November 15, 2016
CSG Justice Center Report to MOCJ

Brief Assessment of New York City's Behavioral Health and Criminal Justice Systems

Introduction:
The Council of State Governments Justice Center (CSG Justice Center) is assisting the New York City's Mayor's Office of Criminal Justice (MOCJ) to identify and describe best practices and successful programs around the country aimed at reducing the number of individuals with behavioral health disorders in jail. The project includes a review of current New York City programs and practices implemented throughout the five boroughs and a brief assessment of the progress made to date on the recommendations of the 2014 Mayor's Task Force on Behavioral Health and Criminal Justice System report. Additionally, this project provides a review of how the best practices identified by the CSG Justice Center can be applied to New York City's criminal justice and behavioral health response system.

The review was completed by analyzing New York City's progress in addressing the following four key measures: ***reducing the number of people with behavioral health disorders booked into jail; decreasing their average length of stay in jail; increasing the percentage of people connected to treatment and community supports; and reducing their recidivism rates.*** These four key measures are a critical component of the Stepping Up initiative—the national effort to reduce the number of people with mental illnesses and co-occurring substance use disorders in jails, spearheaded by The Council of State Governments Justice Center, the National Association of Counties, and the American Psychiatric Association Foundation and supported by the U.S. Department of Justice's Bureau of Justice Assistance. New York City is one among more than 300 participating jurisdictions. These four measures serve as the basis for jurisdictions to measure progress and guide planning and action for improving their responses. The four measures are discussed in the Stepping Up initiative's forthcoming document, "Reducing the Number of People with Mental Illness in Jail: Six Questions County Leaders Need to Ask," which also outlines the framework jurisdictions should use to address the over-representation of people with behavioral health needs in the justice system. We used the *Six Questions* framework to guide this review of New York City's efforts and scan of potential practices.

Our overall observation is that New York City has developed and is implementing a well thought out plan for improving their responses to justice involved people with behavioral health needs through the 2014 Mayor's Task Force on Behavioral Health and Criminal Justice System report. The key goals of this plan are consistent with the four key outcome measures that were developed as part of the Stepping Up initiative:

- Do not enter the criminal justice system in the first place;

- If they do enter, that they are treated outside of a jail setting;
- If they are in jail, that they receive treatment that is therapeutic rather than punitive in approach; and
- Upon release they are connected to effective services.

At the same time, it is our impression based on this review that there are additional steps that New York City can take to build upon progress to date. In this report, we highlight the promising and effective programs and practices that New York City already has in place, as well as identify opportunities to bring such programs or practices to scale, either by moving from a pilot project to a full scale program, or taking a practice from one borough and implementing it city-wide. We also identify additional best practices for New York City to consider for implementation. Given the complexity of a large urban population spread out over five boroughs, each with unique criminal justice systems, the implementation of any new programs and policies in New York City must be responsive and tailored to the City's specific needs and context. As such, it may be more beneficial to implement certain components and practices, rather than trying to replicate entire programs from other jurisdictions. For example, successful programs such as Seattle's Law Enforcement Assisted Diversion (LEAD), provide a diversion opportunity at the street level by law enforcement for low-level substance abuse crimes. However, New York City police currently have several pre-arrest diversion opportunities already in existence across the boroughs. It may be beneficial to focus on bringing these existing programs that have demonstrated success to scale citywide, instead of developing an entirely new program. Likewise, Miami-Dade County, FL has developed four variations of diversion alternatives: pre-booking, post booking misdemeanor, post booking felony, and a program for people found to be incompetent to stand trial. Instead of attempting to recreate the model developed in Miami-Dade County it might be more advantageous to develop specific components of Miami-Dade's diversion programs that address gaps in current diversion services in New York City.

Additionally, a one-stop crisis stabilization center such as the Bexar County, TX model is another example of a program that is quasi-developed in New York City's Comprehensive Psychiatric Emergency Programs (CPEP), the planned addition of drop off centers, and the detoxification services and substance abuse treatment programs offered through the New York State Office of Alcoholism and Substance Abuse Services (OASAS). For New York City, it makes more sense logistically to have multiple sites for crisis stabilization to allow for ease and efficiency for law enforcement. The recommendations in this report include how these various types of services could be co-located in these centers to allow for improved management of resources and ability to transfer clients within a facility based on their needs and options to "step down" as progress is achieved. This is another example of how New York City's

existing programs provide the appropriate range of responses to people with behavioral health disorders in the criminal justice system, but may need to be modified or expanded to have a greater impact.

An analysis of national best practices, current status of NYC programming, examples of best practice sites, and recommendations are presented in chart form for ease of comparison. The chart is framed within the four key measures of the Stepping Up initiative:

- Reduce the number of people with behavioral health disorders booked into jail;
- Decrease their average length of stay in jail;
- Increase the percentage of people connected to treatment and community supports; and
- Reduce recidivism rates.

A focus on these four measures provides a systematic way of identifying and categorizing best practices already in place, services that are demonstrating success but are not available to all five boroughs and should be expanded and brought to scale, services that are in the planning stage that should be implemented, and services that are not in place that should be developed. Additionally, building the plan around these four key measures allows for New York City to establish baseline measures, determine priorities for policy and program implementation, and provides the metrics to measure progress. For example, reductions in the number of individuals booked into jail is an indicator of whether pre-booking strategies and investments are having their intended impact. The continued analysis of these measures is key to demonstrating success, as well as needs to decision-makers. New York City has much of this work already in motion and should be commended for the extensive planning that has already been completed, as well as the implementation of pilot programs and practices.

