The seal of Broome County, New York, is a circular emblem. It features a central shield with a plow, a sheaf of wheat, and a bundle of cotton. Above the shield is an eagle with its wings spread, perched on a globe. The shield is supported by two figures: a Native American on the left and a woman on the right. The outer ring of the seal contains the text "SEAL OF BROOME COUNTY IN THE STATE OF NEW YORK" in a circular arrangement, with a star on the left side.

**MENTAL ILLNESS AND THE CRIMINAL JUSTICE SYSTEM
IN BROOME COUNTY
A Process Evaluation**

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MENTAL ILLNESS AND THE CRIMINAL JUSTICE SYSTEM IN BROOME COUNTY

A Process Evaluation

Summary

This project focused on how individuals with mental illness interact with the criminal justice system in Broome County, New York. This evaluation included an examination of the arrest process, court proceedings, competency exams, procedures at the local correctional facility, and reintegration of these individuals back into our community. At each step, there was an attempt to determine relative strengths and weaknesses of our local system, using interviews with key community members as a means of gauging what is and what is not working. Our goal in completing this project was to obtain an understanding of how the community can better serve the population of mentally ill individuals who interact with the criminal justice system.

Conclusions and Recommendations

- ❖ The combination of deinstitutionalization and increased rights of the mentally ill to refuse treatment has resulted in more untreated mentally ill individuals in the community; some of whom are committing crimes.
 - ❖ Some local police officers have received training to handle arrests involving individuals with mental illness; but this training should become mandatory and ongoing for all local officers.
 - ❖ Every individual booked into a local police lockup is screened for suicidality.
 - ❖ The Mobile Crisis Outreach team brought only two individuals to the Comprehensive Psychiatric Emergency Program (CPEP) in 2007. Increasing the capacity of this team to deliver services would be welcome.
 - ❖ Nearly one-quarter of all presentations at CPEP in 2007 (1,147 out of 4,635) were via police transport.
 - ❖ From 1992 to 2007 the number of misdemeanors committed in Broome County rose by 115% despite a decreasing population.
 - ❖ Opinions on opening a Mental Health Court in Broome County are mixed; further discussion at the county level is warranted.
 - ❖ In the absence of a formal Mental Health Court, local judges should consider greater flexibility in sentencing individuals with mental illness, and/or mandating mental health treatment as a component of sentencing.
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- ❖ There has been a 90% increase in the number of competency exams being ordered over the past three years. Of those evaluated, 37% were found to be incompetent.
 - ❖ Persons with Mental Retardation and Developmental Disabilities can be placed at Broome Developmental Center as an alternative sentencing arrangement or in response to being found incompetent to stand trial. Often they become civilly committed and can remain in this setting indefinitely, sometimes for committing minor offenses.
 - ❖ Individuals who require discharge planning prior to being released from the Broome County Correctional Facility often do not receive adequate connections to appropriate services. Linking inmates to mental health services and to the Medication Grant Program is necessary.
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INTRODUCTION

Background

With
deinstitutionalization has
come a growing concern
about the number of
mentally ill people in
correctional facilities and
state prisons.

In 1955, 559,000 patients were institutionalized in state hospitals in the United States (Lamb & Bachrach, 2001). However, by 1998, the number of residential treatment beds in state and county hospitals had decreased to around 63,000 (Manderscheid et al., 2000). Examining these numbers in the context of the growing U.S. population at the time, the number of occupied state hospital beds during this time period was reduced from 339 per 100,000 to 21 per 100,000 (Bachrach & Lamb, 2001). This is more than a 90% decrease in number of occupied inpatient beds. Several factors contributed to this decline, including effective psychotropic medication for individuals with severe mental illness, stricter standards for involuntary commitment, and a shift in the public's attitudes about patients' rights.

The civil rights movement of the mid-20th century was a fitting backdrop for the change in attitudes about mentally ill patients and their civil rights (Brown, 1985, p. 187). In the 1970's, there were many landmark legal decisions made; from Wyatt v. Stickney, which resulted in a ruling that patients had the right to refuse electroshock or other major surgery, to the 1979 Rogers v. Okin case, in which patients earned the right to refuse psychotropic medication (Brown, 1985, p. 197). These legal challenges worked together to create the deinstitutionalization movement, which moved thousands of individuals out of inpatient units, and prevented new people from being admitted. This resulted in an increased number of mentally ill people living on their own in their communities (Markowitz, 2006).

These trends have been mirrored in both New York State and Broome County. In New York alone, the number of patients in psychiatric hospitals decreased from 93,000 in 1953 to 6,000 in 1999 (Winerip, 1999). Broome County's largest psychiatric inpatient unit, Greater Binghamton Health Center, currently has 149 adult inpatient beds, down from 3,500 in the 1950's. This, too, is more than a 90% decrease in the number of inpatient beds at this facility.

With deinstitutionalization has come a growing concern about the number of mentally ill people in correctional facilities and state prisons (Brink, 2005; Kinsler & Saxman, 2007; Lurigio & Fallon, 2007). It is estimated that in the United States, one in five incarcerated persons is afflicted with a major psychiatric illness

In July of 2007, 21% of the inmates at the Broome County Correctional Facility were taking psychotropic medication.

(Brink, 2005). The presence of a large mentally ill population in a correctional facility has a number of important implications, not the least of which is the idea that the “least restrictive environment” championed by the civil rights movement has resulted in the “trans-institutionalization” of the mentally ill. Those once housed in state psychiatric hospitals are now being housed in local jails and state prisons (Gilmartin, 1986). Thus, the combination of deinstitutionalization and increased rights of the mentally ill to refuse treatment has resulted in more untreated mentally ill individuals in the community, some of whom are committing crimes and becoming incarcerated. Indeed, in July of 2007, 21% of the inmates at the Broome County Correctional Facility were taking psychotropic medication.

Incarceration, however, is only one facet of the complex criminal justice system. From the time of arrest, through court proceedings, sentencing, and eventual reintegration back into the community, the course of a mentally ill offender can take many different turns. At each of these steps it is essential that care and consideration be given to this unique population.

Interactions between police officers and the seriously mentally ill are among the “most difficult tasks of police work.”

In January of 2006 Peter Sablich was fatally shot by Binghamton police officers after a series of dangerous events related to Sablich’s mental illness. This event was a tragedy that shocked the community and prompted a thorough investigation by the Broome County District Attorney, Gerald Mollen. In his January 2008 report, Mollen concluded that while the police officers were inculpable, “[Sablich’s] death highlighted the continuing, daily interactions between the seriously mentally ill and law enforcement.” These interactions, according to police officers who provided information to the District Attorney, “are among the most difficult tasks of police work.” As a result of this shooting, local police departments have been increasing their efforts to become adequately trained to handle mentally ill arrestees. Yet, arrest is only the beginning of one’s journey through the local criminal justice system.

Court proceedings can be affected when a competency exam is ordered. Competency, or the ability of a defendant to (1) understand the nature of the court proceedings and (2) assist in their own defense, often comes into question with severely mentally ill defendants. In the past three years, there has been an increase in the number of competency exams local judges have ordered. Administration of these exams prolongs court proceedings and requires human resources. In addition, the outcome of the exam

affects whether an individual will be hospitalized, restored to competency, or tried as usual.

As previously stated, around one-fifth of Broome County Correctional Facility's inmate population is receiving psychotropic medication while in custody. This creates an additional need in the correctional facility for qualified mental health professionals, doctors who can appropriately prescribe medication, and a caring staff who understand the unique experiences that a mentally ill inmate might have.

And finally, as mentally ill individuals are released from custody into the community, they are faced with a number of obstacles, such as obtaining appropriate and affordable medication, being connected with outpatient mental health services, and ultimately being reintegrated back into Broome County.

CURRENT PROJECT

The purpose of the current project is to examine how the mentally ill intersect with the criminal justice system in Broome County. To achieve this goal, each step of the criminal justice process will be examined, and strengths and weaknesses will be evaluated. This evaluation will encompass (1) situations that occur at the time of arrest; (2) court proceedings and competency exams; (3) Correctional Facility services for individuals with mental illness; and (4) an individual's release from custody and reintegration back into the community.

The aim of this project is to obtain an understanding of the criminal justice system as it relates to the mentally ill; and to ensure, that as a community, mentally ill arrestees, defendants, and inmates are served in the most effective and humanitarian way possible. In doing this, we are also creating a primer for mental health professionals who are not familiar with the criminal justice system.

Process Evaluation

This project is a process evaluation, which is a type of evaluation that (1) describes policies and procedures that are being implemented, (2) assesses the impact of the strategy on groups being served, and (3) determines the scope of efforts a system has attempted. It is *not* aimed at measuring outcomes such as recidivism rates, effectiveness of treatment, or validity of competency exams. The information presented in this report has been provided via interviews with a variety of city and county figures and many other

individuals from various professions and agencies in the area. Where possible, the information that they have provided is bolstered by data.

Systems and Participants

Each of the major institutions that are part of the criminal justice system in Broome County comprises key individuals who have the ability to effect change within their specific area. These individuals, such as the Broome County District Attorney and Public Defender, City and County Court judges, the Broome County Sheriff, local Chiefs of Police, social workers, lawyers, psychiatrists, nurses, nurse practitioners, and various administrative staff at local agencies have provided their insight about the complex topics that compose this project. Each of these individuals has been listed in Appendix A.

