced medications and expanded, community-based psycho-social services. However, for a very significant minority of these people, the progress became "re-institutionalization" from psychiatric beds to prison cells.[4] Correctional facilities, including jails and prisons, are now categorized as the primary mental health institutions in the U.S.,[5] and the criminal justice system has been left to "run a shadow mental health system" using only what is available in its toolbox: detention, arrest, incarceration, and prosecution.[6]

---

[1] D. A. Fuller et al., "Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters" (Treatment Advocacy Center, December 2015), http://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf.

[2] U.S. Census Bureau, 2016

[3] Jennifer Bronson and Marcus Berzofsky, "Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12," U.S. Department of Justice (June 2017): 1. https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf.

[4] Suzanne Yang et al., "Doing Time: A Qualitative Study of Long-Term Incarceration and the Impact of Mental Illness," International Journal of Law and Psychiatry 32, no. 5 (September 2009): 294–303, https://doi.org/10.1016/j.ijlp.2009.06.003.

[5] According to Adams & Ferrandino (2008), between 1956 to 1996, State hospital populations for the mentally ill dropped nearly 90% from 550,000 to 61,700, respectively.

[6] Tom Whitehead, "Mentally Ill Are Not Police's Responsibility, Says Theresa May.," The Telegraph, May 20, 2015, http://www.telegraph.co.uk/news/uknews/law-and-

Because a large number of individuals with mental illness are being cared for by the criminal justice system, the institution has a responsibility to regulate, treat, and rehabilitate those with MHI who violate the law. However, it is clear that the current system is failing, as those with MHI require alternative care and more resources compared to other inmates.[7] Approaches to managing and treating mentally ill prisoners in the U.S. vary considerably by state and even more by individual county. There exists no general standard of care for prisoners suffering from MHI while incarcerated, nor is there a standard for prosecuting offenders who may be suffering from MHI. This has wide-ranging implications for individuals with MI, service providers in the criminal justice system, as well as the broader U.S. public.

Simply put, "[p]rison and jail officials don't have the resources to treat" people with MHI, causing "many" to "deteriorate behind bars."[8] Not only are those with MHI more likely to be arrested than those without, they are more likely to remain in the criminal justice system longer than other prisoners for breaking the rules or behavioral outbursts that hinder their chances of being released early on "good behavior." In New York State, for example, inmates with MHI spend roughly 215 days in the system compared to only 42 for those with those not diagnosed with a mental illness.[9] This issue is exacerbated by the fact that there is a high rate of recidivism among people with mental illness; roughly 75% of inmates with MHI under sentencing have been sentenced and/or spent time in jail prior to that conviction.[10] These compound issues not only put "an unsustainable drain on law enforcement resources," but also "divert[s] them from other important security tasks," like reducing violent crime or building

order/11616937/Mentally-ill-are-not-polices-responsibility-says-Theresa-May.html.

[7] Sasha Abramsky and Jamie Fellner, Ill-Equipped: U.S. Prisons and Offenders with Mental Illness (New York: Human Rights Watch, 2003). 1-214.

[8] Michael Ollove, "What Care for the Criminally Insane Can Teach Us About Mental Health Treatment," Stateline (Pew Charitable Trusts), April 25, 2018, https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/04/25/what-care-for-the-criminally-insane-can-teach-us-about-mental-health-treatment.

[9] Fuller et al. 2014.

[10] Abramsky and Fellner 2003

stronger community relations.[11] In 2015, Theresa May voiced this problem in stark terms: "Nobody wins when the police are sent to look after people suffering from mental health problems; vulnerable people don't get the care they need and deserve, and the police can't get on with the job they are trained to do."[12] Nor does the community win when these individuals, after their average 215 days without proper care—often in worse condition as a result—are then placed back in the neighborhoods and situations from whence they came.

## Evolution of Psychiatric Care, the Modern Criminal Justice System, and Impact on the Mentally Ill

The historical evolution of criminal justice and psychiatric policy in the U.S. during the 20th century provides important context for this reports' analysis of how the system currently manages people with mental illness.

Societal perceptions of mental illness in the U.S. have led to social experimental policies that have exacerbated the lack of treatment for the mentally ill, especially in the criminal justice system. Past research has focused on two areas: the increasing incarceration of people with pre-existing mental health issues, and the ways in which the prison environment itself precipitates new mental health problems, including in inmates who had not experienced MHI prior to incarceration. Based on these foci, researchers have explored how they can inform policy to create more effective rehabilitation programs for those suffering from MHI inside prisons and have also proposed solutions to reduce the large number of individuals with MHI from entering prisons in the first place.

To answer these questions, one must consider the historical underpinnings of the current crisis regarding the mass incarceration of the mentally ill in the U.S. The prevalence of MHI in inmates is

---

[11] DJ Jaffe, "Survey: Law Enforcement Overburdened by Failure of Mental Health Departments," Huffington Post, December 21, 2011, https://www.huffpost.com/entry/police-mental-illness_b_1033848.

[12] Whitehead, 2015.

dramatically disproportionate to the rate in the general U.S. population.[13] In the last forty years, dozens of studies have examined the significant spike in prisoners suffering from serious forms of mental illness. E. Fuller Torrey's (1997) Out of the Shadows: Confronting America's Mental Illness Crisis produced one of the most comprehensive reports on managing mental illness in the U.S., concluding that from 1955 to 1994, the number of mentally ill patients in psychiatric hospital dropped from 558, 239 to 71,619.[14] Extending this work, Erickson and Erickson (2008) and Appelbaum (2011) found a greater than 600% spike in inmates with mental illness during the same period,[15] data supported experientially by the fact that prisons and jails began self-reporting significant increases in the number of mentally ill prisoners in the mid 1970s.[16]

Subsequent research has suggested three primary—and interrelated—factors leading to the inverse correlation between MHI in prison populations and psychiatric hospital populations.[17] The increase in the number of prisoners in the criminal justice system with a mental illness has been attributed to the deinstitutionalization of state-led psychiatric care facilities, the shift from a rehabilitative to a punitive criminal justice model, and changing societal perceptions of mental illness and safety.[18]

---

[13] Marshall T. Bewley and Robert D. Morgan, "A National Survey of Mental Health Services Available to Offenders with Mental Illness: Who Is Doing What?," Law and Human Behavior 35, no. 5 (October 2011): 351–63, https://doi.org/10.1007/s10979-010-9242-4.; H. Richard Lamb and Linda E. Weinberger, "Persons With Severe Mental Illness in Jails and Prisons: A Review," Psychiatric Services 49, no. 4 (April 1998): 483–92, https://doi.org/10.1176/ps.49.4.483.

[14] E. Fuller Torrey, Out of the Shadows: Confronting America's Mental Illness Crisis. (New York; Chichester: Wiley, 1998).

[15] Paul S. Appelbaum, "Law & Psychiatry: Lost in the Crowd: Prison Mental Health Care, Overcrowding, and the Courts," Psychiatric Services 62, no. 10 (October 2011): 1121–23, https://doi.org/10.1176/ps.62.10.pss6210_1121.

[16] Patricia E Erickson and Steven K Erickson, Crime, Punishment, and Mental Illness: Law and the Behavioral Sciences in Conflict (New Brunswick, N.J.: Rutgers University Press, 2008), http://public.eblib.com/choice/publicfullrecord.aspx?p=361655.

[17] Ibid, 26.; L. S. Penrose, "MENTAL DISEASE AND CRIME: OUTLINE OF A COMPARATIVE STUDY OF EUROPEAN STATISTICS," British Journal of Medical Psychology 18, no. 1 (March 1939): 1–15, https://doi.org/10.1111/j.2044-8341.1939.tb00704.x.

[18] Lamb et al. 1998.

Deinstitutionalization

The 19th century U.S. was dominated by Dorothea Dix's progressive "campaign against the imprisonment of the mentally ill," which ultimately led to "far-reaching reforms and the establishment of [state-run] mental hospitals."[19] The institutionalization patient-care-model that arose from Dix's campaign was designed to move mentally ill individuals who were struggling or 'misbehaving' in the community into psychiatric hospitals where they could be provided with diagnoses, treatment, medication, and care by trained professional staff.[20] This model was functional in theory; however, during the early 20th century, the outgrowth of Dix's campaign – "public psychiatric hospitals" – "came to be criticized for inhumane and disturbing treatments."[21]

As a result of the controversy over the effectiveness and practices of these "mental hospitals," in the 1950s, a popular movement arose to "deinstitutionalize mental health," focusing instead on "treat[ing] patients in more community-based," smaller outpatient "treatment centers."[22] This push was based on the argument that such a model would provide a higher quality of life for those with MHI, helping to integrate and rehabilitate them into their own communities; communities would accept and take responsibility for the care and treatment of the mentally ill; and this would "humanize" the treatment and care of people with MHI.[23]

---

[19] Nicholas Kristoff, "Inside a Mental Hospital Called Jail," New York Times, n.d., https://www.nytimes.com/2014/02/09/opinion/sunday/inside-a-mental-hospital-called-jail.html.
[20] "A Brief History of Mental Illness and the U.S. Mental Health Care System" (Unite for Sight, n.d.), http://www.uniteforsight.org/mental-health/module2.
[21] Ana Swanson, "A Shocking Number of Mentally Ill Americans End up in Prison Instead of Treatment," Washington Post, April 30, 2014, https://www.washingtonpost.com/news/wonk/wp/2015/04/30/a-shocking-number-of-mentally-ill-americans-end-up-in-prisons-instead-of-psychiatric-hospitals/?noredirect=on&utm_term=.c70b5c2ff88a.
[22] Swanston, 2015; E. L. Bassuk and S. Gerson, "Deinstitutionalization and Mental Health Services," Scientific American 238, no. 2 (February 1978): 46–53.
[23] Ashley Primeau et al., "Deinstitutionalization of the Mentally Ill: Evidence for Transinstitutionalization from Psychiatric Hospitals to Penal Institutions," Comprehensive Psychology 2, no. 1 (January 2013): Article 2, https://doi.org/10.2466/16.02.13.CP.2.2; Bassuk & Gerson, 1978.

Deinstitutionalization was the result of government objectives as well as wide-spread public-sphere initiatives. Multiple bills passed in the mid-20th century contributed to the process, yet none as drastically as the federally-funded initiative to end state-run psychiatric facilities, the Community Mental Health Centers (CMHC) Act, signed into law by President Kennedy in 1963. This Act lowered the federal budget for care of the mentally ill in the hope of pushing those patients to more successful treatment models, including the use of psychotropic drugs and community mental health care centers.[24] The bill was originally lauded by public officials, mental health officials, and the general public at large for moving from "a dark age of institutional confinement"[25] to a committed community-based care system. As a result of such legislation, state-run mental health hospital populations peaked in 1955, at which point collectively they housed 558,922 patients[26] – enough space for "one bed in a psychiatric ward for every 300 Americans."[27] Today, state-run mental hospitals only hold around 35,000 patients[28] – barely enough for "one [bed] for every 3,000 Americans."[29]

While deinstitutionalization was functional in theory, Mechanic and Rochefort (1990), Lamb and Weinberger (1998), Erickson and Erickson (2008), Appelbaum (2011), and Goldman (2013) have contended that decreasing funding for state-run psychiatric hospitals in the 1950s led directly to an increase in the MI population housed within the criminal justice system. In other words, the evidence in the literature indicates an inverse relationship between imprisonment and mental hospitalization rates.[30]

Once psychiatric facilities began to close, mentally ill individuals were expected to transition seamlessly into U.S. society with the support of local mental health services and medication. However, multiple factors contributed to the growing criminalization of the mentally ill.[31] Deinstitutionalization

---

[24] Yang et al., "Doing Time," 303. Kimberly Amadeo, "Learn About Deinstitutionalization: Pros and Cons," The Balance, March 14, 2018, https://www.thebalance.com/deinstitutionalization-3306067.

[25] David Mechanic and David A. Rochefort, "Deinstitutionalization: An Appraisal of Reform," Annual Review of Sociology 16, no. 1 (August 1990): 301–27, https://doi.org/10.1146/annurev.so.16.080190.001505.

[26] Swanson, 2015.

[27] Kristoff, 2014.

[28] Swanson, 2015.

[29] Kristoff, 2014.

[30] Kim, 2017.

[31] Jonathan Simon, Mass Incarceration on Trial: A Remarkable Court Decision and the Future of Prisons in America. (Perseus Distribution Services, 2016).

assumes that those with even the most severe disorders, such as schizophrenia, can and will take their medications on their own and are capable of travelling to their counseling facilities for other forms of therapy.[32] And while policymakers had outdistanced their original goals for decreasing patient population in psychiatric hospitals, the support services for these patients failed. Lack of support and inadequate care meant mentally ill individuals were more at risk for homelessness, poverty, and becoming a victim or perpetrator of a crime. They began to land in state prisons for small crimes, many stemming from the uncontrollable symptoms of their illness,[33] in staggering numbers: from 1975 to 1979 alone, there was a 227% increase in police incidents involving mentally ill individuals,[34] and despite decreasing psychiatric patient populations, there was an increase in admitted patients with prior arrests, particularly in California, Arizona, New York, and Texas.[35] Instead of being in long-term psychiatric care, many mentally ill individuals have ended up in the criminal justice system, leading White and Whiteford in 2006 to categorize correctional facilities as "the new psychiatric institutions of the 21st century."[36] The American criminal justice system was—and remains—completely unprepared for this sharp increase in mentally ill inmates.

---

[32] Erickson and Erickson, 25.

[33] Ivan G Goldman, "The Insanity of Mental Health Practices," in Sick Justice: Inside the American Gulag (Washington, D.C: Potomac Books, 2013).; E. Fuller Torrey et al., "More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States" (Treatment Advocacy Center and National Sherrifs' Association, May 2010), http://www.sheriffs.org/sites/default/files/uploads/Final%20Jails%20v%20Hospitals%20Study.pdf..;" E. Fuller Torrey, "Deinstitutionalization: A Psychiatric 'Titanic,'" in Out of the Shadows: Confronting America's Mental Illness Crisis. (New York; Chichester: Wiley, 1998), https://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html.

[34] Ibid, 303.

[35] Ibid, 303.

[36] As quoted in Primeau et al. 2013.

## Shift from Social Welfare Model to Punitive or Retributive Justice Model

The current drastic numbers of mentally ill prisoners across the U.S. are also a consequence of an evolving modern criminal justice system that prioritizes retribution, condemnation, and punishment over rehabilitation.[37] Until the mid-1970s, rehabilitation was an essential component of the criminal justice system; however, the late 1970s and 1980s were characterized by a punitive shift in federal law enforcement ideology and practice. Zero-tolerance, quality-of-life policing began to permeate state and local police institutions, which caused arrest and incarceration rates to skyrocket. In tandem with the deinstitutionalization of mental health treatment in the U.S., a sizable portion of adults with mental health issues were incarcerated instead of admitted to long-stay treatment facilities. In 2004 alone, the number of mentally ill inmates in prisons was more than three times higher than the number of those receiving care in hospitals.[38]

David Garland (2001) sketches an important shift in the late-20th century away from "Penal Welfarism" toward a "New Culture of Control" focused on condemnation and punishment.[39] Penal Welfarism, he explains, posits that penal measures, at their core, should be rehabilitative interventions rather than retributive punishments. This model of penal policy "increasingly characterized the field from the 1890s to the 1970s," in turn shaping "the common sense of generations of policy-makers, academics, and practitioners."[40] Between 1970 and 2000, however, Penal Welfarism was "shaken to its roots," according to Garland, a shift that amounted to the "unraveling of [the] conceptual fabric" of American criminal justice policy nationwide.[41] To that end, a number of new trends emerged in American criminal justice: private prisons popped up; victim impact statements began littering sentencing hearings;

---

[37] David Garland, "A History of the Present," in The Culture of Control: Crime and Social Order in Contemporary Society (Chicago: The University of Chicago Press, 2017), 1–27.

[38] Deanna Pan, "TIMELINE: Deinstitutionalization And Its Consequences," Mother Jones, April 29, 2013, https://www.motherjones.com/politics/2013/04/timeline-mental-health-america/.

[39] Garland, p. 9.

[40] Garland, p. 3.

[41] Garland, p. 3-4.

sentencing guidelines handcuffed judges' decision-making and discretion; and law enforcement turned away from major violent crime and focused on 'quality of life' policing.[42]

This massive shift gave rise to what Garland calls the New Culture of Control, a reactive and adaptive system focused on strict "formal controls exercised by the state's criminal justice agencies."[43] Institutions and agencies formerly dedicated to rehabilitation and 'social work,' as it were – like parole and probation services – instead became the carceral state's arms of renewed social control. In all, the rapid shift away from post-war Penal Welfarism and toward the New Culture of Control resulted in an exponential spike in the U.S. prison population: in the 25 years between 1973 and 1997, U.S. prisons saw a 500% increase in population.[44] More people were going to jail for longer, but this was a feature, not a bug, of the New Culture of Control.

When deinstitutionalization is viewed in light of the simultaneous shift away from Penal Welfarism, it is not surprising that the influx of people with mental illness leaving then-deinstitutionalized facilities was seen as requiring control (by the criminal justice system) rather than treatment or rehabilitation (by the health care system). People with mental illness who disrupted the community were categorized as high-risk individuals who should not be permitted freely to integrate and interact with the wider public.[45] This universal stigmatization of the mentally ill as "dangers to the local community" contributed to the mass incarceration of people with mental illness. As a means to "protect" the larger public from these deviant, dangerous, and delinquent individuals, people with MHI ended up in jails and prisons. In this way and for this reason, the public health problem of mental illness became a criminal justice problem in the absence of public health resources devoted – and divorced from criminal justice writ large – to addressing it on the same plane.

---

[42] Garland, p. 4.
[43] Garland, p. 5-6.
[44] Garland, p. 14.
[45] Lamb et al., 1998.

Shifts in Public Values

Erickson and Erickson (2008) have found that the influx of inmates with mental illness into the criminal justice system directly correlates to shifts in the American public's valuing of public safety, individual accountability, and punishment. The modern state has essentially re-invented the prison system to reinforce a societal caste division which "defines, confines, and controls" the low class, stigmatized groups—most notably African-Americans—as well as the mentally ill.[46] Undergirding the shift in criminal justice models was, among other things, a profound public fear of crime that arose from the "re-dramatiz[ation]" and politicization of crime.[47] Fear of crime itself, not just the actual crime, was seen as a social problem warranting policy solutions. To that end, penal policies were put in place not because they would reduce the actual number of crimes committed, but rather because it would satiate the public's desire for increased punitivity and placate the public's fear of crime.[48]

# Current State of Support for Mentally Ill Individuals in the Criminal Justice System

Today's prisoners are protected under 2004's Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA)[49], meant to ensure that they receive necessary support for mental health, as well as by the Comprehensive Justice and Mental Health Act (S. 993/H.R. 1854), introduced by Minnesota Senator Al Franken and passed by Congress on December 11, 2015, which builds on that previous legislation.[50] The 2015 bill asserted that using the justice system to improperly treat the mentally ill is not only detrimental to those with MHI, but also puts at risk law enforcement not properly trained to

---

[46] Loïc Wacquant, "The New `Peculiar Institution':: On the Prison as Surrogate Ghetto," Theoretical Criminology 4, no. 3 (August 2000): 377–89, https://doi.org/10.1177/1362480600004003007.

[47] Garland, 10.

[48] Ibid.

[49] "Mentally Ill Offender Treatment and Crime Reduction Act" (National Center for State Courts, n.d.), http://www.ncsc.org/services-and-experts/government-relations/criminal-adult/mentally-ill-offender-treatment-and-crime-reduction-act.aspx.

[50] Bill, S.993- Comprehensive Justice and Mental Health Act of 2015, 114th Congress (2015-2016), https://www.congress.gov/bill/114th-congress/senate-bill/993.

manage mental health crises.[51] Further, it argues that using the criminal justice system to rid the country of mental health patients is a misuse of the court system and only adds to the increasing cost of the prison system.[52] The bill sought to provide funding for the development and continuation of mental health courts across the country, as well as to fund in-prison programs that focus on rehabilitation in an effort to care for, support, and provide services to prisoners suffering from mental illness.[53]

Despite this legislation, the actual conditions behind bars remain appalling. In 2003, Human Rights Watch reported on several human rights abuses happening across U.S. prisons, including but not limited to extreme neglect of basic human necessities such as water, dirt-ridden cells, cells and persons covered in feces, and prisoners being neglected to cope with hallucinations and delusions with little to no comprehension of their situation.[54] Prison conditions of isolation, inadequate services, overcrowding, and violence impact the mental health of any individual in prison, but are especially detrimental to mentally ill people. Empirical evidence has repeatedly shown, therefore, that retribution and punitive measures are not the answer if the criminal justice system wishes to decrease recidivism and actually help this population.[55]

The Federal Bureau of Prisons states that psychologists and psychiatrists are available for any individual in any moment of crisis,[56] but consistent, regimented psychotherapy and drug therapy to treat mental illness is rarely available to prisoners. The American Psychology Association (APA) suggests that those suffering from certain MHI's, such as depression, schizophrenia, and bipolar disorder, undergo formal therapy on a regulated schedule. Although the effective duration of therapy, both cognitive and drug-based, is highly individualistic, the APA finds that 15 to 20 psychotherapy sessions are usually

---

[51] Ibid.

[52] "The Comprehensive Justice and Mental Health Act: Summary" (Prison Fellowship, 2016), https://www.prisonfellowship.org/site/wp-content/uploads/2016/02/The-Comprehensive-Justice-and-Mental-Health-Act-one-pager.pdf.

[53] Ibid.

[54] Abramsky and Fellner 2003

[55] Jamie Fellner, "A Corrections Quandary: Mental Illness and Prison Rules," Harvard Civil Rights-Civil Liberties Law Review 41 (2006): 394.

[56] "Custody and Care: Mental Health," Federal Bureau of Prisons, https://www.bop.gov/inmates/custody_and_care/mental_health.jsp. "Crisis" is often narrowly defined as any moment when a prisoner is at risk of suicide or becomes a danger to other inmates."

required for 50% of patients to achieve clinically significant improvements.[57] To reach this number of sessions, patients meet with a psychiatrist for a period of 12-16 months. To adequately address chronic personality disorders, such as schizophrenia, the therapy can oftentimes require 12-18 months or several years of regimented treatment. Prisons rarely, if ever, meet these guidelines.[58] The actual number of inmates who receive adequate care to improve their mental state is alarming. Of the 14% of state and federal prisoners diagnosed with a serious mental illness, only 25% receive treatment after incarceration.[59] That number drops to 16% for those held in local jails.[60]

## Two Prevalent Models for Managing Individuals with MI in the Criminal Justice System

The two most prevalent models for mental illness management found in corrections facilities across the country are the Risk/Need/Responsivity Model (RNR) and the Illness Management and Recovery Model (IMR). Bewley and Morgan (2011) found that the RNR approach is the most widely used when specifically treating offenders with mental illness. Primarily implemented in Canada, the RNR model was developed by Andrews and Bonta (1990) and has since shown significant results when evaluating and rehabilitating inmates suffering from MHI. Its three core principles are: risk- the prisoner's likelihood of reoffending; need- the individual's criminogenic need (assessment inclination for criminal behavior) and assigning specific treatment; and responsivity- tailoring the individual treatment to maximize the success and ability to gain critical social learning skills to ensure rehabilitation and likelihood of successful reentry into society.[61]

---

[57] "How Long Will it Take for Treatment to Work?" PTSD Clinical Practice Guideline, http://www.apa.org/ptsd-guideline/patients-and-families/length-treatment.aspx.
[58] "How Long Will it Take for Treatment to Work?" PTSD Clinical Practice Guideline, http://www.apa.org/ptsd-guideline/patients-and-families/length-treatment.aspx.
[59] "Fact Sheet: Mental Illness and the Criminal Justice System," National Alliance on Mental Illness Virginia, https://namivirginia.org/wp-content/uploads/sites/127/2016/03/MIandCriminalJusticeSystem.pdf.
[60] Ibid.
[61] James Bonta and D. A. Andrews, Risk-Need-Responsivity Model for Offender Assessment and Rehabilitation, Corrections Research, User Report 2007–06 (Ottawa: Public Safety Canada,

This model assumes that criminal behavior can be predicted and tailors individual therapy to curb the likelihood of reoffending by offering specific social learning tools based on an individual's personality, learning style, and motivation.[62] The model has evolved to no longer rely on the judgement of corrections officers or other staff members to determine who needs enhanced care or supervision, but rather on evidence-based tools and a systematic and comprehensive risk scale. The major risk factors for predicting criminal behavior are antisocial personality, pro criminal attitudes, social supports for crime, substance abuse, family/marital problems, school/work problems, and lack of prosocial recreational activities. The four non-criminogenic factors that help to determine the rehabilitation programs are self-esteem, feelings of personal distress, major mental disorders, and physical health.[63] Each of these factors is critically evaluated and used to structure the individual's treatment program, with outcome goals ranging from changing substance abuse habits to ridding the individual of depressive symptoms and changing criminal behaviors.[64] A study by Bewley and Morgan (2011) found that the most drastic mental health and cognitive improvements were shown by those offenders who posed the greatest risk of recidivism upon initial evaluation.[65]

The second approach that has shown effective results is the Illness Management and Recovery model,[66] which helps inmates become aware of their illness and develop strategies to improve coping and social skills to prevent relapse, in addition to any psychotropic drugs the individual may be prescribed.[67] This model generally includes a nine-month program which can consist of individual or group therapy, occurring twice a week, as well as requiring that individuals attend 10 educational modules.[68]

---

2007), https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/rsk-nd-rspnsvty/index-en.aspx.

[62] Ibid.

[63] Ibid.

[64] Ibid.

[65] Bewley and Morgan, 352.

[66] Ibid.

[67] Ibid.

[68] Tom Bartholomew and David Kensler, "Illness Management and Recovery in State Psychiatric Hospitals," American Journal of Psychiatric Rehabilitation 13, no. 2 (May 21, 2010): 105–25, https://doi.org/10.1080/15487761003756977.

Several studies have illustrated the positive results of implementing both models of care. In addition to Mueser et al. (2006), Bartholomew and Kensler (2010) and Bewley and Morgan (2011) found strong improvements over a 9-month program and after a 3-month follow-up, suggesting long-term health benefits.[69] However, as noted by several of the studies, although these two models have shown significant effects across the most troubled inmates and patients, there is no standard of care for implementing components of the RNR or IMR approach across corrections facilities or state psychiatric hospitals.

## Limitations of Current Research about Care for Incarcerated Individuals with MI

Despite consensus among researchers that the combination of deinstitutionalization, shifts in criminal justice models, and changing societal attitudes have caused a spike in prisoners with MHI, and that support for those prisoners is underwhelming across the U.S., there is a significant lack of research focused on current treatment programs—and, importantly, their effectiveness—for incarcerated individuals with MI. Mechanic and Rochefort (1990), Erickson and Erickson (2008), and Appelbaum (2011) all argue that policymakers should improve mental health services in prisons and focus on re-entry into society, yet they provide no discussion of how to meet these goals effectively.[70] Bronson and Berzofsky (2017) found that over 50% of surveyed inmates with a mental health disorder reported that they had received some treatment upon admission to jail, but there was no data on the type of treatment they received or length of continuity of care, as well as no dependent factors such as recidivism rates. The World Health Organization and Human Rights Watch (2003), as well as research by Bewley and Morgan (2011) and Reingle and Connell (2014), analyzed the effects of the prison environment on the individual. Each study contended that there is a significant lack of treatment, poor continuity of care, lack of reentry programs, lack of focus on recidivism prevention, and not nearly enough funding. Yet, these studies

---

[69] Bartholomew and Kensler, 117; K. T. Mueser, "The Illness Management and Recovery Program: Rationale, Development, and Preliminary Findings," Schizophrenia Bulletin 32, no. Supplement 1 (August 18, 2006): S32–43, https://doi.org/10.1093/schbul/sbl022.

[70] Appelbaum, 1121; Mechanic and Rochefort, 80; Erickson and Erickson, 185.

provide little information on the specific nature of the services available around the country. While Scientific American (2014) has made bold claims that "treatment works," basing assertions on extremely low recidivism rates for patients who received therapy in forensic hospitals, there is little to no information on the nature of the treatment that inmates received and evidence for why such treatment produced low rates of recidivism.[71] These authors are pushing for more mental health care and pointing to the benefits of therapy without defining the nature of the most effective care based on empirical evidence from specific mental health and rehabilitation programs that have shown success. Further, it is unclear whether there are concrete, shared goals across prison mental health programs upon which mental health professionals can analyze the effectiveness of the treatment, prevention, and rehabilitation programs that do exist. This study will attempt to address that lapse in information.

## Goals of This Paper

The case studies contained herewith survey the current interventions for police, street encounters with individuals with MHI, defendants in the courts, and incarcerated individuals with MHI in prisons and jails in Oneida County, New York. Oneida County has recently taken measures to address the large number of MI individuals in its community, attempting to aid those currently moving through the criminal justice system for nonviolent offenses as well as to take steps to improve the care of MHI prisoners in the County's correctional institutions. These case studies analyze specific initiatives around continuity of care, support networks, therapy approaches, drug dispersion and regulation, stigmatization of the mentally ill, and policing and court processes, providing policy recommendations regarding the most successful practices for improving the treatment of those with MHI in Oneida County, and using those as the basis for suggestions to improve state and federal criminal justice systems.

---

[71] Robert Byron, "Criminals Need Mental Health Care," Scientific American, March 1, 2014, https://www.scientificamerican.com/article/criminals-need-mental-health-care/.

References

"A Brief History of Mental Illness and the U.S. Mental Health Care System." Unite for Sight, n.d. http://www.uniteforsight.org/mental-health/module2.

Abramsky, Sasha, and Jamie Fellner. Ill-Equipped: U.S. Prisons and Offenders with Mental Illness. New York: Human Rights Watch, 2003.

Adams, Kenneth, and Joseph Ferrandino. "Managing Mentally Ill Inmates in Prisons." Criminal Justice and Behavior 35, no. 8 (August 2008): 913–27. https://doi.org/10.1177/0093854808318624.

Amadeo, Kimberly. "Learn About Deinstitutionalization: Pros and Cons." The Balance, March 14, 2018. https://www.thebalance.com/deinstitutionalization-3306067.

Appelbaum, Paul S. "Law & Psychiatry: Lost in the Crowd: Prison Mental Health Care, Overcrowding, and the Courts." Psychiatric Services 62, no. 10 (October 2011): 1121–23. https://doi.org/10.1176/ps.62.10.pss6210_1121.

Bartholomew, Tom, and David Kensler. "Illness Management and Recovery in State Psychiatric Hospitals." American Journal of Psychiatric Rehabilitation 13, no. 2 (May 21, 2010): 105–25. https://doi.org/10.1080/15487761003756977.

Bassuk, E. L., and S. Gerson. "Deinstitutionalization and Mental Health Services." Scientific American 238, no. 2 (February 1978): 46–53.

Bewley, Marshall T., and Robert D. Morgan. "A National Survey of Mental Health Services Available to Offenders with Mental Illness: Who Is Doing What?" Law and Human Behavior 35, no. 5 (October 2011): 351–63. https://doi.org/10.1007/s10979-010-9242-4.

Bonta, James, and D. A. Andrews. Risk-Need-Responsivity Model for Offender Assessment and Rehabilitation. Corrections Research, User Report 2007–06. Ottawa: Public Safety Canada, 2007. https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/rsk-nd-rspnsvty/index-en.aspx.

Bronson, J., and M. Berzofsky. "Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12." U.S. Department of Justice, June 2017. https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf.

Byron, Robert. "Criminals Need Mental Health Care." Scientific American, March 1, 2014. https://www.scientificamerican.com/article/criminals-need-mental-health-care/.

Comprehensive Justice and Mental Health Act of 2015, S.993 § (n.d.). https://www.congress.gov/bill/114th-congress/senate-bill/993.

"Custody and Care: Mental Health." Federal Bureau of Prisons, n.d. https://www.bop.gov/inmates/custody_and_care/mental_health.jsp.

Erickson, Patricia E, and Steven K Erickson. Crime, Punishment, and Mental Illness: Law and the Behavioral Sciences in Conflict. New Brunswick, N.J.: Rutgers University Press, 2008. http://public.eblib.com/choice/publicfullrecord.aspx?p=361655.

"Fact Sheet: Mental Illness and the Criminal Justice System." National Alliance on Mental Illness Virginia, 2016. https://namivirginia.org/wp-content/uploads/sites/127/2016/03/MIandCriminalJusticeSystem.pdf.

Fellner, Jamie. "A Corrections Quandary: Mental Illness and Prison Rules." Harvard Civil Rights-Civil Liberties Law Review 41 (2006): 394.

Fuller, D. A., H. R. Lamb, M. Biasottie, and J. Snook. "Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters." Treatment Advocacy Center, December 2015. http://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf.

Garland, David. "A History of the Present." In The Culture of Control: Crime and Social Order in Contemporary Society, 1–27. Chicago: The University of Chicago Press, 2017.

Goldman, Ivan G. "The Insanity of Mental Health Practices." In Sick Justice: Inside the American Gulag. Washington, D.C: Potomac Books, 2013.

"How Long Will It Take for Treatment to Work?" American Psychological Association: PTSD Clinical Practice Guideline, n.d. https://www.apa.org/ptsd-guideline/patients-and-families/length-treatment.

Jaffe, DJ. "Survey: Law Enforcement Overburdened by Failure of Mental Health Departments." Huffington Post, December 21, 2011. https://www.huffpost.com/entry/police-mental-illness_b_1033848.

Kim, KiDeuk, Miriam Becker-Cohen, and Maria Serakos. "The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System: A Scan of Background and Analysis." Urban Institute, March 2015.

Kristoff, Nicholas. "Inside a Mental Hospital Called Jail." New York Times, n.d. https://www.nytimes.com/2014/02/09/opinion/sunday/inside-a-mental-hospital-called-jail.html.

