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New York Supreme Court

Appellate Division–First Department

BRAD H., et al.,

Plaintiffs-Respondents,

- against -

THE CITY OF NEW YORK, et al.,

Defendants-Appellants.

BRIEF FOR *AMICI CURIAE:*

The National Alliance for the Mentally Ill, NAMI – Metro – NYC, NAMI – New York State, The Judge David L. Bazelon Center for Mental Health Law, The American Orthopsychiatric Association, The Coalition for the Homeless, The Coalition of Voluntary Mental Health Agencies, Inc., Community Access, The Legal Aid Society of the City of New York, The Mental Health Association of New York State, Inc., The Mental Health Empowerment Project, The Mood Disorders Support Group, Inc., The New York Association of Psychiatric Rehabilitation Services, The New York State Defenders Association, The New York State Independent Living Council and The State Communities Aid Association

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The National Alliance for the Mentally Ill ("NAMI"), NAMI-Metro-NYC, NAMI-New York State, The Judge David L. Bazelon Center for Mental Health Law, The American Orthopsychiatric Association, The Coalition for the Homeless, The Coalition of Voluntary Mental Health Agencies, Inc., Community Access, The Legal Aid Society of the City of New York, The Mental Health Association of New York State, Inc., The Mental Health Empowerment Project, The Mood Disorders Support Group, Inc., The New York Association of Psychiatric Rehabilitation Services, The New York State Defenders Association, The New York State Independent Living Council, and The State Communities Aid Association (collectively "amici") respectfully submit this brief in opposition to defendants' appeal of the Order of the Supreme Court, New York County (Braun, J.S.C.), dated July 9, 2000, and entered on July 18, 2000, which preliminarily enjoined the defendants from continuing to violate Section 29.15 of New York's Mental Hygiene Law and Part 587, Title 14 of New York's Code of Rules and Regulations ("NYCRR") by failing to provide discharge planning to mentally ill inmates of New York City jails ("City Jails") as part of the mental health treatment these inmates receive while incarcerated.

I. Preliminary Statement

In the last few decades, the criminal justice system has replaced the mental health system as the primary mental health care provider in the United States. In New York City, approximately 25% of the 130,000 inmates admitted annually to City Jails are in need of mental health treatment. Record on Appeal (hereinafter "R.__") 238. And, approximately 15,000 of these patients suffer from serious and persistent mental disorders. R. 238, R. 274. That number

is over three times the total population of adult patients in all state run public mental hospitals in New York. R. 274.[1]

The most common mental illnesses suffered by these inmates are psychotic disorders, including schizophrenia, and mood disorders, such as bipolar disorder and major depression. R. 238. Each of these illnesses is described below:

- *Schizophrenia* is a severe brain disorder that affects approximately 2 million Americans. NAMI, Understanding Schizophrenia 1 (1994). It typically produces major disabilities in thinking, feeling and behavior. Id. at 2. People suffering from schizophrenia may frequently experience visual or auditory hallucinations and paranoid delusions which can significantly impair a person's ability to communicate. Id. at 2-3. Although there is currently no cure for schizophrenia, its symptoms can usually be successfully controlled with medication. Id. at 5.

- *Bipolar disorder* is a disorder of the brain which, if untreated, is frequently characterized by rapid and uncontrollable shifts between severe mania and severe depression. NAMI, Understanding Bipolar Disorder 2 (1998); see also Frederick K. Goodwin, M.D. and Kay R. Jamison, Ph.D., Manic-Depressive Illness 4-5 (1990). Bipolar disorder is a chronic condition with recurring episodes, much like diabetes, and it generally requires ongoing treatment. If it is left untreated, the disorder tends to get worse and the symptoms become more pronounced. With proper treatment, it can be controlled. NAMI, Understanding Bipolar Disorder, at 2.

- *Major depression* is a serious medical illness that affects one's thoughts, feelings, behavior, and physical health. NAMI, Understanding Major Depression 4-6 (1998). It is among the most treatable of the major mental illnesses, usually through a combination of medication and psychotherapy. Id. at 9. When left untreated, however, major depression can severely impair mood, concentration, sleep, interpersonal relationships, and performance in work, school and other aspects of daily life. Id. at 4-6. Major depression should be distinguished from "situational depression" which typically lasts for a short period of time. Id. at 2-4.

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[1] This trend is not unique to New York City or New York State. On any given day, almost 200,000 people behind bars (approximately 1 in 10) suffer from schizophrenia, manic depression or major depression. R. 272. In contrast, there are only 72,000 patients with mental illnesses in state institutions. H. Richard Lamb, M.D. & Linda E. Weinberger, Ph.D., Persons With Severe Mental Illness in Jails and Prisons: A Review, 49(4) Psychiatric Services 483, 486 (Apr. 1998).

> By contrast, major depression may last for weeks or even months at a time and can be profoundly disabling. Id.

While incarcerated, these inmates receive various forms of treatment for these disorders on both in-patient and out-patient bases. Depending on the inmate's diagnosis, the City Jails provide psychotropic[2] medication, individual and group therapy, and/or 24 hour medical supervision. R. 240-42. When released, however, virtually all of these inmates are sent into the community without any discharge planning -- that is without the provision of a supply of their psychotropic medication, follow up appointments for the continuation of their therapy, and assistance in obtaining housing or other necessary public assistance. See infra part III.3.

Without this assistance, most inmates with mental illnesses cannot continue their mental health treatment after they are released. Many of these inmates were homeless and receiving Medicaid and other forms of public assistance at the time of their arrest. These public benefits are not immediately reinstated upon release, and as a result, many inmates have no way to pay for their medication and treatment. And, even those inmates with resources to obtain treatment need assistance in making the transition from the structured jail environment to the community, where they encounter complex rules, long waiting lists and other barriers to mental health services. In the absence of discharge planning to assist these inmates in obtaining treatment, they are unlikely to obtain mental health care after release. See infra part III.4.

As a result of the abrupt termination of their treatment, many inmates experience a relapse of symptoms of their mental disorder, an increased risk of suicide, and frequently wind up in a "'revolving door' of successive periods of hospitalization and reincarceration, interrupted

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2 "Psychotropic" medication refers to all medications used to treat psychiatric disorders and includes antidepressants, antipsychotics and antianxiety medications. R. 30.

by periods of release in which their psychiatric treatment is suspended and their symptoms recur." R. 59. Despite these consequences, and the emotional, physical and financial costs associated with them, the vast majority of inmates are released from City Jails without any type of discharge planning. See infra part III.5.

As discussed below, see infra part III.7., mental health professional organizations uniformly require that adequate discharge planning be provided to persons with mental illness before they are released or transferred from treatment by a health care provider. And, defendants do not (because they cannot) dispute that these services are essential. However, in spite of the fact that discharge planning is a widely accepted component of mental health care, defendants fail to provide this treatment to a vast majority of plaintiffs. As plaintiffs complain, defendants' failure to provide this planning violates New York's Mental Hygiene Law, New York's Code of Rules and Regulations and the Constitution of the State of New York.

This brief will describe the need for discharge planning and the consequences of not providing that treatment to these inmates, their families and their communities. For the reasons set forth below, as well as the reasons set forth in the brief of plaintiffs-respondents, dated September 12, 2000, the Order of the Supreme Court of New York should be affirmed and the injunctive relief requested by plaintiffs should be granted.

