

Fall 12-16-2016

Breakdown: Treatment Gaps in New York City's Mental Health System

Christine Brink Kjeldgaard
Cuny Graduate School of Journalism

Noah Caldwell
CUNY Graduate School of Journalism

Mary Hanbury
CUNY Graduate School of Journalism

Mike O'Brien
CUNY Graduate School of Journalism

Joanna Purpich
CUNY Graduate School of Journalism

See next page for additional authors

[How does access to this work benefit you? Let us know!](#)

More information about this work at: https://academicworks.cuny.edu/gj_etds/205

Discover additional works at: <https://academicworks.cuny.edu>

Author

Christine Brink Kjeldgaard, Noah Caldwell, Mary Hanbury, Mike O'Brien, Joanna Purpich, and Anthony Izaguirre

BREAKDOWN

How a fractured treatment system leaves New York City's mentally ill with little place to turn, sometimes with tragic consequences.

The New York deinstitutionalization movement of the 1960s and 1970s spurred the closings of mammoth state psychiatric wards as government officials promised to channel taxpayer dollars to more humane community programs for the mentally.

But more than four decades later, as New York City First Lady Charlane McCray [put it](#) in a 2015 Daily News op-ed piece touching on local and national concerns, “Our mental health system is broken.”

A NYCity News Service investigation found a well-intentioned but threadbare safety net, where demand can outstrip resources, leaving tens of thousands of mentally ill with little place to turn, sometimes with tragic consequences. Interviews with dozens of stakeholders at the center of the crisis and an examination of countless court records, inspection reports, budget documents and audits, revealed:

- Mentally ill New Yorkers dying needlessly in hospitals and in police encounters.
- Most violence inside New York’s jails involves inmates with a history of psychiatric illness.
- Accusations of overuse of restraints on adults and children in psychiatric wards at city-owned Bellevue Hospital.
- Understaffed schools unable to handle mentally challenged youth too often unnecessarily ship them off to hospitals by ambulance.
- Too little city supportive housing to help mentally ill New Yorkers get back on their feet.
- Private adult group homes improperly pressuring mentally ill residents to remain in their housing complexes – despite a court settlement allowing clients to decide for themselves whether to live more independently. The reason, advocates say: Money.

Our reporters also detail the human toll of a system struggling to help people with psychiatric needs – from a schizophrenic man who says police needlessly beat him, to a Bellevue patient who charges she was improperly medicated, to an elderly ex-Marine trying to leave a group home he calls “a hellhole.”

Mayor Bill de Blasio has made mental health care reform a key part of his administration.

“Breakdown” looks at how far the city has to go.

--

Police Encounter the Mentally Ill: Little Training and Tragic Outcomes

By Anthony Izaguirre

As Dustin Grose recalls how city police officer’s boot grinded his face into the pavement outside his Brooklyn home and how he squirmed as officers hit his prone body, he’s left with one question: “Is it a crime to be diagnosed with a mental illness?”

Grose's parents called police that January 2007 morning because they wanted their son, diagnosed with bipolar disorder and mild schizophrenia, to take his medicine. But they never imagined the confrontation that would ensue.

A decade later, the NYPD still grapples with how to handle the mentally ill. The department responded to more than 120,000 "emotionally disturbed person" calls in 2016 alone.

Yet despite well-intentioned efforts to improve how police deal with the mentally ill, only about 10 percent of New York officers are trained how to deal with those mentally troubled.

Recently departed NYPD Commissioner Bill Bratton told the Daily News that as other city agencies are unable to keep up, police "have become responsible for treating a host of society's maladies" – including mental illness. He estimated about 40 percent of police encounters are with the mentally ill.

An NYCity News Service review of news accounts, police reports and lawsuits found at least two dozen shootings, beatings and other violent police encounters over the last five years.

Some of these cases ended in death.

'WE FAILED'

In mid-October, a police sergeant fatally shot a 66-year-old mentally ill Bronx woman – leading Police Commissioner James O'Neill to tell reporters, "We failed."

The shooting death of Deborah Danner also reignited a city-wide conversation on how the police deal with the mentally ill.