Lamb, H. Richard, and Linda E. Weinberger. "Persons With Severe Mental Illness in Jails and Prisons: A Review." Psychiatric Services 49, no. 4 (April 1998): 483–92. https://doi.org/10.1176/ps.49.4.483.

Mechanic, David, and David A. Rochefort. "Deinstitutionalization: An Appraisal of Reform." Annual Review of Sociology 16, no. 1 (August 1990): 301–27. https://doi.org/10.1146/annurev.so.16.080190.001505.

"Mentally Ill Offender Treatment and Crime Reduction Act." National Center for State Courts, n.d. http://www.ncsc.org/services-and-experts/government-relations/criminal-adult/mentally-ill-offender-treatment-and-crime-reduction-act.aspx.

Mueser, K. T. "The Illness Management and Recovery Program: Rationale, Development, and Preliminary Findings." Schizophrenia Bulletin 32, no. Supplement 1 (August 18, 2006): S32–43. https://doi.org/10.1093/schbul/sbl022.

Ollove, Michael. "What Care for the Criminally Insane Can Teach Us About Mental Health Treatment." Stateline (Pew Charitable Trusts), April 25, 2018. https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/04/25/what-care-for-the-criminally-insane-can-teach-us-about-mental-health-treatment.

Pan, Deanna. "TIMELINE: Deinstitutionalization And Its Consequences." Mother Jones, April 29, 2013. https://www.motherjones.com/politics/2013/04/timeline-mental-health-america/.

Penrose, L. S. "MENTAL DISEASE AND CRIME: OUTLINE OF A COMPARATIVE STUDY OF EUROPEAN STATISTICS." British Journal of Medical Psychology 18, no. 1 (March 1939): 1–15. https://doi.org/10.1111/j.2044-8341.1939.tb00704.x.

Primeau, Ashley, Thomas G. Bowers, Marissa A. Harrison, and XuXu. "Deinstitutionalization of the Mentally Ill: Evidence for Transinstitutionalization from Psychiatric Hospitals to Penal Institutions." Comprehensive Psychology 2, no. 1 (January 2013): Article 2. https://doi.org/10.2466/16.02.13.CP.2.2.

Simon, Jonathan. Mass Incarceration on Trial: A Remarkable Court Decision and the Future of Prisons in America. Perseus Distribution Services, 2016.

Swanson, Ana. "A Shocking Number of Mentally Ill Americans End up in Prison Instead of Treatment." Washington Post, April 30, 2014. https://www.washingtonpost.com/news/wonk/wp/2015/04/30/a-

shocking-number-of-mentally-ill-americans-end-up-in-prisons-instead-of-psychiatric-hospitals/?noredirect=on&utm_term=.c70b5c2ff88a.

"The Comprehensive Justice and Mental Health Act: Summary." Prison Fellowship, 2016. https://www.prisonfellowship.org/site/wp-content/uploads/2016/02/The-Comprehensive-Justice-and-Mental-Health-Act-one-pager.pdf.

Torrey, E. Fuller. "Deinstitutionalization: A Psychiatric 'Titanic.'" In Out of the Shadows: Confronting America's Mental Illness Crisis. New York; Chichester: Wiley, 1998. https://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html.

———. Out of the Shadows: Confronting America's Mental Illness Crisis. New York; Chichester: Wiley, 1998.

Torrey, E. Fuller, Aaron D. Kennard, Don Eslinger, Richard Lamb, and James Pavle. "More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States." Treatment Advocacy Center and National Sherrifs' Association, May 2010. http://www.sheriffs.org/sites/default/files/uploads/Final%20Jails%20v%20Hospitals%20Study.pdf.

Wacquant, Loïc. "The New `Peculiar Institution':: On the Prison as Surrogate Ghetto." Theoretical Criminology 4, no. 3 (August 2000): 377–89. https://doi.org/10.1177/1362480600004003007. Whitehead, Tom. "Mentally Ill Are Not Police's Responsibility, Says Theresa May." The Telegraph, May 20, 2015. http://www.telegraph.co.uk/news/uknews/law-and-order/11616937/Mentally-ill-are-not-polices-responsibility-says-Theresa-May.html.

Yang, Suzanne, Alane Kadouri, Anne Révah-Lévy, Edward P. Mulvey, and Bruno Falissard. "Doing Time: A Qualitative Study of Long-Term Incarceration and the Impact of Mental Illness." International Journal of Law and Psychiatry 32, no. 5 (September 2009): 294–303. https://doi.org/10.1016/j.ijlp.2009.06.003.

# CASE STUDY 1

## THE TREATMENT OF THE MENTALLY ILL IN THE CRIMINAL JUSTICE SYSTEM: SURVEY OF THE CORRECTIONS AND FORENSIC ENVIRONMENTS IN ONEIDA COUNTY, NY

Samantha Walther
Spring 2018

# Introduction

There is a dramatically disproportionate rate of mental illness in inmates compared to the general population of the U.S.[72] This is due to the interrelated issues of deinstitutionalization, the move to a punitive justice model, and shifts in the public's perceptions of mental illness discussed in the Introduction to this paper. In addition, the prison environment itself not only exacerbates mental health problems but can also produce the onset of new mental illnesses.[73] Prisoners are constantly exposed to violence, sexual abuse, assault, exploitation, extortion, isolation, segregation, and excessive use of force. Due to the innate danger of the prison environment, self-harm and suicide attempt rates are also higher in prisons compared to the general population.[74]

Further, a 2015 report by Mental Health America (MHA) noted a positive correlation between number of adults in the criminal justice system and individual states' lack of mental health care.[75] The top six states with the highest incarceration rates (Alabama, Mississippi, Texas, Georgia, Florida, and Arkansas) also ranked the lowest on scales of access to mental health care in general society. The states with the lowest incarceration rates (Massachusetts, Maine, Rhode Island, and Minnesota) also provided the highest access to mental health care.[76] Thus, insufficient public policy and funding for mental health care directly translates to higher incarceration rates.

Because of these issues, researchers have sought to address how they can inform policy to create more effective rehabilitation programs for those currently suffering inside jail and prisons as well as how

---

[72] *Marshall Bewley and Robert Morgan, "A national survey of mental health services available to offenders with mental illness: Who is doing what?" Law and Human Behavior 35 (5), 351.; Richard Lamb and Linda Weinberger, "Persons With Severe Mental Illness in Jails and Prisons: A Review," Psychiatric Services 49, no. 4 (1998).*

[73] Jennifer Bronson and Marcus Berzofsky, "Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12," U.S. Department of Justice (June 2017): 1. https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf.

[74] Erickson and Erickson, 42.

[75] "Access to Mental Health Care and Incarceration." Mental Health America. Accessed February 4, 2018. http://www.mentalhealthamerica.net/issues/access-mental-health-care-and-incarceration.

[76] Ibid.

to prevent recidivism and keep those with mental health problems out of the criminal justice system in the first place. However, there is a significant lack of research focusing on current treatment programs available to inmates. The World Health Organization and Human Rights Watch (2003), as well as research by Bewley and Morgan (2011) and Reingle and Connell (2014), have analyzed the effects of the prison environment on the individual. Each contended that there is a significant lack of treatment, poor continuity of care, lack of reentry programs, lack of focus on recidivism prevention, and not nearly enough funding. Yet, these studies provided little information on the specific nature of the services offered around the country. In Executive Order 62, Virginia Senator Tim Kaine announced his commitment to divert the mentally ill away from the criminal justice system as well as to improve services for current inmates, but he also provided no clear direction for how to achieve such goals.[77]

Another limitation of the research regarding mental illness and the criminal justice system is that the few studies that have focused on specific treatments available to inmates have primarily examined jails rather than prisons. Bewley and Morgan (2011) found that the four most common treatments for mental illness available in jails were psychotropic medications, crisis intervention, case management services, and mental health referrals, but these findings may not extend to prisons.[78] Prison sentences are usually much longer than jail sentences, and therefore inmates require long-term continuity of care, longer prescriptions, and more psychotherapy.

Until Bewley and Morgan's (2011) study, there existed no comprehensive reports surveying the availability of mental health services in prisons or jails across the United States. While many studies point to potential areas of reform, none seem to address which prisons and jails, if any, may have mental health and rehabilitation programs that have shown significant success. Further, it is unclear whether there are

---

[77] "Fact Sheet: Mental Illness and the Criminal Justice System." National Alliance on Mental Illness Virginia. https://namivirginia.org/wp-content/uploads/sites/127/2016/03/MIandCriminalJusticeSystem.pdf.

[78] Bewley and Morgan, "A national survey of mental health services available to offenders with mental illness: Who is doing what?" 351.

concrete, shared goals across criminal justice mental health programs upon which professionals can analyze effectiveness.

This study will attempt to address that gap by surveying the actual interventions and current care practices available to inmates in prisons, jails, and forensic units in Oneida County, New York. The facilities studied include Oneida County Correctional Facility, Marcy Correctional Facility, Auburn Correctional Facility, Mid-State Correctional Facility, Mohawk Correctional Facility, Central New York Psychiatric Center (CNYPC), Hutchings Psychiatric Center, and Forensic Units (FU) in inpatient facilities. Oneida County has recently taken steps to address the large number of mentally ill individuals in its community, attempting to aid those who are currently going through the criminal justice system for nonviolent offenses as well as to improve the care of mentally ill prisoners in the County's correctional institutions. This study will analyze the nature of these institutions' continuity of care, availability of support networks, therapy approaches, drug dispersion and regulation, and stigmatization of the mentally ill in the County. Relying on the determinants of success established by Bewley and Morgan (2011), the study will determine the most successful practices available and will make informed policy suggestions to better aid the treatment of the mentally ill in Oneida County.

# Methodology

## Oneida County Overview

Oneida County is in the 5th judicial district in New York State, which consists of the Oneida County Supreme Court-Utica as well as the Oneida County Supreme Court-Rome, one county, and three city courts.[79] It is home to several corrections facilities, including The Oneida County Correctional Facility (a county jail that currently houses 634 prisoners)[80] and The Marcy Correctional Facility (a medium security prison that provides a residential mental health unit to treat inmates with mental health disorders).[81] This study also reviewed reports from other New York State correctional and psychiatric facilities including Marcy Prison, Mohawk Prison, Mid-State Prison, Auburn Prison, Central New York Psychiatric Center, and Hutchings Psychiatric Center.

In 2013, Oneida County established the Utica Mental Health Hub Court (UMHHC) in an attempt to divert mentally ill offenders from jail and prison to a court-mandated rehabilitative program.[82] In collaboration with the UMHHC, the Oneida County Department of Mental Health, Central New York Services, and the public defender's office have started to address the prevalent—and often related—issues of mental illness, drug/alcohol abuse, and criminal activity in the County.

In order to deduce how these allied organizations view the intersection of mental illness and criminal justice, and to assess which programs are working most effectively, we conducted in-person and telephone interviews with several stakeholders from across the County as well as with statewide agencies involved in the same cause. The aim of this study is to survey the current approaches to the treatment of

---

[79] "5th Judicial District: Oneida County Family Courts,"New York State Unified Court System, https://www.nycourts.gov/courts/5jd/oneida/family/index.shtml.
[80] "Correction Division," Oneida County Sheriff's Office, http://oneidacountysheriff.us/correction/correctionmain.aspx.
[81] "Marcy Correctional Facility," The Correctional Association of New York: Prison Visiting Project, April 2008: 1. https://www.correctionalassociation.org/resource/marcy-correctional-facility.
[82] For a more in-depth discussion of the UMHHC, see "Case Study 2" in this report.

the mentally ill in prison, jail, and forensic environments in Oneida County and to assess their applicability to other facilities in the State.

## Qualitative Interviews

In order to conduct a comprehensive analysis of how officials in Oneida County approach the treatment of the mentally ill in the criminal justice system, we conducted unstructured interviews with ten professionals from a range of related institutions.[83] While some of the interview questions were direct, most were open-ended and were organized into ten categories: Assessment/Evaluation Process, Diagnoses, Housing Units, Medication Management, Therapy Approaches, Continuity of Care, Training, Self-harm and Suicide, Recidivism and Re-entry, and Stigmatization and Problems. These categories were designed to ensure a holistic consideration of the variety of factors that contribute to the care of the mentally ill as well as of the effectiveness of the strategies currently employed by Oneida County to address that aim. The open-ended questions allowed the interviewees to provide information based on their personal experiences and influenced by their unique professional backgrounds. Open-ended questions also provided researchers with the opportunity to ask follow-up questions. Each interview lasted approximately one hour and provided several pages of notes. After conducting the interviews, we transcribed them and analyzed them for common themes.

## Interviewee Bios

### Robert Maciol, Oneida County Police Sheriff

Maciol has served as Sheriff of Oneida County since January 1, 2011. Prior to that, he was a police officer with the Whitesboro Police Department for 21 years, during which he had taken significant steps to implement more effective programs to serve the County's mentally ill population by working closely with the Oneida County Correctional Facility and its mental health units.[84] During the interview, he was joined by his Undersheriff and Erica Jalonack from Central New York Services.

---

[83] Through seven in-person and one telephone interview.

[84] "Sheriff Robert M. Maciol," Oneida County Sheriffs Office, http://oneidacountysheriff.us/admin/sheriff.aspx.

Robert Swenszkowski, Undersheriff, Oneida County Police Department

Swenszkowski has served as Oneida County's Undersheriff since 2010, where he has assisted Sheriff Maciol's collaboration with the Oneida County Correctional Facility. Prior to that, he was a Corrections Officer at the Oneida County Correctional Facility as well as a Deputy Sheriff and a police officer with the Village of New York Mills before being promoted to its Chief of Police in 2009.[85]

Erica Jalonack, Forensic Behavioral Health Coordinator, Central New York Services, Oneida County Correctional Facility

Jalonack works for Central New York Services, which has contracted with the Oneida County Correctional Facility to provide forensic mental health beds and medication dispersion to inmates. Jalonack was interviewed twice: once with Sheriff Maciol and Undersheriff Swenszkowski, and then again independently, during which she led the researchers on a tour of the mental health unit at the Oneida County Correctional Facility.

Tina Hartwell, Esq., Oneida County Public Defender's Office

Hartwell worked at the Oneida County Public Defender's Office-Criminal Division for 15 Ω years as a drug court specialist before transferring to the Regional Immigration Assistance Center in May 2017. She helped create the County's mental health court and has extensive experience with mentally ill populations in the criminal justice system. Hartwell was joined by her colleague Jaclyn Whitfield in the interview.

Jaclyn Whitfield, Public Defender's Case Worker, former Mental Health Court Coordinator

Whitfield is a certified Alcoholism and Substance Abuse Counselor with a specialty in mental health. She has experience in both outpatient substance abuse clinics and outpatient mental health clinics and served

---

[85] "Undersheriff Robert S. Swenszkowski," Oneida County Sheriff's Office, http://oneidacountysheriff.us/admin/usheriff.aspx.

as the case manager in the Forensic Evaluation Unit in the Utica City Court before transferring to the public defender's office.

Cheyenne Schoff, Captain, Rome Police Department

Schoff has served as Captain of Support Services for the Rome Police Department since January 2014.

Linda Nelson, Regional Commissioner of the NYS Office of Mental Health

Nelson is a Field Office Director for State Operations across twenty counties in central New York. She allocates state funding for treatment, program development, and coordination of services for the mentally ill, including those in the criminal justice system. Prior to assuming her current position, Nelson served in Oneida County as the Commissioner for Mental Health. Many of the facilities she oversees have forensic units on site. Nelson was joined by her colleague Garrett Smith for the interview.

Garrett Smith, Regional Advocacy Specialist for NY State Office of Mental Health

Smith's experience in the criminal justice system is both professional and personal. Prior to transferring to the NYS OMH in 2017, Smith spent twenty months at the Erie County Holding Center while awaiting his own court proceedings. Working under Linda Nelson at the NYS OMH, Smith is primarily responsible for connecting patients with peer networks, family, and community support to promote inclusion and aid re-entry.

Various Corrections Officers, Auburn Correctional Facility, Auburn, NY

Prior to proposing this study, researchers toured the Auburn Correctional Facility and spoke with several staff members there. Although Auburn is not in Oneida County, the data collected and narratives recorded elucidated many of the treatments and programs available for prisoners with mental illness as well as overarching stigmas about these prisoners that are heard in criminal justice facilities across the U.S.

<u>Lynn Chapman, Deputy Director of Operations, Adult Services, Hutchings Psychiatric Center</u>

Chapman has worked at Hutchings Psychiatric Center in Syracuse, NY since 2008. She began as the Director

of Rehabilitation and now serves as the Deputy Director of Operations for the adult unit. She has a master's

degree in Vocational Rehabilitation Counseling.

## Sample Questions

Assessment/Evaluation Process
- ∑ How do caseworkers, officers, and doctors assess the risk that an individual may pose for recidivism?
- ∑ What is the evaluation process/screening for new inmates?

Diagnoses
- ∑ What would you say are the most common types of mental health issues?
- ∑ Are certain diagnoses more difficult to handle?
- ∑ Do you see problems managing an Axis 1 diagnosis versus an Axis 2 diagnosis, which we have found to be prevalent in the prosecuting stage?

Medication Management
- ∑ Do you feel there is an imbalance between the need for medicine and what is actually being prescribed to inmates? Too much/too little?
- ∑ How many inmates are on a regulated medication for psychiatric, emotional, or behavioral problems?
- ∑ Is there an issue of overmedication in correctional facilities?

Therapy Approaches
- ∑ How are specific treatment programs chosen or assigned for inmates?
- ∑ Can treatment be tailored to fit the individual's needs, attitudes, personality, and specific problems?
- ∑ What is the most common therapy approach?
- ∑ Are there community-based treatments, such as relationship/community building, group therapy, or group activities?
- ∑ Is Cognitive Behavioral Therapy or Dialectical Behavior Therapy used?

Continuity of Care
- ∑ How often do inmates see a therapist?
- ∑ How many psychologists and psychiatrists are available?
- ∑ How would you describe the nature of continuity of care? Do inmates often receive follow-ups, medication help, checkups, etc.?

Training
- ∑ What is the training like for suicide awareness and prevention?
- ∑ Is training offered to manage or be aware of common signs of mental health issues?
- ∑ Do you feel you are personally trained well enough to handle a mental health crisis?
- ∑ What is training like for police officers and/or corrections officers?

Self-Harm and Suicide
- ∑ Are there any statistics regarding self-harm or suicide prevalence?
  - ∀ If not, what do you feel is the nature of suicidality in this county?
- ∑ When are individuals at the most risk for suicide or self-harm?

Recidivism and Re-entry

∑   Do prisoners often find jobs or have a support network when they leave the institution?

∑   How does your program measure success when treating inmates?

∑   Are there programs in place that are aimed to help prisoners change their inclinations towards criminal behavior, whether through skills training, jobs, therapy, etc.?

∑   What is the most important factor in determining whether or not an inmate or patient will be able to successfully reenter the community?

Stigmatization and Problems

∑   Do you feel there are enough services to support the number of mental health issues in the prison?

∑   Do you feel mental illness is stigmatized in the prison environment? (Between inmates or between guards and inmates?)

∑   Do you feel there are enough resources and funding for mental health services inside the corrections facilities in this county?

∑   What steps have been taken to help those suffering from mental illness inside correctional facilities?

∑   What steps do you see that have been the most effective?

∑   Are there certain strategies, treatment, training, or approaches that you would like to see the county implement?

∑   Do you have suggestions for other counties and corrections facilities based on your work that you feel would help reduce the stigmatization of mental illness and offenders?

∑   Why do you feel the number of those incarcerated with mental illnesses has increased significantly over the past few decades?

# Data Narrative

Narrative research evaluates the written transcripts of individuals' responses to a specific question or problem, typically focusing on some aspect of the individual's life.[86] In this study, that aspect is individuals' professional and lived experiences in the criminal justice field, with special attention to mental illness. This type of research allowed us to compile extensive qualitative information across several facets of the criminal justice system ranging from the treatment of the mentally ill in state corrections environments to first-hand stories of prisoners and inmates. The data narrative that follows is a shortened dialogical analysis of pieces from the interviews that were particularly useful in addressing

---

[86] "Narrative Research: What is Narrative Research?"atlasti, http://atlasti.com/narrative-research/.

the research question posed by this case study: What is the nature of the treatment of the mentally ill in jails, prisons, and other forensic holding units in Oneida County?

## Assessment/Evaluation Process

Researcher: When are 730s ordered?

Tina Hartwell: If [individuals are] not able to follow standard questions, then we order a 730 exam. They are put into custody for their own safety. The competency exam requires 30 days in jail before I can get the report back. With misdemeanors, the charge would be dismissed, and a 90-day observation period happens in custody, usually in a psych facility, and then they are released. Then it's determined if they are safe to return to the community.

Researcher: What are the consequences of the volume of 730s shooting up?

Jaclyn Whitfield: So if a 730 is ordered, the person cannot assist the attorney in their own defense and they can't grasp the concept of the charges. There are two psychologists that will meet with the individual. If the judge decides to keep them held in jail to get the 730 exams, they hope to hold them there for 30 days; the two psychologists will go, write the reports, and give them to Linda Rude to figure out if they're competent or not competent. Linda forwards them to the court; then if they're not competent, and it's a misdemeanor charge, the judge will dismiss the charge and put the orders into the custody of the Office of Mental Health [OMH]. So then they'll go to the hospital for however long the hospital feels necessary and [it will] discharge them to SPOA (Single Point of Access).

Researcher: So if it becomes a misdemeanor, the charges are dismissed. Where is the client then sent?

Jaclyn Whitfield: The 730 order goes to Albany to Cheryl Flagler. She'll look at it and figure out what hospital has an opening for this person. Typically they go to Hutchings Psychiatric Center in Syracuse. We don't have any here anymore [in Oneida County]. We used to have a psych center here, but they took that away, which is horrible. We need it. Because now there's waiting lists at Hutchings, so you have people who failed the 730, who are clearly not competent, sitting in jail where they should not be. If it's a felony level, and the person fails the 730, their charges are not dismissed. They are sent to the hospital for 90 days to get stable. And then once they're stable they return to court and have to address their charges. So I mean at some point they might reduce the sentences; we've had plenty of felonies that have been reduced to misdemeanors based on the 730, but their charges aren't going to be dismissed.

Researcher: What is your role here?

Jaclyn Whitfield: The attorneys can refer their clients to me if they feel that their client has a substance abuse or mental health issue. They'll say, "Hey, can you go to the jail and meet with my client and see if we can recommend some treatment to the judge instead of them going to prison...I do a full biopsychosocial assessment. I look at their whole history: family, drugs, alcohol, mental health history, and I type a report up. I have them sign a release and gain records if they've done treatment before...then I come up with recommendations to present to the court instead of a jail sentence and see if the judge is willing. The judges have been really great, and the DA's office has been really great in giving these people the opportunity to get help instead of sending them to prison where they just get worse, and come out, and do it again. So, I send them to treatment, I get reports for the court, and see how they do.

Researcher: The evaluation process is all based off of review of their records (at Oneida County Correctional Facility)?

Erica Jalonack: We'll do an intake so we will get where they're going to treatment, last use, suicide history, hospitalization, and then have them sign a release for their records.

Researcher: As to people who come in with mental health problems but also substance abuse...how is that dealt with?
Sheriff Maciol: Constant supervision is actually a status and they'll do it in certain units and it's more of a status and how they're observed. So, we can do it one-on-one or they're continually watching one person, one officer per inmate or one officer per three inmates. It just depends on the status of the person. The first 24 hours they are clocked in and constantly supervised. Our population is transient, so there's two types of inmates: pre-trial and sentenced inmates. They can come and go, and even a sentenced inmate is usually 12 months or less, but there are some exceptions, like our federal inmates who are more long-term. Before they would be able to get anything established (therapy), they're already gone.

The evaluation process for someone facing criminal charges who is suspected to be suffering from a mental illness begins during their initial arrest, where a 730 can be ordered by the Judge or the District Attorney's office. Correctional facilities including Oneida County Jail, as well as state prisons like Marcy, Auburn, Mid-State, and Mohawk, seek permission to obtain inmates' medical records upon arrival. When the inmate signs the release, the medical departments can then order any medication that the inmate has received from a pharmacy or prescriber in the last month. Most correctional facilities will monitor new inmates constantly for their first 24 hours. The facilities also have the option to call in the DA's office to conduct new exams for inmates who may need more attention. The evaluation process therefore does not stop once an individual is sentenced; rather, those suffering from mental illnesses, psychotic breaks, or new symptoms can receive care at any point as a result of communication between their facility and the DA.

The 730 exam requires that two psychologists assess the inmate. If found not competent, the individual is put on a waiting list to be moved to a psychiatric facility, but many of our interviews revealed that it can take months or even years before a bed becomes available, as there are only two psychiatric centers in New York State: Hutchings and Rochester. One major limitation to the criminal justice system in Oneida County is that neither of these centers is in the County. Once transferred, individuals undergo at least 90 days of supervision at the psychiatric center to determine whether they are safe to reenter the community. If the 730 finds an individual not competent, their felony charges can often be dropped to misdemeanors, and misdemeanors can be dropped altogether.

Diagnoses

> Researcher: What is your role at the Public Defender's Office?
>
> Jaclyn Whitfield: I'm a Certified Alcoholism and Substance Abuse Counselor with a specialty in mental health. When you have a substance abuser, most likely they also have some type of a mental illness, whether it be something mild or severe. Depression and anxiety go hand-in-hand with alcoholism.
>
> Researcher: Do you think the system does a good job ferreting out the differences between Axis 1 and Axis 2 disorders?
>
> Jaclyn Whitfield: You have mental illness like an Axis 1 diagnosis, then you've got your personality disorders, which is a whole different thing. Axis 2s are difficult, especially if you've got your borderline personality disorders in mental health court. We've taken our share of borderline personality disorders. Those are the individuals that kind of thrive on chaos, thrive on tension. I mean, we've had clients just do full-on seizures in court that weren't really having seizures. It's difficult in a mental health court situation to deal with a personality disorder because there's so much treatment that is needed for those individuals that we just don't have.
>
> Researcher: In terms of diagnoses, what would you see as the most prevalent? Do you see difficulties between managing Axis 1 disorders and personality disorders? Are there systems in place for therapy and treatment that approach these differently, in either a correctional facility or a psychiatric center?
>
> Linda Nelson: It depends on the person in that minute. Now we're always going to have a group, we call them seriously and persistently mentally ill. These are people who see things and hear things. Relatively a significantly smaller percentage of those people are coming in. The majority of diagnoses coming in really are a lot of personality disorders and combinations of those…we see a lot of personality disorders and substance abuse, a lot of depression…I see more of those types in the local jails. Now in the state system, I see more of the serious and persistent.
>
> Tina Hartwell (on comorbidity): They are always intoxicated, covered in feces. I see them in Oneida Square. Nobody will take them...When I first started, the majority of cases were fueled by alcohol and drugs. Still, 90% is alcohol and drugs. And 80% of that is mental illness.
>
> Researcher (on Oneida County Correctional Facility): The other thing that raises the numbers that we've seen are very high for people who come in with mental health problems but also substance abuse, and it's usually people self-medicating on the streets, so how is that dealt with? Is there some kind of way of sort of dealing with their withdrawal when they're here?
>
> Erica Jalonack: So if they come in and they have any use, they go right into our constant supervision housing, and medical monitors their withdrawals. Once they score lower on a withdrawal protocol, then they can be cleared from constant supervision and our medical department monitors that; they can give some medication and if it gets too bad, they will send them out to a hospital.

The Office of Mental Health (OMH) has identified over 8,000 inmates in New York who need mental health treatment.[87] The interviews revealed that there are two categories of mental illness: Axis 1 and Axis II. Axis 1 illnesses include anxiety and mood disorders, such as PTSD and depression, as well as substance abuse. Axis II disorders are more serious and persistent and include borderline personality

---

[87] "Mental Healthcare and Incarceration," Correctional Association of New York, https://www.correctionalassociation.org/issue/mental-health.

disorders. Oftentimes, those with serious mental illnesses end up in higher security state or federal prisons, as their disorders are harder to assist and produce higher rates of criminal behavior. At Mid-State Correctional Facility, 133 inmates were identified as having a serious mental illness after the latest visit by the Correctional Association of New York.[88] All of the interviews conducted in this study revealed that comorbidity between substance abuse and mental illness is a significant issue that should be addressed.

Housing Units

> Researcher: On average, how long does an individual stay at [Oneida County Correctional Facility]?
> Erica Jalonack: The longest someone can be here is a county year. If they lose their good time, they can be here that whole year; if they keep their good time, they can be here 8 months. However, we do have federal inmates here because we are a max facility, so we can board in. These people might be here for a few years before getting shipped to their final federal prison. Oneida is a holding ground for 730 inmates. Inmates don't leave very quickly when they are found incompetent. They are held up to 30 days while the county brings in 2 professional examiners [psychiatrist, psychologist] who will interview them and write a report on whether they are competent. There are no beds in these facilities [in Oneida County]. There are only 2 facilities in all of New York State. Once they are found incompetent to aid in their own defense, they leave the facility to go to in-patient treatment. We have one particular pod that is a mental health pod, and we also have linear housing, so that's a special watch pod. The special watch pod has 10-minute tours and usually 2 officers on the unit, so we have a podular special watch housing and we have a linear special watch housing. There are 56 beds in a pod. The capacity for linear has 20 on each side, and the rest have 16. We have male and female; it depends on what the need is at that time. We have right around 115 out of the population of 425.
> Undersheriff Swenszkowski (on Oneida County Correctional Facility): There's 4 linear units downstairs in the old jail and 2 upstairs, so they vary. In some are 20, some are 16, some are 8. There's a capacity of about 100; one unit was turned into an infirmary. And then the pods are about the same, 4 per floor, the max is 56...We have 2 floors and they were actually designed to be able to be continually built on top; they were built to expand.
> Researcher: Is solitary or isolation used at all?
> Erica Jalonack: No. We have inmates locked in for behavior, but that too is a whole pod and there's 56 people in there and they manage to talk to each other and they rec together. So there's nobody in actual solitary in here.
> Researcher: Can you explain a little bit the difference between a Forensic Unit and maybe other units?
> Garrett Smith: A forensic setting is the most secure mental health setting you can be in, and to go into a forensic setting, legally your mental illness has to be deemed dangerous. So you are an imminent risk to harm yourself or others. "Imminent" can be tomorrow or ten years from now, but the probability of you doing something illegal based on suffering from your mental illness is high. There are three ways you go into a forensic unit. The most common way is a 330.20 [CPL § 330.20], which is the insanity plea. The other way is a 730 [CPL § 730], which would be you're going there for evaluation to be deemed competent to go to court. So they would go to a

---

[88] "Mid- State Correctional Facility," The Correctional Association of New York: Prison Visiting Project, April 2009: 13.

psychiatric center for stabilization. And then there's 508's [CL § 508(3)] - a 508 would be a person that's in jail that's still going through their court proceedings. Whether they're going through hearings or trial, and they have a psychotic break in some form or fashion. Whether that's a suicide attempt or they had a relapse or they're having a manic episode or any type of psychotic feature and they are brought to a psychiatric center for stabilization and then they are discharged back to the jail because they still have pending charges. Forensic is a locked door facility, so you can have a person who can technically be in forensic for 7 years and not really go outside that often. You may go outside once a day, one hour a day.

Linda Nelson: This is the state system.

Researcher: So it's like Marcy?

Garrett Smith: Yes, but Marcy is a little different because people at Marcy are convicted. A 330.20 is not necessarily convicted of their crime because they're not found guilty, but they're also not found not guilty. They are found not responsible due to mental disease or defect. That's the legal definition of it. And for that reason they're not penalized or punished by going to prison; they are sent to a forensic setting for rehabilitation, but they're still considered dangerous. That's why they are in the forensic setting. So a 330.20 can fall under three tracks...One is the forensic, which means you're dangerous and you suffer from a mental disorder. So your mental disorder is dangerous. Track 2 is you are not dangerous, but you're suffering from a mental disorder. You're not showing any signs of dangerousness, but you may not comply with medication or you might have some psychotic features that you still need to learn how to manage. So, you would go to a civil setting which would be like Hutchings PC or Greater Binghamton Health Center, or St. Lawrence.

Researcher: What is the average stay for someone in a Forensic Unit?

Garrett Smith: The average stay in forensic is 3 to 5 prison years. You have some who've been there for 30 years. Peers would consider your stay in forensic "one day to life" because technically you can be released in six months or you can be there until you are transferred to a geriatric unit...But you can have somebody that's in jail that can spend upwards of five years before they're actually taken to court where a trial or they find some type of plea agreement or anything like that where that case is resolved in some form or fashion. So that's a huge issue because you have people who may be found not guilty, but they spend five years in jail and everything that comes with being in that environment: witnessing suicides, or having to be strip-searched, having to be shackled, all these things that can create trauma.

Researcher: How is Central New York Psychiatric Center (CNYPC) different from other mental health units across the state?

Erica Jalonack: CNYPC is over in Marcy, New York, but they have county wards, prison wards, the sex offender units, and then people from county jails or prisons who are deemed incompetent or just have an extreme mental health referral can do their time there until they are stable and then they'll go back to their facility. CNYPC actually runs all the mental health in all the prisons. So when you have to send records from a prison, it's CNYPC at Five Points or whoever, but that is their main hub.

There are several types of housing units in Oneida County for individuals with a mental illness who are in the criminal justice system. This report surveyed Oneida County Correctional Facility, several state prisons (Auburn, Marcy, Mid-State, and Mohawk), Central New York Psychiatric Center (CNYPC), Forensic Units, and community-based centers.

Oneida County Correctional houses both federal and state inmates awaiting trial, with the limit being a county year except for federal inmates, who may be there longer awaiting transfer to their final federal institution. The facility has a special mental health unit run through Central New York Services (CNYS), as well as a special watch pod with a capacity of about 100. Unlike other state prisons, Oneida County Correctional does not use solitary confinement units. Many of those interviewed mentioned that often, inmates who are found incompetent remain locked in jail for several months before being transferred to a psychiatric center to receive adequate treatment.