II. Interests of the Amici

Amici include a variety of local, state and national groups such as: organizations representing people with mental illness and their families; organizations of mental health professionals; organizations which provide services and advocacy for people with mental illness, for people with disabilities generally, and for homeless people; lawyers specializing in mental health issues; criminal defense lawyers for the indigent; and public policy advocates. On certain

issues some of these groups vehemently disagree with one another, but this diverse group of amici stand united on the issues presented by this appeal.[3]

Amici are uniquely qualified to discuss the issues presented by this case, including what constitutes appropriate mental health treatment for inmates with mental illness. The outcome of this case will have a profound impact not only on the plaintiffs and members of the class, but also on the millions of individuals with mental illness, their families and their communities. By this brief, amici will put the legal issues presented by this appeal into historical and social context.

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3 Each of these organizations is described in detail in the attached Appendix.

III. Argument

1. Jails Have Become the Primary Health Care Provider for Persons With Mental Illness in the United States.

There has been a dramatic shift in mental health care over the last forty years. Whereas in the past, most individuals with serious mental illnesses resided and were treated at state mental hospitals, in recent years mentally ill individuals have become more likely to be treated for their illnesses in jail. Many attribute this shift to a process known as "deinstitutionalization."

Beginning in the 1960's, and continuing over the last several decades, there has been a mass closing of public mental hospitals. At the same time, there have been significant cuts in the budgets of those state hospitals remaining open. As a result, in approximately 40 years, the United States has reduced its number of state in-patient hospital beds from 339 per 100,000 persons to 29 per 100,000 persons. H. Richard Lamb, M.D. & Linda E. Weinberger, Ph.D., Persons With Severe Mental Illness in Jails and Prisons: A Review, 49(4) Psychiatric Services 483, 486 (Apr. 1998).

Due to the dramatic decline in the number of in-patient beds available in state mental health facilities, states have accelerated the discharge of large numbers of severely and persistently mentally ill persons from public mental hospitals. Gerald N. Grob, The Mad Among Us: A History of the Care of America's Mentally Ill 287 (1994). Whereas in the years before 1965, many patients spent years, if not decades, in asylums, after 1970, the length of stays began

to be measured in days or weeks. Id. The numbers are striking: in 1955 there were 559,000 patients in state institutions; today that number has dropped to 72,000. Lamb, supra at 486.[4]

This process of deinstitutionalization was not intended to result in the end of treatment of the mentally ill. When deinstitutionalization began in the 1960s, new antipsychotic drugs had begun to make medicating patients on an out-patient basis a viable, less expensive and sometimes therapeutically preferable alternative to long-term hospitalization. It was believed that after their discharge the mentally ill would receive care, treatment and follow-up services while living in the community. The concept of deinstitutionalization contemplated the replacement of hospitals with a comprehensive network of out-patient clinics, residential programs, supported employment and other necessary services. See, e.g., U.S. Department of Health and Human Services, Mental Health: A Report of The Surgeon General 79 (1999) (hereinafter "Surgeon General Report"); E. Fuller Torrey, et al., Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals 52-53 (1992).

Unfortunately, due to inadequate funding and development, the community based services were unable to provide adequate care for a large portion of mentally ill individuals. See id. Even as New York has increased funding for community-based services and supports, people with mental illness are frequently unable to access community-based services on their own. This has left large numbers of mentally ill individuals without any treatment for their symptoms.[5] As

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4 There has been a similar trend in New York State. In 1953, there were 93,000 patients in New York State's mental hospitals; today there are less than 6,000. Michael Winerip, Bedlam on the Streets: Increasingly, the Mentally Ill Have Nowhere To Go. That's Their Problem -- And Ours, N.Y. Times Magazine, May 23, 1999, at 45.

5 As defendants put it:

[Footnote continued on next page]

a result, today many mentally ill people are being arrested and incarcerated for criminal behavior that most likely never would have occurred if these individuals were properly cared for in the community. See, e.g., R. 272-79; Lamb, supra at 486; Winerip, supra at 46; David Michaels, Ph.D., et al., Homelessness and Indicators of Mental Illness Among Inmates in New York City's Correctional System, 43(2) Hospital and Community Psychiatry 150, 154 (Feb. 1992).

In addition, some people with serious and persistent mental illnesses are arrested and jailed on misdemeanors or even no charges at all -- in so called "mercy bookings." See, e.g., Torrey, supra at 44-46 (29% of respondent jails admitted that they sometimes hold people with mental illnesses without charges). In those circumstances, "jails are merely being used as substitutes for psychiatric hospitals." Id. at 45. In New York City in particular, the recent crackdown on "quality of life" crimes has resulted in more people with mental illness than ever being jailed for misdemeanors that were previously virtually ignored by the police. See Patricia G. Barnes, Safer Streets at What Cost?, 84 A.B.A.J. 24, 24 (1998). As a result of these "junk arrests" of homeless people with mental illness, New York City "has turned prisons and jails into a catchment for mentally ill people who get into trouble." R. 274.[6]

[Footnote continued from previous page]

> [T]he greatest and most catastrophic gap is the failure in transition. While services may be sufficient, forensic mental health clients do not get those services because they do not get to those services. R. 304.

Without linkages, for many released inmates, services might as well not exist.

6 Amici do not contend that deinstitutionalization was a mistake or that the process of deinstitutionalization should be reversed. Rather, amici contend that the failure to allocate adequate resources and to adopt proven, evidence-based systems for addressing the needs of people with serious and persistent mental illnesses who were deinstitutionalized has contributed significantly to the problem of criminalization.

2. Mental Illnesses Can Be Successfully Treated.

The goals of deinstitutionalization were not unrealistic. In fact, due to significant breakthroughs in the last few decades, including the introduction of safe and effective psychotropic medications, new advances in treating co-occurring mental illness and substance abuse, and the development of comprehensive community services, the vast majority of people with mental illnesses can live successfully in the community. See R. 30.

As the U.S. Surgeon General has reported, "for most mental disorders, there is generally not just one but a *range* of treatments of proven efficacy." Surgeon General Report, at 65. In the past decade, there has been an outpouring of new medications for the treatment of mental illness. Id. at 68. Researchers have made significant achievements in developing effective therapeutic agents with fewer side effects, which are targeted to correct the biochemical alterations that accompany mental disorders. See id. at 68. In addition, researchers studying drugs for different purposes have found certain medications to be useful for treating mental disorders. This has led to the availability of medications such as chlorpromazine (for psychosis), lithium (for bipolar disorder), and imipramine (for depression). Id.

In addition to psychotropic medication, individuals with mood disorders, anxiety disorders, schizophrenia, and personality disorders can be successfully treated with various types of psychotherapy, which work primarily through the exchange of verbal communication. Surgeon General Report, at 65.[7] In some circumstances, the combination of pharmacological

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[7] There are a variety of forms of psychotherapy. They include: *psychodynamic therapy*, which focuses on a patient's past and his unconscious to understand the origins of behavior; *behavior therapy*, which focuses on current patterns of behavior, rather than early behavioral patterns of the patient; and *humanistic therapy*, which focuses on present behavior and the potential for future development. See Surgeon General Report, at 66-68.

and psychosocial treatment -- known as multimodal therapy -- can be even more effective than each individually. Id.

