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Report

Crime and Mental Illness in New York City: Framing the Challenge for the New Mayor

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Executive Summary

Throughout Bill de Blasio's two terms as mayor of New York, a decline in crime and criminal justice reforms pushed down the jail population to historically low levels. More recently, though, the jail population has leveled off, raising questions about the plan to "close Rikers" (which would require even sharper reductions still) and the criminal justice reform agenda more generally.

Reformers' ability to reduce the jail census from the current average daily population, of 5,000–5,500, to their goal of about 3,000 will depend on a number of factors. One is addressing the intersection of crime and mental illness.

In New York, as well as across the nation, the rate of mental illness is higher among the incarcerated population than among the general adult population. Throughout Bill de Blasio's mayoralty, policymakers devoted considerable attention and resources to addressing this problem. Most major mental health initiatives had a criminal justice motivation, at least in part, and most major criminal justice initiatives had a mental health motivation, at least in part. For example, bail reform was supposed to reduce the deterioration that many mentally ill individuals experience in the city jail system. At the same time, Mayor de Blasio's high-profile "ThriveNYC" mental health program was supposed to prevent the deterioration of seriously mentally ill individuals in the community, and thereby keep them out of jail.

This report will take stock of these efforts and frame the debate on crime and mental illness for the new mayor.

Chief findings include:

- In absolute terms, the number of seriously mentally ill people in jail in NYC has declined in recent years, tracking the jail decline more generally. In relative terms, though, the rate of serious mental illness remains as high as ever (above 15%, compared with about 5% for the

general adult population). This means that while general reforms aimed at reducing the jail population have kept some seriously mentally ill out of jail, the more targeted interventions designed for their specific benefit have been less effective.

- Average length of stay in jail has been increasing for inmates with any mental disorder.
- Inmates with any mental disorder and who have been charged with a violent felony constitute a growing share of the city jail population.
- Concerns about public disorder remain persistent, as reflected in press coverage and 311 data. New York is host to more than 13,000 seriously mentally ill homeless adults. That number rose throughout the de Blasio years.

If Mayor Eric Adams seeks to effect further reductions in the jail population by reducing the rate of mental illness, he should focus on the following:

- Protect the integrity of mental health courts. This will require avoiding sentencing reforms that make participation in mental health courts unattractive.
- Reduce the rate of substance abuse among criminal offenders via desistance mandates.
- Speak honestly and forthrightly about the problem of violent mentally ill offenders.
- Cease the reduction of inpatient psychiatric beds and increase use of outpatient civil commitment.

Introduction

New York City differs from other major cities in criminal justice policy in at least three ways. First, New York makes lower use of pretrial detention than elsewhere.[1] Second, the city's local jail population has plunged since the early 1990s, whereas incarceration numbers nationwide have declined more modestly.[2] Third, serious crime, though it has risen recently in the city, is still well below historical levels seen three decades ago.[3]

But one way New York does not differ is in its struggles with mentally ill criminal offenders. About 4%–5% of the general adult population has a "serious mental illness," meaning a functional impairment stemming from a psychiatric disorder.[4] The figure is about 15%–25% for jail and prison inmates.[5] The rates are similar nationwide and in New York City.[6]

Inmates with mental disorders remain incarcerated for longer, on average,[7] and recidivate at markedly higher rates than inmates without mental disorders.[8] Per one estimate, half of all Americans with serious mental illness will be arrested at some point in their lives.[9] They are less likely to make bail[10] and, while behind bars, are victimized at disproportionately high rates.[11] About 1 million mentally ill Americans are in jail, prison, or community supervision at any given time.[12]

The high rate of mental illness among incarcerated Americans is difficult to account for in its entirety. A convincing explanation must explain both why the rate of mental illness is so much higher than among the general population, and why that rate has risen over time. (Though historical data on jail and prison inmates' psychiatric conditions are elusive,[13] most experts suspect that the rate of seriously mental illness rose among the incarcerated population through the last decades of the 20th century.)[14] Some blame "mass" incarceration and the war on drugs,

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in particular.[15] Though seriously mentally ill individuals use illegal drugs at a higher rate than the general adult population, drug offenses alone account for only a fraction of the incarcerated population,[16] and that fraction is especially small in New York's jail system.[17]

The most obvious explanation for why there are so many mentally ill offenders is that mental illness causes criminality—and violence, in particular. Mentally ill people do tend to be more violent than non–mentally ill people.[18] But some criminologists argue that crimes caused by psychosis are real but too rare to account for why so many mentally ill people are incarcerated.[19] According to them, community-wide studies that find increased criminality among the mentally ill pick up various other risk factors such as substance abuse, malign social influences, unemployment, poverty, and antisocial personality disorders, which are standard drivers of criminal behavior.[20] Scholarly critics of the connection between mental illness and crime and violence don't argue that no connection exists but rather that the connection is overstated and indirect or "upstream."[21]

One advantage of focusing on the link between mental illness and crime is that it imparts a sense of urgency to mental health reform. Deinstitutionalization—which began in the mid-20th century—was premised on the idea that the mentally ill would receive appropriate community-based treatment outside an inpatient setting.[22] But community surveys report that about one-third or more of adults with serious mental illness receive no treatment.[23] Thus, in the 21st century, thousands of mentally ill Americans who, in former eras, would have been civilly committed to a mental hospital, are now confined to jails and prisons.[24] Careful social science analyses have estimated that some degree of trans-institutionalization—substituting incarceration for institutionalization—must have occurred, but does not, on its own, explain all the intersection between crime and mental illness.[25]

Criminal Justice Reform

Throughout the 2010s, New York policymakers actively pursued reducing the rate of mental illness in the city jail population. Some reforms targeted the criminal justice reform system proper; others targeted the mental health system.

In this report, I will first discuss the mental health implications of major recent criminal justice reforms undertaken during the 2010s, and then describe the criminal justice implications of major mental health reforms undertaken during the 2010s.

Bail Reform

The overarching goal of the criminal justice reform movement in New York City is to reduce contact with the criminal justice system and, especially, city jails. Contact with the criminal justice system is often presented as even worse for the mentally ill than the general population, due to their higher rate of recidivism and higher rate of victimization. The NYC jail system is administered by the Department of Correction, a local agency. The jails are used mostly for pretrial detention (to hold individuals charged with a crime but not yet convicted of it), as well as to impose short-term sentences. At the beginning of the de Blasio administration, use of pretrial detention in NYC was lower than in most other major cities.[26] Over 90% of individuals charged with a misdemeanor crime and over 60% charged with a felony were not held pretrial.[27] But advocates still believed that jail was overused. In April 2019, the state passed bail reforms that went into effect in January 2020, eliminating money bail and pretrial detention for almost all misdemeanor and nonviolent felony cases.

Bail reform was undertaken for several reasons, one being the threat that incarceration poses to mental health.[28] Reformers have frequently presented the case of Kalief Browder as somehow paradigmatic of the experience of thousands of Rikers inmates, particularly those with a

mental disorder. Browder was a Bronx resident who, while a teenager, was held for three years in the Rikers Island complex, while awaiting trial for an alleged assault and robbery. He had been on probation when charged with the new crime and was thus ineligible for bail. Though the robbery charge against him was eventually dropped, Browder committed suicide in 2015 after being released from jail.

The city jail population declined in the wake of bail reform and hit a low during the Covid-19 pandemic—about 3,800 inmates in April 2020—but has since risen. The average daily populations in December 2019, December 2020, and December 2021 were about 6,400, 4,900, and 5,400, respectively.[29] Some of the rise may be attributed to the crime increase since the passage of bail reform. Five out of seven index crimes increased between 2019 and 2021; murders are up almost 50% since 2019. Shootings doubled.[30] Still, the jail population is lower than it would be without bail reform. Despite the increase in crime, criminal justice researchers have found that, as intended, judges are detaining fewer people than they would have under pre–bail reform circumstances.[31]

Punitive Segregation

The limits placed on the use of punitive segregation is perhaps the clearest example of a criminal justice reform motivated by mental health considerations.[32] The de Blasio administration banned punitive segregation for the seriously mentally ill in 2015. Toward the end of his administration, Mayor de Blasio pushed for a categorical ban of punitive segregation. The city Board of Correction voted to end it in March 2021.[33] A majority of the current city council supports a ban on punitive segregation.[34]

Activists regularly insist that punitive segregation, in addition to causing mental deterioration, does not make jails safer. But in New York, the limits on punitive segregation have coincided with a sharp uptick in violent incidents among inmates, serious injury to inmates stemming from those incidents, and assaults on staff, none of which are optimal from a mental health perspective.[35] Mayor Adams opposes a categorical ban on punitive segregation.