Central New York Psychiatric Center is located in Marcy, New York and consists of 220 beds in a secure inpatient facility. It also offers corrections-based mental health units to all of the correctional facilities in New York State; the mental health units that will be discussed in Auburn, Marcy, and Mid- State are considered satellite units of CNYPC. Combined, CNYPC provides 205 crisis beds, 781 Intermediate Care Program beds, and psychiatric services to over 8,500 inmates across its 15 satellite units throughout New York.[89] CNYPC also provides 28 outpatient facilities.[90]

There are also seven Forensic Units (FU) in psychiatric facilities throughout the state that are distinct from the satellite units; these include FUs in CNYPC in Marcy as well as one in Rochester Psychiatric Center.[91] These are where inmates in Oneida County are often sent under CPL§402 (standards for psychiatric hospitalization), CPL§330.20 (insanity plea), CPL§730 (incompetency), and CPL§508 (emergency commitments). Inmates must be deemed dangerous to be placed in a forensic setting. However, they are not necessarily convicted, like those in the mental health satellite units at Marcy Prison. Individuals can remain in a locked door forensic unit for any length of time ranging from one day or until they are sent to a geriatric unit.

Researchers were able to meet with corrections officers and to tour Auburn Prison, in Auburn, New York. Although Auburn is a maximum security prison in Cayuga County, the interviews there provided information on the types of services available at state prisons and helped to address the

---

[89] "Central New York Psychiatric Center," Office of Mental Health, https://www.omh.ny.gov/omhweb/facilities/cnpc/.
[90] Ibid.
[91] Ibid.

limitations that researchers faced when trying to contact prisons and correctional facilities in Oneida County. Auburn has the capacity for 1,821 inmates, with 1,533 of those in the general population. The prison is an OMH Level 1 facility and has a mental health treatment unit through the OMH and several mental health professionals on staff, but it does not have a residential mental health treatment unit.[92] One significant issue regarding mental illness at Auburn is that the Correctional Association found that 43% of those housed in solitary were participants in the OMH programs, despite the SHU Exception Law, which requires that these individuals not be placed in solitary.[93] Similarly, Marcy has historically shown high rates, at roughly 20%, of mentally ill inmates placed in SHU.[94]

Mid-State Correctional Facility is also a Level 1 OMH facility.[95] This categorization provides 24-hour mental health services to patients in the mental health unit. Mid-State provides a Residential Crisis Treatment Program, similar to Auburn's, to address acute mental health crises such as suicidality and dangerous behavior, but still struggles with a higher percentage of mental illness than other NYS facilities.[96] Nearly 39% of the entire population at Mid-State receives OMH services, while the average across the state is about 14%.[97]

Lynn Chapman, the Deputy Director of Operations-Adult Services at the Office of Mental Health, forwarded the program description for Hutchings Psychiatric Center. Hutchings is a community-based mental health facility with 105 inpatient beds for adults. It is considered a civil setting and serves three classes of individuals, including: those being held in pre-trial detention who require medical care for their mental illness but who must remain in custody by the Sheriff's Department; felons who are found incompetent to stand trial; and those who have been acquitted of their charges by reason of mental disease or defect.[98] The Collaborative Transition Team assists these individuals to re-enter society by helping

---

[92] "Auburn Correctional Facility," The Correctional Association of New York: Prison Visiting Project, June 2011: 15.
[93] "Auburn Correctional Facility," 15.
[94] "Marcy Correctional Facility," 12.
[95] "Mid-State Correctional Facility," 5.
[96] "Mid-State Correctional Facility," 1.
[97] "Mid-State Correctional Facility," 13.
[98] Franklin Reed and Robin Fox, "Psychiatric Hospitalization of Criminal Defendants: New Horizons," The Bulletin (1997): 61.

them locate residential community housing.[99] More information on this program is included in the section

on Recidivism and Reentry.


## Medication Management

Researcher: So you would be in charge of medication (at Oneida County Correctional Facility)?
Erica Jalonack: Yep, so we have a nurse practitioner, an MD, and we are in the process of hiring a new psychiatrist that would be working per diem. They are contracted through our organization.
Researcher: But they're not just working here at this facility, they work elsewhere as well?
Erica Jalonack: We are in the middle of nurse practitioners right now...so we just have to fill in right now and she is actually our nurse practitioner at our outpatient clinic, so she actually comes up here one day a week to help us out until we hire a new person.
Researcher: Would you agree that there's an overmedication of inmates in corrections facilities?
Garrett Smith: Yeah, that's just a baseline. That's always been going on. When you think of forensic settings, think of the root being we're in a capitalist society...so hospitals and correctional facilities are compensated based on the number of physical restraints they're able to decrease. So every quarter they're reviewed and if they have a constant decrease in physical restraints, they're compensated for that. But what they do in order to decrease the physical restraints, they increase the chemical restraints. So a person that would typically be hostile or have 5 restraints in 2 days, they would put them on say 8 mg of Risperidol, where now they are so dulled down that they can't do anything, but on paper now you have 5 less restraints. In a month, that's a huge reduction...If you're in a forensic setting, you're given at least two times the therapeutic amount that you would be given if you were in the community. It's the same at any secure facility. They put you on the max amount of dosage they can without killing you, so to speak.
Researcher: Do you see overmedication as a problem here (at Oneida County Correctional Facility)?
Erica Jalonack: Not here, because we just put them on what they came in on, so we don't sit there and overmedicate, we just continue what they're on.
Researcher: So the psychiatrist wouldn't change that dosage?
Erica Jalonack: Unless someone is having side effects or reactions, but we never add or remove.

Larger state facilities are facing a crisis with overmedicating inmates in order to decrease behavioral

problems, due to the compensation facilities receive for doing so. An additional problem with this practice

is that when released back into society, individuals will often reduce their dosage but then will be unable

to function. Overmedication is often not found in smaller county correctional facilities because the

regulations regarding providing inmates new prescriptions and changing their dosage are much stricter.

This may be due to the fact that county inmates are often incarcerated for much shorter

---

[99] Program Description for Prospective Staff, "Hutchings Collaborative Transition Team." Provided by Tracy Lord- Mortas, Director of OMH Certified Residential Programs for Central New York Services.

periods compared with those at state facilities. The nurse practitioner in Oneida County Correctional Facility can only continue previously prescribed medication and only in cases of severe side effects will alter the dosage.

Therapy Approaches

Erica Jalonack: So we don't do weekly therapy [at Oneida County Jail]. We are strictly crisis intervention, medication management, and suicide prevention. And that's partly because we don't even know how long someone is going to be here. So to sit there and start to open a can of worms with someone and then they get released the next day and don't follow through with anything, it's just too hard. We get their records from the outside and whenever they were diagnosed on the outside and whatever medications they were on the outside, we continue here. We do have a nurse practitioner, a doctor, we have all that on site, but they don't do any diagnosing or initial prescribing.

Researcher: If those additional resources were available, do you think it would be a good idea to provide treatment here if someone were to be here for more than just a few weeks?

Erica Jalonack: Well like I said, as long as they're here and they're on meds, we follow up with them so we do, it's not therapy, but we see them. We make sure all their needs are met, whatever services they need when they leave, we make sure that all that is covered.

Researcher: But beyond that, psychiatric talk therapy, that might be useful?

Erica Jalonack: I don't know.

Researcher: It's declining all around the country; it's all about drugs, by and large.

Sheriff Maciol: I think we're going to come right back to that elephant in the room. To run this place it costs me 40 million dollars a year, and we don't do anything fancy here. I mean our ratio of officers to the general population is one correctional officer for 56 inmates. That's the minimum standards. If I had more money, I'd hire more officers, but we can't get people to work here either.

Researcher: What is your staff here?

Erica Jalonack: There's myself, another LMSW, 2 counselors, and our discharge planner, and we have two openings. One has been since August and one since December.

Sheriff Maciol: And this facility has 560 inmates.

Erica Jalonack: And for finding mental health beds, there's one [unit] in Rochester, Hutchings, and CNYPC in Marcy.

Researcher: They [Marcy] accept from state corrections and 730s; they have a county ward, which will take any inmate in any county in the whole state.

Sheriff Maciol: But you don't have any access there, it just seems that their criteria is so hard to reach to get in to.

Researcher: If someone comes in with substance abuse, what does that withdrawal process look like?

Erica Jalonack: So our medical department does all that. Depending on what they come in on, they would go to our constant supervision unit where there's an officer on them at all times. So they have COWS [Clinical Opiate Withdrawal Scale] and CIWA [Clinical Institute Withdrawal Assessment for Alcohol]. If they can't manage that here, they will send someone to a hospital.

Researcher: And what if any, with people with substance abuse, what programs are available that the facility provides for them?

Erica Jalonack: We do run a couple groups here. We do a substance abuse group, an anger management group, wellness group. We can't personally set up rehab because we don't know when someone is leaving. So we work with the public defender's office very often to get services set up for people [for when they re-enter society, or get 730s ordered].

Researcher: What do those programs look like?

Erica Jalonack: It's just a 6-week educational group. We run one each in the male pod and one each in the female pod.

Researcher: And those are run by trained instructors?

Erica Jalonack: Yeah.

Researcher: How long are they?

Erica Jalonack: Those are once a week for an hour, because we're just so short-staffed.

Researcher: How many generally go to those groups?

Erica Jalonack: They start out with usually 12; that's pretty much all the room will hold.

Researcher: And that's on a voluntary basis?

Erica Jalonack: Yeah, all of our services are voluntary. We can't mandate meds; we can't mandate them to see us.

Researcher: What do the inmates' day-to-day lives look like?

Erica Jalonack: It all depends on what they sign up for. There are services in the building; there is a school in the building. There's our Alternative to Incarceration (ATI) program: they hold resume building, career building, job training, help them get DSS applications set up. But none of these are mandated. The program has computers and books, all of that.

Researcher: What is the nature of the classes here?

Erica Jalonack: They are run through Oriskany School. It's only through GED; I don't think we offer any college at this point. They provide the teachers and social workers.

Garrett Smith (on CNYPC): When I go there, there's always a lot of issues, but the main issue is that they are sitting around doing nothing. A lot of inmates say that they want to get their GED or want to do this and want to do that. They don't have structured treatment... They're spending years of pretty much atrophy, not doing anything, and then they get out in the community and you expect them to be successful. You know they weren't getting any type of structured treatment. So we're trying to really address it well...how do you really help this person get back into the community and be successful, where you teach them basic skills or helping them relearn those basic skills they're going to use. That's not really being done, especially in jails. The majority of the day you're locked in. Some jails have it where you're locked in for 16 hours. Some have it where you're locked in for 12 hours. But, you spend half a day in a cell for years before you actually get back into the real world. So, are the jails offering any type of services for people who are within the mental health world that can use these services so if they do get out they can get on their feet and have a plan in place for when they leave? No, you don't have that in the jails.

Garett Smith (on mental health): Serious mental illness is a really small percentage of people. The majority of people have some form of a mental illness that takes up the majority of services, so there's two things with this. One, a lot of people who are coming into the mental health ward have a lot of substance abuse, but they don't really relate to the substance abuse community. So one of the things that has started up across the state, it's sporadic because it's still new, but it's SMART Recovery. It's an alternative to NA and AA, and it's being done a lot by clinicians because it infuses DBT, and what that does is allows the person to then focus on the psychotic features that they deal with that can be addicting...to then bring them to the most therapeutic form of recovery that they can go into. It helps tailor it.

Officers at the Oneida County Correctional Facility emphasized that they do not offer structured therapy due to time, staff, and funding constraints. Care is focused strictly on medication and suicide prevention. Both Jalonack and the sheriffs mentioned that perhaps if more funding and trained psychologists were available, some form of short-term therapy might be beneficial for inmates. The

facility does assist with substance abuse issues, offering both withdrawal services and 6-week educational groups. It also offers groups for wellness and anger management, but those are the only options for cognitive and talk therapy. Finally, the facility offers GED courses through the Oriskany School and job application and resume building through an Alternative to Incarceration (AIT) program.

CNYPC also lacks structured treatment. Interviewees expressed that this was a significant concern because clients spend their entire days in this inpatient care facility but lack things to do and treatment for the issues that caused them to be there in the first place. Most of the services offered by CNYPC and Forensic Units are used by inmates suffering from serious mental illness or comorbidity between MI and substance abuse.

Auburn Prison provides three treatment programs for those in the mental health unit. These include a Residential Crisis Unit (RCTP) with 10 beds, an Intermediate Care Program (ICP) with 50 beds, and a Transitional Intermediate Care Program (TrICP) with 26 beds.[100] RCTP is a temporary unit with a median stay of four days for those in immediate danger to themselves or others.[101] ICP is a residential unit for those suffering from a serious mental illness. Most people in this unit see an individual therapist and report being relatively satisfied with that service. TrICP is specifically focused on helping individuals transition back to the general population; the average stay is about one year.[102] This unit provides two group therapy programs that occur twice a week.[103] While these units serve as evidence that Auburn tries to address issues of mental illness in its population, 66% of inmates there reported that their individual therapy sessions were not long enough, and 73% stated that the quality of the therapy was poor.

Both Auburn and Mohawk offer a cognitive behavioral therapy program called Thinking for a Change (T4C) that lasts for 22 sessions across 11 weeks. The program is a promising initiative intended

---

[100] "Auburn Correctional Facility," 28.
[101] "Auburn Correctional Facility," 29.
[102] "Auburn Correctional Facility," 32.
[103] Ibid.

to address both social and problem-solving skills. Yet, it faces familiar underfunding and understaffing problems in prisons across the state, and currently, 789 inmates are on the wait list to enter T4C.[104]

Similarly, Mid-State provides an Intermediate Care Program (ICP) for those with serious mental illness and a Residential Crisis Treatment Program (RCTP) for those whose behaviors may indicate that they are a risk to themselves or others. The ICP includes medication management as well as individual and group talk therapy, psychiatric rehabilitation therapy, recreation therapy, skills training, education, vocational training, security services, crisis intervention, substance abuse counseling, and religious counseling if wanted.[105] It is a four-step program with the end goal of reentry into the general population. Mid-State has also taken steps to address comorbidity—which the facility identifies as a serious problem— through a program called Mentally Ill and Chemically Addicted (MICA), in which two Corrections Counselors work with inmates who show signs of both addiction and mental illness. While these programs are positive steps toward addressing these issues, they suffer from the usual problem of not being able to provide services for everyone who needs them; for example, the RCTP has capacity for only 12 inmates at a time, while the ICP can only house 20. These small capacities are concerning given that Mid-State's mentally ill population is significantly higher than other institutions'.[106]

One positive state-wide initiative regarding mental health issues is New York's SMART (Self-Management and Recovery Training) Recovery program, which is available in both inpatient facilities and community centers to infuse dialectical behavioral therapy with elements from NA (Narcotics Anonymous) and AA (Alcoholics Anonymous). This initiative offers a way for individuals to tailor their recovery to their specific needs.

---

[104] "Mohawk Correctional Facility," The Correctional Association of New York: Prison Visiting Project, July 2010: 10-11.
[105] "Mid-State Correctional Facility," 15.
[106] "Mid-State Correctional Facility," 13.

## Continuity of Care

Researcher: Can you talk about what the continuity of care is like [in Oneida County Jail]? If somebody comes in already on medication, how do we figure out what that is and make sure they are getting it when they are in here, and what happens when they are restored to competency?

Erica Jalonack: So once somebody is here on site, we go right to booking. We will have them sign a release from whoever their provider is to get that information. Our medical department actually has them sign a release from their pharmacy, so they get the information from the pharmacy and if it's a prescription that they have picked up within the last 30 days, our medical department starts it for them immediately until they can see our nurse practitioner.

Researcher: One of the complaints I get is that, "Oh if I go in there I won't get my meds for 3 days or something," and what you're telling me is that's not true?

Erica Jalonack: It's usually about 24 hours. So we don't have any medication on site. Our medical department, if they push it in before 4 pm, it's here the next day. There are some medications that they won't use here, like no controlled substances.

Researcher: Oh I see, so if somebody was on some type of opioid as a treatment, that just can't be used here?

Erica Jalonack: Correct...So anyone that is on medication, as long as they're here, they get monitored here. State prisons is through Central New York Psychiatric Center (CNYPC).

Researcher: What does that follow-up look like? If they receive treatment here and they get out, how do you keep track of where these people are?

Erica Jalonack: So, we have a discharge planner and we'll set up appointments for inmates. Being that we are a Level 1 referral, any outpatient referral has to get the inmate the referral within the first 5 days of them being released, and that's just an assessment. It takes months sometimes to see a doctor. We give them a 30-day script when they leave here so they do have a month's worth of medication, but due to us not being able to monitor them when they leave, that's all the nurse practitioner can give. CNY Services has discharge case management services, so those individuals come up here before the inmate is released, meet with them, know what services they need once they are out in the community, and follow up with that once they are out in the community.

Researcher: How many psychiatrists are on staff at the mental health unit in [Oneida County Jail]?

Erica Jalonack: We have a psychiatrist opening, but normally there is one that did more of the extreme cases that would come in to the mental health unit. She would do the referrals for hospitalization for some people.

Researcher: How do you know whether someone is mentally ill? If someone is in the courtroom, if you're doing a 730 that's pretty apparent, but I imagine that in some cases people will manifest symptoms once they're already here [at Oneida County Jail]?

Erica Jalonack: Right. Unfortunately, we are not treatment, we are crisis intervention and medication management, so they have to come in on medication or have had medication within the last 6-12 months, and usually if we see someone who is still going through the court process, our public defender's office works amazing with us. We'll call them and be like, "Hey listen, maybe you should talk to the judge who is overseeing the case, maybe we should order the 730." When something more may need to be done, the public defender's office also has a social worker who can come up, so she works well with us as well. So, we have a lot of collateral working relationships with the courts, with the public defender's office, the district attorney's office, we work hand-in-hand all the time...

While many of the institutions surveyed for this study offer some type of assistance for mentally ill prisoners, that support is often curtailed by a lack of resources, personnel, and funding. Because inmates primarily stay at Oneida County Jail for a relatively short period of time, it is difficult to implement continuous therapeutic treatments outside of medication management. But the facility does have a discharge manager to help inmates schedule doctor's appointments and receive referrals and scripts as necessary, with optional possibilities to follow up with CNY Services case managers. One recurring issue is that many individuals choose not to use these services. More incentives should be provided to increase the use of discharge and community services.

Mohawk, Mid-State, and Auburn correctional facilities offer Alcohol and Substance Abuse Treatment through individual and group therapy. At Auburn, social workers do rounds five days a week in the mental health unit. Further, the staff screens individuals in solitary for suicide risk within 24 hours of entering the unit.[107] Inmates in the mental health unit also meet with the social worker for a private interview, and they meet with the nurse practitioner to manage their medication each month.[108]

At Mohawk Correctional Facility, each inmate is paired with a Corrections Counselor. Each Counselor is assigned approximately 150 inmates at one time, which is clearly an overload of cases. Similarly, Marcy has struggled with hiring enough physicians since opening its Residential Mental Health Unit in 2008.[109] Although no one from Marcy was available to be interviewed for this study, reports from 2008 found that there was only one clinical provider at that facility for every 550 inmates.[110]

Training

> Captain Schoff: Police receive training in the academy and follow-ups thereafter on mental health, PTSD, veterans' issues, etc.., but this requires that they adopt the "non-traditional" role of policing by "social services counseling." This softer approach doesn't mesh with the rest of officer training and roles. Mental health training in the Rome Police Department is offered at the highest level ever now.

---

[107] "Auburn Correctional Facility," 15.
[108] Ibid.
[109] "Marcy Correctional Facility," 8.
[110] Ibid.

Researcher: And what types of training do the nonmedical/non-psychiatric staff have, just like the regular corrections staff in terms of handling mental health crises or identifying people who might be having an issue?

Erica Jalonack: So we do training right in the academy; it's a suicide and lock-up training, so they get some mental health right there off the bat. All the mental health staff go through "train the trainer training." It's suicide, city lockup, and county jails. And we do the training at the academy. Then every year they do 4 hours of suicide and mental illness training. Anyone new coming on gets a full 8 hours.

Training begins at the academy for all corrections and police officers, while mental health professionals working for Central New York Services (CNYS) and the Forensic Units often have educational and professional backgrounds in their specified areas. In addition to academy training, members of the CNYS team in Oneida County Correctional undergo education modules each year to review guidelines, laws, and training regarding healthcare and mental health awareness. While much of the training for those in the county jails seems to be sufficient in reducing suicides and emergency intervention, the Correctional Association of NY found a significant lack of training for staff members when dealing with mental health issues in Mid-State.[111]

Almost all officials interviewed for this study agreed that there is a significant and serious lack of money and personnel properly trained in psychiatry and psychology to adequately assist incarcerated individuals with mental illness. Further, due to Oneida County's geographical location, many officials noted that they simply aren't receiving applications for the open positions they do have, many of which are medical positions such as full-time psychiatrist and registered nurse.

## Self-Harm and Suicide

Sheriff Maciol (on Oneida County Correctional Facility): There's a division of criminal justice services which now oversees all the training for the State Commission of Corrections, but there are general topics and specified courses. Suicide Prevention and Awareness is actually a specialized course. On top of being a general topic instructor, the instructor has to take a special course just to teach Suicide Prevention and Awareness. So, that just goes to show you the attention that goes to it…In the academy, which is roughly 8 weeks for corrections, they spend a significant amount of time on mental health awareness and specifically suicide because it's always something they're trying to prevent. Our tours are designed, whether it's the constant supervision, the active supervision, it's designed to protect the inmates and identify if people have issues and prevent suicides.

---

[111] "Mid-State Correctional Facility," 2.

Erica Jalonack: Our Mobile Crisis Assessment Team (MCAT), employed by the Neighborhood Center, actually works really well with us. If we ever have a suicidal inmate, or [someone] made any suicidal statements throughout their stay here, or are in constant supervision and refusing discharge, we actually have MCAT meet them here upon their release to further assess.

Sheriff Maciol: And there are specialized [MCATs] for veterans with mental health issues, youth, adult, all levels.

Sheriff Maciol: Under mental hygiene law 9.41...the police officer has the authority and the custody to go get [a suspect in custody] evaluated. So, it is an arrest and we do an arrest report, but it's under mental hygiene law where we can get the person evaluated, but it's specifically if they are deemed a threat to themselves or someone else. It's specifically geared towards someone who is suicidal or homicidal, where they can get evaluated.

Researcher: How would you characterize the rate of suicide?

Linda Nelson: Okay, so if you're looking for things to measure, first and foremost there was a huge state initiative on suicide because two weeks after release into the community, the rates spike. The first 14 days when someone leaves either incarceration or a place like this [CNYPC], they need to be monitored closely for suicide. That's how dangerous the reintegration is. The second thing is stable housing.

Researcher: What would you say the prevalence of suicide and self-harm is?

Erica Jalonack: I've been here 6 years and there's been 3 suicides. In the 25 years since CNY Services had been here, there's only been 6. With self-harm, it just depends. If you have someone self-harming on the outside, the chances of them self-harming on the inside are high.

In 2010, the rate of suicides in New York State correctional facilities was double the national average, one of the highest rates in the country.[112] From 1998-2007, 57% of suicide victims in the State were OMH level one, two, or three, even though combined this population makes up only 15% of the entire State incarcerated population.[113] The Correctional Association of New York has subsequently focused specifically on suicide in both solitary confinement and in residential mental health units across state prisons. Yet, these high suicide rates are not consistent across facilities. Auburn, Clinton, Coxsackie, Elmira, and Wende accounted for over half of the suicides in New York from 2014-2016.[114] The rates of suicide in the institutions in Oneida County are lower than the state average.

Rates of suicide are 28 times higher in mental health crisis units and 122 times higher in residential mental health units across the State compared to the general population.[115] The Correctional Association of New York found that oftentimes these significantly higher rates are due to the fact that

---

[112] "Mental Healthcare and Incarceration," The Correctional Association of New York.

[113] "Mid-State Correctional Facility," 17.

[114] "Suicide and Self-Harm- Why is it so High in NYS Prisons?" The Correctional Association of New York, February 21, 2018, https://www.correctionalassociation.org/news/suicide-and-self-harm-why-is-it-so-high-in-nys-prisons.

[115] Ibid.

these units often become punitive, rather than focused on rehabilitation, a theme directly related to the transition of the U.S. criminal justice system as a whole.[116]

At Auburn, suicidality and self-harm is particularly high in the solitary units (63% reported self-harm as a "very frequently" or "frequently" behavior).[117] Although Mid-State did not report any suicides between 1998 and 2007, reports found that the general rates of suicide and self-harm there were much higher among the mentally ill inmates.[118] The prevalence of self-harm is also higher at Mid-State than at most medium and maximum security prisons.[119]

Suicide is also currently the leading cause of death in jails, with the rate estimated at 46 per 100,000 inmates.[120] Oneida County Jail has experienced only 6 suicides in the 25 years since CNYS entered the facility, making the rate of suicide in the county jail lower than the national average of jail inmate suicides. However, 3 of those 6 suicides have occurred in the last six years.

Most of the training for police officers, corrections officers, and mental health staff focuses on crisis intervention and suicide prevention. These efforts do seem to be working in Oneida County facilities, where suicide rates are lower than both the national and state average. In addition to training all staff members on site, Oneida County has a Mobile Crisis Assessment Team (MCAT) employed by the Neighborhood Center that can be brought in to prisons and jails to assist a suicidal inmate. MCAT can also follow up with and supervise individuals upon their release, facilitating the reentry process. These efforts should be extended to other counties.

## Recidivism and Reentry

Researcher: So you would say when you have inmates or clients who have connections outside, that it's a lot easier for them to find employment and opportunities to re-enter?

---

[116] Ibid.

[117] "Auburn Correctional Facility," 16.

[118] "Mid-State Correctional Facility," 17.

[119] Ibid.

[120] Margaret Noonan, Harley Rohloff, and Scott Ginder, "Mortality in Local Jails and State Prisons, 2000-2013- Statistical Tables," U.S. Department of Justice: Bureau of Justice Statistics, August 2015: 1. https://www.bjs.gov/content/pub/pdf/mljsp0013st.pdf.

Garrett Smith: The success rate is much higher. There's a course I developed with a professor from Rutgers University and it's on peer support in justice system-involved settings, so criminal justice settings. It covers everything from OMH forensic settings to prisons to jail, and it also addresses from state-to-state comparatives.

Linda Nelson: Employment is key, and those studies bear out repeatedly that the longer a person is unemployed and out of society, it's harder to just get an interview.

Garrett Smith: That's one of the things Governor Cuomo is doing with the NY Employment First Commission. The goal of the Commission is for them to increase the employment rate amongst people with a disability. One of the main focuses is mental health, to increase the employment rate by 5%. Right now it's right below 15%. So they want to increase that to 20%.

Researcher: In terms of a timeline, you can't keep up with people forever. At what point, once they find a place to live, does the monitoring stop?

Jaclyn Whitfield: These people will be on parole for a certain amount of time, so parole will continue to monitor that to make sure they're doing okay. And we still bring them up when they complete parole or max out at parole, their names still come up, you still have the chronic people.

Researcher: At what point does a client's progress stop being your responsibility, or the responsibility of the people here? At what point are they completely just kind of removed from the criminal justice system and the monitoring stops?

Jaclyn Whitfield: For me, I do a lot of the felony stuff for them... So I will monitor them for as long as their case goes on in court. And then when we're satisfied with their progress, like they don't have to complete something necessarily, because a lot of times with mental health it's going to be ongoing. It just depends on the level they're going to be getting treatment. So I say, "You know what, it's been this many months, I'm satisfied with their progress, the court is satisfied." So they'll finish up the case. And then when they don't have anything over their head, it's on them to continue their treatment if they decide to continue.

Jaclyn Whitfield: Other than MHC, there's something called AOT, which is Assisted Outpatient Treatment, which is also a court-ordered program where people have to comply with meds and appointments. Those people get referred through SPOA as well. These are pretty severely mentally ill people. We talk about the AOT people. Then we also talk about prison, the ones that go to prison, and a prison woman comes to these meetings too. She is awesome. People that are mentally ill but had to do time, she'll come and we'll coordinate according to release schedules; we figure out where they're going to live, we get their parole officers there, we figure out the date they're getting released (these are mostly Clinton Correctional Facility releases) and what we're going to do to help. So we know that when they get out they're going to have their meds, they're going to have a place to live, and all of that, which you don't see in other counties…. There is also Human Technologies Corporation [HTC], an employment program for people that have limitations, that might have anxiety issues or severe kinds of mental health stuff going on. They'll have a job coach, they'll meet with this job coach and figure out what are the things they like, what are the things they're good at, what kind of job can we put them into. Actually, this building is an HTC Corp building. A lot of our maintenance people are part of that program.

Jaclyn Whitfield: There are Neighborhood Center and York Street Clinic, which have a program called the Corner. It's kind of like a social calendar full of activities that people with mental illness can partake in. They've got art classes, cooking classes, they'll bus people to the mall to do mall walking. They'll go bowling. It's great. A lot of the clients really enjoy that. And they also do peer-type groups where they can kind of figure out whatever topic they want. Neighborhood Center does something similar; it's called Adult Recovery Services (ARS), where they offer calendars of different things that they offer the clients. I think if you can get a client to get over that hurdle and start it for the first time, that's really great.

Researcher: How would you measure the effectiveness of the programs at Oneida County Correctional Facility?

Erica Jalonack: I guess we just look at recidivism: who's coming back, who's not, who's staying on their meds when they do leave. Who is following up with our discharge case management services.

Researcher: Do you measure that? Do you actually keep records of that?

Erica Jalonack: I'm not sure. When we first started we did somehow try to track it, but it's difficult.

Sheriff Maciol: But, we do know when the same name keeps coming back to us, absolutely. We look at it in a more rudimentary fashion too...when there's no suicides, because really that's our primary goal. So, we look at really just the bare bones of are suicides and attempts down or someone going into crisis, is their behavior off scale and can we mitigate that.

Researcher: So you've been here for nearly 25 years, so you have a good timeline of recidivism; what's the number at this point?

Sheriff Maciol: We're not sure of numbers, but if you look at it from a charges standpoint, the prostitutes are in here on a regular basis, the drug addicts, the shoplifters.

Researcher: How often do you see the same people coming in?

Erica Jalonack: There's quite a few. Right now we have one individual who's in for her 57th time. There's a few that come in quite a bit.

Researcher: Would you say recidivism is due to lack of resources within the community, or are they not set up with the proper plan when they leave?

Erica Jalonack: No, they are. We have a discharge planner who does great work. She sets up all their appointments and she gets them a med grant card so they can pick up their meds as soon as they're released. Their mental health appointment has to be in the first five days of them being released, so it's not like they're waiting. But it's up to the individual to go through, and we find a lot of people do not go. We do have discharge case managers who attempt to follow through with them after they're released into the community, but it's not a mandated service.

Peer support and employment are key to successful integration, and that is where most programs have focused across state prisons, local jails, and inpatient facilities. However, there exist no guidelines regarding when or for how long the mental health staff at these facilities should continue to monitor individuals after they reenter society. The only non-voluntary programs that exist are the Assisted Outpatient Treatment facilities, which individuals enter through a mandated court order to help them comply with their medications and appointments.

The Collaborative Transition Team at Hutchings focuses specific attention on reentry. The team is comprised of two MSW staff, one RN, and one Peer Mentor. It works in both the Hutchings facility and in residential settings and participants' communities. The team focuses on medication management through providing medicine on a regimented schedule and teaching participants about their specific

healthcare needs. Members of the team also accompany participants to social, recreational, and community programs to ensure active engagement in the community.[121]

Marcy, Auburn, Mid-State, and Mohawk each have four Transitional Services (TS) programs to assist inmates with reentry. These include Phase I, Thinking for a Change, Phase III, and Aggression Replacement Therapy (ART). In 2011, there were 215 inmates enrolled across these programs, with 3,729 on the wait list.[122] The transitional services staff at Mohawk also aid inmates in identifying community-based resources and obtaining employment and job skills to aid in reentry via the Phase III TS program.[123] The facility also provides an Alcohol and Substance Abuse Treatment (ASAT) program, a Residential Substance Abuse Treatment (RSAT) program, and an Integrated Dual Disorder Treatment (IDDT) program, which specifically targets comorbidity between alcohol/substance abuse and mental illness.[124] Unfortunately, the completion rate for these programs is extremely low. From 2009-2011, only 321 inmates completed the ASAT, 158 completed the RSAT, and 16 completed the IDDT.[125]

Because of the general lack of support available to those with mental illness after their reentry to society, recidivism remains a problem across local and state facilities. Many of the local facilities see individuals repeatedly cycling through the criminal justice system. Oftentimes, recidivism occurs when an individual fails to follow through with appointments and services that discharge or transition teams have scheduled for them. Attending doctors' appointments and complying with medication requirements are largely left to individuals once they transition into their communities. Several interviewees agreed that there need to be more community-based living areas where people can slowly adjust to reentering society under the supervision of mental health workers, social workers, and other professionals until they are fully capable of being successful on their own.

---

[121] Program Description for Prospective Staff, "Hutchings Collaborative Transition Team." Provided by Tracy Lord- Mortas, Director of OMH Certified Residential Programs for Central New York Services.
[122] "Auburn Correctional Facility," 24.
[123] "Mohawk Correctional Facility," 11.
[124] "Auburn Correctional Facility," 25.
[125] "Auburn Correctional Facility," 27.

## Stigmatization and Problems

Researcher: Do you see a stigma between inmates regarding mental illness?

Erica Jalonack: I don't think there's a stigma regarding mental illness inside, because a lot of the people from the mental health pod will end up in general population.