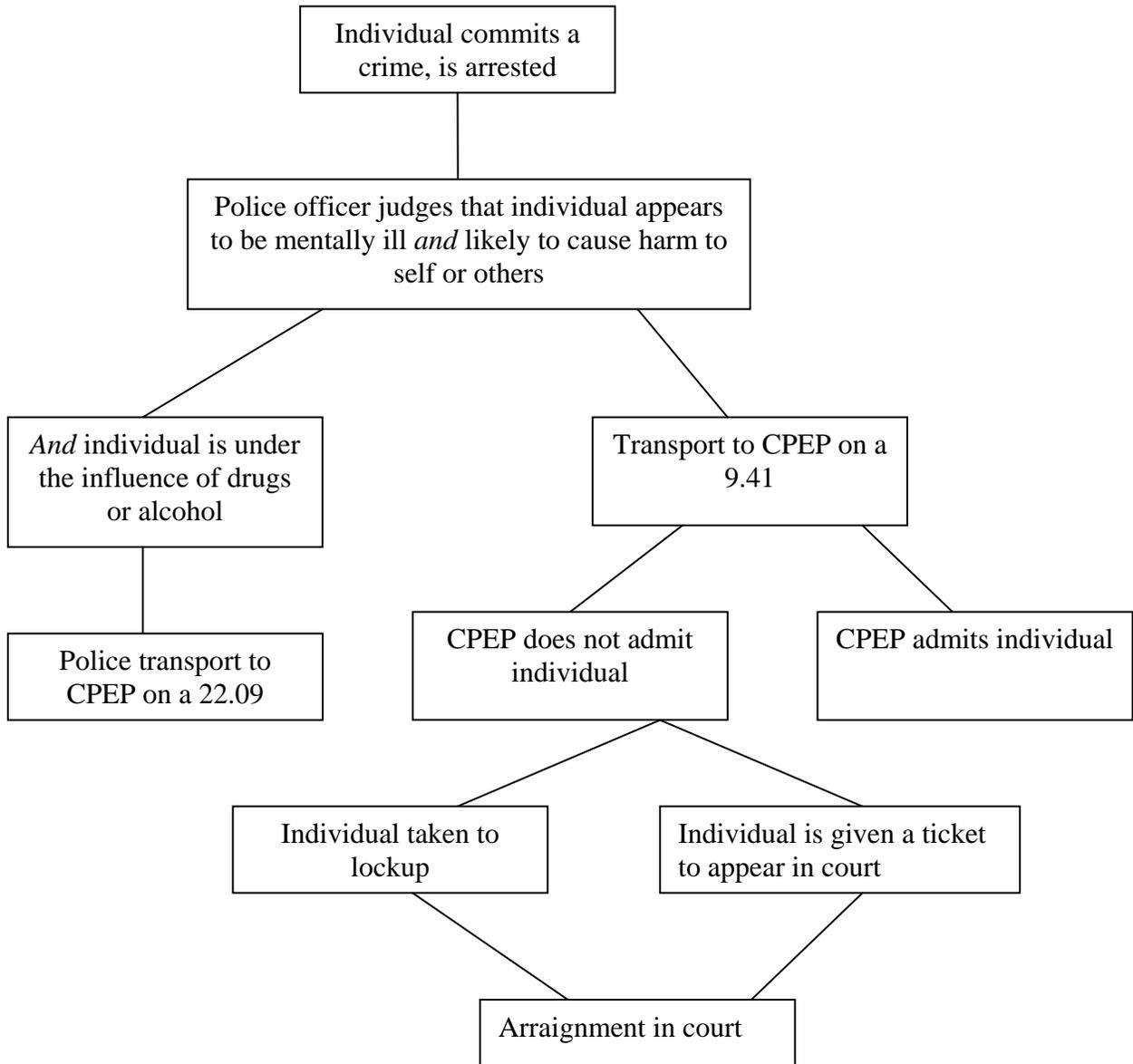
Limitations of the Current Project

As previously stated, the major limitation of completing a process evaluation is that outcomes are not specifically targeted or studied. In addition, the use of personal perspective is subject to bias and interpretation. Another limitation of the project is the low number of offenders and released inmates who were interviewed.

Flow Charts

There are multiple ways in which an individual with mental illness can proceed through the criminal justice system. For instance, they may be taken to CPEP prior to being booked; they may be given a competency exam; and they may or may not receive discharge planning prior to being released from the Correctional Facility. Rather than examining this process in a linear fashion, in which one step necessarily precedes another, it is being depicted as a flow chart. The flow chart representation allows for description of the variety of decision points that occur within the criminal justice system, and the many ways in which one person can move through this process.

Figure 1
Arrest Flow Chart



ARREST

Police Officer Training

Because an individual's entry into the criminal justice system begins at the time of arrest, it is essential that police officers are appropriately trained to respond to arrestees with mental illness. There are a number of techniques that police officers are trained to use with a mentally ill population, which police forces refer to as "emotionally disturbed persons" or EDP's.

The office of the District Attorney completed a report at the time of Peter Sablich's death that investigated the various aspects of the tragedy that occurred that night. Within this investigation the office examined police departments across the state and those departments' resources for mentally ill offenders. Gerald Mollen, District Attorney, was most impressed with the Rochester Police Department, a force that had trained one-quarter of their force for handling emotionally disturbed persons (EDP's). These trained officers had 40 hours of additional training focused on mental health and the ways in which the arrest of a mentally ill individual can be handled. The Rochester Police Department also tracked the number of incidents involving mentally ill offenders and the use of force by officers. Since the implementation of the additional training, the number of incidents had decreased dramatically in Rochester. With one-quarter of the force trained, there was always a trained officer on duty who could be called to the scene of an arrest and de-escalate the situation, or handle the situation, appropriately within the context of the arrestee's mental illness. This is an expressed goal for the Broome County District Attorney, who feels as though it is essential to have a police force that is appropriately and specifically trained to handle mentally ill arrestees.

It is essential that police officers be appropriately trained to respond to arrestees with mental illness.

Following the death of Peter Sablich, two officers from the Binghamton Police Department attended training in Albany that was co-sponsored by the New York State Office of Mental Health, Bureau of Forensic Services and the New York State Division of Criminal Justice Services, Office of Public Safety. At this training, entitled "Responding to Situations Involving Emotionally Disturbed People," the officers obtained information about how to identify the indicators of emotional disturbance, to understand the causes of emotional disturbance, to appreciate the experience of mental illness, to utilize the NYS Mental Hygiene Law, to make effective assessments and interventions, and to appropriately document their actions. After returning to Binghamton, these officers, along with representatives from local agencies such as CPEP, then guided the

local police force through Mental Hygiene Law (MHL) associated with mentally ill arrestees, and various other aspects of a well-handled arrest. The mental health training has become a part of the yearly in-service training for Binghamton police officers. In 2007, for example, 4 hours of the yearly training focused on mental health issues.

One key component of the officers' training includes knowing to "slow down" in an arrest with a mentally ill individual.

One key component of the officers' training through Albany includes knowing to "slow down" in an arrest with a mentally ill individual. Officers are trained to understand symptoms associated with severe mental illness, such as delusions and hallucinations in schizophrenia, the re-experiencing of trauma by individuals with Post-Traumatic Stress Disorder, and how mania presents in someone with Bipolar Disorder. One of the Binghamton officers who attended the training in Albany indicated that a lot of knowledge about handling symptomatic individuals comes from years of experience on the police force, and also said that the trainings were helpful. The Police Department has plans to re-administer the training in the spring of 2008.

The Vestal Police Department also undergoes training specific to mental health, but their model of training is slightly different. The Vestal police force, under Chief John Butler, attended training with other local police forces (e.g., Johnson City, Endicott) with a local clinical psychologist with experience in forensics. At this training, the officers learned about various aspects of mental illness from someone who has had years of experience in a variety of psychological and legal roles.

As the two models of training are different, it's important to understand the strengths and weaknesses associated with each of them. In the training for the Binghamton Police, local officers receive information about mental health issues of arrestees from fellow police officers. The inherent strength of this model is that the officers have a common language and set of common experiences that create an environment in which information is easily related. In the alternative (Vestal Police) model, the instruction is given not by a police officer, but by a doctorate-level psychologist who has years of experience with various aspects of mental illness and how it impacts individuals. Some feel as though it's best to utilize resources in our community to obtain such training, while others feel that the state's training is an appropriate method.

Local law enforcement agencies are making a concerted effort to train police officers to handle mentally ill arrestees in a humane and appropriate way.

In either case, it is known that local law enforcement agencies are making a concerted effort to train police officers to handle mentally ill arrestees in a humane and appropriate way. This cannot be

understated or ignored because of the enormous role that police officers play in the interaction of mentally ill offenders with the criminal justice system.

Comprehensive Psychiatric Emergency Program (CPEP)

One situation that often arises with mentally ill arrestees is presentation at Binghamton General Hospital's Comprehensive Psychiatric Emergency Program (CPEP). This is the first point at which an arrestee with mental illness could follow a different course than someone without mental illness. If at any point during the arrest process an individual indicates suicidal or homicidal ideation, the police force has been trained to immediately bring the arrestee to CPEP, where the individual can be evaluated and assessed for dangerousness.

The number of police transports to CPEP makes up nearly a quarter of all presentations.

A benefit of this practice is the elimination of liability for the police officer and police station in the case that an individual is suicidal or homicidal at the time of arrest. Allowing the arrestee to be evaluated by a trained professional provides a check in a complicated system, where the arresting officer is not the most effective judge of dangerousness or mental illness.

However, police transport to CPEP (that is, being brought to the hospital by a police officer) does not always occur following an arrest. It is also possible for the police to bring an individual to CPEP from a location such as the YMCA or the individual's home. In any case, the number of police transports to CPEP makes up nearly a quarter of all presentations. In 2007, there were 4,635 face-to-face presentations at CPEP total; the police brought in 1,147 of these cases. This large percentage (approximately 25%) highlights the continuing interaction between the police force and emergency psychiatric services in Binghamton.

The sections of Mental Hygiene Law that correspond to different types of presentation at CPEP are discussed in detail below.

Mental Hygiene Law

9.58 Mobile Crisis Outreach (MCO) Team Authorization for Transport

In this situation, an individual comes into contact with a Mobile Crisis Outreach team and the social worker or nurse on the MCO authorizes a transport to the hospital because the individual "appears to be mentally ill" or "is conducting him or herself in a

In 2007, the Mobile Crisis Outreach team saw two individuals.

manner which is likely to result in serious harm to the person or others.” An MCO exists through CPEP, but ability to complete these transports is entirely contingent on staff availability. In 2007, the Mobile Crisis Outreach team only saw two individuals. A staff dedicated to CPEP’s Mobile Crisis Outreach team would be appreciated in Binghamton, but lack of funding prevents this from happening.