Decriminalization

Bail reform deals with the contact that someone has with the criminal justice system after being arrested and charged with a crime. Reformers have also taken steps to reduce the severity of charges filed for certain behaviors, as well as the likelihood of arrest in the first place.

Much emphasis in the debate over mentally ill offenders has been placed on arrests for low-level crimes. The de Blasio administration's Behavioral Health Task Force, convened in 2015, highlighted a cohort of 400 individuals who had, collectively, accounted for 10,000 jail admissions during 2009–14. Some 85% of their charges were for misdemeanors or violations.[36] (Misdemeanors are crimes theoretically punishable by jail, though for no more than a year; violations are not crimes and theoretically punishable by up to 15 days in jail.)

To reduce contact with the criminal justice system stemming from low-level offenses, the city council passed the Criminal Justice Reform Act in June 2016. This law downgraded the seriousness of the following offenses: having an open container of alcohol, breaking park rules, public urination, littering, and unreasonable noise. These five offenses accounted for half of all criminal summonses issued before the bill was passed.[37] Police officers issue criminal summonses to appear in court in lieu of detaining someone while charging him with an offense. Before the act, the vast majority of criminal summonses were either dismissed (65%) or punished by a fine (21%).[38] Failure to appear in court can result in an arrest warrant.

Between 2009 and 2016, the issuance of criminal summonses declined by a third.[39] A city council report at the time acknowledged that "despite the fact that it is legally possible, defendants rarely receive jail time from a summons court."[40] Still, advocates argued that "these penalties are disproportionate to the respective crime,"[41] especially for those who failed to show up and had an arrest warrant issued.[42]

The five offenses are all now violations (a few were previously misdemeanors), punishable by a fine or community service with no possibility of jail for noncompliance.[43] The law went into effect in June 2017. In 2016, 267,763 criminal summonses were issued in New York City. In 2020, 55,600 were issued, a 79% decline, and a 90% decline since 2010.[44]

Local prosecutors have gone beyond decriminalization to unofficial legalization through formal "decline to prosecute" policies.[45] The most notable recent example of this practice is Manhattan District Attorney Alvin Bragg's "Day One Memo,"[46] but in Brooklyn and Manhattan, especially, local prosecutors had already been implementing decline to prosecute policies throughout the de Blasio years.

The Criminal Justice Reform Act reclassified certain offenses but still defined them as illegal. Decline-to-prosecute-policies treat illegal activities as if they are legal by announcing that, categorically, the charges will not be prosecuted. Examples of offenses that local prosecutors have said that they will decline to prosecute include turnstile jumping, drug possession, unlicensed street vending, prostitution and unlicensed massage cases, protest-related charges, and taking up two seats on the subway. The Manhattan district attorney formally declined to prosecute about 19,000 cases between 2015 and 2020.[47]

Theoretically, "declination" policies only reduce court-based contact with the criminal justice system and leave open the possibility of arrest. In practice, though, the New York Police Department has dramatically reduced arrests for offenses that prosecutors have announced will not lead to prosecution, as intended by those prosecutors.[48]

Close Rikers

Another major element of the de Blasio–era criminal justice reform agenda that had a mental health justification is the "Close Rikers" campaign. Rikers Island, in the East River, is host to eight of the 10 jail facilities run by the Department of Correction.[49] The city has committed to close the Rikers Island jail complex and replace it with four borough-based jails by 2027.[50] "Close Rikers" is seen as a symbolically important repudiation of New York's purported legacy of over-incarceration and as an opportunity to design jails that function in a more "rehabilitative, not just punitive"[51] fashion. Opponents of Rikers claim that the complex had had a tendency to exacerbate mental disorders among its inmates.

It will be difficult for the city to close the facility at all, however, if it cannot first address the crime rate among the seriously mentally ill. The planned borough-based jail system will be significantly smaller than the current system, not just different. A target jail census of about 3,000 is considered realistic,[52] which would entail a more than 40% reduction from the current census. As one Department of Correction official told the city council, "[T]he Borough-Based Jail System is at its core a jail population reduction plan."[53]

Interventions targeted toward the large cohort of offenders with mental health disorders have been proposed as a means of reaching that goal.[54] If NYC could lower the rate of mental illness among jail inmates to that of the general adult population, the jail census would decline by hundreds, perhaps even over a thousand.[55]

Severing the connection between crime and mental illness is not the only strategy behind the Close Rikers plan. But if New York fails to make any progress with that strategy, it will need to outperform with other strategies, including keeping crime down.

Crisis Response

In addition to reducing arrests and incarceration, the de Blasio administration sought to change the character of interactions between police and mentally ill people in the community. NYPD fields more than 100,000 calls for service every year that are coded as somehow related to mental health. Nationwide, about 200–250 fatal police shootings each year are related to mental health.[56] Police are said to lack the relevant expertise for helping people in psychiatric crisis. Those concerned about the risks posed by police contact with mentally ill people in the community have called for giving police specialized training or replacing police for some 911 calls. NYC, under de Blasio, pursued both routes.[57] At least 15,000 NYPD officers have received Crisis Intervention Training in de-escalation techniques, which would supposedly reduce the likelihood of police shootings and make incarceration a less likely outcome.[58] There is, as yet, no definitive evidence that this training has reduced fatal police shootings of mentally ill individuals, which ticked up after the training began.[59]

The Mayor's Office of Community Mental Health also pursued replacing cops on certain calls, through its highly touted Behavioral Health Emergency Assistance Response Division (B-HEARD).[60] This program was launched in June 2021, as a pilot in certain precincts, to "reimagin[e] New York City's mental health emergency response."[61] However, police continue to respond to most mental health crisis calls,[62] as is the case in other jurisdictions whose alternative emergency response programs on which B-HEARD was modeled.[63]

Mental Health Reform

The above-listed policies were all examples of criminal justice initiatives with a mental health tie-in. The de Blasio administration also pursued several mental health initiatives for their potential to reduce mentally ill New Yorkers' involvement with the criminal justice system.

Correctional Mental Health

When mentally ill people are arrested and put in jail, the city provides them with mental health services for two reasons. First, incarcerated Americans have a right to mental health care, thanks to courts' interpretation of the Eighth Amendment's prohibition against "cruel and unusual punishment." Second, jail-based mental health services may help forestall mental deterioration and suicide, as well as reduce recidivism, which, as noted earlier, is higher for mentally ill inmates than non–mentally ill inmates. Reducing recidivism among mentally ill offenders, in theory, should help continue to push down the local jail population and push jail inmates' rate of mental illness down closer to that of the general adult population.[64]

Before the de Blasio administration took office, city government already devoted tens of millions of dollars annually to jail-based mental health care.[65] Under de Blasio, New York increased its investment in correctional mental health services and restructured their delivery as part of a broader restructuring of jail-based health care. In August 2015, the de Blasio administration established Correctional Health Services (CHS) as a new arm of New York City Health + Hospitals. CHS took over functions previously contracted out to a private provider, with the goal of "a community level of care in the jail setting."[66]

Medical professionals screen everyone taken into the city jail system's custody and refer inmates for mental health evaluations.[67] Outpatient-style clinical services are available to any member of the general adult inmate population. CHS makes dedicated staff available to manage medication and provide therapy to mentally ill individuals who are otherwise mixed in with the general population.

The city also manages specialized housing units for mentally ill inmates, which, according to many scholars, are preferable to either being mixed in with the general population (where the risk of victimization is pronounced for the mentally ill) or to solitary confinement (which reduces the risk of victimization but increases the risk of mental deterioration).[68] NYC operated specialized mental health housing units for decades before de Blasio,[69] but these were expanded during the current administration over the last decade.

Mental Observation units, which comprise more than 500 beds, operate similarly to residential treatment programs, with direct access to medication management and therapy. Program for Accelerating Clinical Effectiveness (PACE) units (150 beds) offer a more intensive, hospital-like level of supervision and services. The Clinical Alternative to Punitive Segregation units (20–30) beds provide PACE-level care for inmates who would otherwise have been considered for punitive segregation (which was eliminated for inmates with serious mental illness in 2016).[70] At the end of the de Blasio administration, plans were announced for about 400 Outposted Therapeutic Housing units, another form of specialized housing for inmates with intensive health needs.[71]

ThriveNYC

ThriveNYC was a major community mental health initiative launched by Mayor de Blasio in 2015.[72] It originally comprised "54 targeted initiatives," a combination of 23 new programs and 31 existing programs reorganized under the ThriveNYC rubric.[73] Thrive's goal was to expand access to mental health services by overcoming the fragmentation of public mental health and create a better-integrated and more "comprehensive" system. Thrive specifically sought to provide services for those with a wide range of mental disorders, not just the cohort of "serious mental illnesses," such as schizophrenia, that attract so much public attention.