Captain Schoff: [Oneida County's] mental health system is broken. The system fails people...it's a revolving door...and it's absolutely not a caring issue – it's not that people don't care. It's a lack of money…

Tina Hartwell: First of all, there is no money. It needs to start with state funding. We need psych hospitals. It can't just be outpatient. They need structure. They could thrive in institutionalized settings. Misperceptions among the public regarding mental illness…people could think about a person that goes and shoots up a high school… But that's a small fraction. The media feeds into fear...it's a huge stigma.

Researcher: Have you seen any changes since you've been here?

Erica Jalonack: It's definitely not getting better. I think with a lot of programs not existing anymore and rehabs aren't covered by insurance, insurance doesn't cover a 28-day program anymore. And then people are going back into the community and aren't as stable as one would hope, and they're right back to the same cycle.

Researcher: What would you say are the most common reasons that we're seeing so many mentally ill inmates now?

Erica Jalonack: I think because they just have nowhere else to put them. There's a waitlist for community residences. There's just nowhere for people to go, and they are out on the streets left to their own devices, so they end up here.

Researcher: So do you think mental hospitals or more state institutions would be beneficial?

Erica Jalonack: I don't think a hospital per se, but more community-based resources, such as residential living programs, and have programs on the outside. You know some people don't need a hospital, but they also don't need to be here. I think there's a lot missing in the middle.

Most interviewees noted that the mentally ill are often left on the streets with no support, where their illnesses can lead to criminal behavior and they wind up in jail because there are no other institutions or programs that understand them or are willing to help. The stigmatization of the mentally ill does not necessarily exist between inmates or between inmates and staff, because they all understand the impacts of mental illness. However, most officials noted that deinstitutionalization has been a large factor in the influx of mentally ill inmates into the criminal justice system and in the exacerbation of stigmas in the general public surrounding mental health issues.

# Discussion & Recommendations

Recognizing the need for a new approach to the treatment of the mentally ill, Oneida County has recently changed the way it attempts to support this population in the criminal justice system. The

interviews conducted for this study, in addition to other literature, have allowed us to draw several conclusions and policy suggestions regarding the nature of the County's correctional and forensic facilities.

Erica Jalonack, Linda Nelson, and Jaclyn Whitfield all recognized the need for more alternative environments to prison and psychiatric hospitals. While they acknowledged that the County has many correctional facilities and is in the process of building a new hospital, it offers few options in between. Jalonack clearly elucidated how many inmates do not belong in prison but also do not necessarily need hospitalization. Nelson agreed, suggesting that due to deinstitutionalization, there are only a limited number of units in the County to house the mentally ill. She suggested that the County desperately needs to allocate funding for a civil psychiatric center similar to Hutchings Psychiatric Center, as well as for more residential living programs. Those who commit minor crimes may not need long-term incarceration or hospitalization, but rather a support network in a community residential center, where staff members can help them learn how to live on their own. Further, it was clear that all three interviewees felt there is a significant lack of mental health beds not only in Oneida County, but throughout the State. Because there are so few psychiatric centers, civil or forensic, inmates often remain in jail for long periods before entering a facility that can address their specific mental health problems.

The second problem we found is that there is a high prevalence for comorbidity between substance abuse and mental health issues. Tina Hartwell noted that this is apparent not only in correctional facilities, but also on the streets throughout the County. When individuals exhibit clear signs of mental illness and substance abuse in the public sphere, it encourages a stigma that they are dangerous. The SMART Recovery Program is an effective initiative that addresses substance abuse; it should be advertised more in inpatient and outpatient facilities in the community. This program was one of only a few examples we could find that Oneida County is basing its programs on empirically-proven methods. Numerous studies have compared the success rates of the tools employed in SMART to those used in AA

and NA programs and have suggested that they produce a one-year recovery rate between 35% and 50%.[126]

Although some reports condemn SMART for failing to emphasize social networks,[127] the County's use of the program shows that it is embracing certain aspects of the Risk/Need/Responsivity (RNR) and Illness Management and Recovery (IMR) models for rehabilitation. SMART allows clients to tailor rehabilitation to address their specific addictions and the cognitive processes that may be leading to their inclinations or need threshold for substance use and resulting criminal behavior. SMART also encompasses the idea of accepting your illness, understanding addiction, and building skills to live successfully in the community.[128]

Third, our study found that the problem of overmedicating inmates in state prisons must be addressed. By using overmedicating to receive financial support, prisons are pushing the boundary of exploitation and ethical medical practice. Overprescribing has recently come to the general public's attention due to the national opioid epidemic. As indicated by Garrett Smith, correctional facilities will often prescribe the highest dosage possible, which is oftentimes two times higher than what an individual would receive outside a prison. As a result, when an individual re-enters society, their dosage is often reduced, exacerbating behavior problems and hindering their ability to function, which ultimately leads to a lower chance of successful integration. Studies across the country have shown similar findings. California, Louisiana, and Massachusetts prisons were all recently found to overmedicate psychotropic drugs for disciplinary—rather than therapeutic—reasons.[129] New York State needs to adjust its standards

---

[126] Matthew Leichter, "Why SMART Recovery Will Not Replace Alcoholics Anonymous," The Fix, September 23, 2014. https://www.thefix.com/content/why-smart-recovery-will-never-replace-alcoholics-anonymous

[127] Ibid.

[128] "Introduction to SMART Recovery," SMART Recovery. https://www.smartrecovery.org/intro/.

[129] Matt Davis, "Overmedication young inmates called chemical restraint," The Lens, July 27, 2011. https://thelensnola.org/2011/07/27/jailedjuvenilesanddrugs/; Susan Sered, "Professor Analyzes the Issue of Overmedicated in Women Prisoners," Suffolk University Boston, August 8, 2013, www.suffolk.edu/news/20300.php#.Wta5Xo5920V.l.; David Reutter, "California Overmedicates Prisoners with Psychotropic Drugs," Prison Legal News, March 7, 2016. https://www.prisonlegalnews.org/news/2016/mar/7/california-overmedicates-prisoners-

of care for prisoners with mental illness. Psychiatrists need to examine dosages regularly and help individuals successfully wean off of medication when able, especially with Axis I disorders.

Our specific recommendation for Oneida County Correctional Facility is that it should implement short-term therapeutic strategies for all patients. Cognitive Behavioral Therapy (CBT) has been shown to provide better long-term effects than psychotropic drugs when used to treat anxiety and mood disorders.[130] Although it is not productive for inmates to begin individual CBT when they leave the facility after only a few sessions, CBT methods could be incorporated into the already-existing groups offered by the facility. For example, talk therapy is an inexpensive method that could be added to the wellness group to help individuals transform negative thinking patterns. This would allow groups of inmates to engage with each other's negative thoughts and help one another to identify the issues with which they struggle; they could also help each other practice positive thinking. Although this approach may not be as individualized as regular CBT, by engaging in an open-forum talk group, individuals may be able to better develop peer support networks to help their mental wellbeing. This approach is also beneficial for the issue that Erica Jalonack raised—that facilities do not want a therapist opening a can of worms when an individual might be released the next day. An open forum in a wellness class would allow individuals to decide what and when they want to share.

CBT can also help individuals develop coping mechanisms as simple and inexpensive as writing therapy, meditation, yoga, and other physical practices that can be incorporated in both group and individual settings, such as writing in one's cell during rec time. Although it is difficult to address the problem of increasing the number of staff members and trained psychologists in the County, approaches like those mentioned above could be implemented with a minimum of new hires. Similar suggestions should also be incorporated at CNYPC. As Garrett Smith noted, often clients sit around doing nothing for

---

psychotropic-drugs/.
[130] "Talk Therapy- Not Medication- Best for Social Anxiety Disorder, Large Study Finds," Johns Hopkins Bloomberg School of Public Health, September 25, 2014. https://www.jhsph.edu/news/news-releases/2014/talk-therapy-not-medication-best-for-social-anxiety-disorder-large-study-finds.html.

most of the day. Through building peer networks, attending scheduled groups, and developing easy coping mechanisms, the Center could implement inexpensive but effective therapeutic strategies into clients' daily routines.

Further, recent studies have described Brief CBT, which compresses CBT to reduce the number of average sessions from 12-20 to 4-8, a much more feasible number for a County facility, although it would require more funding and trained therapists.[131] Because the program is compressed, individuals have a significantly larger amount of reading and homework compared to those on the regular schedule, but Brief CBT has been shown to help those struggling with less severe mental illnesses like anxiety, depression, assertiveness/anger, and social isolation.[132] The Appendix contains an example of the Brief CBT schedule.

One of this study's most concerning findings is that several of the state correctional facilities in Oneida County, as well as Auburn, put large numbers of individuals suffering from mental illness into solitary confinement or solitary housing units (SHUs), which not only exacerbates existing and produces new mental health problems, but which also directly leads to higher rates of self-harm and suicide. SHUs have also been found to negatively affect recidivism rates, especially if individuals are released into society directly from a solitary unit.[133] In accordance with the UN Convention Against Torture as well as several other international bodies and European countries, solitary confinement should be eradicated.[134] Although it may provide an immediate solution to a behavioral incident, its lasting effects not only compromise inmates' physical and mental health, but increase the chances of recidivism.

Further, solitary confinement costs significantly more than housing the general prison population. A 2015 report by Solitary Watch found that one year of solitary costs $75,000 per inmate, compared to

---

[131] Jeffrey Cully and Andra Teten, "A Therapist's Guide to Brief Cognitive Behavioral Therapy," published by the Department of Veterans Affairs South Central Mental Illness Research, Education, and Clinical Center (MIRECC), 2008. https://www.mirecc.va.gov/visn16/docs/therapists_guide_to_brief_cbtmanual.pdf
[132] Ibid.
[133] "Solitary Confinement in the United States," Solitary Watch, 2015: 3. http://solitarywatch.com/wp-content/uploads/2017/09/Solitary-Confinement-FAQ-2015.pdf
[134] Ibid.

$25,000 in a general housing unit.[135] There are nearly 80,000 inmates in solitary at any given time in the U.S. Housing them costs nearly $60 billion per year.[136] If those inmates were given alternative punishments and programming and were housed in general population, the government could save $40 billion.[137] While estimates, these numbers indicate that abolishing SHU, in addition to saving incarcerated individuals from drastic psychological and physical deprivation, could save NYS millions of dollars that could be used more effectively for mental health and rehabilitation efforts that could lower recidivism rates. Finally, the Correctional Association's report on prison visits noted that Mid-State Correctional Facility, specifically, lacks training around mental health issues. State facilities should consider requiring more educational and crisis intervention programs on mental illness and suicide prevention. This is particularly important at Mid-State, which has an SHU.

This study did find three positive conclusions regarding the nature of Oneida County's treatment of the mentally ill in the criminal justice system. First, the initiatives and training used to reduce the prevalence of suicides seem to be effective. Although no statistical analyses were performed, the facilities in Oneida County—specifically the state prisons and County correctional facility—have lower suicide rates than other facilities in New York and the U.S. more generally.

Second, the County's implementation of the free, 24/7 Mobile Crisis Assessment Team (MCAT) is an extremely positive step toward helping individuals in crisis, both in the community and in correctional facilities. Its success in Oneida County is evidence that an MCAT approach should be used in counties across the State. One of MCAT's goals is "keeping the problem outside of the legal system and avoiding hospitalizations when appropriate," and the entire County seems to have undertaken this goal in recent approaches to its treatment of the mentally ill.[138] Although improvement is clearly needed inside

---

[135] Ibid.

[136] Dan Nolan and Chris Amico, "Solitary by the Numbers," PBS, April 18, 2017. http://apps.frontline.org/solitary-by-the-numbers/.

[137] "Solitary Confinement in the United States," Solitary Watch, 2015: 3.

[138] Brochure, "Mobile Crisis Assessment Team (MCAT)." http://www.neighborhoodctr.org/wp-content/uploads/2018/02/MCAT-Brochure.pdf.

correctional facilities, ultimately the County's goal should be to divert the mentally ill to other alternatives, such as its Mental Health Court and other civil institutions and forensic units.

Finally, although many of the recommendations in this report revolve around rehabilitation services, it does appear that the County programs in place to reduce recidivism and help individuals successfully reenter society are working. Prior to conducting this study, the research team had the opportunity to survey the Swedish criminal justice system. That field work demonstrated that integration policies were the most significant factor in reducing crime rates. One finding of particular note was that Swedish policymakers approach the problem of reintegration similarly to how they approach the problem of how to integrate immigrants into a relatively homogenous society. They have found that the most effective way to incorporate both populations is by providing employment opportunities, which reduced recidivism for former inmates and reduced the onset of crime for immigrants.[139] We found that in suburbs around Stockholm, police officers are more likely to come across crimes such as petty theft, but most of these areas are socioeconomically depressed, and their residents have turned to such crimes as a means of income, stability, and support for their families, a cycle similar to that in the U.S.[140] Transition programs for nearly all inmates in Sweden begin inside the correctional facility and provide them with essential skills to enter the workforce, in addition to access to halfway houses and social workers, which helps to break this cycle when they reenter society.[141]

Although Sweden is a welfare state with more funding and a significantly smaller inmate population than the U.S., research by Sedgley et al. (2010) found that employment opportunities in prisons reduce the risk of recidivism, saving roughly $7,000 per individual.[142] Those facilities that

---

[139] Maja Cederberg, "Gender, inequality and integration Swedish policies on migrant incorporation and the position of migrant women," in Gender, Migration, and Categorization, edited by Marlou Schrover and Dierdre Moloney (Amsterdam University Press: 2013):198.
[140] Lennart Pettersson, Study Visit: Police Precinct, June 7, 2017.
[141] John Pratt and Anna Eriksson, "'Mr. Larsson is walking out again'. The origins and development of Scandinavian prison system," Australian and New Zealand Journal of Criminology 44(1) (2011): 8.
[142] Norman Sedgley, Charles Scott, Nancy Williams, & Frederick Derrick, "Prison's Dilemma: Do Education and Jobs Programs Affect Recidivism," Economica 77 (2010): 512.

implemented schooling in addition to employment saved another $2,000 per individual.[143] Some argue that education and rehabilitation programs are too expensive, but significant research has suggested that investment in such programs will reduce long-term costs by reducing recidivism rates. Just as important, such programs will help individuals with mental illness successfully reintegrate into society, which should be the ultimate goal of our criminal justice system. By working toward this goal, Oneida County will help to reduce the stigma around mental illness in the larger public by demonstrating that these individuals can be successful, independent, contributing members to their communities. Therefore, the most significant recommendation of this study is to continue to reduce recidivism through programs to increase employment and social networking services for individuals who are reintegrating into society.

## Limitations of the Study

By conducting face-to-face interviews to gather qualitative data for this study, researchers encountered several overlapping limitations. First, while the interviews provided the opinions of the most qualified professionals in Oneida County, oftentimes it was difficult to gather actual statistics from any of the facilities, and therefore the researchers could conduct no statistical analyses. It was left up to the research team to decide the potential effectiveness of treatment of the mentally ill in the County, and the conclusions we draw about the most effective policies and approaches may not be applicable to other counties that do not have the same resources or community support.

Further, it was extremely difficult to contact staff at the state prisons compared to conducting interviews at the County jail and other psychiatric facilities. Marcy Prison, in particular, proved the most difficult regarding clearance and access to the facility. To deal with these limitations, we collected data regarding the treatment of the mentally ill in state institutions—Marcy, Mohawk, Auburn, and Mid- State— from the most recent reports conducted by the New York State Correctional Association, which conducted tours of the prisons and interviewed staff members and inmates in addition to collecting quantitative data to produce reports of the conditions across institutions in the State.

---

10.1111/j.1468-0335.2008.00751.x.

[143] Ibid.

# Conclusion

This study revealed that Oneida County's criminal justice system is still focused on retributive justice rather than rehabilitation, especially in its state correctional facilities. However, the County has taken significant steps toward improving the treatment of its mentally ill population and reducing the number of mentally ill inmates in both state and local correctional facilities. In particular, training around suicide prevention has produced significantly lower rates of suicide compared to other counties in New York State, in both local and state prisons. If suicide prevention is one of the County's priorities, then as many of this study's participants stated, its next step needs to be eradicating solitary confinement. The most significant change the County and State can make is removing all solitary housing units from its correctional facilities, since these drastically increase the prevalence of mental illness, self-harm, and suicide.

Oneida County is a successful example of how local criminal justice systems can incorporate trained individuals to de-escalate suicide, self-harm, and other behaviors. Its Mobile Crisis Assessment Team has been integral to this process, and similar units should be implemented in other counties across the State. In addition, the County's use of SMART Recovery is a significant step toward helping those with mental illness tailor their therapy toward their specific needs, though incorporating more aspects of the RNR and IMR models could prove useful in future. Finally, as discussed in depth in Case Study 2, Oneida County's most significant effort to reduce the number of prisoners with mental illness has been to implement effective programs that act as an alternative to incarceration, such as the Utica Mental Health Court.

While the state prisons offer several beneficial and effective programs that provide therapy and support for reintegration, those programs are not extensive enough to serve all of the prisoners who need them. There simply are not enough resources to treat the large numbers of individuals suffering from mental illness in the County's criminal justice system. In particular, jail inmates often receive the least

amount of psychiatric care compared to prison and inpatient clients, and this finding was reflected by our research. Oneida County Correctional Facility is equipped only for crisis intervention, suicide prevention, and medication management. Although inmates in county facilities are often incarcerated for short periods, Oneida County Correctional could incorporate methods to improve its therapeutic resources and approaches for these inmates, including talk therapy and Brief CBT.

Overall, this study revealed that deinstitutionalization still affects the criminal justice system today, even in small counties like Oneida, which demonstrates the extent to which criminal justice facilities have become the "new psychiatric hospitals." Closing formal, state-run psychiatric institutions has left many individuals on the streets with few support networks or resources to help them survive. Many of the participants in this study gave specific examples of individuals they knew who were victims of this shift in federal policy. These stories put names, faces, and individual lives to the more abstract concept of deinstitutionalization, showing its devastating effects. In addition to developing better standards of therapy inside correctional facilities, the County should focus on aiding mentally-ill individuals with reentry by helping them develop the skills necessary to seek and retain employment, as this is the most significant factor in reducing recidivism. Additionally, it is imperative that Oneida County open more mental health units and residential living areas for those who do not need imprisonment or hospitalization, but who instead need daily assistance in a community-based facility that can help them thrive.

Although policymakers often stress the impossibility of allocating more funding to mental health programs, this study makes several recommendations that would curtail costs related to harmful practices, such as solitary confinement. The money saved could be put toward inexpensive rehabilitation methods that could be implemented in various types of facilities, many of which do not require additional staff. By incorporating these small strategies and continuing to develop alternatives to incarceration, Oneida County has the potential to drastically reduce the number of mentally ill individuals in its correctional facilities as well as to increase the effectiveness of programming for all incarcerated individuals.

Appendix

**Potential Brief CBT Session Structure**

| | Session Content | Possible Modules |
|---|---|---|
| **Session 1** | Orient the Patient to CBT. Assess Patient Concerns. Set Initial Treatment Plan/Goals. | Module 5: Orienting the Patient Module 4: Case Conceptualization Module 6: Goal Setting |
| **Session 2** | Assess Patient Concerns (cont'd). Set Initial Goals (cont'd) Or Begin Intervention Techniques. | Module 4: Case Conceptualization Module 6: Goal Setting Technique Modules 9-13: Maladaptive Thoughts, Behavioral Activation, Problem Solving, Relaxation |
| **Session 3** | Begin/Continue Intervention Techniques | Technique Modules 9-13 |
| **Session 4** | Continue Intervention Techniques. Re-assess Goals/Treatment Plan. | Technique Modules 9-13 Module 4: Case Conceptualization Module 6: Goal Setting |
| **Session 5** | Continue/ Refine Intervention Techniques. | Technique Modules 9-13 |
| **Session 6** | Continue Intervention Techniques. | Technique Modules 9-13 |
| **Session 7** | Continue Intervention Techniques. Discuss Ending Treatment and Prepare for Maintaining Changes. | Technique Modules 9-13 Module 14: Ending Treatment and Maintaining Changes |
| **Session 8** | End Treatment and Help Patient to Maintain Changes. | Module 14: Ending Treatment and Maintaining Changes |

An example of a Brief CBT Session Schedule[144]

---

[144] Jeffrey Cully and Andra Teten, "A Therapist's Guide to Brief Cognitive Behavioral Therapy," published by the Department of Veterans Affairs South Central Mental Illness Research, Education, and Clinical Center (MIRECC), 2008. https://www.mirecc.va.gov/visn16/docs/therapists_guide_to_brief_cbtmanual.pdf

# References

"5th Judicial District: Oneida County Family Courts." New York State Unified Court System.
https://www.nycourts.gov/courts/5jd/oneida/family/index.shtml

"Access to Mental Health Care and Incarceration." Mental Health America. Accessed February 4, 2018.
http://www.mentalhealthamerica.net/issues/access-mental-health-care-and-incarceration

Amadeo, Kimberly. "Learn About Deinstitutionalization: Pros and Cons." The Balance.
March 14, 2018. https://www.thebalance.com/deinstitutionalization-3306067

Andrews, D. A., Bonta, J., & Hoge, R. D. "Classification for Effective Rehabilitation:
Rediscovering Psychology." Criminal Justice and Behavior, 17 (1990): 19-52.

Appelbaum, Paul. "Lost in the Crowd: Prison Mental Health Care, Overcrowding, and the
Courts." Law & Psychiatry 62, no. 10 (2011): 1121-1123.

"Auburn Correctional Facility." The Correctional Association of New York: Prison Visiting
Project. June 2011: 1-46.
https://www.correctionalassociation.org/resource/auburn-correctional-facility-2

Bartholomew, T. & Kensler, D. "Illness Management and Recovery in State Psychiatric
Hospitals." American Journal of Psychiatric Rehabilitation 13, no. 2 (2010): 105-125.

Bewley, M. & Morgan, R. "A National Survey of Mental Health Services Available to Offenders with
Mental Illness: Who is Doing What?" Law and Human Behavior 35, no. 5 (2011): 351-363.

Bonta, J. & Andrews, D.A. "Risk-Need-Responsivity Model for Offender Assessment and
Rehabilitation." Public Safety Canada (2007): 1-19.

Bronson, J. & Berzofsky, M. "Indicators of Mental Health Problems Reported by Prisoners and
Jail Inmates, 2011-12." U.S. Department of Justice (June 2017): 1-16.
https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf

Byron, Robert. "Criminals Need Mental Health Care." Scientific American. March 1, 2014.

https://www.scientificamerican.com/article/criminals-need-mental-health-care/

Cederberg, Maja. "Gender, Inequality and Integration: Swedish Policies on Migrant Incorporation and the
Position of Migrant Women." In Gender, Migration, and Categorization. Ed. Marlou Schrover &
Dierdre Moloney. Amsterdam University Press, 2013: 193- 214.

"Central New York Psychiatric Center." Office of Mental Health.
https://www.omh.ny.gov/omhweb/facilities/cnpc/

Cohen, F. & Dvoskin, J. "Inmates with Mental Disorders: A Guide to Law and Practice." Mental
and Physical Disability Law Reporter 16, no. 3 (1992): 339-346.

"Correction Division." Oneida County Sheriff's Office.
http://oneidacountysheriff.us/correction/correctionmain.aspx

Cully, J. & Teten, A. "A Therapist's Guide to Brief Cognitive Behavioral Therapy." Department
of Veterans Affairs South Central Mental Illness Research, Education, and
Clinical Center (MIRECC), 2008.
https://www.mirecc.va.gov/visn16/docs/therapists_guide_to_brief_cbtmanual.pdf

"Custody and Care: Mental Health." Federal Bureau of Prisons.
https://www.bop.gov/inmates/custody_and_care/mental_health.jsp

Davis, Matt. "Overmedicating Young Inmates Called Chemical Restraint." The Lens.
July 27, 2011. https://thelensnola.org/2011/07/27/jailedjuvenilesanddrugs/

Erickson, P. & Erickson, S. Crime, Punishment, and Mental Illness: Law and Behavioral
Sciences in Conflict. New Brunswick: Rutgers University Press, 2008.

"Fact Sheet: Mental Illness and the Criminal Justice System." National Alliance on Mental Illness
  Virginia.
   https://namivirginia.org/wpcontent/uploads/sites/127/2016/03/MIandCriminalJusticeSystem.pdf

Garland, David. "A History of the Present." In The Culture of Control: Crime and Social Order in
  Contemporary Society. Oxford: Oxford University Press, 2001: 1-27.

Goldman, Ivan. "The Insanity of Mental Health Practices." In Sick Justice: Inside the American Gulag.
  Nebraska: Potomac Books, 2013.

"How Long Will it Take for Treatment to Work?" PTSD Clinical Practice Guideline,
http://www.apa.org/ptsd-guideline/patients-and-families/length-treatment.aspx

"Hutchings Collaborative Transition Team." Provided by Tracy Lord- Mortas, Director of OMH Certified
  Residential Programs for Central New York Services.

"Ill-Equipped: U.S. Prisons and Offenders with Mental Illness."
  Human Rights Watch (2003): 1-214.
   https://www.hrw.org/reports/2003/usa1003/usa1003.pdf

"Introduction to SMART Recovery." SMART Recovery.
   https://www.smartrecovery.org/intro/

Kadera, S., Lambert, M., & Andrews, A. "How Much Therapy is Really Enough? A Session By
  Session Analysis of the Psychotherapy Dose-Effect Relationship." Journal of
  Psychotherapy Practice and Research 5, no. 2 (1996): 132-151.

Lamb, R. & Weinberger, L. "Persons With Severe Mental Illness in Jails and Prisons:
  A Review." Psychiatric Services 49, no. 4 (1998): 483-492.

Leichter, Matthew. "Why SMART Recovery Will Not Replace Alcoholics Anonymous."
  The Fix. September 23, 2014.
   https://www.thefix.com/content/why-smart-recovery-will-never-replace-alcoholics-anonymous

"Marcy Correctional Facility." The Correctional Association of New York: Prison Visiting Project. April
  2008: 1-15. https://www.correctionalassociation.org/resource/marcy-correctional-facility

Mechanic, D. & Rochefort, D. "Deinstitutionalization: An Appraisal of Reform."
  Annual Review of Sociology 16 (1990): 301-327.

"Mental Health and Prisons." World Health Organization.

   http://www.who.int/mental_health/policy/mh_in_prison.pdf

"Mental Healthcare and Incarceration." The Correctional Association of New York.
   https://www.correctionalassociation.org/issue/mental-health

"Mentally Ill Offender Treatment and Crime Reduction Act." National Center for State Courts.
   http://www.ncsc.org/services-and-experts/government-relations/criminal-adult/mentally-ill-
   offender-treatment-and-crime-reduction-act.aspx

"Mid-State Correctional Facility." The Correctional Association of New York:
  Prison Visiting Project. April 2009: 1-25.
   https://www.correctionalassociation.org/resource/mid-state-correctional-facility

"Mobile Crisis Assessment Team (MCAT)."
   http://www.neighborhoodctr.org/wpcontent/uploads/2018/02/MCAT-Brochure.pdf

"Mohawk Correctional Facility." The Correctional Association of New York: Prison
  Visiting Project. July 2010: 1-33.
   https://www.correctionalassociation.org/resource/mohawk-correctional-facility

Mueser, K., Meyer, P., Penn, D., Clancy, R., Clancy, D., & Salyers, M. "The Illness
  Management and Recovery Program: Rationale, Development, and Preliminary
  Findings." Schizophrenia Bulletin. 32, no.1 (2006): S32-S43.

"Narrative Research: What is Narrative Research?"atlasti.
   http://atlasti.com/narrative-research/

Nolan, D. & Amico, C. "Solitary by the Numbers." PBS. April 18, 2017.
   http://apps.frontline.org/solitary-by-the-numbers/

Noonan, M., Rohloff, H., & Ginder, S. "Mortality in Local Jails and State Prisons, 2000-2013-Statistical Tables." U.S. Department of Justice: Bureau of Justice Statistics. August 2015.

O'Brien, Alexis. "Survey Finds that Americans Value Mental Health and Physical Health Equally." American Foundation for Suicide Prevention. Released September 1, 2015. https://afsp.org/survey-finds-that-americans-value-mental-health-and-physical-health-equally-2/

Pan, Deanna. "Timeline: Deinstitutionalization and its Consequences." Mother Jones. April 23, 2013. https://www.motherjones.com/politics/2013/04/timeline-mental-health-america/

Penrose, L.S. "Mental Disease and Crime: Outline of a Comparative Study of European Statistics." British Journal of Psychiatry 18, no. 1 (1939): 1-15.

Petterson, Lennart. Study Visit: Police Precinct. Stockholm, Sweden. June 7, 2017.

Powers, Ron. No One Cares About Crazy People: The Chaos and Heartbreak of Mental Health in America. New York: Hachette Books, 2017.

Pratt, J., & Eriksson, A."'Mr. Larsson is Walking Out Again.' The Origins and Development of Scandinavian Prison System." Australian and New Zealand Journal of Criminology 44, no. 1 (2011): 7-23.

Reed, F. & Fox, R. "Psychiatric Hospitalization of Criminal Defendants: New Horizons," The Bulletin 5, no. 1 (1997): 61-67.

Reingle Gonzalez, J. & Connell, N. "Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and Medication Continuity." American Journal of Public Health 104, no.12 (2014): 2328-2333.

Reutter, David. "California Overmedicates Prisoners with Psychotropic Drugs." Prison Legal News. March 7, 2016. https://www.prisonlegalnews.org/news/2016/mar/7/california-overmedicates-prisoners-psychotropic-drugs/

S.993-Comprehensive Justice and Mental Health Act of 2015. 114th Congress (2015-2016). https://www.congress.gov/bill/114th-congress/senate-bill/993

Sedgley, N., Scott, C., Williams, N., & Derrick, F. "Prison's Dilemma: Do Education and Jobs Programs Affect Recidivism." Economica 77 (2010): 413-611.

Sered, Susan. "Professor Analyzes the Issue of Overmedicated Women Prisoners." Suffolk University Boston. August 8, 2013. www.suffolk.edu/news/20300.php#.Wta5Xo5920V.l

"Sheriff Robert M. Maciol." Oneida County Sheriff's Office. http://oneidacountysheriff.us/admin/sheriff.aspx

"Solitary Confinement in the United States." Solitary Watch. 2015. http://solitarywatch.com/wp-content/uploads/2017/09/Solitary-Confinement-FAQ-2015.pdf

"Suicide and Self-Harm—Why is it so High in NYS Prisons?" The Correctional Association of New York. February 21, 2018. https://www.correctionalassociation.org/news/suicide-and-self-harm-why-is-it-so-high-in-nys-prisons

"Talk Therapy—Not Medication—Best for Social Anxiety Disorder, Large Study Finds." Johns Hopkins Bloomberg School of Public Health. September 25, 2014. https://www.jhsph.edu/news/news-releases/2014/talk-therapy-not-medication-best-for-social-anxiety-disorder-large-study-finds.html

"The Comprehensive Justice and Mental Health Act: Summary." Prison Fellowship. 2016. https://www.prisonfellowship.org/site/wp-content/uploads/2016/02/The-Comprehensive-Justice-and-Mental-Health-Act-one-pager.pdf

Torrey, E.F. "Deinstitutionalization: A Psychiatric 'Titanic.'" In Out of the Shadows: Confronting America's Mental Illness Crisis. New York: John Wiley & Sons, 1997. https://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html

Torrey, E.F., Kennard, A., Eslinger, D., Lamb, R., & Pavle, J. "More Mentally Ill Persons Are in Jails and
      Prisons Than Hospitals: A Survey of the States." Treatment Advocacy Center (2010): 1-20. http://www.treatmentad

"Undersheriff Robert S. Swenszkowski." Oneida County Sheriff's Office.
      http://oneidacountysheriff.us/admin/usheriff.aspx

Wacquant, Loïc. "The New 'Peculiar Institution': On the Prison as Surrogate Ghetto." Theoretical
      Criminology 4 (2000): 377-389.

CASE STUDY 2

HOPE AND A PLAN:
AN EVALUATION OF THE UTICA MENTAL HEALTH COURT

Alexander J. Scheuer
Spring 2018

# Introduction

Beginning in the 1960s, the deinstitutionalization of mentally ill Americans was an effort to cut government budgets and theoretically increase the quality of care for the mentally ill. The initiative—supported by both the federal government and a large segment of the American public—precipitated the closing of a majority of the state-run in-patient psychiatric facilities in the United States. Within those facilities, individuals had received round-the-clock care by medical professionals. When they closed, many of the individuals they had housed were released into the general public, where they were less effectively supported and were therefore more susceptible to mental health crises. Combined with the punitive shift in federal law enforcement ideology and practice in the late 1970s and 1980s, this deinstitutionalization resulted in a substantial increase in the number of individuals suffering from mental illness who are incarcerated in the U.S.

Currently, incarceration has effectively replaced hospitalization for many of those who struggle with mental illness. According to a 2017 survey conducted by the Treatment Advocacy Center, U.S. psychiatric institutional capacity decreased from 559,000 patients in 1955 to approximately 35,000 patients today.[145] When psychiatric facilities began to close, those with mental illness were expected to transition seamlessly into the general public, but the severe lack of local mental health services prevented that goal for many.[146] Those without family aid often found themselves in local jails or state prisons for small crimes, many stemming from the uncontrollable symptoms of their illnesses. According to Torrey et al. (2017), 383,000 mentally ill people were incarcerated in 2016 alone. The U.S. criminal justice system today holds over nine times the number of mentally ill individuals as U.S. psychiatric hospitals, yet the system remains unprepared and ill-equipped to properly support this population.[147]

---

[145] Torrey et al., 2017.
[146] Simon, 2014.
[147] Ibid.