A Bronx neighbor called police at about 6 p.m. on Oct. 10 to report that Danner was acting irrationally. This wasn't the first time: Police had responded to similar calls before about Danner, who suffered from schizophrenia.

This time, moments after officers arrived, Danner was shot twice in the stomach. Reports said she charged at officers with a wooden baseball bat. Danner died an hour and 15 minutes later in a hospital.

It is unclear why deadly force was apparently the first measure taken by police.

People in her building told reporters that Danner, who lived alone, often screamed and shouted as if she was arguing with someone.

Danner wrote about coping with her disorder in an essay titled "Living with Schizophrenia."

"Any chronic illness is a curse," she wrote. "Schizophrenia is no different -- its only 'saving grace,' if you will, is that as far as I know it's not a fatal disease."

The mayor and the police commissioner called Danner's killing a mistake. "What is clear in this one instance, we failed," O'Neill told reporters. A police union president said the shooting was justified because the victim was wielding a weapon.

A LIST OF DEATHS

More than half of the cases reviewed by the NYCity News Service resulted in death. Nearly all the calls involved an armed mentally ill person who had prior contact with the police.

The list of deaths include [Shereese Francis](#), a 29-year-old schizophrenic woman who was reportedly suffocated by police during an arrest outside her Jamaica, Queens, home in 2012. It includes [Denis Reyes](#), who went into cardiac arrest as he was being hauled into an ambulance after his bipolar symptoms prompted police to go to his Bronx home in 2015. It includes [Erickson Gomez Brito](#), who family said battled depression. He reportedly swiped an officer's baton in the hallway of a Brooklyn housing project in 2016 and was shot seven times. Links?

To be sure, the review is by no means comprehensive. It reflects only a small percentage of overall police interactions with the mentally ill. While these cases were often covered by local news outlets, there are likely many others that did not get media attention.

Yet the accounts reviewed by the NYCity News Service and interviews with advocates for the mentally ill suggest these events are not isolated.

The police do not make such figures public and did not respond to requests for data regarding contact with the emotionally disturbed. Even less clear is the role drug abuse may play in exacerbating flare-ups.

'DON'T RESORT TO VIOLENCE'

Dustin Grose knew his bipolar disorder and mild schizophrenia had frightened his parents. Smoking marijuana did not help his mental condition. He said blood tests would later show marijuana and PCP in his system the morning of his clash with cops.

When the police arrived in the early hours of Jan. 13, 2007, Grose said they urged him to go with them to a hospital. He refused, saying he just wanted to stay home with his parents.

Outside his home, he said, an officer punched him in the chest and knocked him to the ground. One cop held a boot on his head while two others struck him repeatedly. When the police handcuffed him and wrapped him in a strait jacket, blood was flowing from Grose's mouth and nose. His face was severely swollen.

"I was like a criminal outside of my house," he recalled. "I was suckerpunched, handcuffed, wrapped in a mat and beaten."

The subdued Grose said he was then "lifted like a luggage," tossed into an ambulance and taken to Woodhull Hospital. He said he was handcuffed to a bed while an officer questioned him. He was released a few hours later.

Grose filed a lawsuit and received a \$17,500 settlement, though police did not admit any wrongdoing. He still questions why he was assaulted and had advice for officers who respond to the emotionally distressed: "Don't resort to violence."

"They really don't understand or know how to deal with people who are under distress mentally," he said.

Grose is now 31, a father and engaged to marry. He said he still fears police.

CALLS FOR MORE TRAINING

Few would deny cops face pressure on the job. Police officers make decisions in fractions of a second and they must act in self-preservation when confronted by an armed person. When an armed person is showing signs of a psychiatric illness, tensions heighten. The erratic nature of the mentally ill complicates best practices when police encounter the mentally ill.

Police protocol requires officers to take an emotionally distressed person into protective custody with as little force as possible or wait for specialized units to arrive.

But only approximately 4,000 of the 35,000 officers in the NYPD have undergone specific training to deal with the mentally ill. When officers are being dispatched to deal with someone showing signs of psychiatric instability, those trained officers may not even be sent to the scene. Nothing denotes their expertise during the dispatching process, advocates said.