During his 2013 campaign for mayor, de Blasio roundly criticized the outgoing Bloomberg administration, but one exception was public health. De Blasio admired the Bloomberg initiatives on reducing smoking and obesity. When he became mayor, de Blasio tried to replicate those efforts for mental health with ThriveNYC.

ThriveNYC was based on providing assistance for a wide range of mental disorders as an end in itself, but it also wanted to prevent those disorders from degenerating into graver, more serious conditions. Another goal was to reduce social stigma: ThriveNYC architects believe that a central reason that so much mental illness goes untreated is that too many people are embarrassed to admit that they have a mental disorder and to seek help for it.[74] ThriveNYC officials always made a point to downplay violent mentally ill offenders, who commit crimes such as subway pushings and mass shootings, as unrepresentative of the broader population with mental disorders. Reducing criminal justice involvement for people with mental disorders was one of Thrive's goals.[75]

In ThriveNYC's first year of full operation, fiscal 2017, its budget was $200 million, a sum that would rise to nearly $300 million by the time de Blasio left office.[76]

Though inadequate access to treatment for seriously mentally ill New Yorkers was one of Thrive's stated goals,[77] many critics thought that the initiative lacked focus because of its aspirations toward comprehensiveness.[78] Since, as anti-stigma advocates regularly remind us, most people with a mental disorder aren't dangerous, it's very difficult to target mental health investments meant to function as "upstream" solutions to the mentally ill offender problem. ThriveNYC's performance metrics were also criticized as overly vague.[79] These criticisms led, ultimately, to the "rebranding" of Thrive as the "Mayor's Office of Community Mental Health" (MOCMH) in April 2021. As part of this rebranding, city officials claimed to "continue to enhance our focus on people with serious mental illness."[80]

Outcomes

Jail Population and Recividism

The de Blasio administration left office with fewer mentally ill people in jail than it inherited under Bloomberg. However, as **FIGURE 1** shows, that's mainly because it left office with fewer people in jail overall. The *share* of inmates with any mental disorder and inmates with a serious mental illness, as a share of the total inmate population, is as high as ever. The final column in FIGURE 1 shows what the average daily population of seriously mentally ill inmates would be if the rate of serious mental illness, in the city jails, mirrored that of the general adult population in New York City.

Figure 1.

The de Blasio Legacy on Mental Illness and Incarceration

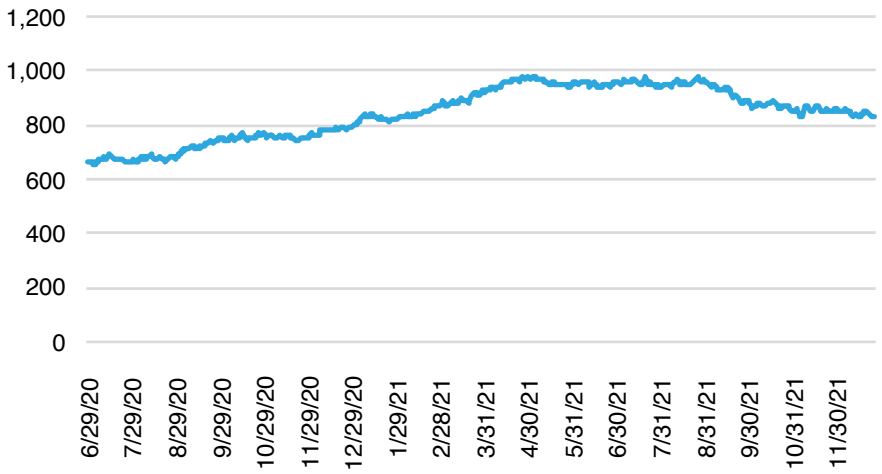
	Average Daily Jail Population (ADP)	Inmates with any mental health diagnosis (% ADP)	Inmates with a serious mental health diagnosis (% ADP)	# Inmates with a mental health diagnosis	# Inmates with a serious mental health diagnosis	5% of ADP
FY13	11,827	**37.0%**	9.5%	4,376	1,124	591
FY14	11,408	**38**	10.2	4,335	1,164	570
FY15	10,240	**41**	11.1	4,198	1,137	512
FY16	9,790	**42**	11.0	4,112	1,077	490
FY17	9,500	**42**	10.3	3,990	979	475
FY18	8,896	**43.0**	14.3	3,825	1,272	445
FY19	7,938	**45.0**	16.8	3,572	1,334	397
FY20	5,841	**46.0**	14.8	2,687	864	292
FY21	4,961	**53.0**	16.5	2,629	819	248

Source: Office of Mayor of New York City, "Mayor's Management Report," https://www1.nyc.gov/site/operations/performance/mmr.page

Recently, the number of seriously mentally ill inmates in NYC jails has risen (**FIGURE 2**), as has the average length of stay for inmates with any mental disorder (**FIGURE 3**).

Figure 2.

New York City Jail Inmates with a Serious Mental Illness, 2020–21



Source: Local Law 59 reports, published by NYC Correctional Health Services, https://www.nychealthandhospitals.org/correctionalhealthservices/publications-reports

Figure 3.

Trends in Average Length of Stay, Inmates with Any Mental Disorder vs. All Inmates, 2018–2021

Quarter	Average Length of Stay, All Inmates (days)	Average Length of Stay for Inmates with Any Mental Disorder (days)	Gap (days)
Q32018	77	134	57
Q42018	78	132	54
Q12019	82	131	49
Q22019	85	138	53
Q32019	81	146	65
Q42019	98	169	71
Q12020	101	160	59
Q22020	85	125	40
Q32020	87	166	79
Q42020	75	168	93
Q12021	84	163	79
Q22021	109	203	94

Source: Local Law 58 reports, published by NYC Correctional Health Services https://www.nychealthandhospitals.org/correctionalhealthservices/publications-reports

City government has tracked various outcomes in evaluating its efforts to address the intersection of crime and mental illness. Some of these evaluations have reported modest success. According to the Mayor's Office of Community Mental Health, between 2015 and 2019, reports of access to treatment, among adult New Yorkers with "suspected serious psychological distress," rose from 46% to 58%. Calls for service coded as "mental health calls" stood at 153,000 in 2020, down from 170,000 in 2018.[81] A 2020 paper published in *Psychiatric Services* reported

lower rates of violent injuries and higher rates of medication adherence among residents of one of the Department of Correction's specialized housing units for the seriously mentally ill, when compared with a similar cohort.[82]

The Department of Correction publishes an annual report on recidivism among inmates with mental disorders.[83] The recidivism rate, one year out from release, was higher in 2019 (compared with 2015) for inmates with mental disorders than for all inmates. However, the gap had shrunk (FIGURE 4).

Figure 4.

Trends in Recividism Among Inmates with Any Mental Disorder, New York City Jails, 2015–2019

	Recividism Rate, One Year of Release, All Inmates	Recividism Rate, One Year of Release, Inmates with Any Mental Disorder	How Much Higher Is the Recidivism Rate Among Inmates with Any Mental Disorder?
2015	34.5%	48.3%	40.0%
2016	34.4%	47.1%	36.9%
2017	35.4%	47.8%	35.0%
2018	35.7%	47.1%	31.9%
2019	31.3%	40.4%	29.1%

Source: Local Law 121 report, "Annual Report on Mentally Ill Incarcerated Individuals and Recidivism," published by NYC Dept. of Correction, https://a860-gpp.nyc.gov/collections/zw12z528p?locale=en

Mental Illness–Related Serious Offenses

High-profile cases of mental illness–related violence continue to recur in New York.