Mental Health Courts

As one response to the increasing problems associated with the growing numbers of incarcerated individuals with mental illness, Mental Health Courts (MHCs) have emerged as voluntary criminal diversion programs that remove mentally ill individuals from the traditional sentencing system and place them in court-supervised outpatient treatment programs in an effort to address the psychosocial issues that led to their criminal behavior. There are currently almost 350 MHCs in the United States, serving as an alternative to incarceration for qualifying people with mental illness.[148] The increased prevalence of MHCs in the U.S. can be attributed to the growing sentiment among justice system stakeholders, both on the punitive and rehabilitative side, that it is nonsensical to treat mentally ill offenders the same as other criminals, since the root cause of their crimes is often related to their treatable clinical issues.

Since the 1980s, specialty courts, beginning with drug courts and continuing to MHCs and others that serve minors and veterans, have emerged in the U.S. as an effective and efficient means of solving persistent criminal conduct and diverting those with treatable clinical conditions from the traditional punitive sentencing system. Many specialty courts adhere to a problem-solving approach, one that addresses the underlying factors of individual crime. This often involves rehabilitation and different types of counseling, oftentimes sourced from local organizations and community resources.

The primary goal of diversion programs is to channel people away from the criminal justice system, which often retains them within repeating cycles of crime, arrest, incarceration, release, and re-offense due to untreated issues. Specialty courts like MHCs break the cycle of traditional criminal courts by going beyond the boundaries of jail or prison sentencing, designing instead multifaceted partnerships of administrative and treatment teams composed of lawyers, case managers, judges, and treatment providers who work on behalf of participants throughout their criminal process.[149] Individuals can be referred for MHC qualification through different justice system actors, such as police officers, jail staff, defense lawyers, judges, and sometimes even family or community members.[150] Once they are enrolled in

---

[148] VanGeem, 2015.
[149] Ibid.
[150] Thompson et al. 2007.

the program, they are usually assigned a Case Manager whose professional training can range from court administration to social work. The defendants are often given psychiatric tests in order to properly diagnose them. The administrative and treatment teams then create individualized comprehensive treatment plans for each participant.[151] If and when the participants graduate from their specialized MHC program, the Court has the means to diminish or even void their criminal sentence.

While growing in number throughout the U.S., these Courts lack a standardized model of operation and vary widely in protocol, size, capacity, employee structure, administrative procedures, and requirements for participation/graduation. However, they share similar goals, including targeting and treating the root causes of criminal behavior, reducing recidivism for mentally ill offenders, and helping individuals remain crime-free as they are reintegrated into society so that they may continue to live freely.

## Best Practices of Mental Health Court Evaluation

According to public administration scholars Gerald and Naomi Caiden, as confidence in government has declined and budgets have constrained, program evaluations have become commonplace as a means to provide evidence that institutions are spending stakeholder resources and tax dollars efficiently, streamline operations and increase program efficiency, dictate regimented implementation goals, and show that institutions are effectively serving those who participate. Recently, there has been an increased focus on data-driven evaluation analysis and stakeholder interests in government initiatives.[152]

Performance measures are quantitative or qualitative observations regarding a program's operations, how it is meeting its established goals, and the effects of its activities.[153] Caiden & Caiden write that by the early 1990's, over 2/3 of U.S. cities were engaging in performance measurement practices, and about 50% of federal agencies were using related methods as aids to financial decision-making. Measuring the outcomes of public programs and evaluating their efficiency has become a staple in the ever-growing quest for government accountability and the transparency of resource allocation. In addition, data analysts and researchers alike have increased their use of benchmarking as a tool for

---

[151] Kim et al., 2015.
[152] Caiden & Caiden, 2004.
[153] Ibid.

incorporating new methods and practices into the sphere of their own programs by learning from other programs. In effect, benchmarking measures the efficiency of one program against a standard established elsewhere.[154]

Several program evaluations of MHCs have been conducted since their emergence in the late 1990s. Most MHCs have been evaluated to some extent, yielding meaningful analyses. However, no standard, widely-applicable framework exists for evaluating MHCs in the U.S. The variables measured vary immensely. For example, MHCs use different qualifying criteria, graduation requirements, and operational structures. Therefore, certain criteria often slip through the cracks during MHC evaluation, which limits the scope, efficiency, and accuracy of such evaluations. MHC evaluations are also only as good as the level at which the courts themselves record procedural and participant data on a daily basis. It is therefore imperative that a standardized model of MHC evaluation is theorized so that local MHCs can compare their operational procedures and protocols to a model set of criteria in the pursuit of improved public policy.

Despite the lack of a standardized model, I was able to discern some best practices of MHC evaluation based on a thorough review of extant evaluations to date:

a. Far-reaching Access to Community Treatment Services & Resources

Crucial to the foundation of MHCs is the availability of community treatment services in the local area. All MHC evaluations should provide extensive community context assessment in order to gauge the level of local treatment and support available for the mentally ill. For example, in the 2012 evaluation of the Utah MHC, VanGreen provides a detailed description of the status of mental health issues and figures in the state as well as in the 12th District within which the Utah MHC has jurisdiction. Providing broad community context is critical when evaluating MHCs not only because it can offer empirical evidence of the degree to which municipalities are impacted by issues related to mental health, but also because it can reveal the extent to which local and regional treatment services exist to help manage those issues. For

---

[154] Ibid.

example, treatment services are abundant in cities like Brooklyn, Manhattan, and Rochester, NY. However, the Washoe County (Nevada) MHC urgently lacks community treatment services and programs that can work in tandem with it.[155] These types of big-picture details are important when evaluating the effectiveness of a given MHC and the constraints put upon it by exterior factors.

b. Logic Model Method (Outcome-driven)

Another best practice of MHC evaluation is informed by the best practices of public program evaluation, specifically those that deal with people going through regimented and monitored programs. According to the National Rural Health Resource Center, there are two evaluative schools of thought through which one can design and implement a public program:

∑    Strategic Method: Identifying strategies that will guide an initiative toward its goals, and following the progress of the strategies until they hopefully reach a desired goal.

∑    Logic Model Method: Setting empirical goals from the outset of a program that then serve to direct it. Specific goals and benchmarks must be set, the achievement of which will represent real progress within the context of the program. This requires an extensive approach including a visual flow chart beginning with outcomes on the far right and tracing those outcomes back to specialized activities, program offerings, and procedures. This method focuses on outcomes and works backwards, unlike the Strategic Method, which relies on uncertain measures.[156]

I found that using a Logic Model approach is one of the most efficient ways to set and then meet goals. The aspect of this approach most applicable to MHCs is that it is outcome-driven. If the goal of an MHC is to efficiently diagnose participants and proceed to work diligently to eradicate the root causes of

---

[155] Biondo, 2001.
[156] NRHRC, 2016.

criminal behavior until individuals are ready to reintegrate into society, then setting specific goals to work toward from the outset is crucial. Program designers and evaluators should begin with these goals (possibly taken from an MHC's mission statement) and then work backwards to identify weaknesses, ways to improve, and best practices.

c. Use of a Clinical Survey Pre- & Post-enrollment

It is also crucial for MHC evaluations to include information regarding whether a court conducts clinical surveys before participants enroll and after they graduate. Such surveys often yield positive results. For example, evaluators from the Center for Court Innovation found that the Brooklyn MHC administered the HoNOS (Health of the Nation Outcome Scale) upon enrollment and immediately after graduation. The HoNOS found significant improvements in participant issues including depressed mood, living conditions, and occupation, which provided the evaluation more conclusive material regarding the Court's effectiveness.[157]

d. Analysis of Judge-Participant Interaction

While observing MHC proceedings in both the Rochester and Utica MHCs, I saw firsthand how meaningful, empathetic, friendly, and non-adversarial Judge-participant interactions contributed to the morale of the participants. In addition, the Brooklyn MHC Evaluation conducted extensive research on these interactions and found through participant interviews how effective they are in encouraging long- term success rates. When participants feel respected and heard, they respond positively and are more likely to commit to the MHC program, which benefits everyone involved, as it makes it easier for staff to work efficiently and effectively on their behalf.[158]

e. Communication

---

[157] O'Keefe, 2006.
[158] O'Keefe, 2006.

The most effective MHC evaluations I found contained sections on staff communication. These included the Brooklyn MHC Evaluation, Manhattan MHC Evaluation, and Utah MHC Evaluation. For any bureaucratic program that engages with human lives, it is crucial that all stakeholders and staff members communicate effectively regarding participant needs and developments. Therefore, it is important to evaluate this component of MHCs. If possible, it is ideal for MHCs to facilitate in-person meetings of stakeholders from all sides of the local MHC landscape at least once per month to discuss clients and how best to help them. This would help streamline communication and increase procedural efficiency on multiple ends of the MHC operational structure. In-person meetings are much more effective than communicating via phone or email and are key for the success of an MHC and keeping those with mental illness out of jail, which will be evident in the following evaluation of the Utica MHC.

## Conclusion

A likely explanation for the growing implementation of diversion and problem-solving programs like drug and mental health courts is performance evidence. This includes recidivism studies, statistical and data-driven evaluations, and anecdotal/interview evidence of the positive impacts of such courts. According to Stephen VanGreen, the ethos of problem solving courts lies in their focus on rehabilitation and prevention—as opposed to the traditional focus on criminal guilt and prompt prison sentencing— which acknowledges that the factors that lead to crime are heavily affected by behavioral risk factors like mental illness.[159]

Accordingly, this study explores both the best and most effective practices of MHCs through a detailed evaluation of the Utica Mental Health Court (UMHHC), which has been operating for 10 years and has not yet been formally assessed. I hope to contribute in some way to the pool of justice reform research that is working to establish the best practices of MHC operation and evaluation.

---

[159] VanGeem, 2015.

# Overview & Evaluation of the Utica Mental Health Hub Court

## Methodology

The primary goal of this case study is to provide a holistic and detailed analysis of the effectiveness of the Utica Mental Health Hub Court (UMHHC) using qualitative and quantitative data. Researchers use various methods to evaluate MHCs, as there is no standard model of either evaluation or operation in the U.S. This study's analysis is based in part on the 2006 evaluation of the Brooklyn MHC, which proved one of the most comprehensive, clear, and behavioral health-oriented evaluation models I encountered in my research. Other MHC evaluations also influenced my analysis to a lesser degree.

## Qualitative Data

In Spring 2018, I conducted interviews of the following individuals in order to assess the full scope of the UMHHC, including information about its operating procedures and timeline, procedural strengths and weaknesses, qualifying and disqualifying traits for participants, staff communication, referral process, and effectiveness as a means to reduce recidivism.

Interviewees:

- ∑ Ralph Eannace, Utica City Court Judge and Founder of the Utica Mental Health Court
    - o March 28, 2018 at the Utica City Court
- ∑ Adelle Gaglianese, Director Forensic Programs at Central New York Services
    - o March 7, 2018 at the Utica City Court
- ∑ Amanda Santamaria, UMHHC Coordinator, Forensic Counsellor for FEU
    - o March 7, 2018 at the Utica City Court
- ∑ Linda Nelson, Director of the CNY Field Office of the NYS Office of Mental Health
    - o April 11, 2018 at the NYS Office of Mental Health
- ∑ Jaclyn Whitfield, Oneida County Public Defender's Office Alcoholism and Substance Abuse Counselor & former UMHHC Coordinator
    - o February 21, 2018 at the Oneida County Public Defender's Office in Utica
- ∑ Hon. Judge Jack Elliot, Presiding Judge of Rochester Mental Health Court
    - o April 5, 2018 at the Rochester, NY City Court
- ∑ Tina Hartwell, Former Public Defender assigned to Specialty Courts
    - o February 12, 2018 at the Rome, NY Public Defender's Office

All questions pertained to the experiences of the individual interviewees with mental health courts, specifically with the UMHHC (if applicable). While interview questions varied according to the position and experience of the interviewee, they pertained generally to the following topics:

- ∑ Personal experience with mental health courts/mentally ill in Oneida County
- ∑ Perceived best and worst practices of mental health courts
- ∑ Community context re: available services
- ∑ Qualifying criteria for program participation
- ∑ Court staff structure
- ∑ Enrolled participant responsibilities
- ∑ Protocol for participant removal from program
- ∑ Perception of MHC participant post-grad life outcomes, including housing, employment, emergency service use, and criminal history
- ∑ What works best and what needs improvement in day-to-day operations

The answers to these qualitative questions provided the basis for an assessment of the structure and procedures of the UMHHC, with emphasis on the design of the program, participant qualifications, operational procedures, outcomes for program graduates, and the indirect effects that the UMHHC may have on the City of Utica as a whole. Recidivism has to date been the main focus of MHC evaluations. However, there are other qualitative outcome measures that vary across other evaluations, such as housing placement, employment integration, and social relationships.

## Quantitative Data

On April 17, 2018, I received a set of Excel data from Captain Lisa Zurek, Administrative Captain of the Oneida County Sheriff's Department. The data set includes detailed quantitative information pertaining to the 43 individuals who graduated from the UMHHC between January 2009 and March 2016. The data set includes:

- ∑ Case I.D.
- ∑ UMHHC enrollment date
- ∑ UMHHC graduation date
- ∑ Dates graduates were jailed 2 years prior to UMHHC enrollment & the charges
- ∑ Dates graduates were jailed while enrolled in the UMHHC & the charges
- ∑ Dates graduates were jailed within 2 years after UMHHC graduation & the charges

The data set allowed me to analyze a sizable sample of UMHHC graduate records in order to gauge the Court's effectiveness in reducing the recidivism. It also provided insight into:

∑   Any commonalities in the crimes committed by graduates
∑   Average length of participation in the UMHHC program
∑   How often participants are jailed while enrolled
∑   How often participants recidivate after graduation
∑   Which crimes participants commit after graduation

## UMHHC Background

The Utica Mental Health Hub Court (UMHHC), established in 2008, is a post-plea criminal diversion program within Utica City Court in Utica, New York. The UMHHC is a hub-court: criminal cases from throughout Oneida County, NY can be referred to it. The Hon. Judge Ralph Eannace currently presides over the UMHHC and has been running it for over 10 years with the help of a core group of six members drawn from the court, the local case contractor with the court, and the offices of the District Attorney, the Public Defender, and the County Probation Office.

Similar to many other MHCs, individuals are referred to the UMHHC program, are screened for eligibility, plead guilty to at least some of their charges, and enroll in the court via contract. Their criminal sentencing is adjourned to allow them to move through the program, though they have pled so that the UMHHC team can sentence them if they violate protocol. They then draw up, with the court's casewriter, an individualized treatment plan that allows them to remain out of jail so long as they comply with the treatment obligations and UMHHC-mandated rules and guidelines. If they avoid violations and graduate from the program, they are allowed, in most cases, to withdraw their plea.

When initially established, the UMHHC enrolled roughly 15-20 participants per year. In 2018, that number has grown to over 40, with the largest increase occurring since 2016. This rapid growth in local enrollment makes now a critical time to study the UMHHC and its role in the local criminal justice sphere within Oneida County.[160]

---

[160] A. Santamaria, interview, March 7, 2018.

Planning & Implementation

1. Long-term goals of the UMHHC

   Since its inception, the focus of the UMHHC has been holistic, goal-oriented approaches to helping participants become crime-free, drug-free, and in control of their own mental health situations. Judge Eannace, who presides over the Court, says that his ultimate goal is to get to the root of the problem so that it can be addressed in the effort to re-integrate individuals into society and prevent them from committing more crimes. The UMHHC Core Group strives to achieve long-term goals of creating better quality of life for the participants, long-term mental stability, housing stability, access to primary care doctors and therapists, and—most importantly— participants' permanent removal from the court/crime system.[161]

2. Short-term goals of the UMHHC

   In the short term, the UMHHC staff works to provide participants with regular access to treatment services such as drug rehabilitation and therapy. To this end, Phase 1 of the UMHHC program consists of participants creating an Individual Recovery Plan (IRP) with a Case Manager. The IRP addresses participants' specific problems and provides an individualized plan of action based on explicit goals set by the participants in consultation with the Case Manager to solve behavioral and personality issues. IRPs directly address questions such as:

   ∑ What is the mental health diagnosis of the participant, and what are the most effective ways to address it?
   ∑ What goals does the participant want to reach?
   ∑ What goals does the Case Manager want the participant to reach?
   ∑ What goals do the treatment providers have, and how can those goals become realities?
   ∑ Are there exterior issues, such as housing, family, abuse, substance, or vocational issues, that need to be addressed, and how?

---

[161] R. Eannace, interview, March 7, 2018.

IRPs may include goals like managing depression, abstaining from drugs and alcohol, reducing violent outbursts, earning a G.E.D., getting a job, and reconnecting with family.

1. Eligibility

A participant's eligibility for the UMHHC relies on multiple decisions made on a case-by-case basis. Focused discretion is vital to how the Court operates. Most importantly, the UMHHC team decides whether it can be helpful to a participant and whether the participant is likely to respond positively to the program. There is some truth to the argument that the UMHHC cherry-picks participants, as it only takes people it believes it can help, including violent offenders. This is also a strategic decision: the UMHHC is currently a small operation that lacks the funding and staffing necessary to run an MHC that could implement effective programs for participants with a wide range of mental illnesses, disabilities, and histories. It therefore uses its available resources strategically to make the greatest impact on the greatest number of people possible.[162]

2. Diagnosis

Once an individual is deemed eligible for the UMHHC by its Core Group and the D.A., they are usually referred to the Forensic Evaluation Unit (FEU) for diagnosis and evaluation. The FEU serves as an alternative to incarceration in the Utica City Court, and for the purposes of this court, it is considered a gateway for eventual MHC placement because the judge can immediately from arraignment, with the defendant's counsel, place the defendant with FEU for less structured temporary referrals, supervision of evaluation and initial treatment. The only time the Court does not place someone into the FEU is if the individual does not wish it or if they have a history of total non-compliance or extensive violence. However, it is possible for individuals to be placed right into the UMHHC without FEU referral.

---

[162] R. Eannace, interview, March 7, 2018.

In the FEU or in a pre-plea observation period with the UMHHC, individuals are given a demographic psychosocial evaluation. From there, they are linked to treatment, which may include substance abuse treatment, mental health treatment, a primary care doctor, parenting classes, anger management, or anything else that can be court-monitored. A forensic counselor then diagnoses whether the root cause of an individual's behavioral problems is primarily mental health-oriented, substance abuse-oriented, or something else.[163] This begins before a contract is signed with the UMHHC in most cases.

With the criminal charges, referral details, and FEU diagnosis, the UMHHC Coordinator then evaluates the individual to determine whether they meet the criteria and should be placed into the more structured and intensive UMHHC. If the individual is not a good fit, they are offered the opportunity to remain with the FEU or to have their case proceed under regular criminal court process. For example, someone with mild depression might remain in the FEU because they likely would not need to come in every week and to be monitored as heavily as participants in the UMHHC.[164] The UMHHC also disqualifies individuals who are severely developmentally disabled. While it does take some people with developmental disability symptoms, it recognizes that it is not equipped with the resources to fully support those with severe symptoms, unstable personality disorders, or traumatic brain injuries; Judge Eannace argues, "It's cruel to them to put them in a program they can't succeed at."[165] The UMHHC Coordinator can also speak to local treatment providers like doctors, psychiatrists, or psychologists about whether an individual is a good match for the UMHHC. This is especially helpful when determining whether an individual is too severely disabled to participate.

---

[163] A. Santamaria, interview, March 7, 2018.

[164] R. Eannace, interview, March 7, 2018.

[165] R. Eannace, interview, March 7, 2018.

3. Stakeholder approval

A committee of six stakeholders, what the UMHHC calls the "Core Group," decides whether an individual is eligible and recommended for UMHHC enrollment. This group is drawn from court staff, the FEU, and the offices of the District Attorney, the Public Defender, and the County Probation Department. Judge Eannace is not in the Core Group. He says, "I take no part in our review before a contract is signed. This [individual] is still in front of me for a criminal charge. So, I keep my role very formal at this point." It is important to note that much like in other MHCs, the County District Attorney has veto power over participant enrollment and may decide to deny enrollment based on criminal history or public safety risks. Judge Eannace explains that "They're given veto power up front. If they don't feel that the MHC is appropriate because of a criminal history or the nature of a charge, or if they feel that this person is too dangerous for them to engage in an outpatient-based or community-based program, they can veto."

Drug courts were implemented prior to mental health courts in the United States and to date often receive federal funding, which makes them subject to federal regulations that can stipulate certain automatic disqualifications for enrollment. The UMHHC receives no federal funding and abides by no specific federal MHC regulations. While drug court disqualifying factors are often considered by the D.A. regarding the UMHHC, the UMHHC has more discretion when accepting individuals. "I think public safety is the biggest issue that they have," Judge Eannace says of County D.A.s. "They don't want to bring in people that are going to be then based in the community and are going to have another offense." The D.A.'s decision can occur at the initial referral in the courtroom, but they can also agree to a referral and subsequent forensic evaluation, and veto any time until a contract is signed.[166]

---

[166] R. Eannace, interview, March 7, 2018.

Timeline

The time from UMHHC referral to graduation averages one year. Once an individual is referred, evaluated, approved by stakeholders, and opts into the program, a contract is negotiated that stipulates one year as the goal for program completion. Part of the contract negotiations also involves the individual's sentence; for example, if there are three charges, the D.A. may agree to accept a plea to reduce them to one and then to dismiss the final charge upon successful completion of the program. The defendant agrees to a set of rules, but most importantly, they plead guilty to the charges in the contract. They also agree that they can serve up to one year in jail if they fail to follow the program. Finally, they agree to treatment, attending UMHHC meetings, staying clean of drugs, and other stipulations.

1.  Enrollment

    Once the contract is signed, the participant and the UMHHC Coordinator develop an individual recovery plan (IRP) that outlines their issues—both diagnosed and holistic—and provides a specific blueprint for how to solve them. The IRP examines not just an individual's mental health diagnosis, but also any housing, family, abuse, substance, and vocational issues. The participant and the Coordinator agree on a set of goals, and then the Coordinator makes treatment referrals to services across the County and State. These can include things like substance abuse treatment, group and/or individual therapy, doctor-prescribed medications, vocational help, and housing referrals.

    From this point, the participant visits the Court regularly to appear in front of the Judge. These meetings involve the entire Core Group and all of the treatment agency representatives. Before meeting with the staff and participants, the Core Group reviews each case to be heard that day. The first Tuesday of each month is designated "all-in" day: every UMHHC participant is obligated to attend. The second Tuesday is for participants in Phase 1 who must attend court

every week. The third Tuesday is for Phase 1 and Phase 2 participants (those who must attend twice a month). The fourth week of the month is just for Phase 1 participants, and then the cycle repeats.[167]

2. Phase 1

Phase 1 usually lasts two to three months. The goals in this Phase revolve around making sure participants stick to the IRP, keep appointments, stay clean, and stay out of trouble. The IRP may be revised as necessary. Phase 1 is the participant's chance to show that they belong in the UMHHC and have the ability to succeed in diversion programs. After a few months of following the IRP, the UMHHC Coordinator makes a recommendation to the Core Group for the participant's advancement, and a review meeting is scheduled. At that meeting, the Judge might ask the participants questions like, "Are you ready for Phase 2?" and "Why do you think you're ready?" Based on the participant's desires, the UMHHC decides whether to submit them to Phase 2.[168]

3. Phase 2

The first step of Phase 2 is for the UMHHC Coordinator to meet with the participant to determine whether they want to revise their IRP and goals. During this Phase, participants visit court twice a month instead of every week, but they usually meet the Coordinator weekly to report on their progress on the IRP. The UMHHC receives reports from the Coordinator and the relevant treatment providers. As in Phase 1, the UMHHC Core Group reviews the progress reports and developments before UMHHC proceedings.

4. Phase 3 & Graduation

---

[167] A. Santamaria, interview, March 7, 2018.
[168] R. Eannace, interview, March 7, 2018.

Eventually, the UMHHC Coordinator recommends Phase 3, which can occur as much as nine months after enrollment. In this Phase, the participant visits court once a month and continues their IRP and treatment plans. In consultation with the Coordinator, participants also revise those plans as they near completion to reflect how they will continue them independently. After the Core Group approves a participant's graduation, Judge Eannace informs the individual that they will graduate from the UMHHC in the next month provided that they stay on track. On additional focus in this phase is making sure the participant has and is carrying all necessary supports to stay stable and continues to progress on their own after graduation. Their support an be family, groups like AA, or more formal psychiatric appointments.

## Referral & Assessment

The referral process takes about one month, and the flow of participants fluctuates, from six referrals in one month to three months with no referrals at all.[169] Referrals can come from judges at other courts, police, family members, treatment providers, and anyone in the community who wants someone they know to get help but to avoid incarceration. When community members contact the UMHHC, the staff tells them to contact the D.A., a public defender, or an attorney. Judge Eannace, with the consent of the District Attorney, then refers the case to the Core Group.

When Judge Eannace receives a referral for the UMHHC, he decides whether it is worth exploring, taking into consideration the nature of the charge, behavioral issues, and past criminal experience. The first step of the referral process involves asking the defense whether the individual wants to be screened for MHC during court proceedings. Judge Eannace personally provides the individual with a brief sketch of what the court is about to do. The defense counsel is usually the public defender, who is already aware of the UMHHC procedures. The individual and attorney discuss the option privately and then return to Judge Eannace at the podium, at which point, if the individual indicates interest in the UMHHC program, they are almost always referred to the FEU because they need to sign release forms for

---

[169] A. Santamaria, interview, March 7, 2018.

their medical histories, including psychiatric and substance abuse history. Referral to the FEU also means the start of the diagnosis process so that the UMHHC can effectively tailor the program to the individual.

The individual is then scheduled to observe the UMHHC proceedings in person, where they are introduced to the members of the Core Group and some of the other stakeholders from mental health/substance abuse agencies who attend MHC proceedings. Now that the Judge has referred the individual for participation, the Core Group reviews the file to decide whether it will recommend the person for the UMHHC. If recommended, the individual agrees to the terms of the negotiated contract, signs releases, and then is officially enrolled in the UMHHC.[170]

## Use of Sanctions

The UMHHC uses sanctions for participants who violate its guidelines. These include sitting up front in court or verbal warnings from the judge, writing essays about what they did wrong and how it is impacting their progress, doing community service, or even going to jail. The first jail sanction is usually for three days. The next is a week, followed by two weeks; if a participant continues to violate protocol, they are required to make a presentation to the Core Group regarding whether they should stay in the UMHHC.

In order to remove participants from situations where they are set up for failure, the UMHHC might send them to an inpatient rehab program in Syracuse or Pennsylvania to keep them away from the negative influences in their current surroundings, or just to start getting any addiction issues or urgent mental health issues under some control up front. "The Core team members decide if someone's going to get sanctioned," explains Adelle Gaglianese, Director of Forensic Programs at CNY Services and member of the UMHHC Core team. "We try to get creative, because ultimately them sitting in jail is not going to help them. They need to be in the treatment. So, if we can get creative with a sanction we try to do that." In addition to the above, the team has also mandated more treatment for participants who violate protocol. For example, Gaglianese says, "Just recently someone had two positive drug tests. We told them they

---

[170] R. Eannace, interview, March 7, 2018.

have to go to 30 meetings in 30 days, and if they miss a meeting, then they go to jail."[171] Amanda Santamaria, UMHHC Coordinator, explained what happens when a participant goes to jail: "We inform the treatment providers," she says, and once they tell us how long the person will be in jail, the Core Group deliberates, "What can we set up for them so that when they get out this doesn't happen again?"[172]

## Participation Process

### a. Courtroom Experience

When participants appeal to Judge Eannace on any given MHC meeting day, they appear in front of him individually. By then, the Judge has reviewed their case, progress, problems, successes, and failures. Successes might include finding an apartment or finishing a treatment program. Failures would include missing treatment apparent, failing a drug test, getting arrested, or having a violent episode. Judge Eannace speaks to the participants in front of the courtroom, reviewing their progress, successes, failures, and any new or relevant developments in the IRP.

The UMHHC, like the Brooklyn MHC and many others, is run by a very caring, empathetic, involved Judge, which is a central component of its success. While the scope of this project did not allow for as extensive an analysis of Judge-participant interactions as that conducted by the Brooklyn MHC Evaluation, it did allow for some conclusions. Judge Eannace started the UMHHC after experience in politics and providing local resources for the mentally ill. This work is a passion of his and his way of making a better world for those who come after him. He talks to participants when he runs into them in the street, gets creative with solutions to help them, and does everything in his vested authority to keep mentally ill people out of jail. He often asks participants how they are doing, praises them when possible, and is never quick to put someone in jail for a violation unless it is well deserved. After participants complete a Phase of the program, finish a treatment program or class, or something similar, Judge Eannace ensures that the entire courtroom applauds.

---

[171] A. Gaglianese, interview, March 7, 2018.
[172] A. Santamaria, interview, March 7, 2018.

Judge Eannace and his team also do everything in their power to intervene in situations that are hindering participants from success. If a participant has a recurring violation or complaint about their experience, the Judge will ask his review team whether they have considered exactly why this person continues to get in trouble for the same thing and what can be done about that. For example, once there was a participant who became paranoid that his neighbors hated him. When it came up as a recurring issue, Judge Eannace had someone visit the individual's home, upon which it became clear that the neighbors were upset because the home was derelict and smelly. The Judge then made sure that the participant cleaned the property, which resolved the issue.

On graduation day, participants are invited to bring anyone with them, including friends, family, and other supporters. Judge Eannace explains why he is proud of them and what they have accomplished. Each participant receives a certificate of graduation and a small sterling silver-coated keychain with an engraving of a gavel and the snakes of the caduceus, which symbolizes law and medicine working together. The participants receive a few minutes to speak to the Court, vocalizing whatever they wish. They are then invited to return any time just to say hello or to volunteer to help new participants. Their lawyer moves to have their plea withdrawn and the D.A. dismiss their charges. Most avoid any jail time at all because of their completion of the UMHHC program. Judge Eannace likes to hold graduations on all-in days (when all participants are in the courtroom) so that everyone involved can see how possible it is to succeed and have a goal to aspire to. He brings in cake (or tomato pie) for everyone in the room and altogether goes out of his way to truly celebrate each individual's success.[173]

b. Communication

---

[173] R. Eannace, interview, March 7, 2018.

The Utica MHC staff communicates very well, which is one of the keys to its success. They meet every week in person with all six members of the Core Group and the Judge; representatives from local treatment providers also attend to provide input and insight into participant progress.

Effective communication is also embedded into UMHHC practice through biweekly in-person meetings with almost all stakeholders in mental health treatment programs throughout Oneida County. These meetings occur under the S.P.O.A. (Single Point of Access for Adults) program founded by the County branch of the Department of Mental Health. Also present at these meetings are probation and parole officials and sometimes sheriffs, which allows representatives from all sides to come together to discuss how best to help difficult clients—especially those who are severely mentally ill—succeed in the community. "We put our heads together," says Jaclyn Whitfield, an Alcoholism and Substance Abuse Counselor who now works at the Oneida County Public Defender's Office as a Mental Health liaison.[174] As Whitfield explains, the group leaves these meetings with concrete ideas and plans about how to help specific individuals: "Having all of those representatives in one room, talking about clients, and trying to come up with solutions is fabulous. It's helped me a lot."

This local resource that works to better the lives of individuals who are in and out of the hospital and justice system is essential to the UMHHC's functioning, as it ensures that the treatment providers who work with the Court are prepared to inform the Judge about the status of individuals who may appear or qualify for and succeed in the program. The UMHHC does occasionally have difficult clients who need to be dropped from the program or who recidivate after graduation, but access to community resources like the S.P.O.A. helps to decrease that number by keeping all stakeholders informed about the best way to support struggling participants.

---

[174] J. Whitfield, interview, February 21, 2018.

Key Issues Faced by the Utica Mental Health Court

Below are some of the major difficulties the UMHHC has faced during its operation:

a.) Occasionally, veterans opt out of the UMHHC program even though they might greatly benefit from the services. Judge Eannace believes that this is because many veterans own firearms and think that if they enroll in an MHC, the Department of Veteran Affairs will retract this right. While this is a problematic reason for opting out of treatment, it is unclear whether MHC participation disqualifies individuals from owning firearms.

b.) When troubled participants have glaring past charges or behavioral records, service providers often deny them admittance to their programs. For example, if a UMHHC participant is removed from an in-patient living situation due to behavioral problems, word gets around and records are shared, and then suddenly other providers and housing options decline to take that person. This is problematic because if the UMHHC wants to remain firm about imposing sanctions on the participant, it must keep in mind that those sanctions can lead to future problems in finding housing or treatment, the very goals of the program. As UMHHC Core Group member Adelle Gaglianese remarks, "It's very frustrating because you don't know if that time that they're saying 'no' can be the time that it works for the person."[175]

c.) Staffing is a large issue for the UMHHC. As a hub court, it serves people from all areas of the County. Participant enrollment has doubled in the past few years, but the Court still has only one Case Manager and no funding to hire anyone else. Gaglianese put the staffing concerns into context: "In FEU we have probably 300 cases, and that's just Utica. That's not counting Rome,

---

[175] A. Gaglianese, interview, 2018.

town and village courts, domestic violence cases, or veteran diversion. And there's only a few of us on staff. We really need another staff member. It's very overwhelming."[176]

d.) If and when participants are arrested, they are deprived of their medications in the county jail. "Chances are if they're only there for a few days or a week, they're not going to get their medication," says Gaglianese. "There isn't time with the way the jail psychiatrist works to get the medication," she explains. Medication services only kick in after about two weeks. This is troubling, since medications may keep participants from lashing out, having an episode, or experiencing the behavioral issues that landed them in jail in the first place. Their off-medication behavior could lead to more issues that would only prolong their incarceration. This is antithetical to the spirit of diversion programs as a whole and especially problematic in Oneida County.[177]

e.) Housing is a persistent issue for MHC participants. It is difficult enough to obtain an apartment with a criminal record and pending charges, but when a landlord sees that an applicant is also undergoing mental health treatment, they often decline the application. The housing issue in Oneida County is part of the larger issue of a lack of in-patient mental health institutions in New York State, most of which have been dismantled over the past seventy years. When UMHHC participants burn their bridges at community residences and clinics, where else can they go?

f.) The selective nature of the UMHHC normalizes the disqualification of individuals with severe mental illnesses such as bipolar disorder, psychosis, and personality disorders, as well as those with developmental disabilities. The UMHHC only takes people it can help, which means in practice that it cannot take people who need the most help. This is an enormous problem given the lack of in-patient mental facilities in the region. An entire population of mentally ill

[176] A. Gaglianese, interview, 2018.
[177] A. Gaglianese, interview, 2018.

individuals in Oneida County does not qualify for the UMHHC but would greatly benefit from the kind of public service it provides. This is not to suggest that the UMHHC should expand its eligibility standards; the Court is doing incredible work with very few resources. But it is important to note that not all mentally ill people in the criminal justice system have the privilege of MHC participation, which is often less available to those with more severe illnesses.