Instead, members of the so-called Emergency Service Unit, who are typically outfitted with heavy weaponry and militarized garb, are the designated handlers of the emotionally distressed. A [press release](#) from a recent graduation of the elite officers noted they had learned how to detect nerve gases, rappel from helicopters and scale the Brooklyn Bridge.

More officers need to undergo the situation-based crisis training where actors are used to play the part of armed mentally ill people, said Carla Rabinowitz, an advocacy coordinator at a mental health center called Community Access. The NYPD needs to make clear who's taken the course so that dispatchers can appropriately utilize these officers, she added.

The classes in crisis intervention training for New York police began being offered about a year ago. The department also has since added elements of the course into its academy curriculum. Veteran officers can volunteer to take the class to better handle emotionally distressed people, advocates said.

The program teaches officers to defuse a situation with words, not with a show of force. Brandishing weapons – Tasers, batons and firearms – is strongly discouraged as it increases wariness and fear among the mentally ill. The training also encourages officers to confront their own fears about the mentally ill. De-escalation, rather than aggravation, is the mantra of the crisis training.

But training alone may not be the answer.

The overarching problem, according to Steve Coe, the chief operating officer of Community Access, is that police officers are being asked to act as mental health workers while being law enforcers.

“They shouldn’t be the social workers,” Coe said.

--

Restrained and Medicated: Psychiatric Patients in the E.R.

By Noah Caldwell

The ambulance crew rushed the woman to St. Barnabas Hospital's emergency room because she was in an "altered mental status" – agitated and uncooperative, according to records.

Workers at the Bronx hospital laid her on a stretcher, but she kept falling off and hitting the floor.

By 2:29 a.m. on May 11, 2013, hospital staff administered 4 milligrams of Versed, a sedative so potent it also is used in lethal injection cocktails. An hour later, her wrists were cuffed with restraints, and she was placed on "security monitoring."

Her heart began to seize up. The lower chambers stopped beating properly. An electronic monitor failed to trigger an alarm.

Sometime between 4:20 a.m. and 5 a.m., her heart stopped all together – the exact time is uncertain, because no one checked on her until it was too late.

Two weeks later, state inspectors investigating the woman's death found staff failed to follow the hospital's monitoring policies on patients placed in restraints. St. Barnabas "did not provide a safe and secure environment" in the psychiatric emergency room, the inspectors wrote.

Details of her case were made public in federal Centers for Medicare and Medicaid (CMS) inspection records the reviewed by the NYCity News Service. Her identity, though, was redacted.

The findings are not unique to St. Barnabas. Over the last four years, at least a dozen New York City hospitals and emergency rooms have been cited by state inspectors for improper use of restraints, inadequate monitoring of psychiatric patients, poorly trained security staff and a lack of clear policies for handling patients with mental illnesses.

For example, last year at Beth Israel Medical Center inspectors found multiple patients had been handcuffed, against the facility's own policy. Advocates contend city-run Bellevue Hospital excessively uses restraints.

At Lutheran Medical Center, inspectors found that security staff were untrained in the use of first aid and physical restraints, and, contrary to hospital policies, orders for restraints were not filed with licensed physicians.

At Kingsbrook Jewish Medical Center in Brooklyn, emergency room security staff failed to monitor an elderly psychiatric patient at risk for running way. He wandered from the unit, entered an unlocked, empty building, and jumped from the fourth floor and died.

RISE IN PATIENTS, DECLINE IN FACILITIES

An emergency room is not the ideal treatment setting for many mentally ill patients. Emergency rooms are designed more for acute care – heart attacks, broken legs, wounds that require stitching. And yet, psychiatric patients are often funneled into emergency rooms – from homeless shelters, schools, family home settings – instead of into individualized outpatient treatment centers.

For example, at the Urban Pathways homeless shelter in Midtown Manhattan, mentally ill clients are shuttled to the closest hospital emergency room when psychiatric crises arise.

“If it happens here, we do call EMS,” said Lisa Lombardi, deputy executive director of the shelter. “When we do that, because the hospitals are so full, it’s challenging. They wait.”