We hope that this review and scan provides useful information to further enhance the already strong efforts being made in New York City to achieve its goal of reducing the number of people with mental health and/or substance use disorders in jail. Furthermore, we would be happy to provide any additional assistance around how to adapt these practices to New York City's context, as well as to measure their impact.

Methodology:
The analysis of New York City's criminal justice and behavioral health systems includes: a review of data provided by MOCJ; a sampling of screening and assessment processes in place; a compilation of services in place in all five boroughs as determined by a review of completed Sequential Intercept Maps (SIM); 2015 and 2016 progress reports on implementation of the 2014 Mayor's Task

Force recommendations; and one in-person meeting with the MOCJ staff for clarification and direction, as well as email and phone communication to review draft versions of this report.

Data was requested from MOCJ to provide context on where NYC stands in regards to Stepping Up's four key metrics. However, given the agreed upon scope of this project, the CSG Justice Center limited its analysis to data and measures that are already collected and used by MOCJ. In some cases, data to construct the key measures was not available. Additionally, the CSG Justice Center requested background information on existing programs, policies, and practices targeted towards people with behavioral health disorders in the criminal justice system. This information was provided via existing reports, and no additional analyses were requested. This information was then reviewed and assessed in comparison to existing national practices and outcomes that have been identified by the CSG Justice Center's staff through work on the Stepping Up initiative and through technical assistance provided to jurisdictions nationwide.

Based on the analyses of the available materials, a chart was developed to give an overview of best practices, address what New York City already has underway or planned to achieve these practices, give examples of other jurisdictions that are implementing these practices, and provide recommendations specific to the needs of New York City on how they can implement these changes. Finally, a summary of priority recommendations and immediate next steps is provided at the conclusion of this report. Due to the limited scope of this project, and the complexity of New York City's data and existing programs and practices, this report does not address all of the data that is available in New York City for analyses and may miss or mischaracterize some existing programs and polices underway in New York City.

Brief Assessment and Recommendations:

1. Reduce the number of people with mental illnesses and/or substance use disorders booked into jail:

***Before Arrest and on the Street*; Key Data:** In 2015 there were 141,017 incidents of Emotionally Disturbed Persons (EDP: A person who appears to be mentally ill or temporarily deranged and is conducting him or herself in a manner which a police officer reasonably believes is likely to result in serious injury to him or herself or others). During this time period there are 89,662 reported dispositions, with 27,672 (30.9%) transported to the hospital (30.9%), and 1,411 (2.6%) arrested.

Best Practices	NYC Current Status	Example Jurisdictions	Recommendations
Create citywide management and administrative oversight of all specialized behavioral health police responses, through the creation of a specialized mental health section.	NYPD does not appear to have a current division overseeing responses to people with behavioral health needs.	• The Los Angeles Police Department has established a Mental Health Crisis Response Section within their department, with a Mental Health Specialist who serves as the section director and oversees all police responses to people with mental illnesses. • The International Association of Chiefs of Police's One Mind Campaign recommends that police departments develop and implement a model policy and oversight process for addressing police responses to people with mental illnesses.	Implement a division of NYPD that oversees all specialized behavioral health responses by the NYPD. Because the NYPD already has a number of police-mental health collaboration programs and practices in operation, it is recommended that the NYPD ensure that these programs are brought to scale, when possible, and are maximizing the impact of available resources. A division that oversees all behavioral health responses in the NYPD could help to ensure that there is consistency in responses and best practices across all five boroughs, despite the extremely large size of the NYPD.
Ask basic mental health questions at 911 dispatch to see if the call is regarding someone in mental health crisis and identify whether a person can receive pre-arrest diversion at the point of dispatch or whether a specialized police response should be made.	NYC does not appear to have protocol in place for 911 dispatch to identify whether a call is related to a mental health crisis.	Houston, TX 911 dispatch asks two basic mental illness questions: 1) are you aware of or do they appear to have mental health issues? 2) Is this call in reference to their mental state? Based on the answers to the questions, the police department may divert the call to a behavioral health response call center.	To the extent that mental health questions are not already asked at 911 dispatch, standardize a set of questions for 911 dispatchers to ask to identify whether the call is related to a mental health crisis and based on the answers to these questions develop protocols for pre-arrest diversion.

Create a triage desk staffed with a police officer and mental health professional who can access available mental health and police databases to identify prior police contact, prior use of services, and match to available resources for crisis calls.	A triage process exists as part of the co-responder pilots available in NYC, but does not exist for other police responses.	The Los Angeles Police Department has a long established triage process as part of the Mental Evaluation Unit. This unit fields calls from patrol officers who have questions regarding situations involving people with mental illnesses. A triage mental health nurse works alongside a police officer and queries the Department of Mental Health databases to identify available response options.	Expand the current triage desk to assist with all 911 calls coming into NYPD identified as a behavioral health crisis and calls from officers at the scene to ensure that available behavioral health diversion opportunities are identified as quickly as possible. Allow for the triage desk staff to access criminal justice and Department of Health and Mental Hygiene (DOHMH) databases to identify prior history and available response options.
Crisis Intervention Team (CIT) training for all cadets and CIT training for veteran officers with the goal to achieve 24/7 coverage of calls.	Following the 2014 Task Force recommendations, NYPD has expanded Crisis Intervention Team training. The training is being integrated into the police academy curriculum. As of FY2016, 3,947 NYPD officers representing every precinct, as well as transit officers stationed in Northern Manhattan, have completed training for CIT.	• New Mexico requires all recruits to receive 40 hour training throughout the state. • Houston, TX, and Portland, ME require all new police officers to be trained in CIT at the academy, while Houston also provides additional training to veteran officers.	Continue efforts to train all cadets and provide initial CIT training as needed for the veteran patrol officers. Additionally, develop a schedule for refresher trainings for all officers.
Implement a co-responder model for police responses. This program pairs a trained mental health professional to respond at the scene with police and provide follow-up short-term case	As of 2015 there were five new NYPD-DOHMH co-response teams that embed DOHMH clinicians with specially trained NYPD officers to more effectively respond to and triage individuals who are at a great concern for violent behavior and likely have a serious and persistent mental illness (SPMI). These	Implemented in multiple jurisdictions: • Johnson County, KS has extensive data and evaluation of the positive outcomes of a co-responder program. • Large cities, including Houston and Los Angeles implement the	The existing co-responder programs should be expanded to shorten response times, to increase the coverage of these units, and to allow for responses to calls related to a person with a substance use disorder. The co-responder units should also include short-term case management by a mental health