There is also evidence that non-traditional voluntary out-patient treatment programs are successful in treating mental illness. In fact, some non-traditional approaches to treatment have been shown to reduce the rate of hospitalization to a greater extent than more traditional approaches. For example, the U.S. Surgeon General has recognized that psychosocial rehabilitation treatment, which involves work and social skills training, provision of affordable housing, and educating patients about their illness and medication, results in "fewer and shorter hospitalizations than . . . traditional outpatient treatment." Surgeon General Report at 287.[8]

Traditional programs requiring individuals with serious and persistent mental illnesses to come to community mental health clinics at fixed times for weekly medication appointments and psychotherapy do not work as well as programs that are designed to respond more flexibly and comprehensively to the needs of individual service recipients. Assertive community treatment and continuous treatment programs utilizing multi-disciplinary teams to provide comprehensive services and supports to people with mental illnesses (many with co-occurring substance abuse disorders) have been highly successful in reducing jail recidivism, inpatient hospital stays, homelessness and other tragic outgrowths of lack of treatment. See, e.g., Jack E. Scott & Lisa B. Dixon, Assertive Community Treatment and Case Management for Schizophrenia, 21(4)

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8 In one program, 269 seriously mentally ill patients from state hospitals were allowed to live in the community with supports such as community housing, vocational clinics, educational supports and social skills training. At the end of the ten-year program, 62-68% of the participants showed no signs of their mental illness. See Courtenay Harding, Ph.D., et al., The Vermont Longitudinal Study of Persons With Severe Mental Illness II: Long-Term Outcome of Subjects Who Retrospectively Met DSM-III Criteria for Schizophrenia, 144(6) Am. J. Psychiatry 730 (June 1987).

Schizophrenia Bulletin 657, 664 (1995); Erik L. Goldman, Program Reduces Jail Recidivism for Mentally Ill, Clinical Psychiatry News, December 1996, at 26.

In addition, studies have shown that a self-help model of treatment can be also effective. In this model of treatment, a group of mental health patients defines its own goals and methods of treatment, making all major decisions. See Sally Zinman, Definition of Self-Help Groups, Reaching Across: Mental Health Clients Helping Each Other 1 (Sally Zinman et al., eds., 1987). The groups can take many forms: support groups, independent living programs, client-run housing, self-supporting businesses, and artistic groups. See id. at 11-12. Members of these self-help groups experience a dramatic decrease in the number and length of hospitalizations, as well as an increase in their abilities to cope with their illnesses. See, e.g., Marc Galanter, M.D., Zealous Self-Help Groups as Adjuncts to Psychiatric Treatment: A Study of Recovery, Inc., 145(10) Am. J. Psychiatry 1248 (Oct. 1998); Linda Farris Kurtz, D.P.A., Mutual Aid For Affective Disorders: The Manic Depressive and Depressive Association, 58(1) Amer. J. Orthopsychiatry 152, 153-54 (Jan. 1998).

As a result of this variety of available and effective forms of out-patient treatments, community based mental health care has not only become possible, it is frequently considered preferable to hospitalization. The "growing consensus within the mental health field [is] that, whenever feasible, people with mental illnesses should receive services in a community, rather than institutional setting." Opening Statement of A. Kathryn Power, Director, Rhode Island Department of Mental Health, Retardation and Hospitals, before U.S. Commission on Civil Rights, November 3, 1998. With the provision of appropriate treatment, including medication, coupled with intensive community services, people with schizophrenia or other serious and persistent mental illnesses are able to work, live independently, and otherwise function with

dignity in the community. See, e.g., Deborah J. Allness, M.S.S.W. & William H. Knoeder, M.D., The PACT Model of Community-Based Treatment for Persons With Severe and Persistent Mental Illnesses 4-6 (May 1999); NAMI, Understanding Schizophrenia 8-9 (1994).

3. Discharge Planning Is an Essential Component of Mental Health Treatment.

"Discharge Planning" is the process of planning and arranging for a patient with mental illness to continue to receive an appropriate level of treatment after discharge from the care of his or her current mental health care provider. R. 29. This planning should begin as soon as treatment for a patient's mental illness has begun and should be tailored to each patient according to his or her illness, the scope of medical services provided to the inmate prior to and during incarceration, and the ability of the inmate to function on his or her own after discharge. R. 41, R. 703, R. 706.

The extent of discharge planning services that should be provided to an inmate with mental illness depends upon a variety of factors, including the inmate's diagnosis, the treatment being provided to the inmate prior to and during incarceration, and the ability of the inmate to obtain treatment and services on his own after release. R. 31.

Adequate discharge planning should include some or all of the following:

(1) providing the patient with a written discharge plan;

(2) providing the patient with a temporary supply of medication and renewal of prescriptions, if necessary;

(3) providing the patient with referrals and linkages to community mental health care providers; and

(4) assisting the patient in obtaining necessary financial benefits, housing, placements, and appropriate linkages.

See, e.g., R. 31-32, R. 129, R. 690, R.703-706; American Psychiatric Association, Psychiatric Services in Jails and Prisons 38-39, 46 (2d ed. 2000).

The provision of these services is crucial. Mental health professionals widely recognize that "timely and effective discharge planning is essential to continuity of care and an integral part of adequate mental health treatment." American Psychiatric Association, supra at 18. Discharge planning helps to ensure that mentally ill patients do not relapse or decompensate after their discharge from the care of their mental health provider. However, although defendants and mental health professionals agree that discharge planning is an essential element of proper mental health treatment (see R. 1242, R. 1353-54, R. 1497, R. 1705), almost all inmates with mental illness are released without even the most basic level of discharge planning. Instead, inmates with mental illnesses who have completed their sentence are typically dropped off along with all other inmates at Queens Plaza early in the morning with nothing more than $1.50 in cash and a two fare Metrocard. See R. 12, R. 308, R. 723.[9] These inmates are returned to the community without appointments, medication, public benefits and very often housing. R. 12, R. 723. Without these crucial linkages to treatment and services, their chances of successful community reintegration are reduced, and their chances of becoming involved once again with the criminal justice system are significantly increased.

4. **Without Effective Discharge Planning, Inmates with Mental Illnesses Will Be Unlikely to Receive Continued Treatment.**

As a result of defendants' failure to provide discharge planning, when plaintiffs are released from the City Jails into the community, they are unlikely to continue their treatment with mental health care providers in the community. One 1992 survey estimated that only one-third of inmates with serious mental illness received continuing psychiatric services once they

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9 Those mentally ill pre-trial detainees who are not convicted or are sentenced to time served are released directly from court. They then must find their own way back to Rikers Island to retrieve their personal belongings. R. 12.

were released from jail. See Spencer P.M. Harrington, New Bedlam Jails -- Not Psychiatric Hospitals -- Now Care for the Indigent Mentally Ill, The Humanist, May/June 1999, at 9-13. Although New York City has a wide variety of community services available, as described below, there are several reasons why these inmates with mental illnesses cannot obtain care without assistance.

First, inmates with mental illness lose their Medicaid and other benefits when they are incarcerated and therefore cannot pay for treatment when they are released. A sample of inmates with serious mental illnesses in City Jails revealed that approximately 39% percent of these inmates had received SSI or SSD (social security disability benefits) before their arrest, 25% had received public assistance, and 16% had no income. Only 2% of these inmates had private health insurance, 63% relied on Medicaid, and 30% had no insurance at all.[10]

These benefits are not automatically reinstated upon an inmate's release from jail. Inmates who have received public benefits before their arrest become ineligible for Medicaid and other forms of public assistance upon incarceration, and it typically takes at least 45 days to reactivate these benefits upon release. R. 32; see also R. 1881 (an individual may have to wait up to 89 days after release to receive Medicaid and other entitlements). Unless these inmates are provided a temporary supply of medication and assistance in reactivating their benefits, they will be unable to obtain medication for a significant period of time. Adequate discharge planning can assist inmates with their applications to minimize the delay in reactivating these benefits.[11]

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10 This information comes from NYC-LINK's Pilot Project's preliminary year one data.