9.41 Emergency Admission for Individuals with Mental Illness

As stated in the police training manual, “MHL section 9.41 authorizes [police officers/peace officers] to take a person into custody and transport to a...hospital any person who *appears* to be mentally ill and is conducting himself or herself in a manner which is likely to result in serious harm to the person or others.” Once presented, a 9.41 requires an evaluation to be completed by an Emergency Room doctor.

Police officers are trained to transport individuals to CPEP if, at any point during the arrest, the individual indicates that they want to hurt themselves or someone else. In this way, the police officers are “screening” for suicidality and homicidality, and bring the arrestee to CPEP for an evaluation. The police officers typically bring the individual to CPEP prior to bringing them to the police department to be booked.

One difficult aspect of this situation occurs when an arrestee a) doesn’t display aberrant behavior to hospital staff; or b) denies suicidality or homicidality upon evaluation. If the CPEP evaluation (completed by social workers, crisis evaluators, and registered nurses) reveals that an individual does not need to be admitted into the psychiatric inpatient unit, they are sent with the police officer to the police station or to the next step in the arrest process.

Another way that 9.41 admission can be complicated is when an individual is presenting with psychological symptoms (suicidality or homicidality), but is also under the influence of alcohol or drugs. Section 22.09 of MHL is specifically directed toward people in this altered state; but often, the two admission standards are blurred.

22.09 Emergency Services for Intoxicated Persons, and Persons Incapacitated by Alcohol or by Substances

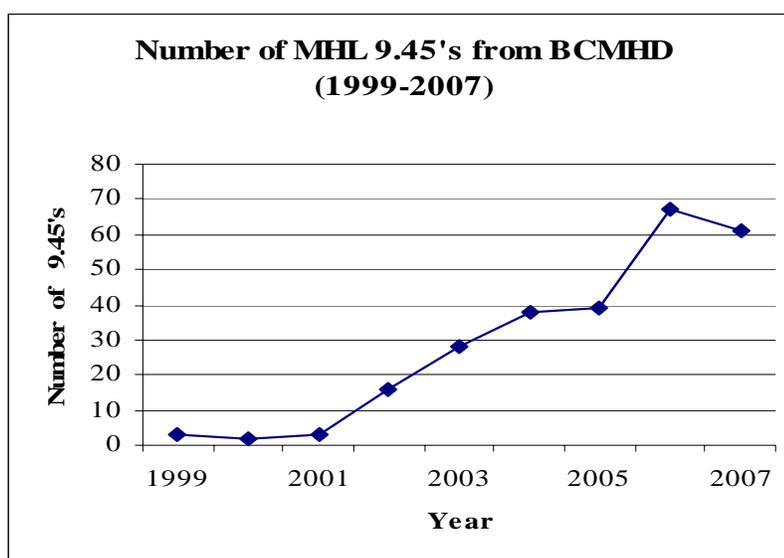
This section of MHL is specifically for individuals presenting for evaluation and/or admission who are under the influence of alcohol or drugs.

9.45 Involuntary Transport

Article 9 of the New York State Mental Hygiene Law contains sections that govern the decision to involuntarily transport a person to the psychiatric emergency room for evaluation. That is, when an individual in the community is acting in a way that seems to present “likelihood of serious harm,” a designee of the Director of Community Services (DCS) can impose emergency transportation of this individual. In these cases, community members will call the Broome County Mental Health Department, and a representative for the Mental Health Commissioner will complete an evaluation of the situation. If the evaluation reveals that the individual in question should, in fact, be seen at CPEP, a 9.45 Involuntary Transport is completed by the police. From 1999 to 2006, the number of 9.45’s completed at the Broome County Mental Health Clinic increased dramatically, and in 2007 dropped slightly. The table below provides data for this trend.

Graph 1

Number of 9.45 Transports from the Broome County Mental Health Department, 1999-2007



The following table presents the number of cases seen at CPEP, divided by the section of MHL which dictated their evaluation:

Table 1
MHL Transports to CPEP (2007)

Mental Hygiene Law Section	Description	No. of Cases to CPEP
9.41	Emergency Admission	1,147
9.45	Involuntary Transport	80
9.58	Mobile Unit	2
22.09	Alcohol/Substance Abuse	15

It's important to make a distinction between someone being brought to CPEP by a police officer when they are being arrested, and when they are not. During a 9.45 transport, for example, the individual in question does not have to have committed a crime – they can merely be presenting as a risk to themselves or others. However, if someone is being arrested at the time that they present a risk of harm, their interaction with CPEP can be very different.

For example, if an individual commits a crime, is arrested, and then indicates suicidality to the police officer, they will be brought to CPEP, evaluated, and possibly admitted into the inpatient unit. If this occurs, they will stay at the hospital until the doctors deem them ready to be released. In some cases, the individual is released from the inpatient unit and it is up to the police to find the individual in the public (if there is a warrant). However, some cases require the police to pick the patient up from the hospital on the day of their release, so that they can then be brought to the Correctional Facility and booked.

Lockup and Arraignment

Once an individual is booked at the Binghamton Police Department, they are held in the police lockup (a small holding area for individuals who have not been arraigned) until they can be arraigned at Binghamton City Court. In Binghamton, arraignments occur six days a week, including full work days Monday through Friday and Saturday mornings. Thus, the longest an individual can stay in the police lockup in Binghamton is around 48 hours – unless they are arrested on Saturday morning after arraignments are finished and they can not be seen until Monday morning.

In each of the local Correctional Facilities every individual is screened for suicidality by a police officer using a state-mandated form.

In Vestal, however, arraignments occur as soon as possible; including in the middle of the night. The holding area in the Vestal Police Department is much smaller than in Binghamton (2 cells versus 26), and it is preferred that individuals are arraigned quickly to prevent a lengthy stay in the smaller police department. In each of the Correctional Facilities though, every individual who is seen is screened for suicidality by a police officer using a state-mandated form. This form assesses for a variety of issues, including social functioning, medical history, and mental health history.

At arraignment the accused individual is brought before a judge. This is the first time the individual appears before the court, and is thus the first time the judge interacts with the individual. During this interaction the arrestee could be identified as mentally ill by the judge, who could order a competency exam. (These will be discussed in detail in later chapters.) In addition, the Public Defender's office has recently started being present for arraignments, which allows the office to become more familiar with the case, and to pre-determine need for their service. However, at this time, the individual does not necessarily have counsel. If an individual is released from court back to their own home, they might enter the system again on their court date. However, it is also possible that the individual is remanded to the Broome County Correctional Facility until his/her next hearing.

Arrest from an Inpatient Unit

One interesting way that individuals with mental illness can interact with the criminal justice system is when they are arrested *from* an inpatient unit. For example, if a patient assaults a staff member at the Greater Binghamton Health Center, it is possible that the staff will call the police. The policy, set by the District Attorney's office, requires that prior to an actual arrest the victim gives a deposition, and the charges must be reviewed. After this review the individual will be arrested if it is found that criminal charges are necessary. The Public Defender, however, feels as though there should be more discretion in choosing who to arrest than has been exhibited in the past.

CITY AND COUNTY COURT, MISDEMEANORS AND FELONIES¹

When an individual is arrested in Binghamton, there are a number of things that can happen. As has been described previously, if the individual presents with symptoms of mental illness, they might be taken to CPEP; however, the person might also be taken straight to the Correctional Facility to be booked; or be given a notice to appear in City Court.

At the pre-trial conference (discussed in detail below), the charges against the individual are reviewed. If the crime is a misdemeanor, it is tried or resolved in City Court. If the crime is a felony, the case is moved to County Court, where it will be either resolved or dismissed. Thus, the majority of cases seen in City Court are misdemeanors, and the majority of cases in County Court are felonies. There are exceptions to this standard; for instance, if a felony charge is sent to County Court and then lessened to a misdemeanor, the case might be resolved in County Court even though it is no longer a felony.

It is unclear if mentally ill individuals are committing more misdemeanors or felonies.

Misdemeanors and felonies are separate classes of crimes that carry different sentences if an individual is convicted. The maximum sentence for a misdemeanor is one year in the County Correctional Facility, and the maximum amount of time that a City Court judge can sentence a defendant to is two consecutive years in County Correctional Facility for two misdemeanor charges (one year per charge). Felony sentencing is beyond the scope of this report, as it generally occurs in a state prison.

Data regarding the incidence of felony versus misdemeanor crimes by individuals with mental illness is mixed; and the key individuals in our community hesitated to guess about who they feel is committing more of each type of crime. Some feel as though the majority of mentally ill offenders are committing the petty crimes, which carry lesser sentences. However, this estimation is qualified, because no data for this is kept in Broome County.

As a general rule, if misdemeanors are seen in City Court and felonies in County Court, the cases that the different judges see differ in severity. Judges Pelella and Lehmann are City Court Judges and the majority of their experiences are with misdemeanor crimes. Judges Smith and Cawley are County Court Judges and thus preside over felony cases. Their roles, and the roles of key figures within court proceedings, are discussed in detail below.

¹ For the purposes of this report, the discussion of court proceedings will focus on Binghamton City Court and Broome County Court. A list of township courts is included in Appendix B.

The Role of the Public Defender or Defense Attorney

The defense attorney is an important part of the legal process. In the case of a mentally ill offender this role becomes even more essential, as the defense attorney's position is that of representing the individual with mental illness in the most appropriate way possible. The addition of psychopathology into an already complex case can make the task of being an effective attorney even more daunting. If a defendant has the financial means, they will likely hire a private defense attorney to represent them in their court case. However, if they are unable to do this, they have the option to use the services of the Public Defender's office, which "provides legal representation to all indigent persons accused of crime in Broome County."²

As was previously mentioned, the Public Defender has begun having a representative present at arraignments in the City of Binghamton. However, the office also interviews each inmate that is booked into the County Correctional Facility. At the time of the interview eligibility is determined and the public defender either takes or does not take the case.

Between 1990 and 2000 the population of both Binghamton and Broome County were shrinking, but the number of misdemeanor crimes was increasing dramatically.