In November 2020, Justin Pena was charged with assault after having allegedly pushed a stranger, who spurned his demand for money, onto the subway tracks;[84] Aditya Vemulapati was charged with attempted murder after having allegedly pushed a stranger onto the subway tracks;[85] and Michael Medlock was charged with attempted murder after having allegedly shoved a woman off a subway platform.[86]

In December 2020, Matthew Montanez was charged with assault for allegedly shoving a woman into a subway platform pillar as a train approached.[87]

In January 2021, Linda Chavez, a Queens woman, was charged with attempted murder after having allegedly tried to push a stranger in front of an approaching subway car.[88]

In February 2021, Rigoberto Lopez, a Brooklyn man, was charged with murder for a series of assaults in the subway system that left two dead and two seriously injured.[89]

In May 2021, Brandon Elliot was charged with hate crimes for having allegedly kicked an elderly Asian woman in the head.[90]

In June 2021, Rashid Brimmage was charged with assault after having allegedly shoved a 92-year-old woman into a fire hydrant.[91]

In August 2021, John Merritt was charged with assault for having allegedly pushed a stranger onto the subway tracks;[92] and Aaron Garcia was charged with attempted murder after having allegedly attacked a stranger with a hatchet in a lower Manhattan ATM booth.[93]

In September 2021, Vladimir Pierre was charged with assault after having allegedly punched a 59-year-old woman, who then fell onto the subway tracks.[94]

In October 2021, Daniel Deloir was charged with attempted murder for having allegedly stabbed a man in Hoffman Park in Queens, after the man had come to deliver food to the homeless, including Deloir;[95] Anthonia Egegbara was charged with attempted murder for allegedly pushing a stranger into the side of an approaching subway car;[96] and Jermaine Foster was charged with murder after fatally colliding with a woman named Maria Ambrocio when fleeing a robbery in Times Square.[97]

In December 2021, Noquisi Burgess was charged with several crimes, including "menacing as a hate crime," for allegedly threatening a subway rider with wooden daggers;[98] and Daniel Rivera was charged with assault for allegedly shoving a stranger onto the subway tracks.[99]

In January 2022, Martial Simon was charged with murder for allegedly pushing Michelle Go to death in front of an incoming subway train;[100] and Harlem resident Lashwan McNeil allegedly shot two cops, one fatally, when they were responding to a domestic disturbance.[101]

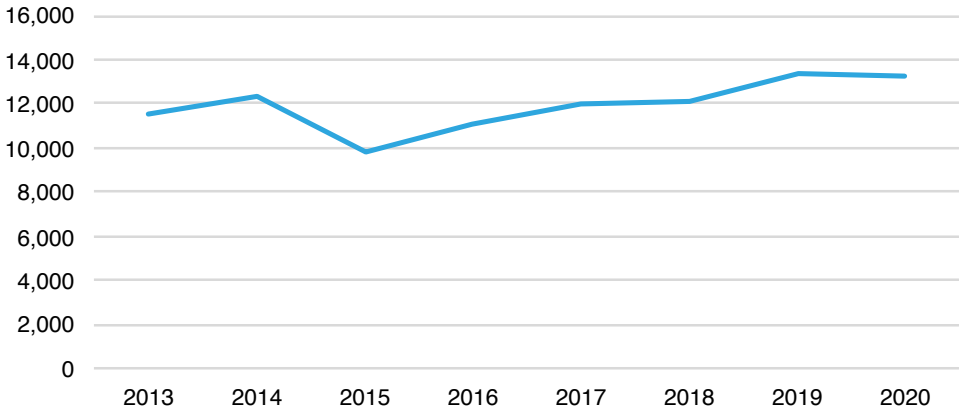
News coverage of these events, which sometimes feature interviews with the alleged perpetrators' families, almost always report a history of psychiatric problems and extensive prior involvement with the criminal justice system. In the first half of 2021, New York added more than 700 new police officers to patrol the subways, in response to concerns that perceptions of danger were driving down ridership.[102] Concerns about homelessness and the mentally ill on the subway were politically harmful for Mayor de Blasio and have been a persistent preoccupation of transit officials.[103]

Mental Illness and Public Disorder

The city estimates that New York is host to more than 13,000 homeless adults with a severe mental illness, a number that has ticked up under de Blasio (**FIGURE 5**). Even when technically "sheltered"—i.e., not sleeping on the streets or in the subway system—any adult member of the homeless population is still living an unstable life.[104] Each year, the city jail system releases hundreds of individuals with mental disorders directly into the city shelter system.[105] NYPD makes hundreds of arrests in city shelters every year.[106]

Figure 5.

Seriously Mentally Ill Homeless Individuals in New York City, 2013–2020



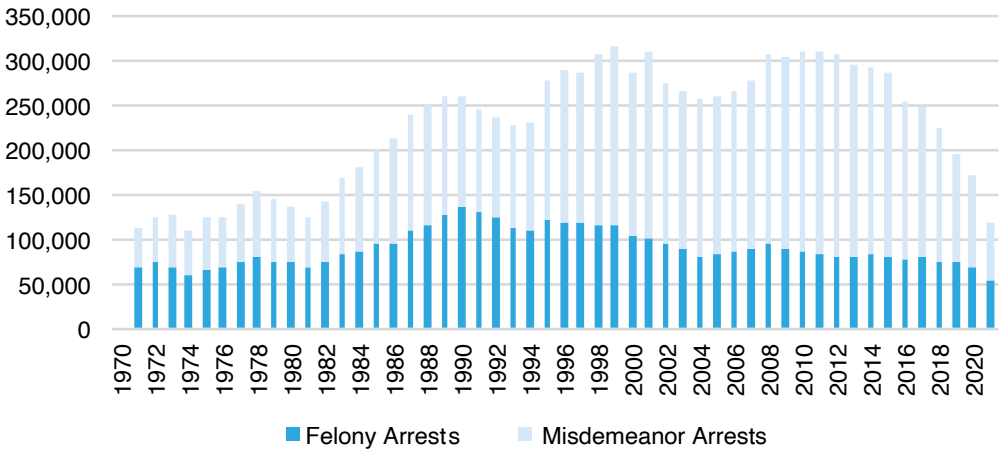
Source: U.S. Dept. of Housing and Urban Development, https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/?filter_Year=&filter_Scope=CoC&filter_State=NY&filter_CoC=NY-600&program=CoC&group=PopSub

Architects of the Broken Windows theory of policing—sometimes credited with reducing public disorder in New York—placed just as much emphasis on creative problem-solving as misdemeanor arrests.[107] But there is no question that misdemeanor arrests rose throughout the Broken Windows era, which was also the era of New York City's revival.[108] Thanks to the efforts of the criminal justice reform movement, however, use of criminal justice measures to manage public disorder has been drastically scaled back.

Total misdemeanor adult arrests peaked in 2010, at 228,751, and they peaked as a share of adult arrests in 2011, at 73%. As **FIGURE 6** shows, adult arrests have not only become less frequent in recent years; they have become much more concentrated on felonies. Misdemeanor arrests have outpaced felonies since the early 1980s, but the gap has been closing rapidly. Taking misdemeanor and felony adult arrests collectively, the proportion of felony arrests increased from 31% to 47% between 2015 and 2020.

Figure 6.

Misdemeanor vs. Felony Adult Arrests in New York City, 1970–2020



Source: New York State Division of Criminal Justice Services, https://data.ny.gov/Public-Safety/Adult-Arrests-18-and-Older-by-County-Beginning-197/rikd-mt35/data

Whether city government can meet the demands for public order—which often come from low-income and minority communities—while also continuing to minimize criminal justice–based solutions to disorder, remains to be seen. In addition to the subway pushings and other violent incidents listed earlier, 311 call data provide one way to quantify levels of concern about public disorder. In 2020 and 2021, the city's 311 service fielded thousands of calls for various public disorder–related complaints (**FIGURE 7**). The extraordinary increase in complaints about encampments between 2020 and 2021 is particularly notable.

Figure 7.

Public Disorder-Related 311 Complaints, 2020 and 2021

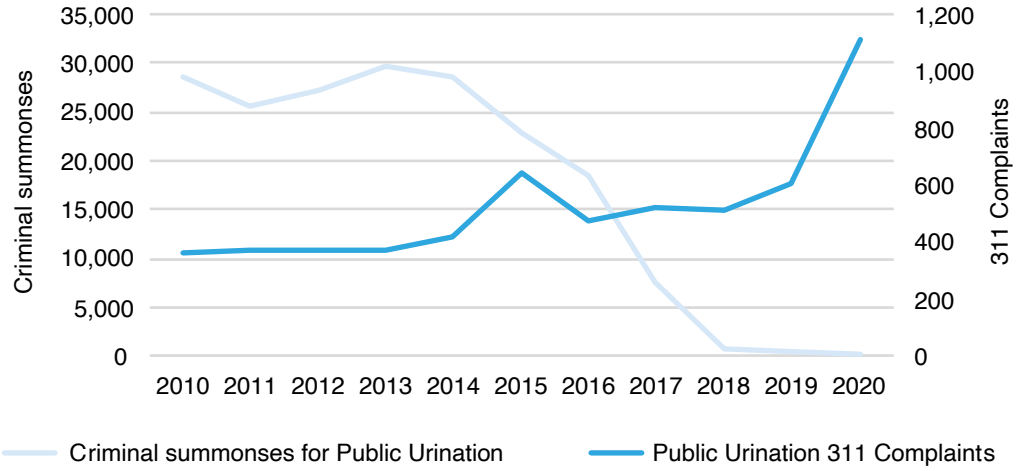
	2020	2021
Homeless Person Assistance	26,732	34,062
Panhandling	1,466	3,502
Encampment	304	26,668
Public Urination	1,116	1,201

Source: Open Data NYC, https://data.cityofnewyork.us/Social-Services/311-Service-Requests-from-2010-to-Present/erm2-nwe9

Criminal summonses for public urination, one of the offenses whose status was modified by the 2016 Criminal Justice Reform Act, are significantly down even as 311 complaints about public urination are significantly up during the same span (**FIGURE 8**).