11 Federal disability benefits under the Supplemental Security Income (SSI) program or the Social Security Disability Insurance (SSDI) program provide both cash support and, in nearly all states, immediate and automatic coverage under Medicaid (or in the case of SSDI,

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Second, many inmates are also homeless. Approximately 43% of the inmates with mental illnesses incarcerated on Rikers Island are homeless at the time of their arrest. See Daniel A. Martell, Ph.D., et al., Base Rate Estimates of Criminal Behavior by Homeless Mentally Ill Persons in New York City, 46(6) Psychiatric Services 596 (June 1995); see also R. 32. The lack of a home and a telephone makes it almost impossible for a patient to arrange and keep appointments with treatment providers. These patients need assistance in obtaining appropriate housing arrangements upon their release so that they can continue to receive their treatment in the community. R. 32-33.

Third, many inmates with mental illnesses also suffer from other illnesses and substance abuse disorders. For example:

- 38% of all jail inmates have a history of alcohol dependence;[12]
- 85% of urban male detainees with severe lifetime mental disorder also have an alcohol disorder;[13]

[Footnote continued from previous page]
automatic coverage under Medicare). In New York, which supplements the federal payment, the maximum monthly SSI benefit is $580. Technical Assistance Collaborative, Inc. & Consortium for Citizens with Disabilities Housing Task Force, Priced Out in 1998: The Housing Crisis for People With Disabilities 43 (1999). SSI and SSDI are cash benefits that can be used to secure housing, and may be the critical difference between stability and homelessness for a person with mental disabilities. Medicaid coverage is critical for successful re-entry following a jail or prison term. Thus, individuals who are on Medicaid when they enter a City Jail should be able to leave with their Medicaid re-established, so as to immediately access services. Individuals who enter a jail without Medicaid coverage should be assisted with their applications and the state should make prompt decisions on eligibility so as to ensure coverage upon release for those who are eligible. Adequate discharge planning should ensure coordination with state Medicaid agencies and local community mental health agencies to facilitate this outcome. See Bazelon, Finding the Key to Successful Transition from Jail to Community (forthcoming 2000); Bazelon, Forging the Key: Recommendations for State and Local Policies to Ensure Successful Transition from Jail to Community for People with Severe Mental Illnesses (forthcoming 2000).

12 Bureau of Justice Statistics, Mental Health and Treatment of Inmates and Probationers, Washington, D.C., U.S. Department of Justice, 8 (1999).

- 58% of urban male detainees with severe lifetime mental disorder also have a drug disorder;[14]
- 85% of the City Jail population has a history of substance abuse (R. 238);
- 7% percent of mentally ill men and 20% of mentally ill women test positive for HIV (R. 237); and
- One in every six New Yorkers with tuberculosis has been in the New York State correctional system. (R. 237.)

These "co-morbidity factors" make inmates with mental illnesses more difficult to treat. These inmates frequently suffer from physical disabilities and require comprehensive integrated care. R. 33. Discharge planning needs to be provided to ensure that these patients receive appropriate referrals to substance abuse programs, medical care professionals and other community based treatment providers for a comprehensive, integrated treatment plan.

Fourth, the mental health treatment system is very complex and difficult to navigate, even for those individuals whose symptoms are not severe or are well controlled. People with serious and persistent mental illnesses frequently encounter long waiting lists, complex rules, unwilling providers, and other barriers to services. See Winerip, supra. Inmates frequently need assistance in making the transition from the structured jail environment to the community where they must obtain treatment, food and shelter on their own. R. 30. "It is generally not advisable for persons who have been hospitalized or incarcerated for a long time to be placed in the community in a living situation with little or no structure. Such individuals are frequently unable to cope with the immediate stress and demands of these arrangements, and they either decompensate or

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13 K. Abram, et al., Co-occurring Disorders Among Mentally Ill Jail Detainees: Implications for Public Policy, 46 American Psychologist 1036-45 (1991).

14 Id.

commit subsequent offenses." H. Richard Lamb, M.D., et al., Community Treatment of Severely Mentally Ill Offenders Under the Jurisdiction of the Criminal Justice System: A Review, 50(7) Psychological Services 907, 911 (July 1999). Individuals who are grappling with severe symptoms of schizophrenia, bipolar disorder or other major mental illnesses, may avoid the mental health system altogether if forced to navigate the often unwelcoming and stressful system without any assistance. The failure to provide these individuals with discharge planning and linkages to services increases the likelihood of homelessness and recurrence of the behaviors that led to their involvement with the criminal justice system in the first place.

Individuals with serious mental illness who have been arrested and spent time in jail or prison face many problems upon their release. Re-integration into the community will not be easy, but it will be nearly impossible if the individual has no source of income and no access to medical and mental health services including necessary medications. Individuals without benefits will not be able to afford housing, food or medications, causing them considerable distress and causing their mental health to deteriorate.

5. The Failure to Provide Discharge Treatment Can Result in Severe Consequences.

As described above, without discharge planning the treatment of many inmates with mental illnesses will abruptly terminate. This abrupt discontinuation of medication and therapy can have severe medical, emotional and financial consequences.

Approximately seventy to eighty percent of all inmates with mental illnesses need psychotropic medication to prevent the deterioration of their condition and to control their symptoms. R. 37. It is widely recognized that, for these medications to be effective, they must be taken continuously for long periods of time. Id. In schizophrenic patients, the stopping of medication is the most frequent cause of a relapse and a more severe and unstable course of

illness. The Expert Consensus Guideline Series: Treatment of Schizophrenia, 60 Journal of Clinical Psychiatry 75 (Supp. 1999). As many as four out of five patients who stop taking their medication after a first episode of schizophrenia will suffer a relapse. Id. In contrast, maintaining medication following recovery from an acute episode of schizophrenia reduces the risk of relapse in the ensuing year by 60-70%. Michael McPhillips & Tom Sensky, Coercion, Adherence or Collaboration? Influences on Compliance with Medication, Outcome and Innovation in Psychological Treatment of Schizophrenia, Chapter 9 (T. Wykes, et al., eds. 1998); see also Delbert Robinson, M.D., Predictors of Relapse Following Response from a First Episode of Schizophrenia or Schizoaffective Disorder, 56 Arch. Gen. Psychiatry 241 (March 1999).[15]

In addition to the return of the hallucinations, paranoia and psychotic thinking associated with an inmate's mental illness, the abrupt termination of medication can also result in physical withdrawal symptoms. "Many changes occur in the brain and the rest of the body after medications have been taken for a long time. In a sense, the body gets used to the drug and makes changes to accommodate it. If a drug is withdrawn too quickly, the body may not have enough time to prepare for the change and may, therefore, react in what seems a chaotic way . . .