The number of cases that are seen by the Public Defender's office annually has been increasing. From 1992 to 2007 there was a 115% increase in cases seen by the Public Defender's office; most of which, they report, were misdemeanors. Interestingly, the population of Broome County, during roughly the same time frame (1990 – 2000), decreased by about 10%. It seems that while the population of both Binghamton and Broome County were shrinking (the city shrinking at a quicker rate than the County), the number of misdemeanor crimes was increasing dramatically. Public Defender Jay Wilber says the number of felony cases have remained constant (at around 800 per year).

In addition to the increase in the number of cases seen in the county, working with a mentally ill offender creates different challenges for their defense lawyer. Local attorneys have expressed frustration with the combination of factors that affect mentally ill clients. Such factors include the lack of social support that sometimes affects individuals with mental illness, and medication mismanagement (i.e., an individual being over-medicated or under-medicated) that creates an overall barrier to effective communication. These things are further complicated when attempting to work with a client who is currently incarcerated.

² <http://www.gobroomecounty.com>

The Role of the District Attorney

The office of the Broome County District Attorney is in charge of prosecuting criminals in Broome County. The office, which prosecutes around 1,600 felonies and 3,800 misdemeanors a year, is led by the District Attorney (DA), Gerald Mollen.

Some people feel that when mental illness is involved prosecution is not always appropriate.

While the DA is given *some* discretion over which cases his office chooses to prosecute, he is generally guided by statutes. When mental illness is involved, there is often no recourse or discretion allowed. For instance, in particularly heinous crimes where mental illness may play a role, the defendant and their lawyer have the opportunity to use Not Guilty by Reason of Mental Disease or Defect as a defense, but the complexity of this type of defense is beyond the scope of this report. In lesser crimes when mental illness may be involved, the DA has the responsibility of prosecuting individuals who may continue to be a danger in the community. However, other individuals in the system feel that when mental illness is involved prosecution within the criminal justice system is not always appropriate. Other action should be considered, such as mandating treatment or giving the individual probation instead of Correctional Facility time.

A common scenario that arises in the question of whether to prosecute includes an individual with a mental retardation or developmental disability (MRDD) diagnosis. Cases in which someone with MRDD has allegedly committed a crime are difficult; judges, attorneys, the DA, and the Public Defender agree. The issue is based around the idea that someone with MRDD may not be aware of the crime that they've committed, and they might not be maliciously committing a crime. As the DA said, though, he has a responsibility to prosecute individuals who are likely to commit other crimes. The complexity of the intersection of MRDD and the criminal justice system will be addressed later in the report.

Preliminary Hearing

At the preliminary hearing charges are reviewed, and a competency exam might be ordered. Competency exams evaluate the ability of the defendant to (1) understand the nature of their crime and its consequences; and (2) assist in their own defense, or have an appropriate working relationship with their defense lawyer. Competency exams (Criminal Procedure Law 730) can only be ordered by the presiding judge. However, it has been noted by City and County court judges that there are many times in which lawyers come to the pre-trial conference and suggest that their client be

given a competency exam. Judge Mary Anne Lehmann estimated that around half of the competency exams she orders are because she has determined the need for one, and the other half of the exams are ordered because one or both lawyers on the case have requested it. The details of 730 exams are covered in the next section of the report.

Sentencing the Mentally Ill³

Some judges advocate for “creative sentencing” for individuals with mental illness.

Whether an individual with mental illness has been given a competency exam and deemed competent, or not given one at all, sentencing for the crime proceeds as it would with a population without mental illness. There are a number of ways in which individuals can be sentenced. The most stringent sentence is state prison time for a felony, or local Correctional Facility time for a misdemeanor. An individual can be sentenced to a combination of Correctional Facility time and probation, probation only, or they can be given a conditional discharge or an unconditional discharge. A conditional discharge, as its name implies, is a sentence given by the judge that includes certain conditions the defendant must meet. Judge Lehmann has made taking medication a condition of an individual’s discharge, for example. Because it is not always possible to monitor that the conditions of discharge are appropriately met, it is sometimes necessary to include family members as part of the “team” to prevent an individual from coming back to court. Judge Lehmann estimated that nine times out of ten, people do what they’re told, in terms of fulfilling the conditions of their discharge.

When an individual has a mental illness but is competent to stand trial, they typically receive the same sentence as someone without mental illness. However, Judge William Pelella advocates for “creative sentencing” when it comes to individuals with mental illness. He is referring to the ability of the judge to take the individual’s mental health status into account in sentencing, such as allowing for lengthier probation instead of Correctional Facility time. Judge Mary Anne Lehmann tries to follow the same principle. However, both City Court judges and the District Attorney recognize that even with a mentally ill defendant, there are restrictions because of the law. In the same way that the DA is limited in the cases that he can choose to prosecute or not prosecute, the law is designed for mandated length of sentences and

³ Preliminary hearing and sentencing are not the only facets of court proceedings. An individual can also have grand jury proceedings and/or a jury trial. For the purposes of this report, only preliminary hearings and sentencing will be discussed.

types of sentences for certain types of crimes, regardless of whether the defendant has mental illness.

Sentencing the Mentally Retarded

Once placed at BDC, a person with MRDD can stay indefinitely, sometimes many years under a civil commitment procedure.

Mentally retarded persons, including those with significant developmental disabilities (MRDD), who have been convicted of a felony or misdemeanor, often receive traditional sentences (i.e. state prison, Correctional Facility, probation time). Some, however, become civilly committed to the Broome Developmental Center (BDC) as an alternative sentence arrangement. There are three civil commitment procedures including: 1) “voluntary” commitment in which the individual agrees to the placement, 2) “non objecting” commitment which is performed when the individual is thought to be unable to give consent and someone else (i.e. family member) gives the consent for placement, and 3) a two “Physician Certificate” (Two PC) involuntary commitment, when two physicians evaluate the individual and judge this person to be a danger to themselves or others or pose a risk to the community. It is also possible for a person with MRDD to have served his/her time at the Correctional Facility and be ready for release only to have a Two Physician Certificate commitment procedure performed and to be sent directly to BDC. Regardless of how they arrive at BDC, such individuals, once committed, can stay indefinitely—sometimes many years under a civil commitment procedure.

After being admitted they are provided access to legal counsel through Mental Hygiene Legal Services, although it is thought that a large number don’t take advantage of this service. If they are on a voluntary commitment status and request their release, BDC must do so within 72 hours. Mental Hygiene Legal Services are informed about such requests and provide counsel. Often these individuals are persuaded that staying at BDC is in their best interest and they revoke their request. It is believed that approximately half of the individuals who make such requests will change their minds. When a mentally retarded individual is persistent about being released but is thought to be a danger to themselves or others, this individual can be involuntarily committed to the facility, a process referred to as “retention”.

It is thought that many MRDD individuals who were committed to BDC via the courts or through Two Physician Certificate procedures often languish at BDC due to lack of an advocate, suitable housing alternatives, or community supports. Some argue that these individuals are better served at this residential facility where they are safe and their needs can be met, while at the same

time they are no longer a threat to the community. Others argue that the individual's loss of freedom through these indefinite commitments ends up being a much harsher punishment than what this person would have experienced in a Correctional Facility or on probation, especially for petty offenses. MRDD individuals fortunate enough to have a strong advocate, a place to live and community supports, are more likely to be released and returned to the community when their commitment is challenged.

Mental Health Courts

Mental Health Courts began in the 1990's as an alternative to incarceration for mentally ill offenders.

Hoping for the success that Drug Courts have achieved in diverting offenders out of the system, Mental Health Courts began in the 1990's as an alternative to incarceration for mentally ill offenders. The first mental health court (MHC) was established in Marion County, Indiana (Indianapolis) in 1996. This was followed by a MHC in Broward County, Florida (Ft. Lauderdale), a county that has a long history of using a progressive approach to handling mental illness in the criminal justice system. By February of 2005 there were 106 MHC's across the United States. In New York State there are 12 Mental Health Courts, with the two newest courts opening in the summer of 2007. The following table details the 12 MHC's in New York State. In comparison to the 12 MHC's, there are currently over 150 Drug Courts in New York State, 5 Sex Offense Courts and 29 Domestic Violence Courts.

Table 2
New York State Mental Health Courts

Judicial District	Location/County	Judge
Second	Brooklyn (Kings)	Hon. Matthew D'Emic
Fourth	Plattsburgh (Clinton)	Hon. Penelope Clute
Fifth	Utica (Oneida)	
Seventh	Rochester (Monroe)	Hon. Patricia Marks
Eighth	Buffalo (Erie) Lackawanna (Erie)	Hon. Robert T. Russell, Jr.
Eighth	Niagara Falls (Niagara)	Hon. Mark Violante
Ninth	White Plains (Westchester)	Hon. Barbara Zambelli
Tenth	Suffolk	Hon. Madeleine Fitzgibbon
Eleventh	Queens	Hon. Marcia Hirsch
Twelfth	Bronx – Supreme Criminal Division Bronx - Misdemeanor	Hon. John P. Collins

The mission of Mental Health Courts in New York is to “seek to improve public safety, court operations, and the well-being of people with mental illness by linking to court-supervised, community-based treatment defendants whose mental illness is related to their current criminal justice involvement.” This aim is achieved by utilizing a team approach, as in Drug Court, to (1) mandate mental health treatment for those individuals who need it, and (2) create a diversionary system for individuals who might not be appropriate for incarceration. In Drug Court these people might be those who have been arrested only once; in Mental Health Court those “inappropriate” for incarceration are individuals with mental illness who are compliant with and effectively treated by medication and/or therapy.

In the first 12 months as a Brooklyn MHC participant, only 16% of individuals committed a new crime.