Figure 8.

Criminal Summonses for Public Urination vs. 311 Complaints for Public Urination



Source: Open Data NYC, https://data.cityofnewyork.us/Social-Services/311-Service-Requests-from-2010-to-Present/erm2-nwe9; NYPD, https://www1.nyc.gov/site/nypd/stats/reports-analysis/c-summons.page

Mental Health and the New Mayor

Lowering the rate of mental illness among jail inmates has been cited, by reformers, as a way to reduce the jail population overall.[109] Despite increasing outlays, by hundreds of millions of dollars,[110] and high-level attention, de Blasio failed to sever or weaken the link between mental illness and crime. More success will have to be achieved in the 2020s to make progress on closing Rikers and related priorities.

Whether one shares the overall goals of the Close Rikers campaign, reducing the rate of mental illness among the jail population is a worthy goal. And that must mean reducing the *rate* of mental illness, not just the absolute numbers via broad-based jail reductions.

The next sections will discuss avenues to pursue that goal, along with the obstacles.

Mental Health Courts

Some of the recent violent incidents in New York City appear to have been caused by people with psychosis.[111] Research on mentally ill offenders shows that, even after parsing other risk factors such as substance abuse and income status, mental illness is associated with violence.[112] Many researchers acknowledge that crimes directly caused by mental illness are real but also say that they are rare.

But that view simply underscores the importance of targeting. Given that most people with a mental disorder will not commit a serious crime, crime-reduction-oriented mental health interventions will have to be very well targeted to succeed. Court-based mental health programs, thus, are promising, because they are inherently well targeted, as they only involve people already involved in crime.

Mental health courts are special court programs that deal with mentally ill individuals after they have been charged with a crime but before trial and sentencing. They are a variety of "problem-solving courts" patterned on drug courts. They began in the 1990s; about 500 exist nationwide.[113] Mental health courts maintain a special docket and dedicated staff. Defendants agree to participate in a treatment program and, if they complete it successfully, will have their charges reduced or dismissed. The goal is to increase access to treatment for a population that is often treatment-resistant, as well as to lower recidivism. Models vary; these courts generally do not deal with the most serious felonies but with charges serious enough that a prison sentence is a realistic possibility.[114] Participation is voluntary. In NYC, mental health courts exist in all five boroughs (counties) and enroll 100–200 participants annually.[115]

Participants may spend 12–24 months enrolled in a mental health court program, during which time they live in the community and check in regularly with the mental health court. Expectations can include sobriety (enforced by urinalysis); attending all scheduled appointments with the judge, their case manager, and treatment providers; and avoiding arrest. Violations are met with "graduated sanctions," such as more frequent court check-ins and drug tests, remand to jail, and, ultimately, failing out of the program, which entails having one's case sent back through standard criminal court.

One study of the Brooklyn and Bronx mental health courts in New York found that participants in both programs experienced lower recidivism (lower rearrest and reconviction rates) than similar cohorts who went through the standard criminal courts.[116] Conservatively assessed, mental health courts' record on reducing recidivism, according to evaluators, is respectable, though questions remain as to why exactly they work.[117] Some conceive of mental health courts as quintessentially community-based programs, valuable for the personal relationship that develops between judges and participants.[118] Others value incarceration's coercive potential to incentivize participation in treatment.

Mental health courts are generally popular among criminal justice reformers, who even aspire to expand them.[119] But any expansion of mental health courts must reckon with a few realities. First, mental health courts need access to treatment programs, as well as housing, to set up a viable alternative to incarceration. District attorneys, who do not control such resources, must work with the city administration to secure them. Someone is not likely to graduate from mental health court if he is sleeping in the subway every night. Second, mental health courts are not suitable for all defendants with a serious mental illness; courts impose eligibility criteria to exclude those who, they believe, will not be served by the program. Not everyone "graduates."[120] Expanding mental health courts—by enrolling people with more serious mental illnesses and who have been charged with more serious crimes[121]—should not come at the expense of program integrity.

It is important to emphasize that participation in mental health courts is voluntary.[122] Defendants will participate only if they believe that mental health court offers less punishment (reduced charges or charges dismissed) than the standard criminal court process. If, as a consequence of sentencing reform, the standard criminal court process promises less and less punishment, the appeal of mental health court will decline. California has seen reduced interest in drug courts in the wake of the 2014 Proposition 47, the "Reduced Penalties for Some Crimes Initiative," which "changed the calculus for defendants."[123] Diminished participation in mental health court would run two risks: less progress on recidivism; and less access to treatment for mentally ill offenders.

Substance Abuse

Many concerned about "stigmatizing" mental illness have argued that mental illness causes fairly little crime and that the real problem is substance abuse. But if the problem is substance abuse, government should focus more seriously on reducing substance abuse. Despite concerns over overdoses and sustained attention given to reducing smoking, it is not obvious that NYC places a high priority on reducing the rate of drug addiction. In a limited sense, that goal could be pursued by leveraging the unique powers of the criminal justice system—in particular, jail.

Government surveys of sentenced inmates have found that over 50% met clinically diagnosable criteria for drug dependence or abuse.[124] Some research estimates that about 60% of defendants test positive for drugs at the time of their arrest.[125] As much as 85% of all crime may be drug- or alcohol-related in the sense of being committed by someone then under the influence, with a past or active substance abuse disorder, with a drug offense on his record and/or committed to obtain money to buy drugs.[126]

About 25% of seriously mentally ill Americans also have a substance abuse disorder.[127] Having both serious mental illness and a substance abuse disorder is worse than having either on its own;[128] yet comorbidity is the norm, particularly in the criminal justice context.[129] According to the NYC Department of Health, over 40% of the approximately 45,000 psychiatric hospitalizations each year "indicat[e] a co-occurring substance use disorder."[130] About 15% of mental health emergency-room visits have a substance use–related secondary diagnosis, a share that has risen since the 2000s.[131]

Getting offenders *off* mind-altering drugs may be even more important than getting them *on* antipsychotics. This could be pursued, in the judicial context, in more than one way. Mental health courts and drug courts emphasize participation in treatment. But many people who do overcome their substance abuse challenges don't do so based on any formal treatment regimen.[132] They do so because they decide that sober living is more choiceworthy than the previous alternative, and they rely more on friends, family, AA, and social supports developed through a sober-living residential program, than on formal government programs or medical interventions.

"Desistance mandates" have been championed by some researchers as a way to use the leverage of the criminal justice to promote sobriety.[133] "Desistance mandates," associated with "swift, certain, and fair" court programs, focus on changing behavior, not treating a disease. They do so by means of swift and certain—but also brief—jail sentences when a participant fails a drug test. Programs that seek to reduce substance abuse by structuring addicts' choices enjoy much support in the social sciences literature.[134]

The original Hawaii-based "swift, certain, and fair" program was a reform to community supervision, which had not been successful at changing behavior. A short-term jail sentence was considered attractive because it was "impactful, unpleasant, and could be imposed immediately."[135]

New York, however, seems to be moving in the opposite direction. The Less Is More Act, passed in 2021 by the state legislature, reduced the use of incarceration for technical (noncrime) parole violations, a longtime goal of reformers.[136] One recent study by the Center for Court Innovation called for expanding mental health courts while also "limit[ing] jail sanctions in response to noncompliance with programs."[137] In his "Day One Memo," Manhattan District Attorney Alvin Bragg recommended that "for any case in which a person violates the terms of a noncarceral sentence or pre–plea programming mandate, the Office will seek a carceral 'alternative'

only as a matter of last resort. The Office will take into account that research shows that relapses are a predictable part of the road to recovery for those struggling with substance abuse, and the Office will reserve carceral recommendations for repeated violations of the terms of a mandate."[138]

In fairness, not all "swift, certain, and fair" programs have fared equally well.[139] But the goal of using jail to enforce desistance mandates is to be "net incarceration–reducing," especially with respect to prison.[140] It is one thing to say that incarceration is bad for the mentally ill; it's another thing to develop a meaningful alternative. Fines, an alternative to incarceration, are said to criminalize poverty. Community service does not work well for the mentally ill.[141] When issued a summons instead of being taken into custody, the mentally ill run an elevated risk of "failure to appear."[142] Not all "involvement" in the criminal justice system is the same. In a recent book, legal scholar and noted supporter of criminal justice reform Franklin Zimring made the case for jails as an alternative to prisons—that is, a solution to mass incarceration rather than a contributor to it.[143]

To be clear, desistance mandates and special court programs can be used only for some offenders with a mental disorder, and it may be the case that they won't work for the hardest cases with the most serious mental illnesses. But, appropriately applied, these programs hold real potential for making progress for that portion of the problem that truly is driven only by substance abuse.