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15 The effects of relapse or decompensation vary from person to person. When people with schizophrenia describe what they experience, the symptoms most commonly described are: alteration of the senses; an inability to sort and interpret incoming sensations, and an inability therefore to respond appropriately; delusions and hallucinations; an altered sense of self; and changes in emotion, movements and behavior. E. Fuller Torrey, Surviving Schizophrenia 30 (1995). The delusions and hallucinations associated with schizophrenia are frequently terrifying. The most common form of hallucinations are auditory hallucinations, including the hearing of sounds or voices. Paranoid delusions can also be experienced. An individual suffering from symptoms of schizophrenia may become convinced that others around her are trying to kill her, or that friends and loved ones are actually agents of the CIA or the FBI. Patients also commonly experience disorganized thinking and an inability to articulate words and sentences in an intelligible fashion. Id. at 28-83.

For example, . . . abruptly stopping the newer antidepressants-fluxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), [and] fluvoxamine (Luvox) . . . can produce dizziness, nausea and 'shocklike' sensations in the body." Jack M. Gorman, M.D., The Essential Guide to Psychiatric Drugs 41 (3d ed. 1997). Similarly, the abrupt withdrawal of diazepan (valium), a benzodiazepene used for the treatment of severe anxiety disorders, can cause symptoms such as convulsions, tremors, abdominal and muscle cramps, vomiting and sweating. The Physician's Desk Reference, 2527 (52d ed. 1998); see also R. 41.

As symptoms of the inmates' mental illness recur, many inmates will also face a higher risk of depression and suicide. R. 40-41. Fifteen percent of patients with affective disorders and between ten and fifteen percent of patients with schizophrenia commit suicide. Id.; see also Adina Wrobleski, Suicide: Why 55 (1989) (every year approximately ten percent of all persons committing suicide suffer from schizophrenia and another ten percent suffer from manic-depression).

Many inmates released without discharge planning also wind up back in jail. In a 1985 study in Columbus Ohio, 65 patients were followed after their release from state hospitals without discharge planning. Within six months, 32 percent of them had been arrested and jailed, almost all for misdemeanors. E. Fuller Torrey, et al., Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals 54 (1992). In addition to the psychological trauma this recurring cycle of reincarceration causes inmates with mental illness, reincarceration also results in significant financial costs to the defendants and the community. See infra part III.6.

The failure to provide discharge planning also results in significant burdens on community service providers. In the absence of discharge planning, many homeless shelters have become the de facto "discharge plan" for thousands of released inmates with mental illness.

See generally Martell, supra at 596-600; Carol L.M. Caton, Mental Health Service Use Among Homeless and Never Homeless Men With Schizophrenia, 46(11) Psychiatric Services 1139 (Nov. 1995). There currently exists no mechanism by which a community shelter is notified that a released inmate will be arriving, nor is any effort made to provide that shelter with information on the inmate's mental illness. As a result, when these inmates arrive at the shelter without a sufficient supply of their medication, they can disrupt the shelter and endanger themselves and other residents.

Similarly, the failure to provide discharge planning results in an enormous burden on hospitals. As discussed above (see supra part III.1.), many hospitals have significantly downsized their in-patient mental health facilities. For example, in 1953, there were 93,000 patients in New York's state mental hospitals; today that number is less than 6,000. Winerip, supra at 45. Hospitals no longer have sufficient specialized facilities to treat patients with mental illness. As a result, when released inmates suffer a relapse of their condition, many of them wind up in hospital emergency rooms. Treatment of the mentally ill in emergency rooms is not only more costly than community based treatment, it also results in the diversion of essential hospital resources from other emergency patients.

6. Defendants Are Able to Provide Adequate Discharge Planning to Inmates with Mental Illnesses.

Defendants do not claim that discharge planning is not an important component of mental health care. They do not because they cannot. Instead, they complain that because the inmate population is transient, there exists an "insurmountable barrier" to diagnosing and treating illnesses, and that the requested relief cannot be granted because some "inmates leav[e] the system before they are evaluated by mental health professionals." Def. Br. at 52. Defendants, however, are already identifying, evaluating and treating thousands of inmates with mental

illness each year. See R. 238. In addition, the plaintiff class only includes those inmates whose period of confinement in City Jails last 24 hours or longer and who have received treatment during their confinement. The class specifically excludes those patients treated by mental health staff on no more than two occasions who are assessed on the latter occasion as having no need for further treatment.

Moreover, inmates with mental illness tend to be incarcerated four to five times longer than persons charged with similar offenses. American Psychiatric Association, supra, at xix, see also R. 301, R. 1426-27.[16] And, a stay of only a few days is sufficient to develop an adequate discharge plan. The length of a psychiatric hospital stay is often no longer than a week, yet hospitals are able to -- and routinely do -- provide comprehensive discharge planning. See Supplemental Record (hereinafter "SR") 90-91 (discharge planning can be completed in a week for hospitalized patients).

Defendants also argue that because they cannot anticipate the release date of many inmates, they cannot provide "after the fact planning subsequent to release." Def. Br. at 53. However, discharge planning is not "after the fact" planning. Instead, it is widely recognized as a fundamental part of ongoing mental health treatment which should begin as soon as treatment begins. R. 41, R. 703, R. 706. Plaintiffs are simply asking defendants to take steps to ensure that the plaintiffs and the class are linked upon discharge with the treatment and services they need and frequently were already receiving while incarcerated. In any event, defendants have many resources at their disposal to assist them in predicting possible release dates of these inmates. For example, the Department of Corrections Inmate Information System contains information

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16 In any event, according to defendants, 80% of all inmates are incarcerated for more than 3 days, and 50% for more than one week. Def. Br. at 52.

such as scheduled court dates that would facilitate discharge planning for pre-trial detainees. SR. 32-33.[17]

Defendants complain that the requested relief will require "vast amounts of time and resources [to be] expended by both defendants and community-based providers in order to develop and implement an effective discharge plan." Def. Br. p. 54. However, the expense of time and/or resources cannot justify the failure to provide essential medical care. Moreover, there exists evidence to show that effective discharge planning would significantly reduce the reincarceration and rehospitalization rate among inmates with mental illnesses which would result in a significant savings of resources of the defendants and the community.

For example, in one study, a team of social workers and psychiatrists in Rochester, New York, followed the progress of 44 patients with a history of severe mental illness and repeated jail terms after their release from prisons or hospitals. Before entering the program, patients had spent an average of 104 days in jail (at a cost of $77 per day) and 114 days in hospitals (at a cost of $578 per day) at a combined cost of $73,000 per year. After receiving post-release medical and psychiatric treatment, clothing, food and housing through the program, these same patients spent an average of 45 days in jail and only 8 days in hospitals at a combined cost of $39,000 per

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17 Almost without exception, inmates who are not serving a sentence are released from court. By definition, this occurs on a scheduled court date. Information about each inmate's next court date is readily available in the Department of Correction's computer system (see SR. 32-33); indeed, this computer data is routinely relied upon by the Department in arranging to transport inmates to court. Thus, a basic discharge plan prepared upon an inmate's intake and promptly updated as necessary, could be provided to the inmate each time he or she goes to court so that it would be available in the event that the inmate was released at any particular court appearance. The rare instances in which members of the plaintiff class are released directly from a Department of Correction facility because they have posted bail or prevailed on a writ of habeas corpus present even less difficulty, as the previously prepared discharge plan could be given to the inmate by the correctional staff as part of the release process.

year per patient. Tom Hackett, A Dead End for Inmates, New York Daily News, August 27, 2000, at 35.