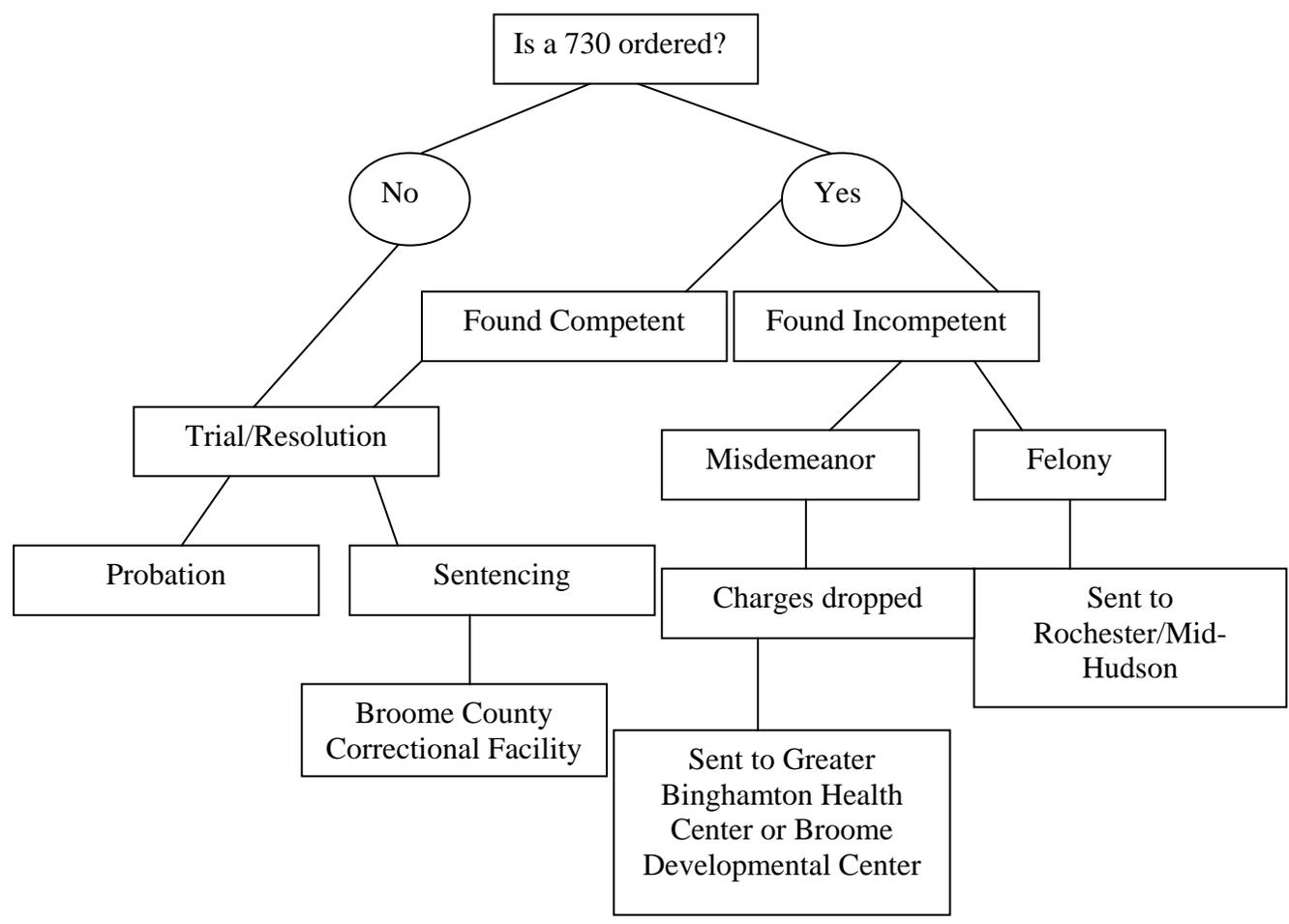
While these courts are relatively new, the Brooklyn Mental Health Court (BMHC) has already reviewed some of its main outcomes. As of June 2006 the BMHC had 262 total participants (current and past), 42% of which had graduated (that is, completed their treatment as mandated by the court). In addition, the BMHC’s study found that alcohol and drug use decreased significantly for participants, and homelessness rates decreased for graduates (although nonsignificantly). When comparing the 12 months prior to arrest with the first 12 months as a Brooklyn Mental Health Court participant, psychiatric hospitalizations also decreased (significantly), even though the court did not view psychiatric hospitalization as a negative outcome; rather, a facet of living with a severe mental illness. Importantly, during the first 12 months as a BMHC participant, only 16% of individuals committed a new crime, compared to 27% having been arrested in the year prior to becoming a participant in the BMHC. This difference is suggestive, but not statistically significant. Arrest during participation was not related to graduation, termination, or sentencing. In terms of psychosocial functioning, participants showed significant improvement on scales measuring problems with cognition, depressed moods, living conditions, occupations, and activities.

While all of these data support the effectiveness of the mental health court in Brooklyn, opinions in Broome County were mixed. City Court Judges Pelella and Lehmann preside over the large majority of misdemeanor cases in the community. While they both see a potential need for MHC, they both expressed hesitation at its implementation in terms of human and financial resources available. Gerald Mollen, Broome County DA and Jay Wilber, Broome County Public Defender, also indicated that there may be a need for a Mental Health Court, but they believe that the same constraints (human resources and available funding) apply. County

Opinions about a
Mental Health
Court in Broome
County were
mixed.

Court Judge Martin Smith denied the need for a mental health court in Broome County, but rather advocated for a more unified court system. However, Judge Cawley expressed enthusiasm about starting a mental health court in the area. Judge Lehmann stated that if there were a judge needed for this type of diversionary court, she would be more than happy to take on the role. One local defense attorney also supported this idea, and thought that a mental health court would be an improvement in our community.

Figure 2
CPL 730 Flow Chart



CRIMINAL PROCEDURE LAW § 730: NOT COMPETENT TO STAND TRIAL AS A RESULT OF MENTAL ILLNESS

Competency exams are intended to assess the ability of an individual to (1) assist in their own defense, by understanding the criminal court process and (2) have the ability to work with their defense attorney during court proceedings. Criminal Procedure Law 730 (CPL 730, or simply 730) exams are ordered by the presiding judge for an individual who appears to be unable to understand the various components of the proceedings. When a competency exam is ordered the County has the responsibility of providing two independent evaluations by psychologists or psychiatrists. In Broome County, competency evaluations are typically completed by county psychiatrists.

A competency exam includes assessment of an individual's understanding of many aspects of the judicial system. For instance, an individual receiving a competency exam might be asked to explain the difference between the defense lawyer and the prosecutor, or the difference between a judge and a lawyer. In the standard competency evaluation used in Broome County defendants are also asked if they understand their charges, and if they understand the possible penalties that can accompany their charges. In addition to basic understanding of questions, defendants are evaluated as to how well they might be able to assist in their defense by challenging witnesses and testifying relevantly. After each of the evaluating psychiatrists completes this objective rating form, they submit their report of competency to the judge. A consensus between the psychiatrists is required to move forward in the proceedings. If the two doctors disagree there is a court hearing, at which time the judge makes the determination of competency.

<p>It has been noted that it is efficient for both psychiatrists to evaluate the defendant at the same time.</p>
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The assessment instrument used in Broome County, called the Competency to Stand Trial Instrument, contains a 4-point scale, ranging from no incapacity, to mild, moderate, and severe incapacity on each of 13 items. There is no specific score on the assessment that determines whether the individual is competent. Rather, the evaluation is made using a combination of clinical judgment and item ratings. The assessment instrument that is currently used in Broome County is not a norm-referenced competency exam, and does not have a specific cut point for scoring to determine if an individual is competent or incompetent.

In 2004 Broome County Mental Health Department psychiatrists began meeting with the defendant together to decrease the frequency of disagreement about competency among the doctors.

Not only is this time-efficient, but it lessens the likelihood that the defendant will exhibit “practice effects” at the second administration of the evaluation. The simultaneous administrations also assist the psychiatrists in obtaining a single clinical impression of the defendant. Prior to the concurrent administrations, sometimes one psychiatrist would see an individual prior to the client being medicated, and the second psychiatrist would evaluate the defendant after two weeks of effective medication. In this case, the defendant’s presentations to the two doctors were quite different, and created a lack of consensus about competency.

Beginning in December of 2007 the County began requesting that the defense lawyer accompany the defendant at his or her competency exam.

Beginning in December of 2007 the County began requesting that the defense lawyer accompany the defendant at his or her competency exam. Having the lawyer and the defendant in the room allows the psychiatrists to evaluate the lawyer-client relationship.

If a defendant is deemed competent, the trial continues as usual. In this instance, the individual is sentenced according to NYS law, per their crime.

Found Incompetent to Stand Trial Due to Mental Illness

Criminal Procedure Law 730 makes a distinction between felony and misdemeanor charges, in which misdemeanor charges are dismissed upon a finding of incompetency, and felony charges are not dismissed, but the defendant is committed to the New York State Office of Mental Health.

Misdemeanors

In Broome County, if an individual is charged with a misdemeanor and they are found incompetent to stand trial, the charges will be dismissed. This is referred to as the CPL 730 Final Order of Observation.

At this time the case is sent to the Division of Forensic Services in Albany, where the case (individual) is designated to an inpatient treatment facility. If the individual, whose charges have now been dropped, is from the 6 county catchment area served by the Greater Binghamton Health Center (GBHC), they are sent there. The designation comes, then, from Albany; not from the local court. Sometimes the treatment facility is at capacity, and it is not possible for the individual to be admitted right away. In those cases, the individual stays at the Correctional Facility until a bed becomes available. Individuals rarely wait more than one or two days for this

Between July and December of 2007, 14 individuals were sent to GBHC after having misdemeanor charges dropped.

to happen. In fact, overall, there are never more than about two people on the waiting list for the GBHC. Between July and December of 2007, 14 individuals were sent to the GBHC on 730's. However, this number represents all six counties that are served by the facility.

With no forensic unit, this local inpatient psychiatric unit houses the individuals until they are ready to be integrated back into the community. Because each case is different, there is no average amount of time spent in the hospital. Stays can range from 30 to 90 days, depending on the severity of the individual's problem, and the extent to which they respond to treatment. In the best case scenario, someone arrives at GBHC, is compliant with and responsive to medication, and this person is discharged in three weeks. In the worst-case scenario, which is extreme and happens very rarely, individuals are committed, and eventually become long stays at the hospital. A long stay refers to an individual who has been at the hospital for more than a year.