management services when possible. It can also include a separate substance use co-responder component.	programs do not currently respond in real time, but within 24-48 hours of a call.	co-responder model citywide. • Portland, ME has a substance use disorder co-responder program for overdose and detoxification crises.	staff person to ensure connection to services in the days following the crisis.
Expand mobile crisis services. Mobile crisis services are a non-police alternative that allows for mental health professionals to begin the process of assessment and treatment in the community in lieu of arrest.	Mobile crisis services are available through 311 in all boroughs. Response times are between 24-48 hours after a call.	This practice is evidence based and widely used in many jurisdictions, including AZ, CT, DE, FL, HI, MS, NC, NJ, NM, OK, VT, WI.	To maximize the impact of existing mobile crisis services, 911 dispatch (and/or a triage desk, if created) should develop a protocol to determine when a call should be diverted to the Mobile Crisis Unit. Mobile crisis services should also be expanded to allow for faster response times.
Implement 24/7 crisis hotlines to provide a direct service over the phone to a person who is experiencing distress with immediate support and/or facilitated referrals.	24/7 crisis hotlines are available through 311 via Thrive NYC.	This practice is evidence based and widely used.	Continue current 311 and 24/7 crisis hotline services.
Provide short-term crisis residential and non-residential services and crisis observation and stabilization for people with mental illnesses and substance use	• In 2015 NYC announced the plan to open two community drop-off centers. These centers will allow for police to bring individuals to this non-residential program and provide an important alternative to jail	• Short-term crisis services are used to varying degrees across the country. • Bexar County, TX's Restoration Center provides short-term crisis residential and non-residential behavioral health	• The existing CPEPs should be enhanced to provide additional alternatives to hospitalization or arrest. While hospitals may also have available detoxification centers and outpatient substance use treatment in the

disorders to address the person's level of distress and/or need for urgent care.	or hospitalization, assess needs and provide short-term care. These programs have not yet been implemented. • Comprehensive Psychiatric Emergency Programs (CPEPs) are OMH-licensed programs designed to directly provide or ensure the provision of a full range of psychiatric emergency services 24/7, for a defined geographic area. Currently, there are 19 licensed CPEPs in New York State operated at 18 Article 28 hospitals. • Emergency Observation Beds (EOB) are intended to provide recipients a safe environment where staff can continue to observe, assess, diagnose, treat, and develop plans for continued treatment as needed in the community or in a hospital or other setting. These beds are usually located in or adjacent to the CPEP Emergency Room, allowing recipients to remain in the area for up to 72 hours. • OASAS Coordinated Crisis Centers/ Pilot for 1st Episode Psychosis in a Brooklyn	treatment in the same setting, including a sobering unit, a licensed residential detoxification unit, a crisis care mental health clinic, medical care, and outpatient opioid treatment.	same facility as a CPEP, it is recommended that the number of facilities where all of these services are available in one place be expanded as well. Additionally, since the drop-off centers have not yet been developed, it would be beneficial to establish these programs in the same facility as the CPEPs to allow for a mental health staff member on site to decide on the level of care needed, and to simplify the decision making process for the police officer and/or the staff at the police triage desk, once in place.

2. **Reduce the average length of stay of people with mental illnesses and/or substance use disorders in jail:**
***In Jail*; Key Data:** In FY2016 24% of people discharged from jail were identified with a "mental health flag" as defined by the Brad H. settlement. That percentage has increased since FY2012 when it was 20%. The overall number of people with an "M" designation discharged from Rikers annually has gone down from 16,887 in FY2012 to 15,083 in FY2016, but the overall number of discharges has gone down as well, from 68,447 discharges in 2012 to 48,371 discharges in FY2016. The FY2016 average daily population for people with a mental health flag is 43%.

Overall length of stay has gone up for people with the "M" designation from FY2012 when it was 117.42 days to 129.72 days in FY2016. The non "M" designation population has also seen an increase from FY2012, when the average length of stay was 59.02 days in comparison to the current average length of stay which is 67.40 days. The "M" designation population has consistently remained close to double the average length of stay in jail than for people without the "M" designation. Data on the average length of stay for people diagnosed with substance use disorders does not appear to be tracked at this time.