In 1996, the average cost of incarcerating an individual in a New York City jail was approximately $63,000. See The State Municipal Services in the 1990s: New York City Department of Corrections (June 1997). This amount does not account for the costs associated with the individual's arrest and processing through the criminal justice system. In contrast, the cost of providing supportive housing to an individual in New York City is approximately $12,000 per year or $33 per day, considerably less than the costs of incarceration. Elizabeth Kolbert, Housing Hope of Mentally Ill is Fading Away, N.Y. Times, January 19, 1998, at B1.

Similarly, the costs of community based treatment is substantially less than in-patient hospitalized care. One study of the costs of treating 321 formerly institutionalized individuals with mental disabilities in the community found that community-based services cost less than one-half as much as institutional care. Aileen B. Rothbard, et al., Service Utilization and Cost of Community Care for Discharged State Hospital Patients: A Three Year Follow Up Study, 156 Am. J. of Psychiatry 920-27 (1999) (total treatment in the community, including the cost of housing, was $60,000 per person per year compared to $130,000 for institutional care); see also, Kolbert, supra at B1 (estimating an annual cost of $113,000 to house a patient in a psychiatric hospital).

The provision of discharge planning in jails is not infeasible. In fact, other correctional systems have already begun to implement discharge planning programs. For example, in Ohio, community linkage representatives meet with the inmates with mental illnesses before they are released and refer the inmates to an appropriate service providers in the community. R. 42. The Cook County Jail system in Illinois is also implementing an expanded discharge planning

program for all released inmates with mental illnesses. SR. 75-77. Similarly, in Nassau County, inmates are provided prescriptions for medications and with referrals to community agencies and public assistance agencies to facilitate their applications for public benefits. R. 42.

By breaking the cycle of reincarceration, and conserving the resources that are necessarily expended by holding and treating these individuals in the City Jails, discharge planning not only benefits the inmates with mental illnesses, but defendants and the community as well.

7. Accepted Professional Standards of Mental Health Care Require That Adequate Discharge Planning Be Provided to Released Inmates.

Both the professional standards applicable to the field of psychiatry generally, as well as those developed in the specific context of jails and prisons, require that adequate discharge planning be provided to mentally ill persons before they are released or transferred from a certain provider's care.

a. Professional Standards Developed Specifically in the Jail Context Require that Discharge Planning be Provided to Inmates with Mental Illnesses.

As the number of incarcerated mentally ill persons exploded in recent years, professional groups such as the American Psychiatric Association (APA), the American Association for Correctional Psychologists (AACP), and the National Commission on Correctional Health Care (NCCHC), were faced with the following questions:

> [W]ith upward of 700,000 men and women entering the U.S. criminal justice system each year with active symptoms of serious mental disorders, with 75% of these people having co-occurring substance abuse disorders, and with these persons likely to stay incarcerated four to five times longer than similarly charged persons without mental disorders, what are our duties and responsibilities? How do we live up to our personal moral principles, our professional ethics, and our public service obligations in the face of these overwhelming numbers?

American Psychiatric Association, Psychiatric Services in Jails and Prisons xix (2d ed. 2000). To address this question, these and other professional groups began to develop standards for the provision of psychological services to inmates in jails and prisons in order to establish the minimum acceptable levels for psychological services for such offenders. This process has resulted in a consensus among these professional groups that discharge planning is an essential element of appropriate mental health care for inmates. In promulgating their standards, these groups have uniformly recognized that discharge planning, which may include services such as pre-release assessment, referral to community-based programs and services, making arrangements with local mental health agencies for the renewal of medication, and providing assistance in obtaining financial benefits and housing, is essential to the professional and ethical treatment of incarcerated persons in need of mental health care.

1. Standards of the American Psychiatric Association.

According to the APA, "[t]he fundamental policy goal for correctional mental health care is to provide the same level of mental health services to each patient in the criminal justice process that should be available in the community." American Psychiatric Association, Psychiatric Services in Jails and Prisons, 6 (2d ed. 2000). In accordance with that goal, the APA's Task Force on Psychiatric Services in Jails and Prisons has recognized that "[t]imely and effective discharge planning is essential to continuity of care and an integral part of adequate mental health treatment." Id. at 18. It therefore includes discharge planning as one of the three core components of psychiatric services to be provided in jails and prisons, with the other two being (1) screening, referral and evaluation, and (2) treatment. Id. at 31, 32.

The APA lists among the "essential services" to be included in adequate discharge planning, that: (1) appointments should be arranged with mental health agencies for all inmates with serious mental illnesses, especially those receiving psychotropic medication;

(2) arrangements should be made with local mental health agencies to have prescriptions renewed or evaluated for renewal; (3) the mental health treatment staff should ensure that discharge and referral responsibilities are carried out by specifically designated staff; (4) each inmate who has received mental health treatment should be assessed to determine appropriateness of a community referral; and (5) mental health staff should participate in the development of service contracts to ensure access to community-based case managers to provide continuity of service. Id. at 38-39, 46. In addition, adequate discharge planning may include help with the obtaining of necessary financial benefits and housing, placements, and appropriate linkages. Id. at 18.

Moreover, the APA has concluded that co-occurring mental illnesses and substance abuse disorders "require[] special attention to discharge planning." Id. at 51. For such disorders, "[*d*]*ischarge planning is required* and *must address* housing and job needs, family reconnection, and continued treatment." Id. (emphasis added).

2. Standards of the American Association for Correctional Psychology.

The standards promulgated by the AACP also include discharge planning as an "essential" component of appropriate mental health services. The AACP's standards, which provide the "minimum acceptable levels for psychological services for offenders," mandate that there be (1) a written, implemented procedure for the orderly discharge of inmate clients from psychological treatment, and (2) written, implemented policies and procedures that require psychological services personnel to ensure that provisions are made for appropriate postrelease follow-up care in the community. See American Association for Correctional Psychology, Standards for Psychological Services in Jails, Prisons, Correctional Facilities and Agencies, 27 Criminal Justice and Behavior 439, 476-77 (August 2000) (emphasis added). Moreover, a

psychological practice or service in a correctional facility that does not comply with these standards "strongly implies an ethical or practice violation," which "could result in litigation with civil and/or criminal consequences." Id. at 440. The AACP explains that the mental health needs of offenders should result in a continuum of care and that services should not stop simply because the person is released from jail. Rather, when inmates who have a continuing need for psychological services are released to the community, "the treating psychologist . . . in collaboration with the social worker, shall ensure that follow-up treatment services are arranged as part of the individual's release plan." Id. at 477.

3. Standards of the National Commission on Correctional Health Care.

The standards promulgated by the National Commission on Correctional Health Care (NCCHC) also include discharge planning among the "minimum requirements for health services in prisons." See R. 700, 703. The NCCHC thus requires "continuity of care from admission to the prison through discharge from it, including referral to community resources when indicated." R. 703. Moreover, in its Position Statement on Continuity of Care, the NCCHC states that "[i]t should be the responsibility of each correctional institution and correctional system to establish policies providing for continuity of care as outlined throughout the NCCHC *Standards for Health Services*." R. 706. Regarding the principles to be incorporated into such a continuity-of-care program, the NCCHC believes that:

> Prior to release, any inmate requiring continuing health care should be evaluated carefully as to post-release needs. An individualized pre-release health care plan should be developed for such an inmate. The health plan should be documented in the health care record and provided to the inmate. An appropriate outside health care provider . . . should be identified for the ongoing care of the inmate.

Id.