## Quantitative Data Analysis

In order to interpret the relevant quantitative data, it is imperative to understand the larger context in which the numbers play a role. As mentioned previously, the quantitative data set for this study includes information pertaining to the 43 individuals who graduated from the UMHHC between January 2009 and March 2016 obtained directly from the Oneida County Sheriff's Department. According to Judge Eannace, approximately 200 individuals have graduated from the UMHHC since its inception over ten years ago. This data set is crucial to understanding the Court's effectiveness as both an alternative to incarceration and a means to reduce recidivism. The ability to obtain and analyze detailed quantitative data regarding almost 25% of total UMHHC graduates is a meaningful step toward evaluating the Court as a whole, laying the foundation for further research and assessment.

Hard data on who enrolled and graduated from the program between 2009 and 2016, what crimes they committed, and whether they recidivated provides empirical evidence for the degree to which the UMHHC has effectively achieved its goal of keeping those with mental illness out of prison. While recidivism (Figure 1) is not the only indicator of whether a diversion program like the UMHHC is effective, it is widely used as a standard for such assessment.
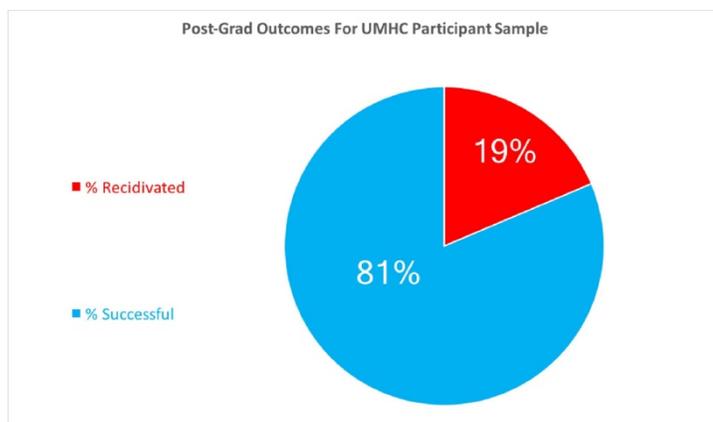
Figure 1. Recidivism rates for UMHHC graduates 2009-2016.[178]

Figure 1 shows that the UMHHC is working. When participants graduate, the vast majority do not return to jail. Given Judge Eannace's assessment that those who enter the Court are often "frequent fliers" and repeat offenders, this is breakthrough data from the standpoint of local justice reform. According to a study by a research team at Case Western Reserve University, mentally ill offenders recidivate at a rate of 54%, well above that of the UMHHC.[179] Table 1 provides a breakdown of the crimes committed by UMHHC graduates 2 years before enrollment and 2 years after.

Table 1. Crimes committed by UMHHC graduates before and after enrollment[180]

[178] Oneida County Sheriff's Office, 2018.
[179] Wilson, 2012.
[180] Oneida County Sheriff's Office, 2018.
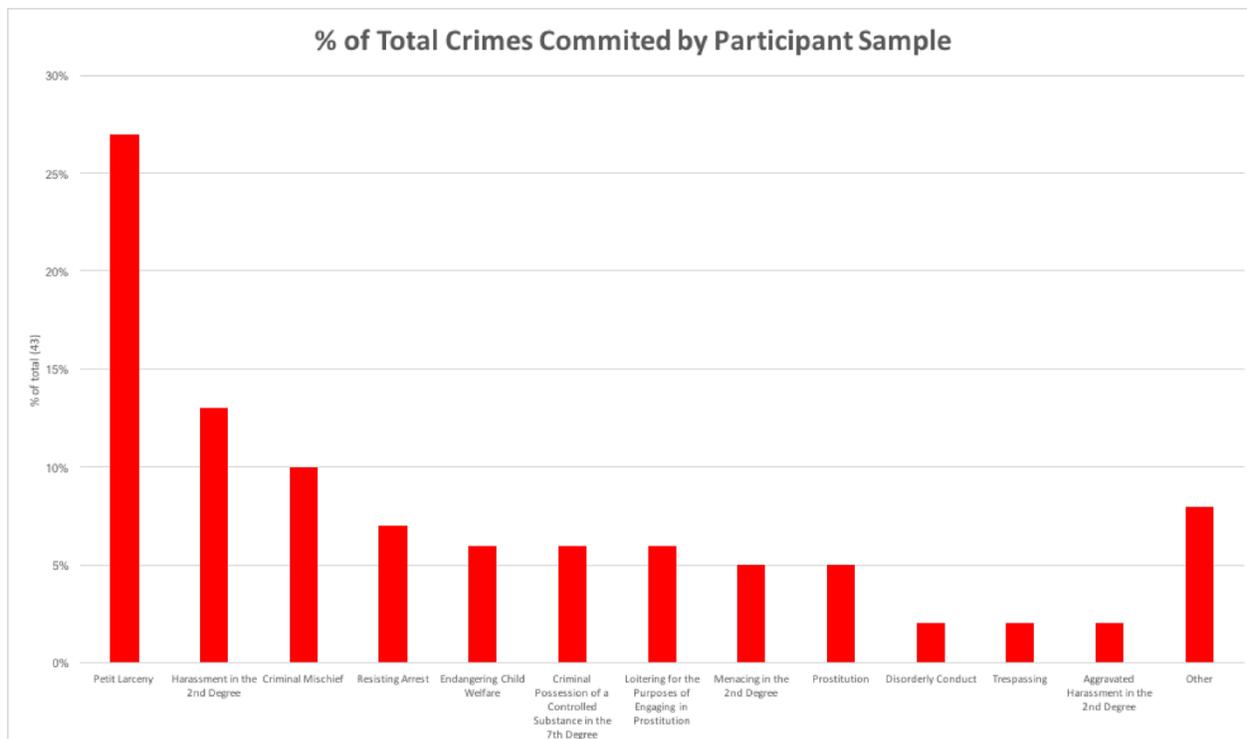
While this data is useful, it does not tell us how the numbers compare to a control group of individuals who entered the County justice system with mental health issues but either opted out or did not qualify for the UMHHC. It would also be useful to compare this data to a control group that had committed similar crimes as the individuals in the "graduated" data set but who did not have access to the UMHHC program. The data set also does not reveal the life outcomes of graduates, and there currently exists no follow-up program within the UMHHC. It would be helpful to know whether graduates had permanently secured housing and employment and whether they had sustained better relationships with family and friends. Therefore, while the current data suggest that UMHHC participants demonstrated considerable improvement, additional research with a comparison group would likely further highlight how the program positively impacts participant outcomes.

To date, the UMHHC has not effectively recorded extensive participant or operational data. In order to obtain quantitative data, I had to go through the Oneida County Sheriff's Office, which took many months. Our research team was told that the Bureau of Justice Statistics would take about one year to deliver even this simple data set because it would require extensive legal agreements to access the data

and many months of paperwork, meetings, calls, and waiting. These bureaucratic formalities severely limited the scope of my evaluation of the UMHHC and forced me instead to focus on qualitative metrics. Being able to substantiate those metrics with quantitative data will better serve the program in the long run, and therefore I recommend that the UMHHC immediately establish an electronic data-collection procedure to aid future assessment and funding requests.

## Conclusion

The UMHHC helps individuals implement structure in their lives so that they can survive in society successfully on their own. Over 80% of program graduates between 2009 and 2016 did not recidivate, a statistic that conclusively indicates that the UMHHC is an effective diversion court. Importantly, it not only diverts individuals with mental illness from the punitive justice system but also helps them manage their issues so that they can continue to avoid incarceration in the future.

The community around the UMHHC provides the foundation to support its effective functioning. The following quote exemplifies how UMHHC stakeholders help each other succeed in their shared mission:

> "The amount of support that I get from other community members is really great. Anyone that I have reached out to and said I need help with this, they jump right on it. They're always willing to help, always to come to the team meetings from some clinic. It's a bottom-up operation right up to the Commissioner of Mental Health, who was here yesterday. Everyone from the whole broad spectrum is always more than willing to help. Having that support for the people that are in my health care is crucial to the success of it."[181]

That said, it is imperative to note that there is an urgent need for more mental health services in Oneida County. Waitlists are long, housing is sparse, and inpatient institutions are few and far between. The UMHHC can only help so many people with so much money and staff. It is also critical to keep in mind that the UMHHC is a publicly-funded program, and that in general there is pressure on mental health courts to produce performance-driven results that show the program is working and therefore justify

---

[181] Amanda Santamaria, Utica Mental Health Hub Court Coordinator, 2018.

continued funding. This is problematic in that it contributes to the pressure on MHC operators to accept only individuals that they know can graduate—oftentimes those with less serious mental illnesses or low-level offenses. This disqualifies a large number of those with mental illness and in theory keeps that population incarcerated, the problem MHCs set out to solve in the first place. The UMHHC is no doubt also subject to this phenomenon. According to almost all stakeholders with whom I spoke, what Oneida County really needs—in addition to more funding for its MHCs—is more inpatient facilities in the State in order to provide 24-hour care to those who struggle so terribly with mental illness.

The growth of MHCs in the U.S. over the past 20 years is a testament to the collective justice reform effort to stop the revolving door of crime: the cycle of clinically troubled individuals getting arrested, serving time, being released into the public, and then getting arrested again. Diverting those with mental illness from the punitive justice system is not only a more humane and rehabilitative method of reducing crime, but also helps to relieve officials such as corrections officers, police officers, and standard criminal court judges from managing a population for which they do not have adequate training. As MHCs have developed across the U.S., they have diverted thousands away from the justice system and have reduced overcrowding in prisons while at the same time helping to reintegrate those with mental illness into society so that they never enter the revolving door again.

Isabel O'Malley for her source recommendations and gracious willingness to help. Daniel, Shelley, Matthew, Joan, Wodo, Charlotte, Cecilia, and Lucy Scheuer for always having my back. Tom Delonge, Mark Hoppus, and Travis Barker for inspiring me outside of the classroom. Ryan Creps for helping me get into Hamilton College.

# References

Belenko, Steven. "Research on Drug Courts: A Critical Review." June 1998. National Drug Court Institute, The National Center on Addiction and Substance Abuse (CASA).

Biondo, Rene. Washoe County, Nevada Mental Health Court Notable Features, Council of State Governments, 2001.

Caiden, G. E., & Caiden, N. J. (2004). "Measuring performance in public sector programs." Public Administration and Public Policy, 2.

Farley, Erin J. (2015), "A Process Evaluation of the Manhattan Mental Health Court."

Goldkamp, John S. and Cheryl Irons-Guynn. (April 2000). "Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage." National Criminal Justice Reference Service, U.S. Department of Justice, Office of Justice Programs, Crime and Justice Research Institute.

Kim, KiDeuk, Miriam Becker-Cohen, and Maria Serakos (2015). "The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System." Urban Institute. Social Science Premium Collection.

National Rural Health Resource Center. (January 2016). Office of Rural Health Innovations. "A Guide to Writing Program Evaluation." Rural Allied Health Network Training Program Technical Assistance.

O'Keefe, Kelly. "The Brooklyn mental health court evaluation." Planning, implementation, courtroom dynamics, and participant outcomes. New York, NY: Center for Court Innovation (2006)

Oneida County Sheriff's Office, Prepared by Captain Lisa Zurek (2018). Utica Mental Health Court Graduate Data 2009 to 2016 [Data set].

Sarteschi, Christine M., Michael G. Vaughn, and Kevin Kim. 2011. "Assessing the Effectiveness of Mental Health Courts: A Quantitative Review." Journal of Criminal Justice 39 (1): 12–20

Simon, J. 2014. Mass Incarceration on Trial: A Remarkable Court Decision and the Future of Prisons in America. New York: The New Press.

Strong, S. M., Rantala, R. R., & Kyckelhahn, T. Census of Problem-Solving Courts, 2012. US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Thompson, M., Osher, F., Tomasini-Joshi, D. 2007. Improving Response to People with Mental Illness: The Essential Elements of a Mental Health Court. New York,: Council of State Governments Justice Center.

Torrey, E. Fuller M.D. "DeInstitutionalization- A Psychiatric Titanic." 1997. PBS, John Wiley & Sons, Inc.

Torrey, E. F., Dailey, L. H. R. Lamb, Sinclair, E., and Snook, John. "Treat or Repeat: A State Survey of Serious Mental Illness, Major Crimes, and Community Treatment." 2017. Arlington, VA: Treatment Advocacy Center.

U.S. Department of Health and Human Services Centers for Disease Control and Prevention. Office of the Director, Office of Strategy and Innovation. "Introduction to Program Evaluation for Public Health Programs: A Self-Study Guide." 2011. Atlanta ,GA: Centers for Disease Control and Prevention.

VanGeem, Stephen Guy, "An Evaluation of the Utah First District Mental Health Court: Gauging the Efficacy of Diverting Offenders Suffering With Serious Mental Illness." 2015. University of South Florida.

Wilson, A. B., Draine, J., Hadley, T., Metraux, S., & Evans, A. (2011). Examining the impact of mental illness and substance use on recidivism in a county jail. International Journal of Law and Psychiatry, 34(4), 264-268.

Wilson et. al., Amy Blank. "Higher Rates of Jail Recidivism Among People With Co-Occurring Severe

Mental Illness and Substance Use Disorders." Center for Evidence-Based Practices, Case Western Reserve University, 1 Feb. 2012.

Wolff, N., Fabrikant, N., & Belenko, S. (2011). Mental health courts and their selection processes: Modeling variation for consistency. Law and human behavior, 35(5), 402-412.

CASE STUDY 3

POLICING & MENTAL ILLNESS IN ONEIDA COUNTY, NEW YORK:
BEST PRACTICES, SHORTCOMINGS, & PROPOSED REFORMS

Conor S. O'Shea
Spring 2018

# Introduction

In the U.S., when someone tries to help an individual suffering from psychological distress – suicidality, PTSD flashbacks, psychosis, bipolar-induced crises, etc. – their first instinct may be to call 9-1-1. Dispatch sends the police. Now, picture the scene from the perspective of the person in crisis. The police pull up in a government-issued squad car, perhaps with lights flashing. They're wearing government-issued uniforms, bulletproof vests, and a utility belt equipped with handcuffs and a firearm. They have critically imperfect information from dispatch and the 9-1-1 caller – sometimes as little as 'My brother is off his meds. He needs help!' or 'I'm scared. My cousin's going crazy!' – and arrive on scene oftentimes only with rudimentary training on how to interact with people in psychological crisis. They might not even recognize that the person is in mental distress, instead attributing the erratic behavior to drug use or the perception that so-called 'crazy people' are inherently dangerous and unpredictable.

It's not hard to imagine how someone with paranoid schizophrenic delusions may become scared, agitated, and furtive in such a situation. They may even (reasonably, from their perspective) grab a weapon or brandish one they were already holding. It's also not hard to imagine how an officer's shouts of 'Put down the knife!' or 'Show me your hands!' may fall on deaf ears, leading to otherwise-avoidable arrests or civilian casualties that will eventually be deemed 'justified' because the officer was 'just following protocol.' This is just a snapshot of the crisis of how American policing and mental illness intersect, but the problems run much deeper than how police officers respond to people with mental illness during 9-1-1 calls.

American policing in particular, and its justice systems more generally, fail when they treat mental illness – a bona fide public health problem – exclusively like a criminal justice problem, thereby forcing "police officers and sheriff's deputies… to become front line mental health workers."[182]

---

[182] Normore, Ellis, & Bone, 2015, p. 137.

Moreover, "the safety of both law enforcement officers and citizens is compromised when law enforcement responds to crises involving people with severe mental illness who are not being treated."[183]

       This problem raises several questions: Should the police be the people who respond to every 9-1-1 psychological crisis call? If they do, how should they approach that situation? What training is required to qualify them to respond? When is use-of-force – especially lethal force – justified in those situations? Are non-law enforcement personnel, like psychiatric medical professionals, better suited to respond to those calls? Should they co-respond with officers? This report makes recommendations regarding these questions as they are presented in Oneida County, New York. Since the County's problems are representative of those in other counties and states, the results also have national implications.

---

[183] Torrey, 2015.

# History and Development of Policing and Mental Illness in the U.S.

## Deinstitutionalization and Law Enforcement

The most significant historical movement in the area of policing those with mental illness was deinstitutionalization. The public health problem of mental illness became a criminal justice problem in the absence of public health resources devoted – and divorced from criminal justice writ large – to addressing it on the same plane. Simply put, "[t]he trend toward deinstitutionalization between the 1960s and 1980s is a major reason for the increased contact between the mentally ill and police."[184] This has upended the purview of the criminal justice system pre-deinstitutionalization: "Once intended to hold people who were dangerous or who might flee before trial, jails have instead become de facto warehouses for people with serious mental illness and those who are simply too poor to post bail."[185] People with mental illness in particular face unique challenges and overrepresentation in the criminal justice system: "An estimated 14.5% of men and 31% of women admitted to jail have a serious mental illness – rates that are four to six times higher than in the general population" (Safety and Justice Challenge, 2017).

The criminalization of mental illness via the systemic funneling of people with MI into the criminal justice system in the absence of institutions appears all the more concerning, however, when considered through the lens of problem-oriented policing.[186] In fact,

> "… one of the best examples of the consequences of 'forced silence' on the part of the police is the nationwide problem resulting from the deinstitutionalization of the mentally ill. The potential harm to both the deinstitutionalized and the community when adequate community resources were not available became apparent to the police very soon after these programs were initiated. But the police were not involved in the policy decisions that led to deinstitutionalization, nor was any effort made to equip them to respond to the difficulty created by the presence of the mentally ill in the community. Rarely did a police administrator take the initiative to call the problem to the attention of the community."[187]

---

[184] Tucker, Van Hasselt, & Russell, 2015, p. 237; see also Zdanowicz, 2001.
[185] Garduque, 2018.
[186] Goldstein, 2015.
[187] Goldstein, 2015, p. 46.

Indeed, among all of the modes of policing that are possible – among "the range of postures that the police can assume" – the status quo is, by and large, characterized by the police "simply resign[ing] themselves to living with recurring problems," the opposite of what problem-oriented policing would require.[188] To date, "policing has," by and large, but with some notable exceptions, "relied on what appears to be ineffective strategies to deal with… the mentally ill."[189] There are, however, areas in which law enforcement agencies have made, and can continue to make, headway in reforming the post-deinstitutionalization status quo of policing.

## Current Best Practices

Overall, successful solutions – even piecemeal ones – to the post-deinstitutionalization mental health crisis in the criminal justice system need to acknowledge that there is no 'one size fits all' solution. Law enforcement needs to recognize the particular textures of mental illness and how they impact criminal behavior and decision-making. Most notably, mentally ill individuals think and function differently than non-mentally ill individuals; their environments, too, introduce different risk factors for criminality. These "criminogenic risk factors" are "unique" to people with mental illness and include: "antisocial personality, criminal thinking, social support for crime, and substance abuse"; they are further exacerbated by additional "psychiatric issues like psychosis, paranoia, cognitive impairment[,] and trauma."[190] Ultimately, this "combination" of criminogenic risk factors "makes people [with mental illness] more vulnerable and less responsive to standard correctional intervention."[191]

The hyper-contextualism required here aligns with a more general strategy of policing, problem-oriented policing – which seeks to cut off recurring problems proactively, at the root, rather than perennially producing post hoc police reactions to them – insofar as it urges concentrating attention on the causes of a problem. This leads Goldstein (2015) to argue that "one of the most effective ways to reduce the magnitude of a much wider range of problems is to design programs specifically to deal with those

---

[188] Goldstein 2015, p. 47.
[189] Normore, Ellis, & Bone, 2015, p. 135; see also, LaCommare, 2010.
[190] Roth, 2017.
[191] Ibid.

who account for a disproportionate share of them."[192] Law enforcement agencies, by and large, are not the best designed programs to deal with people with mental illness, especially when those people are in a state of acute psychiatric crisis or feeling suicidal.

That is not to say, however, that law enforcement agencies should have no role in reform; instead, collaboration and appropriate delegation or reassignment of duties to mental health professionals constitutes the best practice here. Any successful program does so not because it completely swings the pendulum the other way and wholly excises LEOs from the entire process, but rather because it allows and encourages "mental health and criminal justice professionals to problem-solve together."[193] Collaborative problem-solving between law enforcement and mental health professionals has succeeded most in codified programs like the Crisis Intervention Team (CIT) model and the co- response Jail Diversion Program (JDP) model.

---

[192] P. 105.
[193] Roth, 2017.

## Crisis Intervention Team (CIT) Model

Overall, CIT aims to "improv[e] safety during encounters between police and persons with mental illnesses, divert persons with mental illnesses away from the criminal justice system, and increas[e] referral and access to mental health services."[194] The CIT model, at its core, focuses on providing extensive, specialized training to a select group of officers to qualify them as 'CIT officers.' Watson et al. (2011) explain that, "[w]hile the centerpiece of the [CIT] model is 40 h[ours] of specialized training for a select group of officers that volunteer to become CIT officers, … CIT is more than just training."[195] Indeed, the CIT model is not merely a reorientation for members of law enforcement; rather, it is "an organizational and community intervention that involves changes in a police department procedures as well as collaboration with mental health providers and other community stakeholders."[196] As a "systemic intervention," CIT operates at the "organizational" (within police departments) and at the "community" level.[197]

Training lies at the center of the CIT model, focused on a combination of 'book learning' and 'learning-by-doing.' Consider the following training regimen from Chicago:

> The curriculum incorporates lectures, role-play training, and panels of consumers, family members, and providers. Topics covered include recognizing signs and symptoms of mental illnesses, co-occurring disorders, medications, and legal issues and procedures. A significant portion of the training time is devoted to realistic role-play exercises in which officers practice their de-escalation skills while being videotaped. Role play actors are consumers from a local community mental health center theater group. Actors review video tapes of the role play scenarios with officers and provide feedback.[198]

Research reveals that the CIT model teaches officers how to "… interact with people with mental illness who are in crisis in a way that de-escalates, rather than inflames, a tense situation. This approach fosters a partnership between law enforcement and the community through perceived preparedness, quality of response to the mentally ill, diversion from jail, officer time spent on calls, and community safety."[199]

---

[194] Watson et al., 2011, p. 287.
[195] Ibid.
[196] Watson and Fulambarker, 2012.
[197] Watson et al., 2011, p. 287.
[198] Watson et al., 2011, p. 289.
[199] Normore, Ellis, & Bone, 2015, p. 141.

Although "[t]he body of research on CIT is limited" – likely due to its relatively new installation in a moderate number of departments and the infrequency with which police reforms are laid out 'experimentally' – the empirical results remain "promising."[200] As such, researchers have good reason to regard CIT in a "guardedly positive" manner.[201] For example, a 2016 fact-sheet report from The Justice Center, an arm of The Council of State Governments, highlighted a CIT program in Bend, Oregon as a standout example of "Specialized Law Enforcement Responses" that were "[m]aking a [d]ifference" with federal grant money from the Justice and Mental Health Collaboration Program (JMHCP).[202]

With data compiled from the University of Memphis' CIT Center database (UMCCD), Figure 1 shows the county-by-county proliferation of CIT programs:
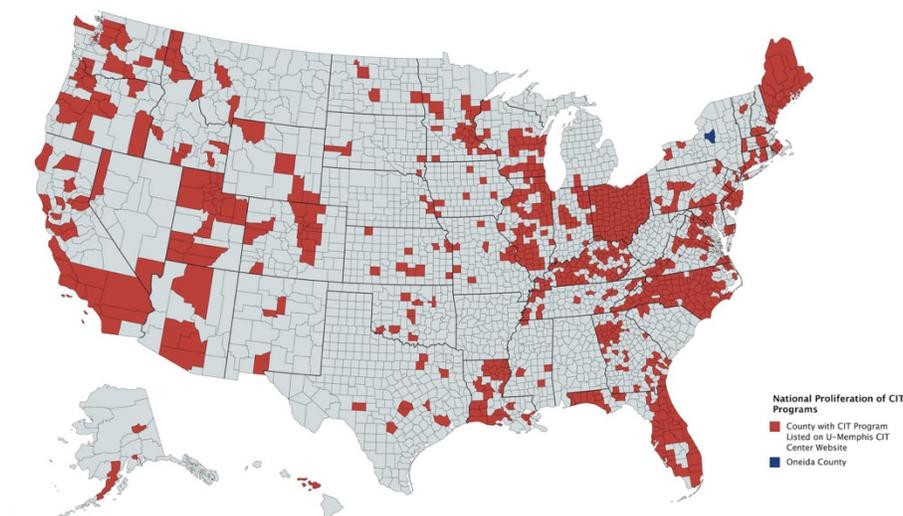
Figure 1: County-by-county Proliferation of CIT Programs[203]

As Figure 1 shows, CIT's proliferation nationally and within states is blotchy but concentrated in some areas, like Maine, North Carolina, and Ohio. While other states, including New York, appear only to have established CIT in a handful of counties, it is important to note that the UMCCD website does not appear to have been updated since mid-summer 2017, so this data may be inaccurate. For example, Utica's

---

[200] Watson and Fulambarker, 2012.
[201] Watson et al., 2011, p. 288.
[202] Justice Center, 2016.
[203] University of Memphis, n.d.

department has engaged with CIT training and established it as part of its policing strategy; yet, according to the U-Memphis data, Oneida County has neither a "regional" nor "local" CIT program.[204]

## To what extent does CIT influence street-level policing?

While the current body of literature on CIT is "limited," it is "growing"[205] and shows empirical support that CIT is an effective program.[206] The following sections display some of the ways the research "suggests that CIT may be positively influencing… outcomes" in policing.[207]

CIT training may influence officer attitudes and abilities. For example, Watson et al. (2011) highlight the CIT-related "improvements in attitudes and knowledge about mental illness" that Compton et al. (2006) found, as well as the increase in "officers' confidence in identifying and responding to persons with mental illness" noted by Wells & Shafer (2006).[208] These attitudes and abilities may, in turn, influence how police respond to psychiatric service calls.[209] Teller, Munetz, Gil, and Ritter (2006) found that CIT increases the number of mental health-related calls that officers are able to identify. Strauss et al. (2005) describe the effectiveness of CIT programs in helping officers to identify psychiatric emergencies as they take place. Further, CIT may increase the likelihood that officers resolve mental health crises.

Research further suggests that CIT appears to increase the utilization of mental health services. Teller, Munetz, Gil, and Ritter (2006) found that CIT increases referrals by police to hospitals for psychiatric services. Dupont and Cochran (2000) found that initial reports also supported this.[210] Broner, Lattimore, Cowell, and Schlenger (2004) found that CIT increased mental health service utilization by persons with mental illness within a 12-month period.

A major concern with diversion programs like CIT is arrest rates and public safety, as well as how the two interact. The results in the literature regarding arrest rates are mixed. Some studies indicate that CIT reduces arrest rates. Watson et al. (2011, 288) describe the "initial reports from Memphis," CIT's

---

[204] Ibid.
[205] Watson et al., 2011, p. 287; see also Compton, Bahora, Watson, & Oliva, 2008.
[206] Dupont & Cochran, 2000.
[207] Watson et al., 2011, p. 287.
[208] P. 288.
[209] See, e.g., Watson, Ottati, Draine, & Morabito, 2011.
[210] Watson et al., 2011, p. 288.

birthplace, as indicating that arrest rates decreased overall with the addition of the CIT program.[211] Furthermore, Steadman, Dean, Borum, and Morrissey (2000) found that CIT decreased the arrest rates of people with severe mental illness, in particular. Yet, Watson, Ottati, Draine, and Morabito (2011) found that CIT did not change arrest rates in Chicago, though the study's primary focus was not on arrest rates.

Regarding public safety, the general trend is one of "mixed findings."[212] Generally, law enforcement officers report that a Memphis-style CIT model is "effective in maintaining safety (94.4% [agreement])."[213] When examining public safety through the lens of SWAT team callouts, Dupont and Cochran (2000) found that Memphis-style CIT decreased the use of "high intensity police units," i.e. SWAT teams. Yet, Compton, Demir, Oliva, and Boyce (2009) did not replicate this connection.

Examining public safety as a function of use-of-force produces similarly mixed results. Morabito, Kerr, Watson, et al. (2010) found that CIT officers use less force than their non- CIT colleagues, even as "subject resistance increased," suggesting that the training and style of CIT policing is effective in de-escalating tense situations. This finding was not replicated in another study by the same research team,[214] as they were unable to find a CIT-related effect on injuries. Yet, at least qualitatively, there appears some evidence that using CIT skills "reduces the risk of injury to officers and persons with mental illness."[215]

For CIT to be efficacious, however, the environment must be just right. "The effectiveness of CIT cannot be fully understood unless considered in context," Watson et al. (2011) note.[216] Specifically, "the availability of mental health services is key."[217] As Watson et al. (2011) found in their study of four Chicago precincts, CIT does not operate in a vacuum: the availability of mental health resources in a community and the proliferation of CIT training within a department play a role in mitigating or accentuating the potential impacts of a CIT-style program.

---

[211] Dupont & Cochran, 2000.
[212] Watson et al., 2011, p. 288.
[213] Tucker, Van Hasselt, & Russell, 2008, p. 240, citing Borum et al., 1988.
[214] Kerr, Morabito, & Watson, 2010.
[215] Hanafi, Bahora, Demir, & Compton, 2008.
[216] P. 292.
[217] Watson et al., 2011, p. 292.

The importance of access to mental health resources is neither new nor unexpected. Indeed, the CIT literature is rife with "extensive evidence dating back several decades that police officers find accessing crisis and emergency psychiatric treatment for persons with mental illness extremely frustrating and time consuming (Bittner, 1967; Green, 1997; Teplin & Pruett, 1992) and that they are dissatisfied with the available options (Wells & Shafer, 2006)."[218] Even if officers are aware of available services, and even when they can and do make use of them, problems still arise.[219] Compton et al. (2010) present a thorough run-down of "system- and policy-level challenges to full implementation" of a CIT-style program. Despite these limitations, however, CIT is a promising and exciting new model of policing. Most importantly, CIT is regarded as a "'best practice' in law enforcement."[220]

## The Co-Response Model: Jail Diversion Program

Another model is the Jail Diversion Program (JDP), which relies on mental health professionals to co-respond – literally in the same squad car as a police officer – to psychiatric crisis calls. These types of programs re-envision policing as involving more than just police officers.[221] JDP programs recognize that "police officers neither have sufficient clinical training to identify and manage" psychiatric emergency situations, "nor sufficient resources to adequately support people to address their complex problems. As a result, these citizens often require repeated attention from police, and never receive effective treatment to resolve their underlying problems."[222]

This traps people with mental illness in a 'revolving door,' condemning them to cycle in and out of the system without improvement, 'burning bridges' along the way as they become 'frequent fliers' – terms that appeared often during interviews for this report. Co-response models seek to disrupt this cycle by providing higher quality intervention during street-level interactions. To that end, the medical

---

[218] Watson et al., 2011, 288, internal citations included.
[219] See, e.g., Stuart, 2016.
[220] Watson & Fulambarker, 2012, as quoted in Normore, Ellis, & Bone, 2015, p. 141.
[221] See, e.g., Baham, 2018.
[222] Watertown Police Department, n.d.

professional on a co-response beat wears a number of hats: "legal diagnostic, enhanced credibility, treatment, teaching, consulting, and medical."[223]

The last few decades of research have demonstrated promising results for co-response models, showing that JDP-style initiatives "can reduce the amount of jail time that persons with mental illness serve."[224] A very recent study of Canadian co-response systems showed that co-responding teams (police officers and mental health nurses) outperformed police-only teams on a number of fronts.[225] Lamanna et al. (2018) found that, compared to police-only teams, co-response teams "had higher overall rates of escorts to hospital, but lower rates of involuntary escorts," suggesting that the increase in voluntary escorts was connected with the addition of a mental health clinician and their specialized knowledge and de-escalation skills.[226] This inference is supported by the qualitative portion of the study, in which patients reported that they "valued responders with mental health knowledge and verbal de-escalation skills, as well as a compassionate, empowering, and non-criminalizing approach."[227]

This style of program has been particularly successful and widespread in states like Massachusetts. There, Advocates JDP is "the only co-responder jail diversion model" in the state, pairing "police officers with masters-level clinicians who ride alongside officers on all calls involving individuals in a mental health or substance-related crisis. They provide much needed de-escalation, crisis stabilization, assessment/evaluation services and on-the-job training."[228] A crucial function of JDP programs like this is their focus on facilitating "dual diversions – both from arrest and from emergency departments," providing two sources of cost-savings.