Best Practices	NYC Current Status	Example Jurisdictions	Recommendations
Implement universal validated screening for behavioral health disorders pre-arraignment and at booking into jail. For people who screen positive for a possible mental illness or substance use disorder, they should receive a follow-up clinical assessment within the criminal justice setting or in the community.	• Rikers Island is screening people for mental illness and substance use disorders, in accordance with the Brad H. settlement. • Only the Manhattan central booking facility is administering screens for behavioral health disorders pre-arraignment during select hours, as part of the Pre-Arraignment Screening Unit (PASU). PASU screened over 8,500 people in FY2016. As part of the PASU, nurse practitioners and other health professionals are piloting a	• Salt Lake County, UT, Travis County, TX, Montgomery County, MD Douglas County, KS and Franklin County, OH, are implementing validated mental health screens and/or substance use disorder screenings at booking into jail which determine the need for a follow up assessment. • The District of Columbia has an Urgent Care Clinic located at their Superior Court to allow for screening and assessment for mental illness and substance use	• The existing PASU program in Manhattan should be expanded to the other boroughs, at a minimum keeping the screening process in place that can be used to inform pretrial decision making. • The current screening process for mental illness at jail must be maintained to remain in compliance with the Brad H. settlement. However, since the current process is identifying 43% of the jail ADP population as screening positive, it may be

	process to identify people with immediate behavioral health needs and connect them to providers for care and potential diversion. The initiative began as a pilot operating Monday through Friday from 6am to 2pm, but in FY2017 will expand to operate 24/7 at Manhattan Criminal Court.	disorders at the courthouse, and allows for immediate short-term treatment.	an overly sensitive process that makes it difficult to use this flag for decision making purposes. It is recommended to further break out the population who screens positive for serious and persistent mental illness (SPMI) to better identify people who need to be prioritized for services. • The existing screening process for substance use disorders at Rikers Island should be modified to include a validated screen, such as the Texas Christian University Drug Screen V (TCUDS V).
Implement a validated pretrial risk assessment during pre-arraignment, and determine release decisions and supervision based on pretrial risk scores, with a focus on connecting the behavioral health population to appropriate and timely care.	• Supervised pretrial release pilot programs have been operating in NYC since 2009 and the Division of Probation and Correctional Alternatives is funding approximately 165 alternative to incarceration and detention programs designed to reduce pretrial detention and/or incarceration. • In 2015 NYC planned to add 2,300 slots to citywide supervised release. The City has released a Request for Proposals	Approximately 10% of counties implement pretrial risk screening, release, and supervision practices: • Some jurisdictions, like Maine, develop pretrial supervision and treatment strategies based on mental health and substance use screening and assessment information. Atlanta, GA also has a pretrial program that administers pretrial behavioral health screening and implements a specialized caseload based on these results.	• MOCJ should continue forward with their plans to implement the Justice Provider System that will allow for the recently developed pretrial risk assessment to be used to determine eligibility for pretrial release and supervision, as well as connection to alternative to incarceration programs. Although not all programs will use this pretrial risk information to determine their eligibility, this should be the final goal of this

	seeking bids from non-profit organizations to administer supervised release in every borough. The chosen providers will use a validated risk assessment tool to determine eligible candidates and set an appropriate level of supervision. • In July of 2015, the City announced nearly $18 million in funding to triple the size of the city's supervised release program by early 2016 and to rollout a citywide validated, updated risk assessment tool that will move the city toward a system in which decisions about pretrial detention are made based on risk. By avoiding setting or posting monetary bail, supervised release avoids the problem of being detained based on ability to post bail. • Pretrial supervision practices vary across all five boroughs, with three different agencies providing supervised release, and more than ten different alternative to incarceration programs operated by different agencies. It appears that some programs have specialized		process, which may include requiring that all providers utilize risk reduction strategies when rebidding for contracts. This system should also allow for behavioral health information to be shared to determine eligibility for treatment programs based on behavioral health needs. • Standardized requirements for private pretrial supervision agencies to operate according to pretrial best practices should be implemented and enforced across all five boroughs to ensure that supervision is matched to meet pretrial risk for failure to appear (FTA) and new criminal activity (NCA) and addressing behavioral health needs.

	mental health caseloads, including the Brooklyn Justice Initiative program and the Bronx Community Solutions. • The NYC Criminal Justice Agency developed a locally validated pretrial risk tool that is predictive for re-arrest and failure to appear in court during the pretrial period. • MOCJ is developing the Justice Provider System to automate the flow of information from state and city criminal justice agencies to facilitate the enrollment to pretrial supervised released and alternative to incarceration programs based on pretrial risk assessment information. In doing so, it will track program participation and outcomes by risk and allow for the population that are not connected to programming to by examined based on their risk profiles.		

3. Increase the percentage of people with mental illnesses and/or substance use disorders connected to treatment: ***Release and Reentry*****; Key Data:** A new substance use program has served 2,246 individuals leaving Rikers in FY2016 with a substance use disorder, but we do not know the total number of people discharged from Rikers who have been identified with a substance use disorder. There does not appear to be data on how many people with mental illnesses are connected to

treatment and services upon release, but we know the number of people discharged from Rikers with an "M" designation, in accordance with the Brad H. settlement (15,083 in FY16). Tracking connection to care data would be helpful in further complying with the Brad H. settlement.