4. Standards of the American Public Health Association.

The American Public Health Association (APHA) also includes discharge planning among its Standards for Health Services in Correctional Institutions. Specifically, the APHA standards require that, upon the release of an inmate who has been receiving mental health care, the correctional staff must create a discharge/transfer summary that "must include specific information for the patient in need of follow-up care with referral to appropriate health care providers." R. 690. In addition, "[i]nmates transferred or discharged from custody must be given a supply of essential medications that is sufficient for several days or until they may reasonably be expected to be able to obtain necessary community follow-up." Id.

5. Standards of the American Association of Community Psychiatrists.

The American Association of Community Psychiatrists recommends that, to "address the serious problem of the mentally ill behind bars," we must "[e]stablish vigorous programs designed to reintegrate inmates suffering from serious mental illness and dual diagnosis into the community following release," by, among other things, (1) creating links to community providers to allow transitional treatment planning and follow-up; (2) establishing case management services prior to and following release, with programmatic links between providers to assure continuity of care; and (3) providing available and affordable housing, especially supportive housing programs that do not discriminate against homeless individuals with criminal histories. Position Statement of the AACP on the Mentally Ill Behind Bars, AACP Newsletter, Vol. 13, No. 2 (American Association of Community Psychologists), Spring 1999, at 2-3.

b. Professional Standards Applicable to Psychiatry Generally.

On a broader scope, in the field of psychiatry as a whole, it is also uniformly recognized that adequate discharge planning is an essential component of appropriate mental health care.

For example, a compilation of expert opinions regarding the proper treatment of schizophrenia emphasizes the importance of proper discharge planning. These guidelines note that "perhaps the most crucial aspect of discharge planning is ensuring that the patient does not fall through the cracks before the first outpatient appointment. The experts recommend scheduling the patient's first outpatient appointment within one week of discharge from the inpatient service." The Expert Consensus Guidelines Series: Treatment of Schizophrenia 1999, 60 Journal of Clinical Psychiatry 20 (Supp. 1999). The guidelines emphasize among the most important responsibilities for the discharging staff: (1) scheduling the first outpatient appointment within one week of discharge; (2) providing enough medications to last at least until the first outpatient appointment; and (3) providing an around the clock phone number to call for problems before the first outpatient appointment. Id.

The ethical standards governing psychiatrists and psychologists similarly require that they plan for the discharge of patients from their care. It is well established that physicians and psychologists may not ethically abandon a patient or client without providing for continuing care where it is needed. Thus, the American Psychological Association requires that:

> (a) Psychologists do not abandon patients or clients; [and]
>
> . . .
>
> (c) Prior to termination [of the professional relationship] for whatever reason . . . the psychologist discusses the patient's or clients views and needs, provides appropriate pretermination counseling, suggests alternative service providers as appropriate, and takes other reasonable steps to facilitate transfer of responsibility to another provider if the patient or client needs one immediately.

American Psychological Association, Ethical Principles of Psychologists and Code of Conduct § 4.09 (1992).[18]

* * * *

Considering this consensus among professionals in the field regarding the necessity of adequate discharge planning, there can be no dispute that defendants are professionally and ethically obligated to provide such services to plaintiffs.

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18 In addition, in New York it is "unprofessional conduct" for doctors, nurses, psychologists and other health care professionals to abandon a patient or client under or in need of immediate professional care, without making reasonable arrangements for the continuation of such care. See 8 N.Y.C.R.R. 29.2(a)(1).

IV. Conclusion

For the foregoing reasons, and those reasons set forth in plaintiffs-respondents' brief, dated September 12, 2000, the Order of the Supreme Court, New York County (Braun, J.S.C.) should be affirmed, the relief requested by plaintiffs should be granted, and this Court should grant such other and further relief as it deems just and proper.

Dated: New York, New York
September 12, 2000

Respectfully submitted,

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Appendix

The National Alliance for the Mentally Ill ("NAMI") is the nation's leading national grassroots self-help support and advocacy organization of individuals who suffer from serious mental illness, their family members and friends. NAMI was formed in 1979 and is currently comprised of over 200,000 members, with over 1,200 state and local affiliates. NAMI's work focuses on educating the public about severe mental illness as treatable brain disorders and advocating for the advancement of treatment and services for people with these disorders. NAMI and its members have a long history of advocating for policies and programs both to prevent the unnecessary incarceration of people with serious and persistent mental illness and to facilitate better services for persons with these illnesses during incarceration and following discharge. NAMI-Metro-NYC is NAMI's largest New York City affiliate. With more than 1,000 members, NAMI-Metro-NYC actively advocates for better treatment and services for people with mental illnesses in New York City. NAMI-New York State is NAMI's state umbrella organization for more than 70 affiliates throughout New York State.

The Judge David L. Bazelon Center for Mental Health Law ("Bazelon") was formed in 1972 and is the leading national legal advocate for people with mental illness and mental retardation. Bazelon's work is currently focused on the reform of public systems to serve individuals with mental disabilities in their communities, the provision of housing, health care and support services for the mentally ill, and protections against discrimination against the mentally ill.

The American Orthopsychiatric Association was founded in 1924 by Dr. Karl Menninger and others to foster a preventive approach to mental health. It is the premier interdisciplinary

mental health organization, with 5,000 members, including nearly 1,000 in New York State. It is comprised of psychiatrists, psychologists, social workers, educators, nurses, counselors, administrators, sociologists, anthropologists, lawyers, clerics and other professionals serving clients in the mental health context. It fosters collaboration among these disciplines, spurs development of new approaches, explores theoretical and clinical issues, and promotes integration of research, treatment and social policy. The Association has served as amicus curiae in many important mental health and developmental disabilities cases, including cases heard in this Court, the New York State Court of Appeals, the Supreme Judicial Court of Massachusetts, the First Circuit Court of Appeals, and the United States Supreme Court. The Association firmly supports efforts to enable mentally ill jail inmates to continue their treatment upon release.

The Coalition for the Homeless is the nation's oldest and most active organization dedicated to providing housing, advocacy and other services to homeless people. Through its housing and direct services programs, the Coalition serves more than 3,000 people daily, a majority of whom have identified special needs, including mental health needs. The Coalition has a long record of advocacy on behalf of New Yorkers with mental illness, including advocacy which helped bring about the provision of supported housing through the New York/New York I and II programs, and litigation to enforce the rights of mentally ill New Yorkers to receive discharge planning and community services upon release from hospitals. The Coalition has also been designated as the institutional representative of the plaintiff classes of homeless men and women in the State Court Callahan v. Carey and Eldredge v. Koch litigations, in which court orders require the provision of shelter and services to homeless adults, including substantial numbers with mental illness. The Coalition firmly supports efforts to enable mentally ill jail inmates to continue their treatment upon release.

The Coalition of Voluntary Mental Health Agencies, Inc. is a not-for-profit incorporated umbrella advocacy organization representing over 100 non-profit community-based mental health agencies that serve more than 500,000 clients in the five boroughs of New York City. The Coalition was founded in 1972. Member agencies provide a variety of mental health services to their clients including day treatment, clinic treatment, supervised housing, healthcare, rehabilitation services and case management. Several member agencies operate substance abuse programs and programs for people with co-occurring disabilities (e.g., substance abuse and mental illness) who have been discharged from correctional facilities after receipt of mental health treatment while incarcerated, and require continued mental health treatment after release. The Coalition conducts research, gathers information and engages in educational efforts directed to the public, legislators and regulators. The Coalition understands the vital importance of community-based mental health treatment and supports efforts to enable mentally ill jail inmates to continue their treatment after release.