New York is not alone. Across the country, the number of psychiatric patients in emergency rooms is rising dramatically.

Every shift, three out of four emergency physicians typically see at least one patient that needs psychiatric hospitalization, according to a [recent survey](#) of thousands of ER doctors by the American College of Emergency Physicians. Between 2002 and 2011, the number of psychiatric patients in emergency rooms nationwide grew from 4.4 million to 6.8 million, an increase of 55 percent.

Yet only about 17 percent of emergency physicians have a psychiatric specialist to evaluate mentally ill patients. Psychiatric patients pose serious challenges for staff ill prepared to handle a volatile behavior.

“They’re not familiar with them, and they don’t know how to handle them,” said Dr. Leslie Zun, the head of the Department of Emergency Medicine at Mt. Sinai in Chicago, who has focused on studying the how emergency physicians handle psychiatric patients.

The result, according to Zun, is a tendency quickly subdue erratic patient.

“Based on a lack of experience and comfort, they tend to jump to physical restraints,” said Zun. “That’s really a problem.”

Meanwhile, the amount of inpatient psychiatric facilities has been [falling](#) nationwide. Psychiatric patients who arrive in emergency rooms wait longer to be transferred to a specialty facility or given an inpatient hospital bed, with some spending [up to five days](#) in the emergency room awaiting admission.

TRAINING GAP LEADS TO TROUBLE

Medical school students often are not required to do stints in emergency rooms that deal with mentally ill patients, and even emergency medicine residents don’t always have to undergo training in psychiatric intervention, according to Zun.

“So they’re quick to medicate [patients] rather than assess their needs and treat them,” Zun said.

CMS inspections of New York City hospitals indicate that medication usually comes in the form of a sedative or an antipsychotic – or both. A common combination is Haldol, an antipsychotic also used in prisons to calm unruly inmates, and Ativan, a sedative.

In theory, mixing the drugs allows physicians to use a smaller dose of each. But [studies have shown](#) that using just one – either a sedative or an antipsychotic – is just as effective, and the combination may be unnecessary.

These drugs are often called “chemical restraints,” because they calm difficult patients. There are “physical restraints,” where hospital staff hold down a patient. And “mechanical restraints,” such as cuffs on wrists and ankles.

According to state inspectors, nursing staff and security officers in multiple New York City psychiatric inpatient wards are often untrained in the proper use of restraints. For example, at Interfaith Medical Center in Brooklyn, security personnel are not required to be trained in the use of restraints – even though the task is listed in their job description.

Last year, state inspectors found inadequate training for hospital police officers at Lincoln Medical and Mental Health Center in the Bronx. Not one of the 91 officers that frequently grapple with aggravated patients had been given training in CPR, first aid or physical restraints. Inspectors concluded that patients were at risk for being seriously harmed during physical confrontations.

Case in point: On May 13, 2015, a young woman diagnosed with a bipolar disorder was admitted to Lincoln’s psychiatric inpatient wing. Her family believed she was trying to kill her grandmother.

Four days into her stay, she became agitated and was confronted by five hospital security officers in the hallway. One guard grabbed her by the hair. Another hit her on the side of the face with his elbow. A guard three punched same cheek three times. She was then put in a chokehold and collapsed backwards, her head hitting the floor.

The patient wasn’t seen by a physician until three days later. Her face was still bruised.

Less than three months later at Lincoln, a man, only identified in the public report as “Patient L,” was standing in the hallway surrounded by three guards. Within a few minutes, the officer contingent grew to nine.

Security camera footage shows that officers put on black leather police-issue gloves. Eventually, the patient picked up a thermometer from a nearby cart, and waved it. After a short standoff, one guard lunged at the patient and struck his arm with a tactical baton three times. The patient, now subdued, was placed in four-point restraints, with cuffs around each ankle and wrist.

State inspectors concluded the hospital officer had not been instructed by supervisors to use the baton. They noted the technique violated Lincoln’s policy on patient rights, which states that patients “have the right to receive care in a safe setting and be free from all forms of abuse and harassment.”