Best Practices	NYC Current Status	Example Jurisdictions	Recommendations
Discharge planning is completed for the behavioral health population being released from jail to the community.	• The City is engaged in on-going coordination efforts to ensure that discharge of individuals with behavioral health issues includes a plan for successful re-entry. The Task Force anticipates completion of expansions to the existing Individualized Correction Achievement Network (I-CAN) discharge planning contracts for 4100 slots. • Substance use disorder services at discharge have been expanded to provide an additional 4,000 individuals annually with referrals to treatment and other essential services upon release from jail by the end of Fiscal 2017. The new substance use program has served 2,246 individuals leaving Rikers in FY2016.	• The APIC Model is a consensus based approach for discharge planning for people with mental Illnesses, including those with co-occurring disorders. • Franklin County, OH and Salt Lake County, UT have identified the number of people who have received services in the community who have been reconnected to treatment to understand the gaps in their discharge planning and need for capacity building of treatment programs in the community.	• Embed staff from DOHMH at Rikers to provided reach-in services and improve the connection to care process. • Expand existing discharge planning processes by I-CAN to include a plan for connecting people identified with SPMI to appropriate levels of care upon release from Rikers Island. • Expand the existing substance use disorders discharge planning pilot to develop plans for connecting all individuals identified with a substance use disorder in jail to appropriate levels of care. • Utilize information from the Service Priority Level (SPL) screening process that identifies potential high utilizers to target this population for discharge planning services and connecting to case management services when possible to ensure engagement in services

			and assistance in establishing healthcare and housing.
Establish navigation services for health care and other entitlement benefits to identify eligibility for services, maintaining enrollment, and connection to community based organizations while in custody or upon release.	To ensure minimal disruptions in public health insurance coverage, the City is investigating various processes by which Medicaid enrollment occurs for people leaving jail. Screening for Medicaid eligibility is taking place at Rikers Island upon admission to the jail and referral to Single Stop enrollment sites in the community are underway.	In Cook County, IL enrollment and eligibility screening for Medicaid is integrated into the intake process at the jail, using a third-party agency to implement the screen. If a person appears to meet the basic criteria for Medicaid eligibility, then applications are completed and submitted on behalf of the individual by the third party agency.	New York State is a Medicaid expansion state, which has prompted New York City's recent addition of Single Stop community based screening centers to assist individuals in determining their eligibility for Medicaid and assist with healthcare enrollment. It is recommended for NYC to expand these Single Stop programs, coordinate with other existing benefit enrollment efforts, such as Human Resource Administration's Customized Assistance Services, and develop a program similar to Cook County's where individuals can receive assistance in completing applications for Medicaid enrollment while in jail. Additionally, the navigation services should include connection to other entitlement benefits such as Veteran's benefits, public assistance, Social Security, Medicaid Health Homes and assisting with connection to care.
Develop a plan to ensure current community based treatment programs meet capacity	• All five boroughs have a Link reentry program for case management services for people	• The sequential intercept mapping process is widely used. • The Stepping Up initiative	• Building on the recent discussions between HRA, DOHMH, and DOC, a system

needs for NYC and are providing levels of care based on risk and behavioral health need.	with mental health needs. • NYC has performed sequential intercept mapping, but has not included data capacity needs in this process and the maps may not be current. • City agencies — the Human Resources Administration, the Department of Health and Mental Hygiene and the Department of Corrections — have convened to coordinate their various discharge planning efforts. An electronic system has been created that shares appropriate information about clients being served by each agency, which helps to avoid duplication of services. Their goal is to collectively ensure that individuals being served by each agency are made aware of the full spectrum of services available to them as they prepare to reenter the community.	recommends that jurisdictions conduct an inventory of services to develop a plan to improve on the four key measures outlined in this document. • Jurisdictions considered to have fully integrated justice and behavioral health data systems include Johnson County, KS, Multnomah County, OR, and Hennepin County, MN, and jurisdiction with progressive systems include Maricopa County, AZ, Salt Lake County, UT, and Camden County, UT. • The White House Data Driven Justice Initiative is working with multiple jurisdictions including New York City to improve data based criminal justice solutions. This work includes the development of a data software program through the University of Chicago to de-identify protected health information while sharing data between justice and behavioral health agencies. Additionally, as a part of the initiative the University of Chicago has worked with Johnson County, Ks to develop a model to project high utilizers.	should be developed, similar in concept to the Justice Provider Network that is being developed by MOCJ, to determine eligibility availability of alternative to detention programs and case management/treatment programs for people identified with behavioral health disorders pre-arraignment or at Rikers Island. This system will not only help in the connection to treatment, but will allow for the tracking of whether people with behavioral health disorders are being connected to care upon release. In order to achieve this, an MOU for information sharing will need to be agreed upon between criminal justice and behavioral health agencies in NYC. Once that MOU is developed, the city can develop a plan to track the percentage of people released from jail identified with behavioral health disorders who are connected to treatment to better gauge the capacity needs for treatment in the community. • Without data on the number of people connected to care in the

			community, it is impossible to project capacity need. Thus the general recommendation for NYC is to expand the number of case management programs for the SPMI population released from jail; particularly people who also have screened moderate to high risk for criminogenic risk.

4. Reduce recidivism for people with mental illnesses and/or substance use disorders:

***Back in the Community*; Key Data:** 47.3% of people with an "M" designation at Rikers return to DOC custody as compared to the non "M" designation population that has a 46.7% return rate from FY2014 to FY2015. Although the recidivism percentages are similar for individuals identified with a mental illness and the general population, it is concerning to see that almost half of the population with an "M" designation return to jail, and 38% of this population return to jail more than seven times. Approximately 60% of the non-"M" designation population received a Service Priority Level (SPL) criminogenic risk assessment tool while approximately 75% of people with an "M" designation received the SPL. 10% of the "M" designation population who received the SPL were identified as high risk, while 63% were medium or medium-high risk, and 28% low or medium low risk.

In FY2015 6,342 single adults receiving services from the Department of Homeless Services also had two or more jail stays over the previous five years. Of that population, 1,405 people were also identified as chronically homeless.