Community Access is a not-for-profit agency providing housing, education and career development for people with psychiatric disabilities in New York City. Through 400 units of transitional and permanent supportive housing, it offers a home and the opportunity to build a social support network to people coming from homeless shelters and institutions. Supportive housing staff assist residents in gaining access to clinical services they need and want. In addition, it engages people with mental illness in relevant policy advocacy. It also provides clients with academic education, training, career planning, internships and job placement. Community Access firmly supports efforts to assist mentally ill jail inmates with continuing their treatment after release.

The Legal Aid Society of the City of New York, which has provided free legal services to indigent New York City residents for nearly 125 years, supports efforts to assist mentally ill jail inmates to continue their treatment upon release. The Society's Criminal Defense, Criminal Appeals and Civil Divisions all have extensive experience in representing poor New Yorkers who are mentally ill. In recent years, the Criminal Defense Division ("CDD") has handled 200,000 cases annually. Because of the prevalence of mental illness among defendants, CDD employs attorneys, paralegals and social workers who are dedicated to serving clients diagnosed with acute mental illness. The CDD's Special Litigation Unit, which litigates cases concerning the civil rights of people accused of crimes, has handled several cases involving the rights of mentally ill defendants. The Society's Prisoners' Rights Project ("PRP") advocates on behalf of inmates in the New York City jails and New York State prisons, and when necessary conducts class action litigation on the conditions under which they live. One such case was Reynolds v. Sielaff, settled in 1990, which addressed the quality of services and the conditions in the City hospitals' forensic units. More recently, PRP has been co-counsel in two class actions seeking to improve the quality of mental health care for prisoners in State correctional facilities. The Civil Division engages in litigation and advocacy on behalf of poor individuals and families with a wide range of problems, among them housing and benefits issues. A significant number of its clients are mentally ill.

The Mental Health Association in New York State, Inc. ("MHANYS") traces its history to the late nineteenth century. MHANYS is a not-for-profit membership organization composed of 32 community-based affiliates serving 39 counties. The affiliates provide services and advocacy to the residents of their communities. MHANYS is a leader in advocating for available and accessible mental health services at the state level. The growing trend toward the

criminalization of mental illness is among MHANYS' principal advocacy priorities. MHANYS is also an active participant in the federal policy advocacy efforts of the National Mental Health Association. MHANYS provides a variety of education and training services in cooperation with the New York State Office of Mental Health, including a training program for mental health service providers who work with people released from state prisons. MHANYS supports diversionary programs, increased mental health services in jails and prisons, and enhanced discharge planning.

The Mental Health Empowerment Project is a not-for-profit organization with the objective of maximizing the freedom, independence and recovery of clients of the mental health system. It provides training in advocacy, empowerment and self-help to consumer groups throughout New York State, and technical assistance to consumer-operated organizations. From its base in Albany, it has helped to start and works closely with over 500 self-help and advocacy groups and 30 non-profit corporations run solely by mental health consumers. The Mental Health Empowerment Project firmly supports efforts to enable mentally ill jail inmates to continue treatment upon release.

The Mood Disorders Support Group, Inc. is a not-for-profit organization founded in 1981. It now has over 700 dues-paying members in the New York City metropolitan area and a mailing list of over 2,000 people. Its primary mission is to assist people with mood disorders and their families and friends. It also educates the community at large about depression and manic depression, in order to emphasize their seriousness and reduce stigmatization. The Mood Disorders Support Group sponsors well over 100 "rap groups" per year, a lecture series by prominent professionals, a newsletter, a helpline, training programs by professionals for its rap group facilitators and telephone representatives, and the distribution of relevant literature. The

Mood Disorders Support Group is particularly interested in this case because manic-depression and major depression are among the serious mental health diagnoses frequently associated with people in the New York City jail system. The Mood Disorders Support Group firmly supports efforts to enable mentally ill jail inmates to continue treatment upon release.

The New York Association of Psychiatric Rehabilitation Services ("NYAPRS") is a statewide coalition of New Yorkers with psychiatric disabilities and the professionals who work in partnership with them in a variety of psychiatric rehabilitation and self-help service settings across the state. The rehabilitation services foster development of goals and skills relevant to the social, work, academic and community aspects of people's lives and include clubhouses, employment services, and intensive psychiatric rehabilitation centers. The self-help organizations include peer advocacy and support organizations, "peer bridge" services and consumer-run drop-in centers. NYAPRS is a not-for-profit organization with approximately 120 individual and organizational members. Through its organizational members, NYAPRS reaches and supports the efforts of approximately 15,000-20,000 recipients and providers of mental health services. It promotes a shift to a recovery-oriented service environment, promoting the wide availability of psychiatric rehabilitation and peer-operated services, and promoting the rights of people recovering from mental illnesses. To further these goals it engages in advocacy on policy and funding issues, acts as a clearinghouse for information, provides a variety of mental health service provider training programs, and operates innovative model programs. NYAPRS firmly supports efforts to enable mentally ill jail inmates to continue treatment following release.

The New York State Defenders Association ("NYSDA") is a not-for-profit membership association of more than 1,400 public defenders, legal aid attorneys, 18-b counsel and private

practitioners throughout the state. With state funding, NYSDA operates the Public Defense Backup Center offering legal consultation, research and training to the more than 5,000 lawyers who serve as public defense counsel in criminal cases in New York. Under its contract with the State, NYSDA is obligated to "review, assess and analyze the public defense system in the state, identify problem areas and propose solutions in the form of specific recommendations to the Governor, the Legislature, the Judiciary and other appropriate instrumentalities." It believes that the failure of New York City to interdict the cycle of recurring harm that occurs when indigent mentally ill prisoners are released without adequate discharge planning, as alleged in this case, represents a crisis for public defense lawyers as well as their mentally ill clients. NYSDA has for years worked with NAMI-New York State (also an amicus) and others to assure that its clients receive appropriate after-care services when they are released from jails. It strongly believes that the decision below represents a tremendous step forward for New York City and for people with mental illness.

The New York State Independent Living Council ("NYSILC") provides support to the statewide network of thirty-seven Centers for Independent Living. These centers are consumer-driven and serve the interests of people with all types of disabilities through "systems advocacy" and the provision of services designed to help people with disabilities gain independence and self-sufficiency. One of NYSILC's primary functions is to develop and pursue a public policy agenda to promote systemic change consistent with its vision of a world in which people with disabilities experience equal rights and opportunities in all aspects of society. NYSILC supports efforts to enable mentally ill jail inmates to continue their treatment upon discharge because it recognizes that, without continuing treatment, many such individuals will be unable to maintain health and freedom.

The State Communities Aid Association ("SCAA") was founded in 1872 when a group of civic-minded individuals was asked by New York State to help develop progressive human services laws. It is an independent, statewide, non-profit public policy organization which promotes progressive policies in health, mental health, children's services, and economic security. SCAA was involved in the development of the Public Health Law and the creation of the State Department of Health, the creation of the first after-care system for people released from state psychiatric hospitals, and the enactment of the Community Mental Health Reinvestment Act. SCAA's work on behalf of people with mental illness dates back to the 1880s, when it sought their release from poor houses. SCAA firmly supports efforts to link mentally ill jail inmates to community-based services upon their release.

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