The District Attorney expressed frustration at this aspect of the criminal justice system, where an individual charged with a misdemeanor is found incompetent and remanded to GBHC. In this case, the charges "go away," and he feels as though it would be more appropriate for the individual to get probation or some sort of penalty for having committed the crime.

Felonies

If an individual is charged with a felony and found incompetent, they are sent to a state psychiatric hospital forensic unit to be "rehabilitated" in order to return to County Court for their trial. This is referred to as the CPL 730.40 Temporary Order of Observation. As opposed to the Final Order of Observation that corresponds with misdemeanor charges, the Temporary Order holds that charges will *not* be dismissed for an individual charged with a felony.

Because felonies are generally seen in the County Court, Judge Martin Smith is the only local judge who has ordered an individual to a Temporary Order of Observation. Judge Smith's perspective on the intersection of mental illness and criminal justice was that mental illness seems to be no more or less important than any other factor precipitating a crime, or factor related to appropriate sentencing. He does feel that when individuals are remanded to an inpatient unit for competency training, they arrive back in court often overmedicated.

Forensic Hospitalization

For individuals who are remanded to Mid-Hudson for competency training, the median length of restoration is between 45 – 60 days.

Mid-Hudson Psychiatric Center has a total of 270 beds, although the institution is typically 10-15 patients over capacity. The number of beds has remained stable since 1996, and there are between 325-350 admissions per year. As a rule, patients at Mid-Hudson have not been sentenced. This means that their population is composed of (1) individuals who have been found incompetent on a felony charge, and have been remanded for competency training (there are 80-90 patients currently receiving competency training); (2) individuals who have been found incompetent on a misdemeanor charge (there are only 1-2 admissions per year for this reason); (3) patients who are found not responsible for reason of mental disease or defect (CPL 330.20, not covered in this report); and (4) individuals who have been convicted but not sentenced, because the patient might have been found not competent to be sentenced. This final cohort is small because this happens infrequently. This will also not be covered in this report. For individuals who are remanded to Mid-Hudson for competency training, the median length of restoration is between 45 – 60 days. Competency training is individualized and addresses the reasons why somebody does not have a rationale or factual understanding of the charges, courtroom procedure and ability to work with their counsel. Treatment might include medication for stabilization of psychosis, forensic education groups and one-on-one work. Data from Mid-Hudson shows that since January 1, 2005, they have had a total of seven admissions from Broome County. Of these, only two were under CPL 730 and of the rest four were CPL 330.20 and there was one admission under Mental Hygiene Law, Article 9.

Mental Retardation/Developmental Disabilities

The legal standard is the same for individuals with mental illness and mental retardation. The law refers to this as a “mental defect,” with no distinction made between the two, very different types of disorders. While the population of mental retardation or developmental disability (MRDD) offenders is much smaller than that of individuals with mental illness (the Public Defender sees between five and ten MRDD cases per year), the distinction becomes important within the context of competency exams.

Individuals with MRDD who are found incompetent to stand trial are not sent to the Greater Binghamton Health Center; instead, they are sent to the Broome Developmental Center (BDC), a state-operated residential facility for individuals with an MRDD diagnosis. These individuals take part in “Competency Training”,

Given the nature of MRDD, competency training for these individuals often takes much longer compared to those individuals who are mentally ill.

which is an attempt on the part of BDC to enable these individuals to become competent to take part in their own trial. There are currently several people who are in Competency Training at BDC. Given the nature of MRDD, competency training for these individuals often takes much longer compared to those individuals who are mentally ill. Those who are at BDC and receiving this training meet once a week with staff who teach them about various aspects of court proceedings, in order to increase their knowledge of the items on the competency evaluation. After 45 days, and then again every 90 days, individuals are re-evaluated for competency using the Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR), an objective competency assessment for individuals with an MRDD diagnosis.

For some individuals, and at the discretion of their attorney, after a year of competency training there can be a hearing to restore the order. This is referred to as a Jackson hearing, in reference to the precedent court case (Jackson v. Indiana, 1972). At this hearing, a determination is made about whether the individual should stay at BDC for further competency training, or be released to the community. If they do return to the community, the District Attorney may still press charges. The decision to proceed with a Jackson hearing is a complex matter and many variables are considered by the public defender or the Mental Hygiene Legal Services attorney as to what would be in the individual's best interest.

Related to this decision is the fact that every year of confinement on a BDC residential unit (excluding group homes) counts as one year of sentence served. If someone serves two-thirds of their maximum sentence allowed for their felony charge while at BDC, their sentence is considered complete due to "time served". At this point this individual can be released or converted to a civil commitment.

There are statutes that limit the amount of time an individual can stay in competency training. According to the law, this limit is described as "a reasonable amount of time," which has never been specifically defined. In the case that an individual has been in competency training for "a reasonable length of time," but is still not ready to be released to the community, the DA can drop charges and the individual's status may be changed to a civil commitment. In this instance, it is no longer a forensic case; it is a civil case, and the individual no longer attends competency trainings, but can remain at BDC, sometimes indefinitely.

Many MRDD persons who are found incompetent to stand trial end up being committed to BDC much longer than any traditional sentence would have required.

MRDD individuals who are charged with a misdemeanor and are found incompetent to stand trial are remanded to BDC where they must stay for 90 days, at which time the court must dismiss their charges. (No competency training is done with these persons.) Some of these individuals leave the facility at this time while others are civilly committed or a Two Physician Certification is performed to involuntarily commit them. Once committed, their confinement at this facility may go on indefinitely. Thus, many MRDD persons who are found incompetent to stand trial end up being committed to BDC much longer than any traditional sentence would have required.

Increase in Competency Exams

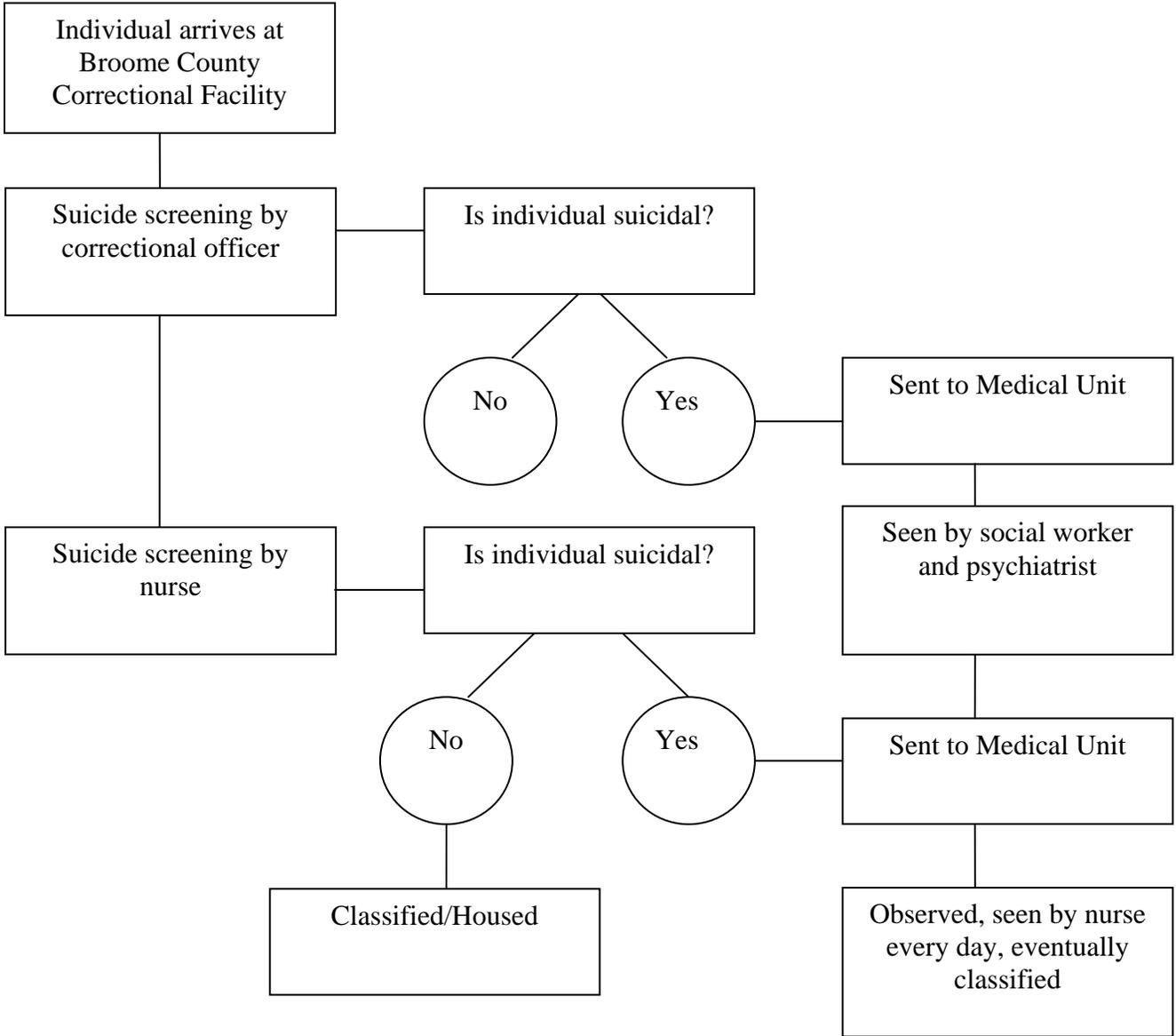
The data show that the number of competency exams ordered per year actually constitutes a very small percentage of the cases seen in City and County courts. However, there has been an increase in the number of competency exams ordered by local judges in the past three years. Judge Mary Anne Lehmann noted that she ordered more competency exams in 2007 than she has in any other year. Table 3 provides data about this trend.⁴

Table 3
Competency Exams in Broome County, 2005-2007

Year	No. of 730's	Incarcerated?	Number Found Incompetent	Percent Incompetent	Number Found Competent	Percent Competent
2005	29	22	10	34%	14	48%
2006	39	24	6	15%	30	77%
2007	55	28	21	38%	25	45%
TOTAL	123	74	37	30%	69	56%

⁴ The number of cases found competent and incompetent do not always sum to the total number of exams given. This is due to individuals pleading guilty, being noncompliant with psychiatrist appointments, being sent to inpatient units, and various other factors.