Beginning in 2007, the city Health and Hospitals Corporation, which runs Bellevue and other city hospitals, began an initiative to reduce the use of restraints on psychiatric patients. The state’s Office of Mental Health has also promoted an initiative called “Positive Alternatives to Restraint/Seclusion.” But the program is voluntary for hospitals.

--

Thousands of Homeless Suffer From Mental Illnesses

By Christine Brink

When Melissa Lindstrom got off the bus in New York City, she thought she was getting a fresh start.

A guitar and a suitcase was all she brought along when she arrived at Port Authority in 2015. In her mind, she carried a heavier load. Lindstrom had been on probation for four years because of child endangerment charges in 2007 after she left her year-old daughter and 8-year-old son alone in their home in Riverside, California.

Two weeks before the incident, Lindstrom started hearing voices, she said.

“The voices said they were going to take away the souls of my children,” said Lindstrom. “I thought, if I leave my children alone and walk away, maybe these voices of these beings that I’m hearing would follow me and leave my children alone, and they would be safe.”

A caregiver found the children in the house. Lindstrom’s daughter was bleeding from numerous lacerations. A week later, Lindstrom was discovered more than 300 miles away, swimming in an irrigational canal in Phoenix.

After her children were taken away, Lindstrom said, she tried to commit suicide three times.

Getting off the bus in New York City with her guitar and suitcase, she looked forward to getting a job – and a new life. Instead, she soon joined the ranks of an estimated 8,800 mentally ill New Yorkers sleeping in the city’s shelters, and on the streets.

The nonprofit-organization Coalition for the Homeless estimates there are thousands of mentally ill homeless in the city. Among the roughly 14,200 single men and women sleeping in the city’s homeless shelters every night, about 4,700 are estimated to be mentally ill.

In addition, on one of the coldest nights of the year at least 2,794 people were sleeping on the streets, according to a federally-mandated annual Homeless Outreach Population Estimate done in February 2016. These people refuse to go to city shelters even on the coldest days of year. The Coalition for the Homeless estimates two-thirds of the street homeless suffer from a mental illness.

Among homeless families, estimates are less certain. Every night about 23,000 homeless adults with families sleep in the shelter.

“I haven’t really seen any good data on the number of families or households that has a member, who is living with a mental illness,” said Frederick Shack, who is the CEO of the non-profit organization Urban Pathways. “But I would think that there are probably 10 to 15 percent.”

At Brooklyn Community Housing and Services, which has run a family shelter since 1991, executive director Jeffrey Nemetsky said the shelter has experienced “a great increase” in mothers with mental illness.

“Probably up until about five or six years ago, every year we would have one or two moms who would come in throughout the year, who would have a serious mental illness,” Nemetsky said. The shelter houses about 150 families a year. “Now we’re probably seeing regularly around 20 percent of the moms with a mental illness.”

The estimates add up to a conservative figure of 8,800 New York City homeless who are mentally ill.

Lindstrom is diagnosed with schizophrenia. She still hears voices that are arguing with her, and sometimes she sees people appear out of shadows on the streets, she said. For a while, Lindstrom stayed in some of the city's women shelters, but she didn't like it there.

"I just didn't feel safe being in a shelter," she said.

Lindstrom recalls getting a black eye from a shelter dormmate.

"The woman got mad at me because I didn't smell very good," Lindstrom said.

That night Lindstrom slept on the steps in front of St Bartholomew's Church on Park Avenue.

Lindstrom is far from the only homeless person who avoids shelters, said Lauren Taylor, deputy director of the Manhattan Outreach Consortium at Goddard Riverside Community.

Taylor runs an outreach team that patrol the streets in order to make the people come inside. But the transition from street to shelter is often challenging.

"It speaks to some of the experiences people have had in shelters," Taylor said. "Having traumatic experiences from the past and maybe being around other people seems more frightening or stressful than staying outside."

In March 2016, the city launched its Home-Stat initiative to help the homeless. [The city](#) increased the number of homeless outreach workers from 191 to 387, and promised to add 500 temporary housing beds in so-called safe havens, where homeless aren't pressured to get services from social workers. Some 284 beds had been added as of December 2016.