The Advocates JDP model produces a number of primary benefits. First, its dual diversion (from arrest and emergency departments) allows trained clinicians to "facilitate arrest diversions and reduce costly and unnecessary referrals to hospital emergency departments."[229] The co-response model also

---

[223] Rosenbaum, 2010, p. 178.
[224] Sirotich, 2009.
[225] Lamanna, Shapiro, Kirst, Matheson, Nakhost, & Stergiopoulos, 2018.
[226] P. 891.
[227] Ibid.
[228] Advocates, 2018. Advocates provides a 'JDP toolkit' that can be accessed on its website.
[229] Ibid.

crucially allows for "individuals who are not able to be diverted from arrest" to "also receive support, resources, and referrals while in police custody."[230] This model has been "successfully replicated" across Massachusetts "in Marlborough (2008), Watertown (2011), and offered on a regional basis in Ashland, Sherborn, Holliston, and Hopkinton (2015)."[231] The Watertown (MA) Police Department, for example, has found its JDP program to be "extremely helpful in reducing repeated calls for service, and has provided a valuable resource to conduct follow-up visits with persons with mental illness."[232]

JDP programs also bring a number of other benefits to localities that use them. For example, Sarah Abbott – who founded the Massachusetts-based Advocates group and pioneered the Bay State's JDP revolution – found that officers in JDP departments tend to "report greater tolerance and acceptance of mentally ill persons living in their communities and more strongly endorse their role in managing persons with mental illness than their counterparts in non-Jail Diversion Program departments."[233] And Massachusetts' Secretary of Health and Human Services (HHS), Marylou Sudders, argues that CIT is "essential in reversing [the] pattern" of "individuals experiencing a behavioral health crisis" and then "find[ing] themselves in jail rather than treatment" – a revolving door that is difficult to escape without intervention.[234]

In her role as HHS Secretary, Sudders has found that the Bay State's adoption of JDPs "has expanded the tools law enforcement and community partners can use when approaching individuals in a crisis state, and more importantly has opened the lines of communication between mental health providers and local police departments."[235] Massachusetts' Department of Mental Health Commissioner, Joan Mikula, describes the state's JDPs as "vital to ensuring that our law enforcement personnel are properly trained when called to an active situation with an individual experiencing an acute behavioral health crisis."[236] To that end, Massachusetts has found that its JDPs "potentially reduce physical harm, for both

---

[230] Ibid.
[231] Ibid.
[232] Watertown Police Department, n.d.
[233] Abbott, 2011.
[234] Newman, 2016.
[235] Ibid.
[236] Ibid.

parties involved, promote an increased awareness of mental health conditions, and strengthen our relationships between treatment providers and public safety officers."[237] In short, JDP co-response programs appear to provide a number of benefits to police departments, mental health systems, and, most importantly, justice-involved people with severe mental illness.

## Conclusion

CIT is regarded as a "'best practice' in law enforcement."[238] Indeed, the CIT model "is internationally recognized as one of the leading police-based models to help individuals with mental illness that come into police contact."[239] Moreover, the advent of JDP programs in general and CIT-JDP hybrid programs, in particular, represents a nationally recognized trend in police reform.[240] Using the two programs in tandem can provide holistic, synergistic benefits. These hybrids "are based on the idea that the more the police and mental health workers collaborate, the better the two systems can serve consumers and each other effectively."[241]

Perspectives from states that use hybrid models are optimistic and instructive. In Massachusetts, co-response programs like JDP have "been a popular request of grant applications and [have] even been adapted to use as a shared resource among several contiguous towns and regions."[242] Newman (2016) argues that "CIT and JDP programs are designed to provide immediate and effective intervention options for first responders with the aim of preventing the incarceration of those with mental health challenges." Given that, it's no wonder that many state-level grant applicant departments in Massachusetts have increasingly requested funding for both CIT and JDP programs over the last decade.[243]

---

[237] Commonwealth of Massachusetts, Executive Office of Health and Human Services 2016.
[238] Watson & Fulambarker, 2012, as quoted in Normore, Ellis, & Bone, 2015, p. 141.
[239] Massachusetts Department of Mental Health, 2017.
[240] Advocates, 2015.
[241] Rosenbaum, 2010, p. 176; see also Zealberg, Santos, & Puckett, 1996.
[242] Massachusetts Department of Mental Health, 2017.
[243] Ibid.

# Case Study of Oneida County

## Methodology

The purpose of this report is to provide a first-of-its-kind, holistic review of how Oneida County's criminal justice system treats people with mental illness at every step of the process. This portion of the report focuses specifically on law enforcement but touches on greater problems in the overall construction of the criminal justice and mental health systems. After inductively determining areas of best practices in the U.S. and abroad, this report provides an evaluation of Oneida County's current policies and practices: How does Oneida County perform compared to the established best practices?

Data sources include interviews with important stakeholders in the local criminal justice system (i.e. police departments, the public defender's office, mental health advocacy and treatment groups); review of government statistics if available; state and local government websites; and any relevant extant scholarly research on the local governments. The stakeholder interviews consisted primarily of open-ended questions, the answers to which guided further questioning. The questions targeted: police attitudes toward people with mental illness; department protocol for responding to 9-1-1 psychological crisis calls; departments' response models; and amenability to exploring CIT and/or similar reforms. To that end, the following interviews were conducted with stakeholders in the Oneida County and Monroe County criminal justice and mental health systems:

Criminal Justice System
- ∑ Tina Hartwell, Esq. Criminal Law Director, Regional Immigration Assistance Center Region 2. (Previously: Public Defender assigned to 'specialty courts,' i.e. Drug Court, Mental Health Court)
- ∑ Jaclyn Whitfield, CASAC. Forensic Evaluation Specialist, Criminal Division, Oneida County Public Defender
- ∑ Hon. Ralph Eannace. Judge, Utica City Court and Utica City Mental Health Court
- ∑ Adele Galignese. Director, Forensic Programs at CNY Services
- ∑ Amanda Santamaria. Utica City Mental Health Court Coordinator, CNY Services; also Senior Forensic Counsellor, Forensic Evaluation Unit
- ∑ Hon. Jack Elliott. Judge, Monroe County (Rochester, NY) Mental Health Court

County Jail and Corrections
- ∑ Robert Maciol. Sheriff, Office of the Sheriff, Oneida County
- ∑ Robert Swenszkowski. Undersheriff, Office of the Sheriff, Oneida County
- ∑ Erica Jalonack. Director of Alcoholism, Substance Abuse, and Co-Occurring Disabilities, Central New York (CNY) Services Inc. – Forensic Mental Health

City-Level Law Enforcement
- ∑ Kevin Beach. Chief, Rome Police Department
- ∑ Kevin Simons. Deputy Chief, Rome Police Department
- ∑ Cheyenne Schoff. Captain, Rome Police Department
- ∑ Mark Liddy. Lieutenant, Rome Police Department
- ∑ Ride-alongs with a number of Rome Police Department (RPD) officers

Mental Health Medical/Treatment System
- ∑ Amy Barrows. Program Director, Mobile Crisis Assessment Team (MCAT), The Neighborhood Center

## What Does Oneida County Do Well?

While conducting research for this report, it became abundantly clear that the Oneida County criminal justice and mental health systems' greatest assets are the dedicated people who work in them. They stretch a dollar further than one imagines it could go. They see the people who come into contact with the justice system – especially those with mental illness – in the full extent of their humanity and in the complexity of their overlapping issues regarding mental health, substance use, cognitive development, trauma, home environment, and other criminogenic factors.

For example, Amanda Santamaria (Utica Mental Health Hub Court [UMHHC] Coordinator for CNY Services and the Senior Forensic Counsellor for Utica's Forensic Evaluation Unit) made sure to highlight the personnel advantages that the Oneida County system enjoys (among the staff that it can afford to have, that is), including "the amount of support" that she gets from other stakeholders. She continued:

> Anyone that I have reached out to and said 'I need help with this,' they jump right on it. They're always willing to help, always to come to the treatment team meetings, from, you know, Joe Schmo at such and such clinic. It's a bottom-up [process] right up to the Commissioner of Mental Health. … So, I mean, everyone from the whole broad spectrum

> is always more than willing to help and I think that having that support like that for the people that are in my health care [programs] is crucial to the success of it.[244]

Indeed, the interviews conducted for this report revealed that across the board, the stakeholders in Oneida County's mental health and criminal justice systems 'get it.' They're familiar with the historical arc of deinstitutionalization and attuned to the continued problems it exacerbates and the future problems it generates. They're aware that the criminal justice system is not the place where people with mental illness should receive treatment or spend time. They know all too well how and why incarceration doesn't help make sick people better. They've seen firsthand how traumatizing the detention-arrest-lockup-prosecution-prison-reintegration rigmarole is for all people, but especially for those with mental illness, who are susceptible to increased levels of trauma and decompensation inside the system given their mental health status.

Moreover, they readily acknowledge that the system is 'broken,' that it traps people with mental illness in a 'revolving door,' and that it requires them to perform jobs that truly belong to other agencies or service providers, or that their agency is understaffed and underfunded to provide in full. This report will reveal the widespread agreement within the criminal justice and mental health systems that something needs to be done in Oneida County. It should be abundantly clear that the issues Oneida County faces at the intersection of law enforcement and mental illness do not arise because the primary stakeholders are uneducated or ignorant of the extant problems. Rather, stakeholders don't have enough time, energy, information, financial and personnel resources, or political capital to bring about systemic change.

There are some structural bright spots in Oneida County: Utica Police Department's (UPD) CIT training, The Neighborhood Center's (TNC) MCAT program, and Judge Eannace's UMHHC. In these areas, Oneida County either aligns with or approaches national best practices. But these few successes will continue to be bright spots on the margin unless they are expanded to increase the efficiency and effectiveness of the criminal justice and mental health systems regarding those with mental illness.

---

[244] A. Santamaria, interview, March 7, 2018.

## Current Issues in Policing and Mental Illness

Almost all stakeholders interviewed for this case study identified the root cause of the status quo as the systematic shift in policy, practice, and general philosophy that followed the deinstitutionalization period. As New York State (and the U.S. more generally) deinstitutionalized, more and more responsibility for people with mental illness fell to law enforcement agencies and the rest of the criminal justice system. The overall impression given by stakeholders in the criminal justice system itself, in law enforcement, corrections, and the mental health care community, was the feeling that the status quo appears at times to be a 'square peg, round hole' situation.

The deinstitutionalization trend hit Oneida County and New York State hard, which stakeholders across the board recognized as a significant issue. Sheriff Maciol, who acknowledges that he has "no mental health background," points to deinstitutionalization as a major source of current problems, noting the decrease in funding and systemic shuttering of mental health facilities that has left many people with mental illness in jail "who shouldn't even be there in the first place."[245]

In the absence of adequate facilities, the importance of "personally curated" one-to-one relationships skyrockets in order to combat structural inefficiencies and resource gaps. For example, when one person calls a facility looking for a bed, it may not be available, but when another person with a 'better relationship' calls, even just minutes later and for the same patient, all of a sudden, a bed appears.[246]

The systemic shift away from inpatient facilities that came with deinstitutionalization has left a tremendous burden on law enforcement officers and criminal justice officials in Oneida County, where the police have become "the catch all, end all, be all" for "society's problems," including (especially) mental illness.[247] Undersheriff Swenszkowski described the County's law enforcement agencies as

---

[245] R. Maciol, interview, February 28, 2018.
[246] T. Hartwell, interview, February 21, 2018.
[247] C. Schoff, interview, April 6, 2018.

"overburdened" by such problems.[248] Mental illness has "become a police issue," despite such 'social service' provisions constituting a "non-traditional" police function.[249]

To that end, police in Oneida County do appear to receive training in the academy and in follow-up sessions on "mental health, PTSD, veterans' issues, etc."[250] But when officers are required to use this training in practice, many feel that they need to adopt a "non-traditional" policing role by offering "social services counseling."[251] This "softer" approach doesn't mesh with the rest of their training or expected roles[252] – especially the "authoritative stance" that police officers are trained to adopt in the academy.[253]

Granted, not all of the ways in which law enforcement intersects with mental illness in Oneida County are avoidable or even undesirable. In the jails, for example, corrections officers receive training on preventing suicide in lockup, both generally and as part of a specialized course that provides "an extra level of training."[254] Guard patrols are designed to "protect inmates and identify those at risk of suicidality."[255] These common-sense, harm-reduction policies do not constitute the over-burdening of law enforcement with mental health issues, per se, but they can become over-burdensome when the system receives an inordinate influx of people with severe mental illness. This dichotomy between (a) functions that law enforcement should be divested of, and (b) functions that law enforcement should retain but hopefully need to perform less frequently, is important to keep in mind.

From cops to corrections officers to courts, the structure and philosophy of the criminal justice system appears incongruous with the structure and philosophy of the mental health care system. Across the board, stakeholders (especially those in law enforcement) conveyed the sense that the criminal justice system simply isn't equipped, in theory or in practice, to serve as the primary vehicle for delivering mental health care and promoting the wellbeing of people with mental illness. Simply put, the current

---

[248] R. Swenszkowski, interview, February 28, 2018.
[249] C. Schoff, interview, April 6, 2018.
[250] A. Barrows, interview, April 6, 2018.
[251] A. Barrows, interview, April 6, 2018.
[252] C. Schoff, interview, April 6, 2018.
[253] A. Barrows, interview, April 6, 2018.
[254] R. Maciol, interview, February 28, 2018.
[255] R. Maciol, interview, February 28, 2018.

system asks people to do jobs that do not align with their background, skill set, or original mission and function. When dealing with people with mental illness and/or drug addiction, police officers continuously expressed that they feel like fish out of water, like "social workers" relegated to doing a job that would best be done by someone else – someone with a different educational background, skill set, and priorities.

Some stakeholders did, however, highlight areas of symbiotic overlap and cooperation between the mental health care and criminal justice systems. Though imperfect, the different skill sets and approaches that law enforcement officers and MCAT's Crisis Counsellors and Case Managers bring to the table can complement one another. At its best, this system creates a whole that is greater than the sum of its constituent parts by combining each of the two groups' best attributes and insights.

Additionally, the threat of jail time "hanging over a client's head" can provide a much-needed shot-in-the-arm for personal responsibility and accountability.[256] The criminal justice system's consequence-heavy system does encourage or can implicitly coerce clients into staying on the straight-and-narrow. Observational visits to Monroe County's in-session Mental Health Court revealed that the threat or imposition of legal consequences (especially jail time) motivated some clients to take ownership for their actions, stick to their treatment plan, and rededicate themselves to community reintegration.

For others, however, these legal consequences can and often do further ensnare people with mental illness in the criminal justice system. Collateral consequences – foreseen and unforeseeable, intended and unintended – stack on top of one another. Prior convictions preclude employment. Unemployment begets homelessness, which begets drug use or mental health decompensation. And so the cycle continues, until the individual recidivates, overdoses, or gets help. This forms a 'revolving door,' a metaphor that nearly every stakeholder interviewed either brought up themselves or agreed with as an accurate characterization of the status quo. Given this, all stakeholders interviewed viewed the criminal

---

[256] J. Whitfield, interview, February 28, 2018; A. Barrows, interview, April 6, 2018.

justice and mental health systems – at least at their intersection, if not top-to-bottom – as underfunded, understaffed, and institutionally ill-equipped to perform all of the functions delegated to them.

Consider the following representative excerpts from interviews with stakeholders across the Oneida County criminal justice and mental health systems, organized thematically by the problem or issue the testimonials reveal:

Stakeholders expressed that the criminal justice system and the police are ill-equipped to perform the functions left to them in the wake of deinstitutionalization:

∑   "The courts and police and jails are simply not equipped" to deal with people with severe mental illness, especially psychosis.[257]

∑   "I don't think [the criminal justice and mental health system interaction] is good for anybody. … You don't have anybody or any facilities out there to help [people with mental illness] with their basic life skills. … And then next thing you know, they're in the criminal justice system and they're in and out of jail. And what help are they getting when they're locked up in a six-by-eight cell?"[258]

∑   "Here in Utica, we used to have a psych center campus, a series of buildings that were mental health hospitals. There used to be at least four. Now there's one. [The] State [is] shutting them all down. What happens to the people? [What] if they don't have family? They stop taking their meds. They cut ties with families. Now they're on the street, and in jail."[259]

∑   "[We need] more mental health services in this county. There [are] not enough [resources available] to help these people. I don't [know] if the community and other people realize just how many mentally ill people need services [in Oneida County] and [how long] the waitlist [is] to get someone in the clinic or to get someone in an inpatient program. It's ridiculous. We need more services in this county."[260]

∑   "We need to be able to get people in [to treatment] quicker. Even once they get in the clinic, sometimes they're waiting three to four weeks to see a psychiatrist for medication. It's frustrating. There is such a need in this county and there's just not enough to help [the patients]."[261]

∑    "It's unfortunate because a lot of these people do not belong in jail. … And that's where they end up and it's through no fault of their own. … It makes it tough because it's not always a criminal justice problem. … But the problem that we have is this: Now, what do you do with them?"[262]

---

[257] T. Hartwell, interview, February 21, 2018.
[258] K. Beach, interview, March 12, 2018.
[259] T. Hartwell, interview, February 21, 2018.
[260] A. Santamaria, interview, March 7, 2018.
[261] A. Galignese, interview, March 7, 2018.
[262] K. Beach, interview, March 12, 2018.

The cyclical nature of the issues in the criminal justice and mental health systems was also a common theme during the stakeholder interviews:

∑ "It's a revolving door, almost."[263]

∑ "And it's just – everybody just keeps passing the buck instead of actually helping the problem at the root. And it's really – it's a tragedy at times to see some of these people that you know, if they just had a little help… that they could have a decent life. But, again, we end up locking them up time after time. … It's, like you said, a revolving door."[264]

Stakeholders constantly lamented the lack of adequate funding and staffing of mental health services that all practitioners would agree is reasonable and necessary:

∑ "First of all, there is no money. [It] needs to start with state funding. [We] need psych hospitals. It can't just be outpatient. They (the patients) need structure. They could thrive in institutionalized settings," but there just aren't enough beds and resources available for all the people who need them.[265]

∑ "We just need another person for the forensic evaluation unit and then that would free up a little bit more of [Ms. Santamaria's] time as the [Utica] Mental Health Court is growing. It's just… it's a lot."[266]

∑ "As far as community services and things like that [go], yeah, we need more help. We need more of them with staff."[267]

All of these structural issues are colored by public misperceptions and fears of mental illness:

∑ "People forget that we're dealing with humans. We're dealing with people."[268]

∑ There's a "[m]isperception among [the] public regarding mental illness, as well. When you say that [someone has a mental illness], people could think about a person that goes and shoots up a high school. ... But that's [just a] small fraction [of people with mental illness who commit those types of violent crimes]. Media feeds into [the public's] fear. [There's a] [h]uge stigma."[269]

∑ "There's a stigma on the public safety aspect."[270]

∑ "[The public seems to think that] mental illness is given to them or catch-able like a disease. It's not. It's an illness."[271]

---

[263] K. Beach, interview, March 12, 2018.
[264] K. Beach, interview, March 12, 2018.
[265] T. Hartwell, interview, February 21, 2018.
[266] A. Galignese, interview, March 7, 2018.
[267] A. Santamaria, interview, March 7, 2018.
[268] T. Hartwell, interview, February 21, 2018.
[269] T. Hartwell, interview, February 21, 2018.
[270] A. Galignese, interview, March 7, 2018.
[271] T. Hartwell, interview, February 21, 2018.

These excerpts from interviews with stakeholders provide a snapshot of the issues that the Oneida County criminal justice and mental health systems face. Structural inefficiencies, institutional deficits, and inadequate funding and staffing (among other factors) all present major problems for the County and should be the primary focus of reform.

# Evaluating Law Enforcement and Mental Illness in Oneida County

## Training

Unlike in some jurisdictions, police in Oneida County do receive training in the academy and in follow-up sessions thereafter. In the RPD, for example, training on mental health is "offered at the highest level ever now."[272] The extent of this formal training during and after the academy, however, depends on the extent to which police department culture encourages adherence to it. There is a widely perceived schism between the methods of 'book smart' policing and of 'street smart' policing. This dynamic came up explicitly during an interview with the RPD's Chief of Police: "I tell them, when they leave the academy, I say: 'Okay, that's great. You did 26 weeks there and I want you to forget everything they told you. And now you're going to see how everything really works.'"[273]

The social science literature paints a vivid picture of the ways in which police officers are socialized within departments to value efficiency and results over following the strict 'letter of the law.' Van Maanen (1973) discusses police socialization as part of a four-step model. First, officers are 'pre-socialized' before they even enter the department; media and other cultural factors play a role in this. Second, cadets receive by-the-book training in the academy; at this point, "an esprit de corps emerges among the recruits."[274] Third, the newly-minted police officers face the day-to-day grind of their position and turn to senior coworkers for guidance, picking up deeply entrenched social norms in the process.

---

[272] C. Schoff, interview, April 6, 2018.
[273] K. Beach, interview, March 12, 2018.
[274] Van Maanen, 1973, p. 749.

Finally, the officers enter the metamorphosis stage and begin to compromise the extent to which they follow formal rules or expectations in order to achieve their well-intentioned ends of promoting public safety, apprehending criminals, and 'getting results.'[275] Similarly, Fekjær et al. (2014) tracked the social "reorientation" of Swedish cadets' attitudes during and after their time in the academy. Within 15 months of working in a police department after leaving the academy, recruits displayed an 8.8 higher approval (out of 100 points) for increased autonomous, non-legalist attitudes.[276] These studies suggest that while training is important, the formal training that police officers receive is often eroded over time by extant subcultural norms within departments.

The degree to which law enforcement officers in Oneida County receive specialized training in the CIT model varies city-by-city. For example, the UPD uses an official CIT model: it sends a Department trainer to 'train-the-trainer' meetings in Albany, who then returns and provides CIT training to a special subset of UPD officers. Therefore, the UPD can and does send specially-trained, seasoned officers to mental health crisis calls. The RPD, however, does not use the CIT model. Absent that program, the RPD cannot rely on the clear delineation between CIT and non-CIT officers that the program creates. Instead, Ms. Barrows says, the RPD has "a guy."[277] This creates asymmetrical preparedness between the police departments of Rome and Utica, Oneida County's two largest cities, and adds variables to effective cooperation between MCAT Crisis Counsellors and Crisis Case Managers. When I discussed this with Amy Barrows – Program Director at The Neighborhood Center's Mobile Crisis Assessment Team (MCAT) – she lamented the asymmetry between the County's two largest police departments.

How, then, does the RPD decide which officers to send to mental health crisis calls? According to Ms. Barrows, the RPD sends its "go-to guys" – officers who have received non-CIT training in mental illness issues and have, over time, distinguished themselves as being among the most qualified and

---

[275] Van Maanen, 1973.
[276] Fekjær et al., 2014, p. 752-3.
[277] A. Barrows, interview, April 6, 2018.

capable in those situations by virtue of their experience and personality. The outcome is that, depending on where a crisis occurs, when the MCAT arrives on scene, they will not necessarily be dealing with officers trained under the same paradigm and with the same protocols, skills, or 'language' to handle these types of crises.

Conversations during ride-alongs with RPD officers and the MCAT interview with Ms. Barrows revealed that officers in Oneida County do not feel prepared to handle severe cases of mental illness. Specifically, Oneida County law enforcement officers have "the least training in psychosis."[278] Even within departments with CIT training (like Utica), there is still room for improvement.

NY Mental Hygiene Law, § 9.41

Another noteworthy law enforcement tool that intersects with mental illness (by design) is NY Mental Hygiene Law, § 9.41, colloquially referred to as "941-ing" someone. § 9.41 allows police officers to put someone in custody for the purpose of bringing them to a health center or hospital for evaluation or treatment if they're showing signs of mental illness that are 'apparent' to the officer and pose a threat to themselves or others.[279] The law is "geared for someone who is suicidal or homicidal."[280]

§ 9.41's purview and philosophy aligns with Goldstein's (2015) problem-oriented policing mandate to "more discriminate[ly] use… the criminal justice system."[281] To that end, relying on § 9.41 taps into the strategy that Goldstein dubs "Intervention without Making an Arrest."[282] Problem-oriented policing tools like § 9.41 do not "preclude [the criminal justice system's] use," even "[d]espite the heavy emphasis" they place "on developing alternatives to the criminal justice system."[283] Although the post-deinstitutionalization movement does champion alternatives to the criminal justice system, it need not – and does not – require that we completely remove it as far as mental illness is concerned.

---

[278] A. Barrows, interview, April 6, 2018.
[279] C. Schoff, interview, April 6, 2018.
[280] R. Swenszkowski, interview, February 28, 2018.
[281] Goldstein, 2015, p. 131.
[282] Goldstein, 2015, p. 135.
[283] Goldstein, 2015, p. 131.

The § 9.41 paradigm, however, has a number of limitations. First and foremost, some stakeholders – including the Oneida County Sheriff – feel that if § 9.41 is used as the primary gatekeeping mechanism for the mental health and criminal justice systems, that would amount to a solution that is "too law enforcement-dependent" to address the extant problem "at its root."[284] Embedded in this issue are thorny questions like: Who should respond to psychological crisis service calls? What options should they have when they get there?

Second, law enforcement officers in ride-alongs and other conversations expressed frustration at the prospect of someone seeming highly "941-able" but not meeting every requirement by the letter of the law. In these cases, an individual 'probably should be' 941-ed but, in the absence of legal justification for compelling the person to get treatment and evaluation, the officer has little recourse. This presents an opportunity to use better de-escalators and informers like mental health professionals who have clinical experience and education to encourage people who cannot be compelled, per § 9.41, to go to the hospital.

Third, § 9.41 raises issues of police discretion. New York State case law does not require officers to take all § 9.41-eligible individuals into custody under § 9.41; they can instead arrest them traditionally for criminal activity: "The police were not required to take defendant into custody pursuant to Mental Hygiene Law § 9.41, and their failure to do so does not require dismissal of the indictment. The officers had reasonable cause to believe that defendant had committed a crime, thus permitting them to arrest him."[285] Indeed, even if officers notice that an individual "seem[s] suicidal or mentally unstable" – including the fact that the defendant in McCottery "once pointed a [shot]gun underneath his chin and [made] numerous comments indicating that he intended to take his own life" – § 9.41 only provides that "police 'may take into custody any person who appears to be mentally ill and is conducting himself in a manner which is likely to result in serious harm to the person or others.'"[286] The police discretion at issue in § 9.41 cases arises from the fact that § 9.41, as a matter of law, "is permissive, not mandatory; there is

---

[284] R. Swenszkowski, interview, February 28, 2018.
[285] People v. McCottery, 90 AD3d 1323 (2011), p. 1-2.
[286] People v. McCottery, p. 2.

no requirement that police detain someone for mental health reasons, especially when they are aware that the person has committed a crime."[287]

## Mobile Crisis Assessment Team (MCAT)

Oneida County also stands out for its Mobile Crisis Assessment Team (MCAT). MCAT handles a "broad range" of calls, from so-called "warm calls" (low-level) to immediate psychological crises and suicidal situations.[288] Calls can also come in from patients themselves, family members, and community members like teachers, police officers, landlords, etc. The Neighborhood Center (TNC), which runs MCAT, has two primary functions: Active Engagement (AE) and Active Rescue (AR). TNC, of course, prefers to focus on AE, citing the larger impact of "acting when it's still the small-c crisis, not the big-C Crisis, when it's still early."[289] AR occurs when TNC sends MCAT to respond to a service call.

From a law enforcement perspective, MCAT's "purpose is good": if people aren't compelled into treatment under § 9.41, MCAT can step in, perhaps convincing the patient or their family to voluntarily get treatment.[290] Furthermore, the presence of MCAT personnel on-scene may help an officer learn more information that would then provide legal justification for invoking § 9.41.

The upshot of the MCAT setup is that its staff members are highly trained, requiring a Masters-level minimum for many positions, with team members ranging from Licensed Clinical Social Workers (LCSWs), those with a Masters in Social Work (MSW), and Licensed Masters Addiction Counselors (LMACs) to Certified Clinical Mental Health Counselors (CCMHCs) and Registered Nurses (RNs). Their educational background and clinical experience fits perfectly with the goal of de-escalating law enforcement encounters with civilians, focusing on treatment and rehabilitation, and steering patients toward the mental health system, rather than the criminal justice system.

A major concern with the MCAT model, shared by both law enforcement and MCAT staff, is the time response. Law enforcement officers cited MCAT response times as the 'number one' issue with the

---

[287] People v. McCottery, p. 2.
[288] A. Barrows, interview, April 6, 2018.
[289] A. Barrows, interview, April 6, 2018.
[290] C. Schoff, interview, April 6, 2018.

system. Within Utica and Rome, MCAT's "goal" is to respond within 30 minutes; within the rest of the county, that "goal" jumps to 60 minutes.[291] MCAT was unable to provide response data in time for the completion of this report but purports to have it available on-hand. An important figure to assess would be the time difference between law enforcement and MCAT arrival on-scene when both are called to a situation. Co-response models would cut that time difference down to zero.

## Proposed Reforms and Changes

### 1. Who Responds? CIT/JDP Hybrid Model

Undersheriff Swenszkowski underscored that the "key to intervention" is to focus on street-level interactions – when a call to the police is made (or not made) – especially with a victimless or nonviolent crime.[292] The cop/citizen interface is the point at which the most important gatekeeping functions occur.[293] This becomes all the more important when considering that law enforcement's arrival on scene at a psychiatric emergency presents an a priori increase in the danger quotient for the person in crisis.

As the Oneida County Sheriff's Office made clear, the wellbeing and even survival of the patient or 'suspect' – in this case, the person in crisis – is at the very bottom of law enforcement's priorities. Pursuant to the "priority of life schema," law enforcement officers are not trained to value suspects' lives above all else; they protect the public and themselves first and foremost (but in that order), thereby endangering people in psychological crisis who are at an increased risk of acting out or failing to comply with an officer's order.[294] So, Oneida County should focus on maximizing non-law enforcement participation in, and attendance at, psychological crisis service calls, while also empowering police officers to make informed, compassionate decisions on the street. This can best be achieved by combining the CIT and JDP programs to form a hybrid co-response model.

---

[291] A. Barrows, interview, April 6, 2018.
[292] R. Swenszkowski, interview, February 28, 2018.
[293] R. Swenszkowski, interview, February 28, 2018.
[294] R. Maciol and R. Swenszkowski, interview, February 28, 2018.

To that end, non-CIT departments in Oneida County (especially the RPD) should become CIT-certified, designating a department 'trainer' who attends 'train the trainer' meetings and then trains the department staff. The CIT model should be especially appealing to the RPD, particularly given its structural commitment to community-oriented policing, as "[P]olice-led diversion programmes [like CIT] represent a promising opportunity to help further the goals of COP [Community-oriented Policing] by strengthening links between neighbourhood officers, community members, and local social service or community providers."[295]

The JDP method should also be palatable to law enforcement officers, if presented as a recognition and alleviation of the undue burden placed on them by the responsibility to act as primary mental health gatekeepers. On the handful of occasions that I was able to broach the possibility of instituting a JDP-style co-response model in Oneida County, law enforcement officers seemed receptive and interested, albeit somewhat skeptical of the fiscal practicality. Given the clear concerns with response time in the current MCAT system, a co-response model would significantly increase the accessibility of a mental health care professional on-scene, likely improving outcomes for people with mental illness who would otherwise have only interacted with the police officer. Co-response models strike an appropriate balance between specialization and delegation of responsibilities and the maintenance of social control and public safety.

Regarding fiscal practicality, some may argue that this is not a cost-effective or 'needed' program, given the volume (or lack thereof) of psychological crisis service calls. But when asked specifically about the need for such a program in Oneida County (which has no co-response model to date), compared to Monroe County (which does use a co-response model), some stakeholders suggested that Oneida County is "definitely" a "high mental health call concentration area."[296]

2. Tools For Response: Mobile Technology

---

[295] Tallon, Spadafore, & Labriola, 2016, p. 215; see also Katz & Bonham, 2009.
[296] A. Barrows, interview, April 6, 2018.

Absent a co-responding, ride-along mental health professional, and regardless of whether an officer has received CIT training, additional tools can help bring Oneida County policing into the 21st century and provide another means by which to divert someone with mental illness from further justice-system contact. Specifically, using mobile technology to provide psychiatric services – sometimes referred to as telepsychiatry – allows individuals to connect with service providers in the midst of crisis much more quickly than waiting for an MCAT team to arrive. This could serve as a supplement for calling MCAT service providers, because it allows officers to interact with a person on the street or in their home without having to convince them to make a phone call. Instead, the officer can just hand them an iPad or tablet with the app pre-loaded. This could also help simplify the 941-ing process.

Although some police departments have adopted paper forms with standardized language to mirror the healthcare system,[297] another option includes equipping officers with more novel mobile technology to help make mental health assessments on-scene. One option includes the iPad or tablet-based service "Cloud 9," which has a demonstrated track record of working with "first responders."[298] Cloud 9's "Test" feature, which lets patients "take digital, gamified mental health assessments conveniently on their mobile device to learn their actual diagnosis and become more self-aware,"[299] could be particularly useful, helping patients who would otherwise not trigger for § 941's compulsory mechanisms to decide on their own to get treatment after being empowered with information.

3. Comprehensive Psychiatric Emergency Program (CPEP) Hospitals

After law enforcement (and mental health co-responders) arrives and detains an individual for treatment pursuant to § 9.41, or after an individual has taken a telepsychiatry screening and been convinced to voluntarily receive treatment, what happens next? Where do we take them for quality care without turning hospitals into 'dumping grounds' for such patients? On this front, Oneida County lags

---

[297] See, e.g., Hoffman et al., 2016.
[298] Cloud 9, n.d.
[299] Cloud 9, n.d.

behind neighboring counties in New York State, given that it lacks a top-rate, state-accredited emergency psychiatric hospital setup: the Comprehensive Psychiatric Emergency Program, or CPEP.

The New York State Office of Mental Health (NYS-OMH) website recommends three options for individuals requiring "emergency assistance" during a mental health crisis: "Call 911," "Go to a Comprehensive Psychiatric Emergency Program (CPEP)" (hyperlink to CPEP search database), and "Go to the emergency room at your local hospital" (no hyperlinks or searchable databases).[300] Oneida County should join neighbors like Onondaga County in acquiring an NYS-OMH-accredited CPEP program in a centrally located hospital within the county.