Best Practices	NYC Current Status	Example Jurisdictions	Recommendations
Prioritize community based services based on criminogenic risk and behavioral health need, as identified through behavioral health and	• Division of Probation and Correctional Alternatives (DPCA) developed in-house behavioral health teams that provide advisory services while screening and assessing the	• CSG Justice Center has released the Criminogenic Risk and Behavioral Health Needs Framework which describes how jurisdictions can use behavioral health and	New York City's alternative to incarceration and detention programs, case management programs and community supervision should focus on reducing recidivism, and helping to

criminogenic risk screening and assessment.	behavioral health needs of individuals on probation, connecting them to clinical and other community-based services. The teams conducted 1,582 case consultations in Fiscal 2016. On May 1, 2016, DPCA implemented a behavioral health screening as part of their intake process to identify behavioral health needs, match services to probationers and provide probation officers with information about various behavioral health symptoms.
	• Manhattan, Brooklyn, and Queens have specialized caseloads for people with mental health needs.
	• DPCA is funding approximately 165 alternative to incarceration and detention programs designed to reduce incarceration and/or pretrial detention.
	• There is funding for four new Forensic Assertive Community Treatment Teams (Forensic ACT), which will provide intensive, high quality treatment to additional 272 individuals
		criminogenic risk information for maximizing the impact of community-based services.
		• Transition from Jail to Community's Targeted Transition Interventions is a useful resource for counties intending to develop evidence based recidivism reduction transition planning.
		• Specialized probation programs are evidence based and widely used based on risk and need information.
		  • Salt Lake County has an embedded behavioral health staff in the probation department, to assess people with substance use needs and provide treatment and intensive supervision to the high risk/high substance use disorder need population, in collaboration with local law enforcement.
		  • Justice Reinvestment states have seen significant investments in behavioral health treatment for people on supervision, including: WV, AL, KS, WI.
			connect people to the appropriate level of treatment. To do so, eligibility for community programs should be based on criminogenic risk levels and behavioral health assessments. All people released to the community from Rikers should receive a criminogenic risk assessment, such as the Service Priority Level assessment tool, in addition to screening for mental illness and substance use disorders. Although Rikers is administering the SPL assessment to people in jail, not all individuals released are receiving this assessment. The results of the assessments should be used to determine the level of supervision and services based on risk and need levels. For example, individuals identified as moderate to high criminogenic risk and diagnosed with a serious mental illness should be prioritized for enrollment in the existing evidenced-based ACT/FACT teams. The process of assigning individuals to supervision and programming should be based on a decision-making tool such as the cited Criminogenic Risk and Behavioral Health Needs Framework.

	assessed at higher concern for violent behavior. These teams require approval for state Medicaid reimbursement. • NYC has committed resources to increase existing City ACT Teams' effectiveness to treat co-occurring substance use and mental illness. • Rikers is using the Vera developed Service Priority Level as a risk assessment tool at the jail to predict whether people entering the NYC Jail are likely to be a high utilizer with a readmission to jail within one year.		
Expand availability of supportive housing units for the chronically homeless criminal justice population with the goal of making homelessness, rare, brief and non-recurring for this population.	• The Mayor's Task Force created a scattered site supportive housing pilot, building on the Frequent User System Engagement (FUSE) model and titled the NYC Justice Involved Supportive Housing (JISH) program. This initiative will provide 120 units of permanent supportive housing and support services to help increase problem solving abilities, address legal issues, improve physical and mental health and	New York City's FUSE program is proven to significantly decrease shelter, hospital emergency rooms, and jail stays for high utilizers of the criminal justice system, including people with "complex needs" such as mental illness and/or substance use disorders.	Expand on the JISH pilot to provide permanent supportive housing to the chronically homeless high utilizers of the criminal justice system, including individuals with substance use disorders and mental illnesses. The current number of a maximum of 120 units does not meet the needs of the chronically homeless criminal justice population. A percentage of the 15,000 to 25,000 units of supporting housing that the city and the state plan to develop should be

	increase financial self-sufficiency. • Mayor de Blasio and Governor Cuomo have each committed to developing 15,000 to 25,000 units of supporting housing.		earmarked for the 1,405 people who are chronically homeless and have had two or more jail stays in NYC.

Recommended Priorities for New York City:
New York City is in an excellent position to build on the recommendations set forth in the 2014 Mayor's Task Force on Behavioral Health and Criminal Justice System report. Much work is underway, including the expansion of CIT training, implementation of pretrial risk and behavioral health screening prior to arraignment along with the implementation of a data management system, planned development of mental health crisis drop-off centers, expansion of the police co-responder program and efforts to increase connections to health care and housing. As a result, this report primarily identifies opportunities to expand, bring to scale, and improve coordination across all five boroughs the various projects that are evidence-based and demonstrating success.

Within the aforementioned recommendations, there are several that would have the most impact on the four key measures. These include:

Measure 1: Reduce the number of people with behavioral health disorders booked into jail
A separate behavioral health department within the NYPD will help maintain oversight and coordination of all behavioral health related programming for the police department. Given the size and logistics of managing services for all five boroughs, this should provide for increased management and efficiency. This includes administering standardized screening protocol for dispatch, the development of a central triage desk staffed by law enforcement and trained behavioral health professionals who have access to data management systems to inform next best steps for the officer on the street, and increasing co-responder services to meet capacity needs across the city (see Appendix A for a flow chart detailing recommended responses for measure 1).