Violent Mentally Ill

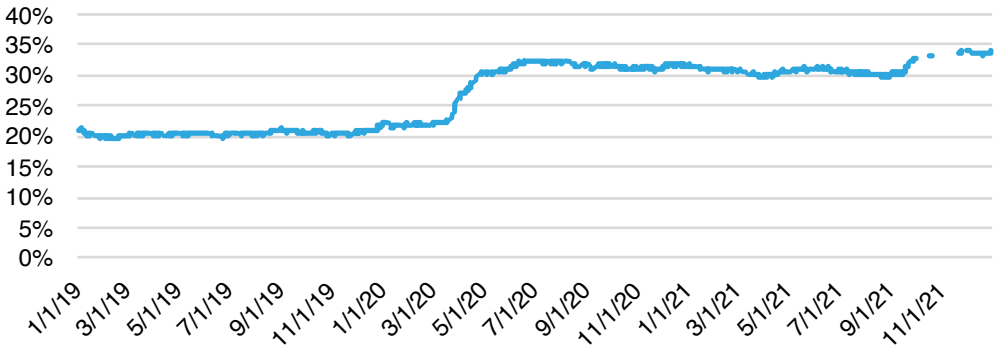
Mentally ill people participate in many varieties of nonviolent crime, which explains why they are so often in contact with police, courts, and jails.[144] But too much emphasis on that point can eclipse the much more vexing problem of violent mentally ill offenders.

The seriously mentally ill account for three-fourths of matricides and two-thirds of patricides.[145] Surely, the rate of serious mental illness among subway pushers is vastly higher than the rate among the general population. As stated by former director of the National Institute of Mental Health Dr. Thomas Insel: "We have to realize that part of having psychotic illness is you are not yourself and you do things you would not do without the illness and violence can be and often is part of this."[146]

In New York, offenders in the city jail population with a mental disorder have a higher average length of stay. A 2015 analysis by the Independent Budget Office speculates that their higher average length of stay may be partly due to a propensity to be charged with more serious crimes than inmates without a mental disorder.[147] Offenders with mental disorders are disproportionately confined for serious crimes. The share of inmates with a mental disorder who are charged with a violent felony, relative to the total jail population, appears to have risen in the wake of bail reform (**FIGURE 9**).

Figure 9.

Share of Inmates with Any Mental Disorder, Charged with a Violent Felony, as a Share of the Total New York City Jail Population, 2019–2021



Source: Author's analysis of data maintained by Vera Institute of Justice, https://greaterjusticeny.vera.org/nycjail

As some criminal justice reformers acknowledge, people held pretrial on violent charges represent the largest barrier to further jail population reductions.[148] That cohort includes many people with a mental disorder.

It's true that "most violent acts are not committed by people with diagnosed mental disorders."[149] But relative to jail census benchmarks that would be needed to make closing Rikers feasible, the violently mentally ill cohort is quite large. Most broad crime reduction strategies view mentally ill offenders as but one among many problems that they must address—and often not the largest one. If anything, broad jail reduction strategies, such as those embraced by progressive reformers, must place more priority on mentally ill offenders.

City officials should talk more honestly about the connection between violence and mental illness. ThriveNYC managers tended to respond to subway pushings or mass shooting by discussing stigma and the risk that psychosis-induced crimes would lead to more social discrimination against the mentally ill. But to the extent that stigma is a problem, the main factor is the mental health system's persistent failures.[150] The connection between mental illness and crime may be qualified in numerous ways; no doubt, the mentally ill offender population is variegated.[151] But the more that officials downplay the link between violence and mental illness, the more likely it will be that mental health reform will continue to ignore mentally ill people who commit violent acts. Regardless of the upshot for crime and jails, that will mean that mental health reform won't benefit the hardest cases.

Hospitals

At an average daily jail population of about 5,000, a seriously mentally ill rate of 16.5% equates to 825 inmates. A rate of 5% (more reflective of the general adult population in NYC)[152] would mean 250 inmates, or a reduction of nearly 600. Relative to the scope of jail reductions that NYC has experienced over the last decade (to say nothing of NYC's 9 million citywide population overall), 600 seems like a small number. But many, perhaps even most, seriously mentally ill inmates are confined on violent charges. (NYC Department of Correction does not publish charge information for the seriously mentally ill cohort but only for those with any mental

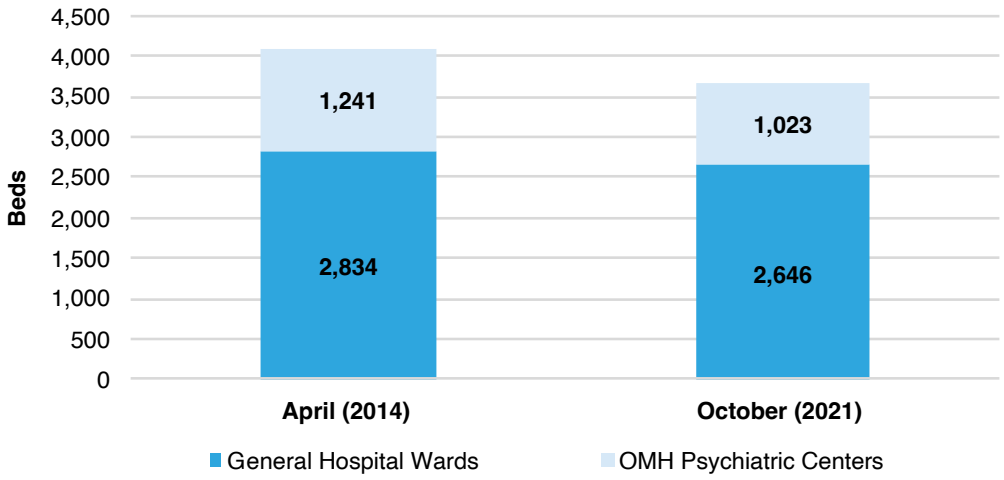
disorder.)[153] What would it mean if, on an average day in NYC, 600 more people with serious mental illness facing violent criminal charges were not in jail but elsewhere in the community? If that's feasible, psychiatric hospitals will play a necessary role.

There are 45,000 psychiatric hospitalizations in NYC each year.[154] Though there is little indication that the need for inpatient treatment has declined in recent years, the bed supply has. Between 2000 and 2018, NYC lost 459 psychiatric hospital beds.[155]

Three major providers of inpatient psychiatric care are in NYC: private nonprofit hospital networks, such as New York Presbyterian; New York City Health + Hospitals (which operates Bellevue); and the state Office of Mental Health, which operates Psychiatric Centers, one in each borough. Pressures to reduce psychiatric beds have remained unrelenting. Recent examples include the desire for nonprofit networks to shift beds toward more profitable health-care functions,[156] the repurposing of beds for perceived Covid-19-related needs,[157] and state government's desire to cut costs.[158]

Figure 10.