Figure 3
Broome County Correctional Facility Flow Chart



CORRECTIONAL FACILITY PROCEDURES

History of the Forensic Unit

At its inception in 1978, the Broome County Mental Health Department's (BCMHD) Forensic Unit operated with one full-time secretary, one part-time social worker, and one psychiatrist. Eighteen years later, at the beginning of 2006, the Forensic Unit comprised a 12-person team working directly in the Correctional Facility. From 1978 to 2006, the utilization of services for mentally ill inmates increased dramatically.

According to reports of Broome County social workers, the number of visits to individuals at the Correctional Facility went from one social worker seeing 1-2 clients per week to a rotating schedule of social workers seeing around 100 clients per month. Broome County Mental Health Department annual reports corroborate this information. In 1986 the county reported serving 100 individuals through the Forensic Unit. By 1999 the Unit was receiving between 350-400 referrals a month from Broome County Correctional Facility. In 2005 Psychiatric Service provided a total of 6,169 routine mental health visits including screening, assessments, psychosocial evaluations, and individual psychotherapy to inmates. Psychiatric and medication management totaled an additional 1,142 units of service for a sum total of 7,311 mental health visits at the Correctional Facility for the year.

On January 1, 2006 Correctional Medical Care, Inc. (CMC), a private company, assumed responsibility for providing mental health services to Broome County Correctional Facility inmates.

On January 1, 2006 Correctional Medical Care, Inc. (CMC), a private company, assumed responsibility for providing mental health services to Broome County Correctional Facility inmates. The following description of procedures applies to CMC.

Screening Process for All Inmates

Upon entry into the Correctional Facility, each inmate is screened by a corrections officer. This screening includes an extensive family history, medical history, and mental health history. Each inmate is then additionally screened by a registered nurse (RN) with forensic training. At this time, the RN obtains a more detailed medical history, as well as a more detailed mental health history. Each inmate is screened for suicidality by both the correctional officer and the nurse with a state-approved suicidality screening form.

If at any point in the screening process an inmate identifies suicidal ideation or intent, they are sent to the Medical Unit, where they are under more intensive observation. According to reports from CMC staff, only a registered nurse or a member of the forensic team (social worker or psychiatrist) can put someone in the Medical Unit for suicidality, and only a member of the forensic team can clear that individual from the Medical Unit. In other words, correctional officers are not making the decision about how to handle suicidal inmates – only nurses, social workers, and the psychiatrist are. In the case that someone is suicidal, the staff at the Correctional Facility has the option to call the psychiatrist, who is contracted for 10 hours per week, but is also on-call 24 hours a day. The psychiatrist does not typically come into the Correctional Facility to evaluate a suicidal inmate.

In the event that an individual arrives at the Correctional Facility under the influence of alcohol or drugs, this person must wait in the intake area or in the Medical Unit until he/she is sober enough to be interviewed. In addition, the individual sees a nurse within eight hours of admission.

Observation

Assuming no suicidal intent is expressed, the individual is sent to observation, which includes being sent to a specific area of the Correctional Facility that is devoted to, as the name implies, observing inmates once they are placed in a cell. As Correctional Facility staff indicated, sometimes people start “acting differently” once in a cell. If it becomes apparent during observation there are unreported mental health issues, the inmate is removed from observation and reevaluated.

The Correctional Facility has 10 days to determine where and under what level of security the individual should be housed. During this time, a background check is completed and the inmate’s behavior is observed. This time frame is essential in determining both dangerousness of the inmate (as evidenced by the criminal history that is provided by the background check) and the psychological stability of the inmate. If, for instance, during observation, the individual starts to express suicidal intent, this person will be referred back to the psychiatrist and Medical Unit. Staff reported that around 15% of inmates are in observation at any given time.

C-Pod, the Therapeutic Pod

The one-year recidivism rate of the Therapeutic Pod is 18%, compared to 67% for the rest of the Broome County Correctional Facility.

C-Pod began as a pilot project on January 1, 2001, intended to assist Correctional Facility inmates with the acquisition of skills and counseling to increase their likelihood of success upon release and reintegration into the community. There are three areas of focus within this Special Housing Unit (SHU): mental health, education, and substance use. Within each of these elements, there are courses, group therapy, and at times, individual consultation, for people who would benefit from these services.

To evidence the utility of this unique programming, in November of 2007, the one-year recidivism rate of the Therapeutic Pod is 18%, compared to 67% for the rest of the facility. This statistic is confounded, in that generally, individuals who are chosen for C-Pod have a variety of characteristics that make it less likely they will be arrested within one year of leaving the Correctional Facility. For instance, to be housed in C-Pod an inmate needs to be a resident of the local community (within 150 miles of Binghamton), expecting to be released into the local area, and motivated to being part of the C-Pod community. These factors are just as likely to predict low recidivism rates as the experience of being housed in C-Pod.

C-Pod has 100 volunteers that provide spiritual guidance, fellowship, education and ministry to inmates.

The chaplain is a key figure within C-Pod, because his team of 100 volunteers helps to provide religious counseling, life skills training, and parenting classes to inmates. Volunteers in the C-Pod do not administer mental health counseling – this is provided only by CMC staff. The volunteers provide spiritual guidance, fellowship, education and ministry – but the chaplain is sure to note this does not extend to mental health counseling. Once an individual in C-Pod has exhausted all of the opportunities for classes and group therapy, which takes around 90 days, this person can be moved back into the general housing unit. This opens up spots in the Therapeutic Pod for other individuals.

The mental health counseling that is provided by the CMC staff includes drug and alcohol groups, which meet four days a week, and typically contain between 10 and 15 people. CMC also provides a mental health group that is run by a social worker. All mental health services provided in the C-Pod (and in the rest of the Correctional Facility) are provided by CMC staff. Currently, this staff is composed of one psychiatrist, one nurse practitioner, two social workers, a drug and alcohol counselor, one discharge planner, and a variety of medical professionals (nurses, doctors, and a dentist).

Mental Health Referrals

During the time that BCMHD's Forensic Unit was in the Correctional Facility, the staff had around 30 referrals per day. A referral occurs when an individual in the Correctional Facility (either in C-Pod or not) requests to see a social worker, nurse or psychiatrist. According to a CMC staff member in the Correctional Facility, there are currently between 16-20 referrals per day.

Medication

In July of 2007, 21% of the population at the Correctional Facility was taking psychotropic medication.

Estimates of prevalence of mental illness in correctional facilities and state prisons have not been consistently reported, because of the lack of similarity of criteria for mental illness across studies. However, as previously stated, it is estimated that around one-fifth of the inmate population is suffering from mental illness. In July of 2007, 21% of the population at the Correctional Facility was taking psychotropic medication. In January of 2008, 26% were on medication. If one looks only at the number of people on medication, and uses this as a rough proxy for the number of people suffering from mental illness, it seems to closely match national estimates.

As part of its mental health services to inmates, CMC provides medication to inmates with psychiatric diagnoses. If an individual comes into the Correctional Facility and is compliant on medication but does not have it with him, medication is ordered over the phone through a contact with both the psychiatrist and current pharmacist. If the individual appears as though they would benefit from seeing a psychiatrist and being prescribed medication, that individual is seen by a social worker and then the psychiatrist. No one is prescribed or given medication without the psychiatrist's approval.

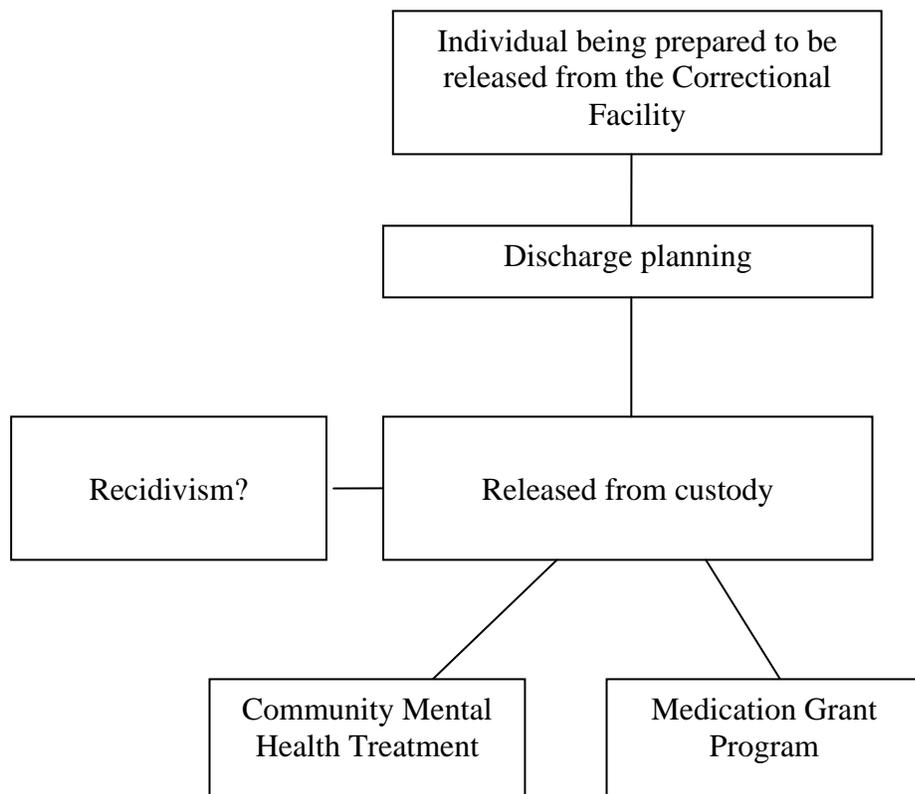
If the individual has filled a prescription for a medication within 30 days of being booked into the Correctional Facility, the Correctional Facility attempts to provide the inmate with the same, or a similar, medication to take while this individual is in custody. However, the Correctional Facility works with a formulary, or list of medications, that is acceptable for use and readily available to inmates. It is from this list that medications are prescribed for inmates.