Measure 2: Decrease their average length of stay in jail
To address reducing the length of stay for people with behavioral health needs who are booked into jail, a validated mental health and substance use screening for all individuals should be implemented prior to arraignment and in jail to determine the population

with behavioral health needs and inform decision making. This is a process that should be brought to scale at all five boroughs and should be implemented in conjunction with the planned pretrial screening and pretrial supervision programming. As was noted, it is recommended that in addition to meeting the Brad H. settlement requirements, which is identifying a broad population of people with mental illnesses, further refining the level of need amongst this population will allow for better matching of criminal risk and needs to the appropriate level of supervisions and services. The highest levels of supervision and services should be reserved for people screening as seriously and persistently mentally ill (SPMI) and moderate to high criminogenic risk. This strategy should be used for people released at pretrial (using pretrial risk information) as well as post-conviction (see Appendix A for a flow chart detailing recommended responses for measure 2).

Measure 3: Increase the percentage of people connected to treatment and community supports

Data could not be provided to verify connection to treatment and community supports upon release from jail, making it impossible to gauge the rate of people connected to services. Additionally, some services do not appear to be in place, such as embedding staff from DOHMH at Rikers to provide reach-in services and improve the connection to care process upon release from jail. This strategy has proved successful in other sites across the country and is recommended for NYC. Additionally, data sharing agreements will need to be developed to allow for the electronic tracking of individuals as they move from jail to the community to ensure engagement in services. Recommendations also include adding health navigators to assist individuals in custody to enroll in Medicaid and other entitlement benefits (see Appendix A for a flow chart detailing recommended responses for measure 3 and 4).

Measure 4: Reduce recidivism rates:

New York City contracts with private provider agencies for most of the post-conviction supervision and treatment services. This places a responsibility on the city to ensure that those contracted agencies are operating under best practices including use of risk assessment tools, matching level of supervision to risk and need as discussed above, and employing evidenced based practices such as use of cognitive based curriculums. As a first step, it is recommended that New York City implement a quality assurance program to address these concerns and demonstrate that those agencies providing supervision are operating on a model of Risk-Needs-Responsivity (RNR) to better ensure that recidivism rates can be reduced. Additionally, it is recognized that New York has developed a tool through the Vera Institute of Justice (SPL) that has demonstrated success in identifying the likelihood that a person booked into jail will commit a new offense within a year of release. This information is primarily used within the jail, but is seen as also relevant to be used to identify people in the highest need of discharge planning and more intensive case management post release. This would include connection to health and housing services. It is also recommended that existing supportive housing services

aimed at connecting high utilizers of the criminal justice system to supportive housing are expanded (see Appendix A for a flow chart detailing recommended responses for measures 3 and 4).