Non-Forensic Adult Inpatient Psychiatric Beds in New York City, 2014 vs. 2021



Source: Author's analysis of data maintained by the New York State Office of Mental Health, https://omh.ny.gov/omhweb/transformation

New York City policymakers should take steps to stabilize the city's supply of psychiatric hospital beds. In his 2021 campaign for mayor, Eric Adams expressed an interest in doing so.[159] To combat the pressures that have been responsible for reducing psychiatric beds, city officials will need to stake out a clear position that hospitals are preferable to jails. Some civil libertarians have long argued that involuntary commitment to a mental hospital is worse than incarceration because it deprives people of freedom without their having committed a crime.[160] But a hospital—purpose-built for treatment—is a better place than a jail. It is difficult for jails and prisons to offer a therapeutic environment without undermining their more overarching goals of enacting retribution and deterring crime.[161] Psychiatric hospitals supplement community-based care systems, by unburdening those programs of the need to deal with the hardest, most dangerous cases. New York's commitment standard—dangerousness to self and others—is unlikely to change anytime soon. But bed availability may influence greater use, even when legal standards for civil commitment standards are unchanged.[162]

Stabilizing and expanding the stock of NYC's inpatient beds will require pressuring nonprofit health systems to cease their bed reductions, maintaining the beds in the city-controlled New York City Health + Hospitals system, requesting state government to staff more beds within the

OMH-run Psychiatric Centers, and working with the local congressional delegation to enact a repeal, at the federal level, of the IMD Exclusion, which restricts the use of Medicaid from funding inpatient psychiatric care.[163]

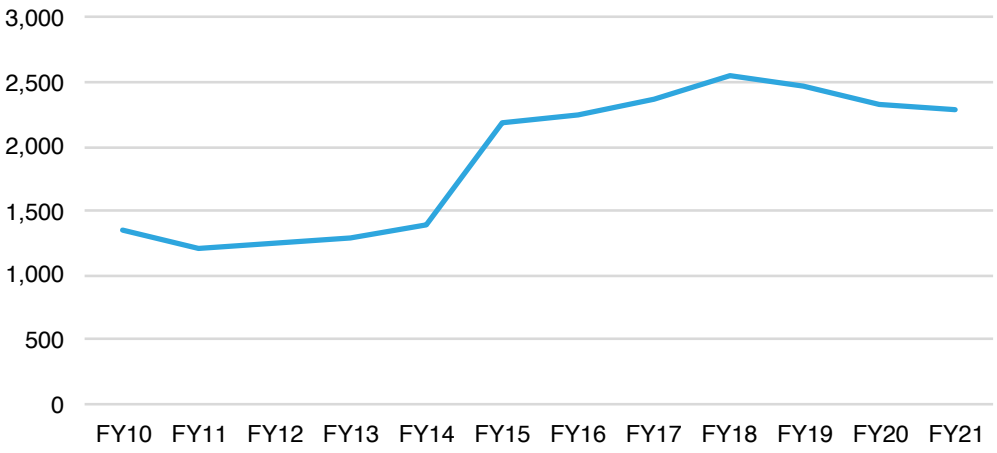
Kendra's Law

Assisted outpatient treatment, known in New York as "Kendra's Law," is a form of court-ordered supervision for seriously mentally ill people.[164] It is a state program, administered locally by the city Department of Health and Mental Hygiene. Those placed under supervision pursuant to Kendra's Law have not been charged with a crime, but they have likely been, in the past, involved with the criminal justice system. Indeed, one eligibility requirement for Kendra's Law is "one of more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months, not including any current period, or period ending within the last six months, in which the person was or is hospitalized or incarcerated."[165]

Though his administration used Kendra's Law, de Blasio never made it central to his mental health agenda. It was not included in ThriveNYC, despite being able to claim a far stronger evidence basis than programs that were included, such as Mental Health First Aid.[166] In response to criticism over inadequate focus on the seriously mentally ill, the de Blasio administration began emphasizing Kendra's Law more toward the end of its second term.[167] Curiously, though, this renewed rhetorical emphasis coincided with reduced use of the program (**FIGURE 11**).

Figure 11.

Number of Kendra's Law Court Order Recipients in New York City, FY10–FY21



Source: Mayor's Management Report," Office of Mayor of New York City, https://www1.nyc.gov/site/operations/performance/mmr.page.

Though disability rights groups continue to call for less use of Kendra's Law,[168] new mayor Eric Adams called for "strengthened use of Kendra's Law" in his platform.[169] Two important advantages of Kendra's Law merit emphasis. First, involuntary treatment must be part of any mental health policy agenda. Mental health services, like the social services more generally, work most effectively for those who actively seek help of their own volition. The hardest cases

are those not actively seeking help. Kendra's Law makes it possible for these individuals to get care before lack of treatment leads to further deterioration and more and deeper involvement with the criminal justice system.

Second, Kendra's Law exerts a "coercive effect on providers," who might otherwise be disinclined to serve people with serious mental illness and a criminal record and record of noncompliance with treatment.[170] It is as unrealistic to expect community-based mental health programs to serve violent mentally ill individuals as it is to assume that all those individuals will voluntarily pursue treatment. Kendra's Law orders the system to serve a population often ignored by the system.

Again, if government is going to get anywhere in reducing crime by investing in mental health interventions, those interventions will have be targeted. Kendra's Law is a targeted intervention. It focuses on seriously mentally ill individuals at risk of criminal offending. Many "criminal justice system–involved" mentally ill people have already had contact with the mental health system.[171] They failed out of the latter and became the responsibility of police, judges, and correctional systems. Any attempt to reduce that failure rate must involve reform of the mental health system, not just efforts to expand access to the system as it exists. New York has always invested expansively in mental health care, as well as social services–style alternatives to incarceration.[172] Even before ThriveNYC, New York spent $2.5 billion annually on mental health.[173] An expanded use of Kendra's Law would reform the existing system by narrowing its focus to those seriously mentally ill people who are not going to access treatment by texting a help line that they read about on a subway ad.

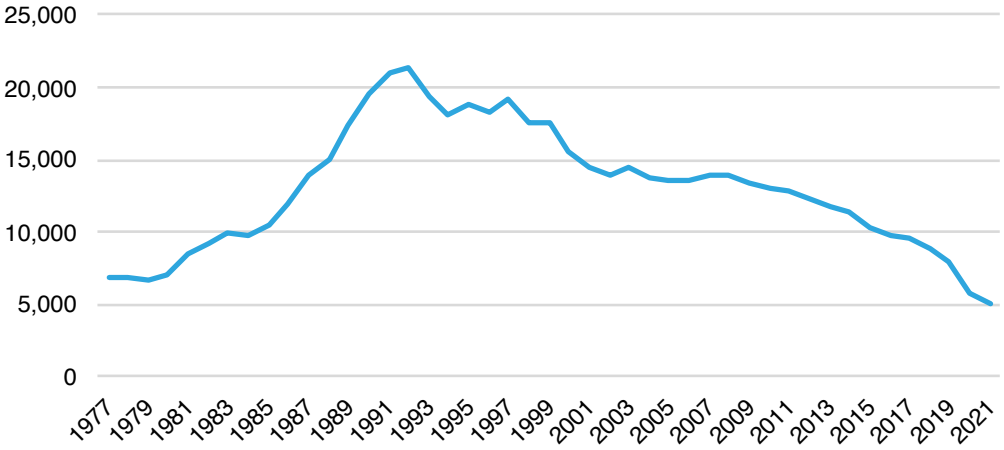
Expanding Kendra's Law would require identifying good candidates for the program who are not currently in it. Most people receive the court order as part of their discharge from hospitals, but psychiatric hospitals are not the only location or institution where candidates could be found. Others include the shelter system and city jails. Thus, the NYC Department of Health and Mental Hygiene could partner with such institutions to do "inreach." Another approach would be a public education campaign about the benefits of Kendra's Law that specifically target families of unstable mentally ill people, many of whom are involved with local chapters of the National Alliance on Mental Illness. It is sometimes easy to forget that many seriously mentally ill people live with their families. Even though these individuals are "stably housed," there can be tragic consequences if they do not receive adequate treatment.[174] Expanding Kendra's Law would require more dedicated resources to set up the treatment regimen for the relevant court order.

Conclusion: Crime Control as Mental Health Policy

New Yorkers with and without mental disorders are coming into contact with the criminal justice system far less now than was the case when Mayor de Blasio took office.[175] Annual jail admissions, which exceeded 100,000 in the 1990s, now stand below 20,000.[176] This decline is due not only to crime rates being lower than they were 30 years ago but policy changes sought by the criminal justice reform movement.[177]

Figure 12.

Average Daily Inmate Population, NYC Dept. of Corrections, 1977–2021



Source: Comprehensive Annual Financial Reports, NY, published by the city comptroller, https://comptroller.nyc.gov/reports/annual-comprehensive-financial-reports

But the modern de-carceration movement will not succeed if it defines success only in terms of less contact with jails and prisons. Manhattan DA Alvin Bragg has spoken of the potential of diversion programs for "individuals in crisis." He has further pledged: "When those charged with crimes present mental health issues, we will find appropriate programs to address those issues, and not send them to jail where we know they will not get the help they need."[178] Diversion means social services. Most mentally ill offenders have already had contact with the social services system. That experience failed to "get [them] the help they need." Many mentally ill people wind up in jail because they failed out of the mental health care system and became the responsibility of the criminal justice system. Unless and until diversion proponents can explain "diverted to where," they are defining success negatively.