## 4. Collaboration

Oneida County is not alone in reform efforts. Nearby Monroe County provides a resource for collaboration with preexisting relationships between critical stakeholders (e.g. the judges who run Utica and Rochester's Mental Health Courts). Specifically, Kimberly Butler, MS, LCSW, who serves as the Chief of Forensic Services at the Monroe County OMH, should be a prime choice for collaboration. Ms. Butler supervises the CIT model in Rochester and has trained with Memphis, New Orleans, and Seattle on CIT/JDP-style programs. Her experience with national best-practice-implementers (like Memphis, which created CIT) would prove invaluable for Oneida County's collaboration efforts. In addition, Onondaga County provides an even closer partner in acquiring a CPEP-certified hospital facility.

## 5. Funding

One notable source of funding that Oneida County should explore comes from the Safety and Justice Challenge (SJC). SJC is a MacArthur Foundation-funded, ""$100[+] million national initiative to reduce over-incarceration by changing the way America thinks about and uses jails."[301] Using SJC funds, in just a few short years, localities from Philadelphia to Oregon have "already seen significant declines in

---

[300] NYS-OMH, n.d.
[301] SJC, 2017.

their average daily jail populations."[302] The SJC's "locally-driven strategies… extend through all aspects of the criminal justice system, from crisis intervention to behavioral health to pretrial release and supervision, and include: pre-arrest and pre-trial diversion strategies; improvements to case processing efficiency; and enhanced services for people with mental illness or substance abuse issues involved with the justice system."[303] Moreover, Director for Justice Reform for the MacArthur Foundation, Laurie Garduque, highlights the resounding local-level success that SJC-funded programs have displayed:

> Leaders from these jurisdictions [that have received SJC funds] are proving that everyone benefits when local justice systems are made to be fairer, to responsibly steward taxpayer dollars, and to safely improve outcomes for families and communities. Given the promise of these efforts, other local leaders should take notice of the solutions being piloted by the cities, counties, and states supported by the Challenge and begin rethinking jails in their own jurisdictions.[304]

Given the past SJC awards, reforms of the type proposed in this chapter in particular, and in this report more generally, are ripe for SJC grant funding. Oneida County should join the movement of 'rethinking jails' for a brighter future.

Other counties have successfully received SJC grants by framing "the overarching goal" of their "work" as aimed at eliminating "unnecessary incarceration," which invokes notions of fiscal responsibility, fairness, and community-mindedness.[305] An infusion from the SJC, even in the amount of a few million dollars, can go a long way toward reforming county-level criminal justice systems. Take, for example, Pima County, Arizona. After receiving a $1.5 million grant from the MacArthur Foundation in Spring 2016, by May 2017, the County had "already seen a 15 percent reduction of the average daily jail population."[306] Pima County earned SJC funding by pitching the "main focus" of its reforms as "targeting people who commit low-level crimes and suffer from mental illness or addiction" – a clear analog to the current hope in Oneida County.[307]

---

[302] SJC, 2017.
[303] SJC, 2017.
[304] SJC, 2017, emphasis added.
[305] SJC, 2017.
[306] Washington, 2017.
[307] Washington, 2017.

Recap of Recommendations

Despite its empirical successes in reducing arrest rates[308] while increasing access to and utilization of treatment[309] as well as public safety,[310] the original CIT-only model still bears the unfortunate signature of the deinstitutionalization movement: framing serious mental illness as a criminal justice problem alone, rather than a public health one – a problem to be handled by (admittedly well-trained) police officers, rather than (definitionally more-qualified) medical and psychiatric professionals. Only by combining the original CIT model with the newer JDP model can meaningful, long-term solutions to the mental health crisis be addressed in Oneida County. This hybrid model puts medical professionals literally in the front seat of an officer's squad car and, in doing so, metaphorically returns them to the driver's seat of the locality's mental illness treatment regime.

The original CIT-only model's focus on training law enforcement officers to be better proxies for medical professionals – rather than re-assigning responsibilities to medical professionals – operates within the old paradigm insofar as it represents a criminal justice-oriented solution. Mental illness is a public health problem; it requires public health solutions. This report does not suggest, however, that Oneida County should wholly exclude law enforcement officers from the array of ways people access mental health treatment. Instead, Oneida County should reevaluate and re-prioritize when and where it uses the particular strengths and skillsets of law enforcement officers and medical professionals alike.

The goal here is symbiotic cooperation. To this point, problem-oriented policing[311] urges law enforcement agencies to look outside of themselves for solutions that address the root cause of long- standing problems. Oneida County needs its "mental health and criminal justice professionals to problem- solve together."[312] The hybrid CIT-JDP program proposed in this report – the likes of which have found success in nearby localities like Rochester, New York and in regional neighbors like the dozens of

---

[308] See, e.g. Dupont & Cochran, 2000; Steadman et al., 2000.
[309] See, e.g. Broner et al., 2004; Teller et al., 2006.
[310] Dupont & Cochran, 2000.
[311] See, e.g., Goldstein, 2015.
[312] Roth, 2017, emphasis added.

Massachusetts police departments that use CIT and JDP in tandem – aims to do just that.[313] Although CIT provides officers with the requisite training to "ask the right questions and then bring in [mental health professionals through the MCAT program]," pairing CIT training with the JDP co-response model cuts out the middle man, so to speak, by putting the clinician on-scene with the officer from the start.[314]

For these reasons, Oneida County should look to emulate successes from places like Rochester and Massachusetts. This requires an expansion of the CIT model to all law enforcement agencies (notably the Rome Police Department) in Oneida County. At the same time, the County should implement the JDP co-response model in a department that has already established itself as CIT-proficient, like the Utica Police Department. This will allow the non-CIT departments to catch up while simultaneously and experimentally assessing how, if at all, the addition of the JDP co-response model influences policing and mental health in Utica. Upon receipt of positive empirical results from the CIT-JDP hybrid study in Utica, Oneida County should roll out the JDP co-response model in the remainder of the County's major police departments, especially in Rome.

This process would encourage departments that have the most room to improve (like Rome) to catch up to those that are already on-board with CIT (like Utica), while simultaneously using Utica's current CIT-style department as a laboratory for the expanded CIT-JDP hybrid model. This rollout plan would inject empiricism and replicability, both historically lacking from police reform nationwide.

## Conclusion

This report has uncovered a number of ways Oneida County falls short of best practices in the field of policing at its intersection with mental illness. All stakeholders interviewed agreed: deinstitutionalization has left a negative mark on Oneida County. In the absence of treatment options and inpatient psychiatric facilities, people with mental illness have been left on the streets at the risk of

---

[313] See, e.g. Newman, 2016.
[314] A. Barrows, interview, April 6, 2018.

mentally decompensating, adopting comorbid substance use issues, becoming the perpetrators or victims of crime, and becoming social pariahs given the levels of stigma associated with severe mental illness.

Law enforcement has been forced to pick up the slack. As such, it is likely that people with mental illness are similarly overrepresented in the Oneida County criminal justice system as they are nationally. Despite the herculean efforts of well-intentioned, dedicated stakeholders, many people with mental illness find themselves trapped in a revolving door, cycling endlessly in the liminal space between the criminal justice and mental health systems. They struggle to stay out of jail, find a place to live, hold down a job, stay clean, and integrate into society. Something is broken in Oneida County. Organizations and institutions – especially law enforcement – are often tasked with responsibilities that, to be done properly and effectively, require training and education beyond what the individuals possess. Oneida County should focus reform on two levels: systemic and law enforcement.

## Systemic Reforms

Oneida County needs to re-conceptualize the problems stemming from mental illness as public health problems requiring public health solutions – not just criminal justice ones. The point, here, is to form a symbiotic relationship between the criminal justice and mental health systems, first and foremost, but to reorient that symbiosis to relieve pressure and responsibilities from the law enforcement side of the equation. Oneida County should also take steps to reverse the structural cause of these issues – to wit, deinstitutionalization – at the national, state, and county levels.

Nationally, Oneida County should identify and apply for federal grant programs to help fund criminal justice reform efforts that help people with mental illness. Aside from government grants, Oneida County should also explore grants from nonprofit organizations like the MacArthur Foundation's Safety and Justice Challenge (SJC), which has already injected millions of dollars into local-level criminal justice reform. The SJC is currently accepting applications for the next round of grants. At the state level, Oneida County should lobby Albany for resources to reopen inpatient psychiatric facilities.

At the county level, Oneida County should prioritize two goals. First, it should work actively with local and county governments to politically prioritize and effectuate the allocation of additional funding for reopening inpatient psychiatric facilities and increasing the efficiency and efficacy of existing institutions and programs. Second, Oneida County should coordinate with neighboring counties – especially Onondaga and Monroe Counties – to explore the possibility of opening the first New York State-approved Comprehensive Psychiatric Emergency Program (CPEP) in Oneida County.

## Law Enforcement-Specific Reforms

Oneida County should take steps in five categories, the first two of which deal with training. First, the County should ensure that law enforcement personnel receive, both during and after their time in the academy, comprehensive and evidence-based training on the following topics, among others: (a) how to identify that someone is in a state of psychological crisis and may be a threat to themselves or others; (b) how to identify signs of acute psychological crisis, including especially psychosis, suicidality, and homicidality; (c) how to de-escalate situations involving mentally ill persons; (d) how to earn compliance from someone in a state of psychological crisis, resorting to use-of-force only when absolutely necessary and only after exhausting all non-use-of-force options while prioritizing non-lethal methods of force; and (e) how to make community members (in states of psychological crisis or not) aware of, and connected to, existing local resources that provide inpatient and outpatient mental health and/or substance use treatment. Second, Oneida County should ensure that all police departments and law enforcement agencies within the County are up to speed and on board with Crisis Intervention Training (CIT).

Third, in the short term, Oneida County should strengthen connections between law enforcement and existing mental health service providers in the community (e.g. MCAT) to make best use of available resources when responding to psychological crisis service calls. Fourth, in the short and medium term, Oneida County should explore the possibility of equipping and training law enforcement officers to use mobile technology (such as Cloud 9's program) as a legitimate psychological crisis intervention strategy.

Fifth, Oneida County should explore the possibility of co-opting the functions of the MCAT program and create a government-run hybrid program that integrates CIT training of officers with a JDP-style psychiatric professional co-response model. The purpose of this proposed reform, the most ambitious of the five, is to ensure that law enforcement responses to psychological crisis 9-1-1 service calls end in the most optimal outcomes for the individuals in crisis.

Whether taken as individual pockets of reform or even in the aggregate, none of these five categories are cure-alls. Long-term change at a systemic level – which stakeholders have made clear, Oneida County does need – requires, among other things, significant financial and political commitment coupled with patience. Reforms like these take time, scientific implementation, and careful monitoring and tracking of data and progress. To maximize Oneida County's ability to make evidence-based decisions, any reforms undertaken should be rolled out experimentally and with a long-enough trial period to allow for the programs to take root.

# References

Abbott, S. (2011, April). Evaluating the impact of a Jail Diversion Program on police officer's attitudes toward the mentally ill (Doctoral dissertation, Northeastern University, 2011) [Abstract]. Retrieved from http://hdl.handle.net/2047/d20000838

AbuDagga, A., Wolfe, S., Carome, M., Phatdouang, A., & Torrey, E. F. (2016, July 14). Individuals with serious mental illness in county jails: A survey of jail staff's perspectives (Rep.). Retrieved February 3, 2018, from Public Citizen and Treatment Advocacy Center website: http://www.treatmentadvocacycenter.org/storage/documents/jail-survey-report-2016.pdf

Advocates. (2018, April 25). Jail Diversion. Retrieved from https://www.advocates.org/services/jail-diversion

Advocates. (2015). Department of Mental Health Pre-arrest law enforcement based Jail Diversion Programs. Retrieved May 01, 2018, from http://www.mass.gov/eohhs/docs/dmh/forensic/jdp-fact-sheet.pdf

Baham, D. (2018, March 29). From "what if" to real results: U.S. police departments explore innovative, collaborative ways to address growing mental health crisis. Retrieved from https://csgjusticecenter.org/mental-health/posts/from-what-if-to-real-results-u-s-police-departments-explore-innovative-collaborative-ways-to-address-growing-mental-health-crisis/

Bittner, E. (1967). The police on skid-row: A study of peacekeeping. American Sociological Review, 32, 699-715.

Bonfine, N., Ritter, C., & Munetz, M. R. (2-14). Police officer perceptions of Crisis Intervention Team (CIT) programs. International Journal of Law and Psychiatry, 37, 341-350.

Borum, R. (2000). Improving high risk encounters between people with mental illness and the police. Journal of the American Academy of Psychiatry and the Law, 28, 332-337.

Bouveng, O., Bengtsson, F. A., & Carlborg, A. (2017). First-year follow-up of the Psychiatric Emergency Response Team (PAM) in Stockholm County, Sweden: A descriptive study. International Journal of Mental Health, 46(2), 65-73. Retrieved February 3, 2018, from https://doi.org/10.1080/00207411.2016.1264040

Broner, N., Lattimore, P. K., Cowell, A. J., Schlenger, W. E. (2004). Effects of diversion on adults with co-occurring mental illness and substance use: Outcomes from a national multi-site study. Behavioral Sciences & the Law, 22(4), 519-541.

Cloud 9. (n.d.). C9 Main Page. Retrieved May 06, 2018, from http://www.cloud9psych.com/

Commonwealth of Massachusetts, Executive Office of Health and Human Services (EOHS). (2016, September 26). Baker-Polito Administration Awards $1.4 Million To Expand Jail Diversion Programs [Press release]. Commonwealth of Massachusetts. Retrieved April 07, 2018, from http://www.mass.gov/eohhs/gov/newsroom/dmh/1-4-million-awarded-to-expand-jail-diversion-programs.html

Compton, M. T., Bahora, M., Watson, A. C., & Oliva, J. R. (2008). A comprehensive review of extant research on Crisis Intervention Team (CIT) programs. The Journal of the American Academy of Psychiatry and the Law, 36(1), 47-55.

Compton, M. T., Broussard, B., Hankerson-Dyson, D., Krishan, S., Stewart, T., Olivia, J. R., & Watson, A. C. (2010). System- and Policy-level challenges to full implementation of the Crisis Intervention Team (CIT) model. Journal of Police Crisis Negotiations, 10(1-2), 72-85.

Compton, M. T., Esterberg, M. L., McGee, R., Kotwicki, R. J., & Oliva, J. R. (2006). Crisis Intervention Team training: Changes in knowledge, attitudes, and stigma related to schizophrenia. Psychiatric Services, 57, 1199-1202.

Compton, M. T., Oliva, J. R., & Boyce, T. (2009). Crisis Intervention Team training and special weapons

And tactics callouts in an urban police department. Psychiatric Services, 60, 831-833.

Dupont, R. T., & Cochran, C. S. (2002). The Memphis CIT model. In G. Landsberg, M. Rock, L. K. Berg, & A. Smiley (Eds.), Serving mentally ill offenders: Challenges & opportunities for mental Health professionals (pp. 59-69). New York, NY: Springer.

Dupont, R. T., & Cochran, C. S. (2000). Police response to mental health emergencies – Barriers to change. Journal of American Academy of Psychiatry and the Law, 28, 338-344.

Ellis, H. A. (2014). Effects of a Crisis Intervention Team (CIT) training program upon police officers Before and after Crisis Intervention Team training. Archives of Psychiatric Nursing, 28, 10-16.

Fater, T. (2017, September 3). Coroner: Fatal shooting shows how handling mental health crises falls to police. Courier & Press. Retrieved February 3, 2018, from https://www.courierpress.com/story/news/local/2017/09/03/coroner-fatal-shooting-shows-how-handling-mental-health-crises-falls-police/625082001/

Fekjær, S. B., Petersson, O., & Thomassen, G. (2014). From legalist to Dirty Harry: Police recruits' Attitudes towards non-legalistic police practice. European Journal of Criminology, 11(6), 745-759.

Fuller, D. A., Lamb, H. R., Biasotti, M., & Snook, J. (2015, December). Overlooked in the undercounted: The role of mental illness in fatal law enforcement encounters (Rep.). Retrieved February 3, 2018, from Treatment Advocacy Center website: http://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf

Garduque, L. (2018, April 06). Data matters in fair and effective American criminal justice system. Retrieved April 07, 2018, from http://thehill.com/opinion/criminal-justice/381965-data-matters-in-fair-and-effective-american-criminal-justice-system

Garland, D. (2001). The culture of control: Crime and social order in contemporary society. Chicago, IL: University of Chicago Press.

Geller, J. L. (2008). Commentary: Is CIT today's lobotomy? The Journal of the American Academy of Psychiatry and the Law, 36(1), 56-58.

Goldstein, H. (2015). Problem-oriented policing (Reprint ed.). McGraw-Hill.

Green, T. (1997). Police as frontline mental health workers: The decision to arrest or refer to mental Health agencies. International Journal of Law and Psychiatry, 20(4), 469-486.

Hanafi, S., Bahora, M., Demir, B. N., & Compton, M. T. (2008). Incorporating Crisis Intervention Team (CIT) Knowledge and Skills into the Daily Work of Police Officers: A Focus Group Study. Community Mental Health Journal, 44(6), 427-432.

Hoffman, R., Hirdes, J., Brown, G. P., Dubin, J. A., & Barbaree, H. (2016). The use of a brief mental Health screener to enhance the ability of police officers to identify persons with serious mental disorders. International Journal of Law and Psychiatry, 47, 28-35.

Jaffe, D. (2011, December 21). Survey: Law Enforcement Overburdened by Failure of Mental Health Departments. Retrieved January 29, 2018, from https://www.huffingtonpost.com/dj-jaffe/police-mental-illness_b_1033848.html

Justice Center. (2016, February). The Mentally Ill Offender Treatment and Crime Reduction Act. Retrieved April 07, 2018, from https://csgjusticecenter.org/wpcontent/uploads/2014/08/MIOTCRA_Fact_Sheet.pdf

Katz, J. & Bonham, G. (2009). Effective alternatives to incarceration: Police collaborations with corrections and communities. Washington, DC: U.S. Department of Justice, Office of Community Oriented Policing Services (COPS).

Kerr, A. N., Morabito, M. S., & Watson, A. C. (2010). Police encounters, mental illness and injury: An exploratory study. Journal of Police Crisis Negotiations, 10(1-2), 116-132.

Kitchen, A. (2017, February). When Pre-Trial Diversion Programs Disappear: The Need to Protect Diverted Defendants' Due Process and Liberty Rights. Criminal Law Bulletin, 53, 1-58. Retrieved from https://ssrn.com/abstract=2922170

Kristoff, N. (2014, February 08). Inside a mental hospital called jail [Editorial]. The New York Times.

Retrieved from https://www.nytimes.com/2014/02/09/opinion/sunday/inside-a-mental-hospital-called-jail.html

LaCommare, P. (2010). Generating new revenue streams. The Police Chief, 77, 22-30. Retrieved from http://www.nxtbook.com/nxtbooks/naylor/CPIM0610/#/22

Lamanna, D., Shapiro, G. K., Kirst, M., Matheson, F. I., Nakhost, A., & Stergiopoulos, V. (2018). Co-responding police-mental health programmes: Service user experiences and outcomes in a large urban centre. International Journal of Mental Health Nursing, 27, 891-900.

Lowery, W., Kindy, K., Alexander, K. L., Tate, J., Jenkins, J., & Rich, S. (2015, June 30). Distraught people, deadly results: Fatal shootings by on-duty police officers. Retrieved January 29, 2018, from https://www.washingtonpost.com/sf/investigative/2015/06/30/distraught-people-deadly-results/?utm_term=.52ee6ef03e7e

Lushbaugh, D. J. (2008). Letter to the editor. The Journal of the American Academy of Psychiatry and the Law, 36(2), 268-269.

Massachusetts Department of Mental Health. (2017, December). Jail/Arrest Diversion Grant Program: FY2018 Mid-year report (Rep.). Retrieved https://www.mass.gov/files/documents/2018/01/19/2018-01-02%20DMH%20JDP%20mid-year%20report-%20FY18.pdf

Mondics, J. (n.d.). Study: One-quarter of people killed by police are mentally ill. Retrieved February 3, 2018, from http://www.treatmentadvocacycenter.org/home-page/71-featured-articles/2846-people-with-mental-illness-four-times-more-likely-to-be-shot-and-killed-by-police

Morabito, M. S., Kerr, A. N., Watson, A. C., Draine, J., & Angell, B. (2010). Crisis intervention teams and people with mental illness: Exploring the factors that influence the use of force. Crime & Delinquency. doi:10.1177/0011128710372456.

Morabito, M. S., Socia, K., Wik, A., & Fisher, W. H. (2017). The nature and extent of police use of force in encounters with people with behavioral health disorders. International Journal of Law and Psychiatry, 50, 31-37.

Moses, J. W., & Knutsen, T. L. (2012). Ways of knowing: Competing methodologies in social and political research (2nd ed.). Houndmills, Basingstoke, Hampshire: Palgrave Macmillan.

New York State Office of Mental Health. (n.d.). Crisis Prevention. Retrieved March 31, 2018, from https://www.omh.ny.gov/omhweb/bootstrap/crisis.html

Newman, A. (2016, September 27). Somerville Police Awarded Grant for Jail Diversion Programs. The Somerville Patch. Retrieved April 07, 2018, from https://patch.com/massachusetts/somerville/somerville-police-awarded-grant-jail-diversion-programs

Ollove, M. (2018, April 25). What care for the criminally insane can teach us about mental health treatment. Retrieved from https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/04/25/what-care-for-the-criminally-insane-can-teach-us-about-mental-health-treatment

People v. McCottery, 90 AD3d 1323 (2011).

Prison Policy Initiative. (n.d.). New York prison and jail population (1978-2015). Retrieved April 07, 2018, from https://www.prisonpolicy.org/graphs/NY_Prison_Jail_Population_1978-2015.html

Prison Policy Initiative. (n.d.). New York profile. Retrieved April 07, 2018, from https://www.prisonpolicy.org/profiles/NY.html

Rosenbaum, N. (2010). Street-level psychiatry – A psychiatrist's role with the Albuquerque Police Department's Crisis Outreach and Support Team. Journal of Police Crisis Negotiations, 10, 175-181.

Roth, C. (2017, June 01). Keeping Mentally Ill Out of Jail and in Treatment: Rochester Model Works in Breakthrough Study. Retrieved April 07, 2018, from

https://www.urmc.rochester.edu/news/story/4785/keeping-mentally-ill-out-of-jail-and-in-treatment--rochester-model-works-in-breakthrough-study.aspx

Safety and Justice Challenge. (2017, October 04). MacArthur's Safety and Justice Challenge Announces Additional $11.3 Million for Eight Jurisdictions to Advance Local Criminal Justice Reform. Retrieved from http://www.safetyandjusticechallenge.org/2017/10/macarthurs-safety-justice-challenge-announces-additional-11-3-million-eight-jurisdictions-advance-local-criminal-justice-reforms/

Safety and Justice Challenge. (n.d.). Join the Conversation: The Overuse of Jails Hurts our Communities. Retrieved April 07, 2018, from http://www.safetyandjusticechallenge.org/

Sirotich, F. (2009). The criminal justice outcomes of Jail Diversion Programs for persons with mental illness: A review of the evidence. Journal of the American Academy of Psychiatry and the Law, 37(4), 461-472.

Southall, A. (2017, August 3). In shooting of mentally ill man, officer followed protocols, police say. New York Times. Retrieved February 3, 2018, from https://www.nytimes.com/2017/08/03/nyregion/police-shooting-of-mentally-ill-man.html

Steadman, H. J., Deane, M.W., Borum, R., & Morrissey, J.P. (2000). Comparing outcomes of major models of police responses to mental health emergencies. Psychiatric Services, 51(5), 645-649.

Strauss, G., Glenn, M., Reddi, P., Afaq, I. Podolskava, A., Rybakova, T., et al. (2005). Psychiatric disposition of patients brought in by crisis intervention team police officers. Community Mental Health Journal, 41, 223-230.

Stuart, F. (2016). Down, out, & under arrest: Policing and everyday life in skid row. Chicago, IL: University of Chicago Press.

Swanson, A. (2015, April 30). A shocking number of mentally ill Americans end up in prison instead of treatment. Retrieved from https://www.washingtonpost.com/news/wonk/wp/2015/04/30/a-shocking-number-of-mentally-ill-americans-end-up-in-prisons-instead-of-psychiatric-hospitals/?noredirect=on&utm_term=.c26835c17032

Tallon, J. A., Spadafore, J. C., & Labriola, M. (2016). Creating off-ramps: Lessons learned from police-Led diversion programmes. Policing, 11(2), 214-228.

Teller, J. L., Munetz, M. R., Gil, K. M., & Ritter, C. (2006). Crisis Intervention Team training for police officers responding to mental disturbance calls. Psychiatric Services, 57(2), 232-237.

Teplin, L., & Pruett, N. (1992). Police as streetcorner psychiatrist: Managing the mentally ill. International Journal of Law and Psychiatry, 15, 139-156.

Torrey, E. F. (2015). Law enforcement and people with severe mental illness. Retrieved from http://mentalillnesspolicy.org/crimjust/law-enforcement-mental-illness.html

Torrey, E. F., Kennard, A. D., Eslinger, D. F., Biasotti, M. C., & Fuller, D. A. (2013, September). Justifiable homicides by law enforcement officers: What is the role of mental illness? (Rep.). Retrieved February 3, 2018, from Treatment Advocacy Center and National Sheriffs' Association website: http://www.treatmentadvocacycenter.org/storage/documents/2013-justifiable-homicides.pdf

Tucker, A. S., Hasselt, V. B., & Russell, S. A. (2008). Law enforcement response to the mentally ill: An evaluative review. Brief Treatment and Crisis Intervention, 8(3), 236-250. doi:10.1093/brief-treatment/mhn014

Tucker, A. S., Mendez, J., Van Hasselt, V. B., & Palmer, L. (2012). Crisis Intervention Team (CIT) training in the jail/detention setting: A case illustration. International Journal of Emergency Mental Health and Human Resilience, 14(3), 209-215.

University of Memphis. (n.d.). USA-MAP. Retrieved April 20, 2018, from http://cit.memphis.edu/citmap/

Van Maanen, J. (1973). Observations on the making of policemen. Human Organization, 32(4), 3-23.

Wagner, P., & Sawyer, W. (2018, March 14). Mass Incarceration: The Whole Pie 2018. Retrieved April 07, 2018, from https://www.prisonpolicy.org/reports/pie2018.html

Washington, C. (2017, May 17). Pima County making progress in reducing jail population. Retrieved April 07, 2018, from http://www.tucsonnewsnow.com/story/35438629/pima-county-making-progress-in-reducing-jail-population

Watertown Police Department. (n.d.). Jail Diversion Program. Retrieved May 07, 2018, from http://watertownpd.org/223/Jail-Diversion-Program

Watson, A. C., & Fulambarker, A. J. (2012). The Crisis Intervention Team model of police response to mental health crises: A primer for mental health practitioners. Best Practices in Mental Health, 8(2), 71-81.

Watson, A. C., Morabito, M. S., Draine, J., & Ottati, V. (2008). Improving police response to persons with mental illness: A Multi-level conceptualization of CIT. International Journal of Law and Psychiatry, 31(4), 359-368.

Watson, A. C., Ottati, V. C., Draine, J., & Morabito, M. (2011). CIT in context: The impact of mental health resource availability and district saturation on call dispositions. International Journal of Law and Psychiatry, 34, 287-294.

Watson, A. C., Ottati, V. C., Morabito, M., Draine, J., Kerr, A. N., & Angell, B. (2010). Outcomes of police contacts with persons with mental illness: The impact of CIT. Administration and Policy in Mental Health and Mental Health Services Research, 37(4), 302-317.

Wells, W., & Schafer, J. A. (2006). Officer perception of police responses to persons with a mental illness. Policing: An International Journal of Police Strategies & Management, 29, 578-601.

Whitehead, T. (2015, May 20). Mentally ill are not police's responsibility, says Theresa May. The Telegraph. Retrieved January 29, 2018, from http://www.telegraph.co.uk/news/uknews/law-and-order/11616937/Mentally-ill-are-not-polices-responsibility-says-Theresa-May.html

Zdanowicz, M. (2001). A sheriff's role in arresting the mental illness crisis. Sheriff, 53(3), 2-4.

Zealberg, J. J., Santos, A. B., & Puckett, J. A. (1996). Comprehensive emergency mental health care: Protocol for collaboration with the police department. New York: Norton.

1

 "The Interface of Mental Health and Criminal Justice." NYADTCP 2019 Annual Training Conference. Saratoga Springs, NY, 2019. For instance, people with mental illnesses are 9 times more likely to be incarcerated than people without mental health issues; over the course of their lives, 40% of people with mental health issues come into contact with U.S. criminal justice system.

2

ibid.

3

 Torrey, E. F., Dailey, L. H. R. Lamb, Sinclair, E., and Snook, John. "Treat or Repeat: A State Survey of Serious Mental Illness, Major Crimes, and Community Treatment." 2017. Arlington, VA: Treatment Advocacy Center. in Scheuer, Alexander J. "Hope and a Plan: An Evaluation of the Utica Mental Health Court." 1. Spring 2018.

4

 Appelbaum, P. "Law & Psychiatry: Lost in the Crowd: Prison Mental Health Care, Overcrowding, and the Courts," Psychiatric Services 62, no. 10 (October 2011): 1121–23, https://doi.org/10.1176/ps.62.10.pss6210_1121.; Erickson, P. and Erickson, S. Crime, Punishment, and Mental Illness: Law and the Behavioral Sciences in Conflict (New Brunswick, N.J.: Rutgers University Press, 2008), http://public.eblib.com/choice/publicfullrecord.aspx?p=361655.

5

 Adams, K., Ferrandino, J. (2008). Managing mentally ill inmates in prisons. Criminal Justice and Behavior, 35(8): 913-927. http://journals.sagepub.com/doi/pdf/10.1177/0093854808318624. Between 1956 to 1996, State hospital populations for the mentally ill dropped nearly 90% from 550,000 to 61,700, respectively.

6

 Whitehead, T. (2015, May 20). Mentally ill are not police's responsibility, says Theresa May.
The Telegraph. Retrieved January 29, 2018, from http://www.telegraph.co.uk/news/uknews/law-and-order/11616937/Mentally-ill-are-not-polices-responsibility-says-Theresa-May.html

7

U.S. Census Bureau, 2016.

8

 Bronson, J., and Berzofsky, M. "Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12," U.S. Department of Justice (June 2017): 1. https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf.

9

ibid.

10

 Roth, C. (2017, June 01). Keeping Mentally Ill Out of Jail and in Treatment: Rochester Model Works in Breakthrough Study. Retrieved April 07, 2018, from https://www.urmc.rochester.edu/news/story/4785/keeping-mentally-ill-out-of-jail-and-in-treatment--rochester-model-works-in-breakthrough-study.aspx. in O'Shea, Conor S. "Policing and Mental Illness in Oneida County, NY: Best Practices, Shortcomings, and Proposed Reforms." 3. Hamilton College, 2018.

11

 Massachusetts Department of Mental Health. (2017, December). Jail/Arrest Diversion Grant Program: FY2018 Mid-year report (Rep.). Retrieved https://www.mass.gov/files/documents/2018/01/19/2018-01-02%20DMH%20JDP%20mid-year%20report-%20FY18.pdf. in O'Shea, 2018. 8.

12

O'Shea, 2018. 4.

13

ibid. 5.

14

 Watertown Police Department. (n.d.). Jail Diversion Program. Retrieved March 27, 2019 from http://watertownpd.org/223/Jail-Diversion-Program. in O'Shea, 2018. 7.

15

 Advocates. (2018, April 25). Jail Diversion. Retrieved from https://www.advocates.org/services/jail-diversion. in O'Shea, 2018. 7.

16

ibid.

17

Scheuer, 2018. 2.

18

ibid. 3-5.

19

 Walther, 2018. 22. The SMART program "allows clients to tailor rehabilitation to address their specific addictions and the cognitive processes that may be leading to their inclinations or need threshold for substance use and resulting criminal behavior. SMART also encompasses the idea of accepting your illness, understanding addiction, and building skills to live successfully in the community."

20

 "Fact Sheet: Mental Illness and the Criminal Justice System," National Alliance on Mental Illness Virginia, https://namivirginia.org/wp-content/uploads/sites/127/2016/03/MIandCriminalJusticeSystem.pdf. The actual number of inmates who receive adequate care to improve their mental state is alarming. Of the 14% of state and federal prisoners diagnosed with a serious mental illness, only 25% receive treatment after incarceration. That number drops to 16% for those held in local jails.

21

 Walther, 2018. 14. The study notes that "Marcy, Auburn, Mid-State, and Mohawk each have four Transitional Services (TS) programs to assist inmates with reentry. These include Phase I, Thinking for a Change, Phase III, and Aggression Replacement Therapy (ART). In 2011, there were 215 inmates enrolled across these programs, with 3,729 on the waitlist."

22

 "The Interface of Mental Health and Criminal Justice." NYADTCP 2019 Annual Training Conference. Saratoga Springs, NY, 2019.

23

 ibid.

24

 Rivero, Daniel, and Nadge Green. "How Miami-Dade's Mental Health Program Steers People to Treatment, Not Jail." WLRN, March 13, 2019. https://www.wlrn.org/post/how-miami-dades-mental-health-program-steers-people-treatment-not-jail.

25

 Walther, 2018. 10. For example, the Central New York Psychiatric Center, located in Marcy, NY, only has "220 beds in a secure inpatient facility….It also offers corrections-based mental health units to all of the correctional facilities in New York State; the mental health units that will be discussed in Auburn, Marcy, and Mid-State are considered satellite units of CNYPC. Combined, CNYPC provides 205 crisis beds, 781 Intermediate Care Program beds, and psychiatric services to over 8,500 inmates across its 15 satellite units throughout New York. CNYPC also provides 28 outpatient facilities."