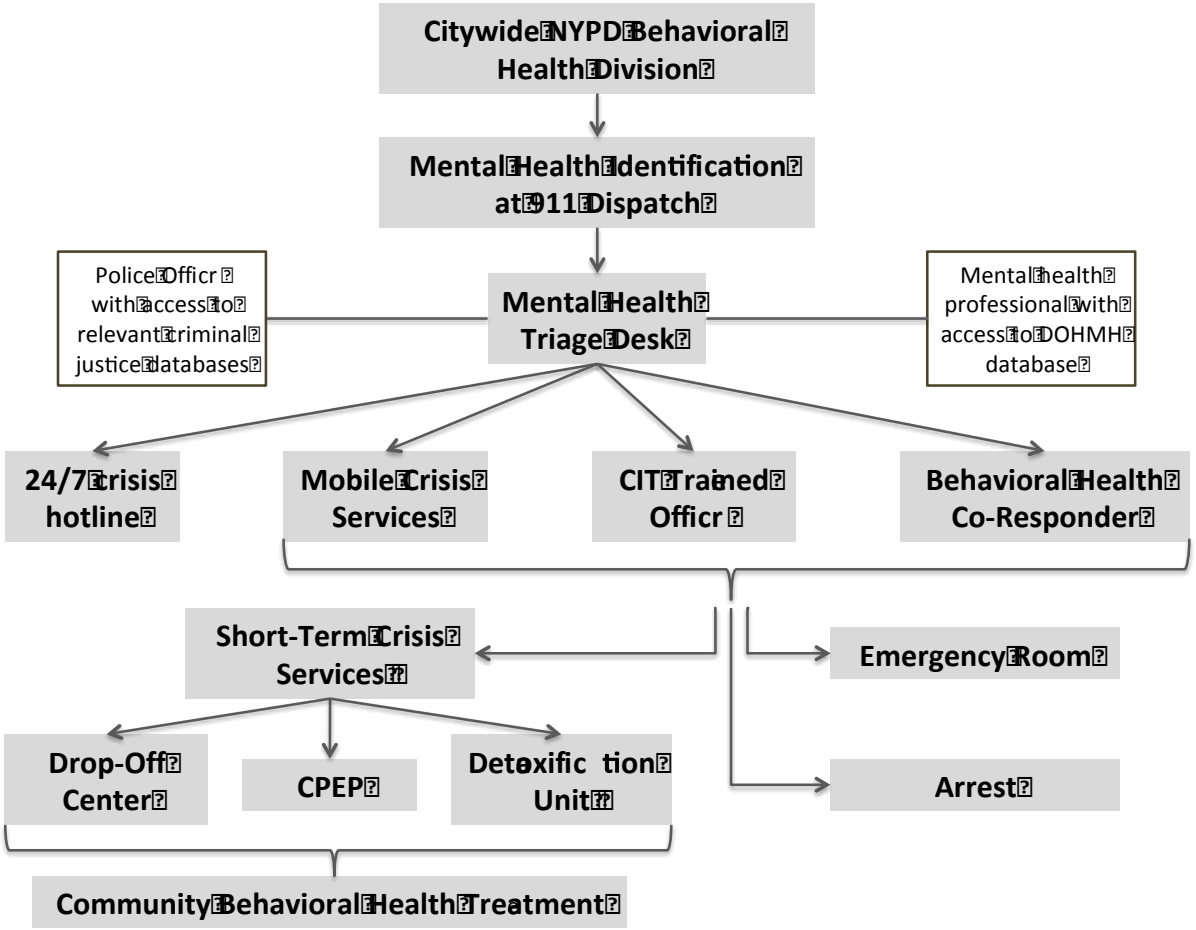
Next Steps for New York City

This brief process of reviewing the status of criminal justice and behavioral health programming in New York City, has made clear that the City has put forth a great amount of effort and demonstrated progress in addressing people with behavioral health needs who come in contact with the criminal justice system. It is intended that this report will provides a focus for the City to build on prior planning efforts and adjust next steps to implement programs and policies that can specifically target the best way to address the four key measures that are designed to reduce the number of individuals in jail with behavioral health needs. Additionally, to improve the ability to establish baseline measures, determine program capacity needs, and track progress moving forward, New York City should develop the needed data tracking mechanisms to accomplish this.

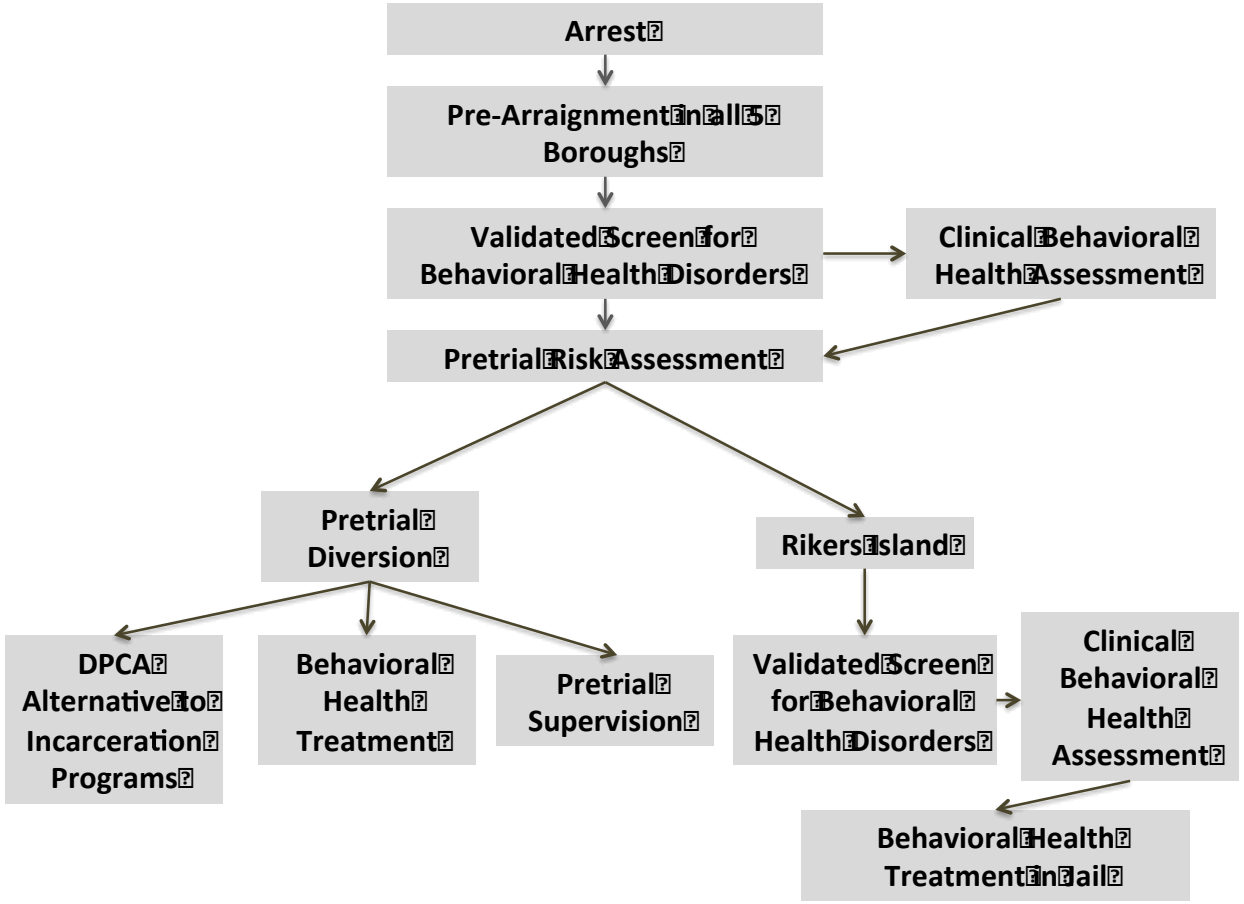
The CSG Justice Center commends New York City for requesting this report and applying an "outside lens" in assessing the current status of the New York City criminal justice system. The CSG Justice Center looks forward to an on-going conversation and sharing reports of progress in the implementation of these recommendations.

Appendix A: The following flow charts provide an overview of recommended processes for responding to people with behavioral health disorders in the criminal justice system:

Measure 1: Reduce the number of people with mental illnesses and substance use disorders booked into jail:



Measure 2: Reduce the average length of stay of people with mental illnesses and substance use disorders in jail



Measures 3 and 4: Increase the percentage of people connected to treatment and community supports and reduce recidivism rates