The staff at the Correctional Facility report that the medications prescribed to individuals in their care are identical to, or closely match, those prescribed prior to entering the Correctional Facility. It is the opinion of many outside of the Correctional Facility, including agency workers, lawyers, and judges that inmates are

frequently taken off appropriate medication and are given different prescriptions or nothing at all, in its place.

Treatment over objection is not allowed at the Correctional Facility, so an individual who is not compliant on their medication is simply not treated with any type of medication.

Figure 4
Discharge Flow Chart



RELEASE AND REINTEGRATION

Discharge Planning

In an ideal discharge plan mentally ill individuals are connected to community treatment programs, housing, transportation, and clothing resources, if necessary.

Each individual who is released from the Broome County Correctional Facility that is on medication is supposed to be given an individualized discharge plan that connects them with appropriate services and agencies in the community who will assist this person with reintegration into a regular life. For these mentally ill individuals this discharge plan is supposed to include a referral to both Broome County Mental Health Department and the Medication Grant Program. However, because of the lack of diagnoses actually determined in the Correctional Facility and the transient nature of some of the inmate population, planning for mentally ill releasees is not always completed. In an ideal discharge plan mentally ill individuals are connected to community treatment programs, housing, transportation, and clothing resources, if necessary. This includes having an appointment made at the Broome County Mental Health Department, sometimes being connected with the YMCA for interim housing, and/or utilizing the Council of Churches' discharge planner, who finds clothing and housing for releasees. An individual who has an MRDD diagnosis is linked to Catholic Charities case management.

For an individual with mental illness who has been on medication within the Correctional Facility, being given access to medication outside of the Correctional Facility is an enormous hurdle. Technically, the Correctional Facility is allowed to dispense 3 days of actual medication (pills) to a releasee, along with a 30-day prescription for their medication that remains available for one week. In other words, the individual has seven days to fill his/her prescription, three days of actual medication, and a possible connection to the Medication Grant Program, a federally funded program that provides temporary Medicaid cards to individuals who are eligible for Medicaid.

Medication Grant Program

Eligibility for Medicaid includes having a low or no income, and no private insurance. If a released inmate needs medication upon release, the Medication Grant Program can provide assistance. During their transition from Correctional Facility to the community, the Medication Grant Program allows them to pay for their medication prior to obtaining a permanent Medicaid card.

This system lacks continuity in many places, which is evidenced by the data gathered on this facet of the process. During a 3-month period, from December of 2007 to February of 2008, discharge plans were created for 17 individuals, all of whom were referred to Medication Grant Program. Five of the 17, or about 30%, have come to Medication Grant Program for an appointment.

Other instances in which discharge planning fails are when individuals are bailed out, or when there are judge-ordered releases from custody that occur at the courthouse. In each of these instances, inmates leave the Correctional Facility prior to contact with the appropriate discharge planning staff members.

From December of 2007 to February of 2008, 5 of 17 scheduled individuals came to their Medication Grant program appointment.
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Even in the best-case scenario, individuals are given a Medication Grant Program business card, and instructed to make an appointment. The Medication Grant Program employee also receives the names of individuals who have been recently released from the Correctional Facility. However, these names are not accompanied by contact information, which means that they are people he could expect calls from, but if these individuals do not contact him, he has no way of getting in touch with them. In addition, it is not known if all of the releasees on medication are eligible for Medicaid. One of the barriers to treatment at this stage is that people who have been released from Correctional Facility are not interested in staying at the Correctional Facility longer than is absolutely necessary, thus leaving before they can be properly discharged.

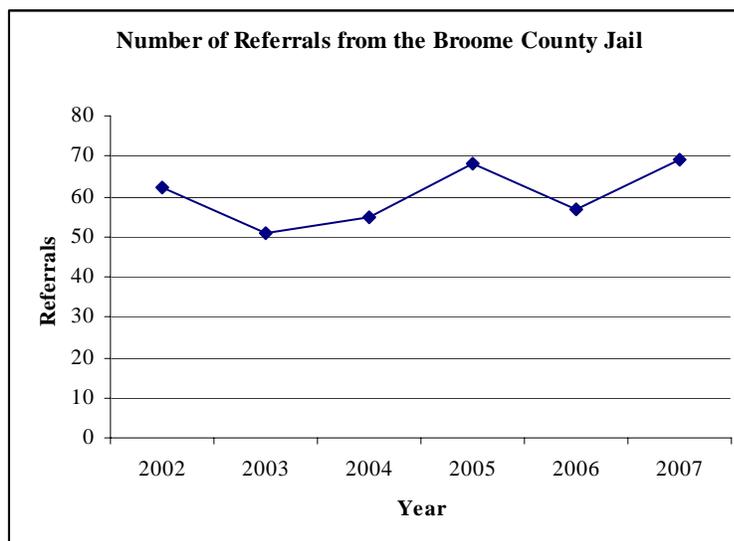
Broome County Mental Health Department

Another connection that can be made between a recently released inmate and the community is through the Broome County Mental Health Department. Only 50% of people who make appointments at the Broome County Mental Health Department ever arrive for their first appointment; the individuals referred from the Broome County Correctional Facility are no different.

Between 2002 and 2007 the average number of referrals from the Broome County Correctional Facility to the BCMHD was around 60 per year. This number has remained relatively stable from year to year, which could be due to a variety of factors. For instance, it could be that the mentally ill population at the Broome County Correctional Facility is neither growing nor shrinking – that the referrals to the Mental Health Department reflect a stable number of inmates with mental illness. It could also be that the number of mentally ill inmates who are being released back into Broome County and who are interested in receiving treatment has remained stable. This graph reflects only the past five years, though a more accurate examination of change over time might be evident in another five years.

Graph 2

Number of Referrals from the Broome County Correctional Facility to the Broome County Mental Health Department, 2002-2007



CONCLUSIONS AND RECOMMENDATIONS

- ❖ The combination of deinstitutionalization and increased rights of the mentally ill to refuse treatment has resulted in more untreated mentally ill individuals in the community; some of whom are committing crimes.
 - ❖ Some local police officers have received training to handle arrests involving individuals with mental illness, but this training should become mandatory and ongoing for all local officers.
 - ❖ Every individual booked into a local police lockup is screened for suicidality.
 - ❖ The Mobile Crisis Outreach team brought only two individuals to the Comprehensive Psychiatric Emergency Program (CPEP) in 2007. Increasing the capacity of this team to deliver services would be welcome.
 - ❖ Nearly one-quarter of all presentations at CPEP in 2007 (1,147 out of 4,635) were via police transport.
 - ❖ From 1992 to 2007 the number of misdemeanors committed in Broome County rose by 115% despite a decreasing population.
 - ❖ Opinions on opening a Mental Health Court in Broome County are mixed; further discussion at the county level is warranted.
 - ❖ In the absence of a formal Mental Health Court local judges should consider greater flexibility in sentencing individuals with mental illness; and/or mandating mental health treatment as a component of sentencing.
 - ❖ There has been a 90% increase in the number of competency exams being ordered over the past three years. Of those evaluated, 37% were found to be incompetent.
 - ❖ Persons with Mental Retardation & Developmental Disabilities can be placed at Broome Developmental Center as an alternative sentencing arrangement or in response to being found incompetent to stand trial. Often they become civilly committed and can remain in this setting indefinitely; sometimes for committing minor offenses.
 - ❖ Individuals who require discharge planning prior to being released from the Broome County Correctional Facility often do not receive adequate connections to appropriate services. Linking inmates to mental health services and to the Medication Grant Program is necessary.
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Appendix A
Interview Participants

- Judge Martin Smith, Broome County Court
 - Judge Joseph Cawley, Broome County Court
 - Judge Mary Anne Lehmann, Binghamton City Court
 - Judge William Pelella, Binghamton City Court
 - Steven Tronovitch, Chief of Police, Binghamton
 - John Butler, Chief of Police, Vestal
 - David Harder, Sheriff
 - Gerald Mollen, Broome County District Attorney
 - Jay Wilber, Broome County Public Defender
 - Dr. Ed Sorel, Broome Developmental Center
 - Dr. Rahman, Greater Binghamton Health Center
 - Dr. Hahn, Greater Binghamton Health Center
 - Dr. Clark Gardner, BCMHD
 - Maryann Fritsch, Greater Binghamton Health Center
 - Linda Daly, Nurse Manager, CPEP
 - Kevin Wright, Professor of Criminal Justice
 - Mark Smolinsky, Broome County Correctional Facility Administrator
 - Michelle Parsons, Head Nurse, Broome County Correctional Facility
 - Lori Roueche, Defense Attorney, Binghamton
 - Abby Mack, Director, Broome County Mental Health (BCMh) Clinic
 - Carole Belardinelli, BCMh Forensic Unit
 - Sandra Westgate, BCMh Forensic Unit
 - Dana Ward, Medication Grant Program
 - Sarah Miles, BCMh Social Worker
 - Dante Mastronardi, Nurse Practitioner, BCMHD, Forensic Unit
 - Robin Davies, BCMHD
 - John Fian, Binghamton Police Officer
 - Andrea Hanover, Sheltered Workshop
 - Heather Bench, Ulster County Forensic Unit
 - Cris Mogenson, Chaplain, Broome County Correctional Facility
 - Jack McAndrew, Resident Director, YMCA
 - Adam Hunter, Case Manager, YMCA
 - A. Laura Bevacqua, Senior Attorney, Mental Hygiene Legal Services
 - Three recently released (and anonymous) mentally ill individuals from the Broome County Correctional Facility.
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Appendix B
Municipality Courts in Broome County

- Barker Town Court
 - Binghamton Town Court
 - Chenango Town Court
 - Colesville Town Court
 - Conklin Town Court
 - Deposit Village Court
 - Dickinson Town Court
 - Endicott Village Court
 - Fenton Town Court
 - Johnson City Village Court
 - Kirkwood Town Court
 - Lisle Town Court
 - Maine Town Court
 - Nanticoke Town Court
 - Port Dickinson Village Court
 - Sanford Town Court
 - Triangle Town Court
 - Union Town Court
 - Vestal Town Court
 - Whitney Point Village Court
 - Windsor Town Court
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