The deinstitutionalization movement had to learn the hard way that less contact with psychiatric hospitals is not an adequate definition of success. Long-term commitment to a mental hospital may not be an attractive life, but many bad things can happen to someone with mental illness when not committed long-term to a mental hospital. By the same token, a lot of bad things can happen to someone even if he is not in jail, and, while incarceration is often criticized for disrupting lives, not everyone was thriving before being put in jail.

We need to be modest in our expectations of how much mental health reform we can achieve, regarding crime reduction. But that only highlights the importance of crime control more generally. Crime control itself is a mental health reform strategy. If a mentally ill individual, leaving a hospital or prison, returns to a high-crime neighborhood and becomes involved in criminal activity, or addicted to drugs, he may be integrated, but not in a healthy way. This was a lesson of deinstitutionalization that the de-carceration movement would do well to heed.[179] The mentally ill won't thrive "in the community" if the community where they live is crime-ridden. Jail might not be a good place for someone with serious mental illness, but neither is a neighborhood wracked with crime and drug addiction.

Endnotes

1 Greg Berman and Julian Adler, "Toward Misdemeanor Justice: Lessons from New York City," *Boston University Law Review* 98 (2018): 988.

2 Cf. fig. 12 below and Bureau of Justice Statistics, Total Correctional Population.

3 New York Police Department (NYPD), Citywide Crime Statistics; Jesse O'Neill, "A Dozen US Cities Set Annual Murder Records with Three Weeks Left in 2021," *New York Post*, Dec. 8, 2021.

4 "Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health," Substance Abuse and Mental Health Services Administration, September 2020, p. 44, B-22.

5 Jennifer Bronson and Marcus Berzofsky, "Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011–12," U.S. Dept. of Justice, Office of Justice Programs, Bureau of Justice Statistics, June 2017.

6 NYC Dept. of Health and Mental Hygiene, "Serious Mental Illness Among New York City Adults," NYC *Vital Signs* 14, no. 2 (June 2015); Office of Mayor Bill de Blasio, "Mayor's Management Report," September 2021, p. 125. Not everyone in the city jail population with a mental disorder has a "serious mental illness." NYC Dept. of Correction (DOC) estimates that 53% of city jail inmates have some sort of mental disorder (see fig. 1). That larger group is sometimes known as the "Brad H." population or cohort. *Brad H. et al. v. the City of New York et al.* was a class action lawsuit that New York settled in the early 2000s by agreeing to provide discharge planning services for inmates with mental health needs. Specifically, the Brad H. cohort comprises inmates who have received mental health services during their confinement, who are known to mental health staff based on a previous incarceration, or who attempted suicide during a previous incarceration.

7 NYC Independent Budget Office (IBO), "Looking Back at the Brad H. Settlement: Has the City Met Its Obligations to Provide Mental Health & Discharge Services in the Jails?" May 2015, p.4; Council of State Governments, "Improving Outcomes for People with Mental Illnesses Involved with New York City's Criminal Court and Correction Systems," December 2012, fig. 5.

8 J. Steven Lamberti et al., "Psychosis, Mania and Criminal Recidivism: Associations and Implications for Prevention," *Harvard Review of Psychiatry* 28, no. 3 (May/June 2020): 179-202.

9 Alisa Roth, *Insane: America's Criminal Treatment of Mental Illness* (New York: Basic Books, 2018), p. 3.

10 Council of State Governments, "Improving Outcomes for People with Mental Illnesses, 6."

11 E. Fuller Torrey et al., "The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey," Treatment Advocacy Center and National Sheriffs' Association, Apr. 8, 2014, 15.

[12] Jennifer L. Skeem, Sarah Manchak, and Jillian K. Peterson, "Correctional Policy for Offenders with Mental Illness: Creating a New Paradigm for Recidivism Reduction," *Law and Human Behavior* 35, no. 2 (2011): 110.

[13] William H. Fisher, Eric Silver, and Nancy Wolff, "Beyond Criminalization: Toward a Criminologically Informed Framework for Mental Health Policy and Services Research," *Administration and Policy in Mental Health and Mental Health Services Research* 33, no. 5 (2006): 548.

[14] What historical data do exist seem to suggest that the rate of mental illness among incarcerated Americans was lower in the past. See E. Fuller Torrey, *American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System* (New York: Oxford University Press, 2014), p. 98; Michael Shellenberger, *San Fransicko: Why Progressives Ruin Cities* (New York: HarperCollins, 2021), p. 103. For dissenting views (arguing that the rate has risen only modestly, if at all), see Richard G. Frank and Sherry A. Glied, *Better but Not Well: Mental Health Policy in the United States Since 1950* (Baltimore: Johns Hopkins University Press, 2006), chap. 7; E. Lea Johnston, "Reconceptualizing Criminal Justice Reform for Offenders with Serious Mental Illness," *Florida Law Review* 71 (2019): 526.

[15] National Research Council, *The Growth of Incarceration in the United States: Exploring Causes and Consequences* (Washington, DC: National Academies Press, 2014), chap. 7; Arthur J. Lurigio, "People with Serious Mental Illness in the Criminal Justice System: Causes, Consequences, and Correctives," *Prison Journal* 91, no. 3, supp. (2011): 74S: "Like dolphins among tuna, many mentally ill, drug-using persons are caught in the net of rigorous drug enforcement policies."

[16] Greg Berman and Julian Adler, *Start Here: A Road Map to Reducing Mass Incarceration* (New York: New Press, 2018), pp. 12–13, 20–21, 24, 27.

[17] DOC, "NYC Department of Correction at a Glance: Information for the First 6 Months of FY2021," Mar. 10, 2021.

[18] DJ Jaffe, *Insane Consequences: How the Mental Health Industry Fails the Mentally Ill* (Amherst, NY: Prometheus, 2017), appendix B; Edward P. Mulvey and Carol A. Schubert, "Mentally Ill Individuals in Jails and Prisons," *Crime and Justice* 46 (2017): 231–277, 242; Eric Silver, "Understanding the Relationship Between Mental Disorder and Violence: The Need for a Criminological Perspective," *Law and Human Behavior* 30, no. 6 (December 2006): 686: "[T]he likelihood of committing violence is greater for people with a major mental disorder than for those without." See also Daniel Whiting et al., "Association of Schizophrenia Spectrum Disorders and Violence Perpetration in Adults and Adolescents from 15 Countries: A Systematic Review and Meta-Analysis," *JAMA Psychiatry* 79, no. 2 (December 2021): 120–32.

[19] Jennifer L. Skeem et al., "Offenders with Mental Illness Have Criminogenic Needs, Too: Toward Recidivism Reduction," *Law and Human Behavior* 38, no. 3 (2014): 222: "[P]sychiatric symptoms seem to directly cause a small but important minority of offenses among OMIS."

[20] Ibid., 212–24. Antisocial personality disorders are formally recognized in the *Diagnostic and Statistical Manual of Mental Disorders*. Like substance abuse disorders, they are not themselves typically considered serious mental illnesses but are found at disproportionately high rates among the seriously mentally ill. See Lamberti et al., "Psychosis, Mania and Criminal Recidivism," 195.

[21] Skeem et al., "Offenders with Mental Illness Have Criminogenic Needs," 213.

[22] President John F. Kennedy, "Special Message to the Congress on Mental Illness and Mental Retardation," Feb. 5, 1963.

[23] NYC Dept. of Health and Mental Hygiene, "Serious Mental Illness Among New York City Adults," 2; "Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health," Substance Abuse and Mental Health Services Administration, September 2020, 60.

[24] H. Richard Lamb and Linda E. Weinberger, "The Shift of Psychiatric Inpatient Care from Hospitals to Jails and Prisons," *Journal of the American Academy of Psychiatry and the Law* 33, no. 4 (2005): 529–34.

[25] Steven Raphael and Michael Stoll, "Assessing the Contribution of the Deinstitutionalization of the Mentally Ill to Growth in the U.S. Incarceration Rate," *Journal of Legal Studies* 42, no. 1 (2013): 187–222.

[26] Berman and Adler, "Toward Misdemeanor Justice," 988.

[27] NYC Criminal Justice Agency, "Annual Report: 2019," June 2021, 1.

[28] Office of Mayor Bill de Blasio, "Mayor's Task Force on Behavioral Health and Criminal Justice: First Status Report," August 2015.

[29] Author's analysis, based on data compiled by the Vera Institute of Justice, https://greaterjusticeny.vera.org/nycjail.

[30] NYPD, Citywide Crime Statistics and Historical New York City Crime Data.

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