Homeless people with mental illnesses can be referred to special mental health shelters where there are more staff. But many end up in dorms in regular shelters. Non-profit organizations like the Coalition for the Homeless and Homeless Service United wants the city to create more shelters homeless people with mental illness. "The supply is not as high as the demand," Trapani said.

After being in and out of hospitals and homeless shelters, Melissa Lindstrom returned to the streets, hoping for a normal life. She recalled sitting in front of St. Bartholomew's Church with a cardboard sign reading "Please, take my resume."

After two weeks on the streets, her guitar and suitcase was stolen. Eventually, a man bought her a new guitar, but Lindstrom pawned it.

"I didn't want to keep losing my stuff," Lindstrom said. "I didn't want to invest in clothes, I really wanted to try to get my life together as far as getting a job."

One of the city's outreach workers found Lindstrom on the street, and she agreed to go to a city-funded safe haven on the corner of Eighth Avenue. and 40th Street.

About 80 percent of the clients are mentally ill, the staff said. The majority suffer from schizophrenia, bipolar disorder or major depression. Safe havens differ from regular homeless shelters by not having any curfews or requirements about sobriety or weekly meetings with case managers.

“What we find is that once we move that barrier, individuals who are chronically homeless are more likely to accept the services,” said Shack. “Once they are indoors and no longer concerned with their very survival, they are a lot more available for the services that we are able to provide to them.”

“More importantly, it provides them with the opportunity to transition to supportive housing, and that's where the real solution comes in,” he added.

But obtaining supportive housing in New York City is far from easy. Only one in six eligible applicant obtain an apartment, homeless advocates say.

At the safe haven on 40th Street in December 2016, Lindstrom had just got back from two job interviews. She was wearing a white form fitted jacket, and her French manicure appeared to have recently dried. She is now sharing a bedroom with one other person.

“It's nicer to just have one roommate instead of having a room full of 10 or nine other girls who have their emotional issues, you have to hear about all the time,” she said.

Lindstrom she was offered both jobs, but she only accepted one. She now works in Times Square selling tickets for the Laugh Out Loud Comedy Club. Once she has made money enough, she plans go to the pawn shop around the corner, and buy back her guitar.

--

Lack of Supportive Housing in New York City (this is companion story to Christine's story on thousands of mentally ill homeless)

By Christine Brink

For the first time in a long time, Cherita Barbuto, who suffers from bipolar disorder, counts herself among the lucky ones.

For years, she was homeless. Now she's living in a modest Bronx apartment, part of a city, state, federal and private financed program called supportive housing, designed to help get the mentally ill off New York City's streets and out of the shelters.

56,

These are more than places to live. Counselors check on residents, and staff help ease the transition.

But for the mentally ill long-term homeless, there is far greater demand for supportive housing than there are places to live. Barbuto, 56, remembers the day she received a call from a social worker in June 2015 telling her an apartment was waiting for her, a decade after she first entered the city's homeless system.

“I just started crying,” Barbuto recalled. “She said ‘Are you crying Ms. Barbuto?’ and I said ‘Yes, I’ve been waiting for a long time for this.’”

Only one in six eligible applicants obtain supportive housing in New York City, according to several supportive housing experts and homeless advocates. If there are no apartments available, they have to stay in homeless shelters, transitional housing – or on the street.

“There’s a lot of competition for the few units of available supportive housing that exists,” said Cynthia Stuart, chief operating officer at the Supportive Housing Network of New York, a coalition representing private nonprofit supportive housing agencies.

“It’s musical chairs with very few chairs.”

HIGH DEMAND

There are about 32,000 units of supportive housing in New York City – about half of which are for homeless people with mental illness, Stuart said. Homeless veterans, people with HIV and substance abuse also can apply for supportive housing.

The apartments may be in a building with only other supportive housing units, with shared community rooms, and services provided in the building. Or supportive housing units can be mixed in a building combined with regular apartments. In this setup, social workers, headquartered elsewhere, visit the tenants.

[A 2015 study](#) by the national nonprofit organization Corporation of Supportive Housing suggested a need for 24,155 new units – a majority of them for homeless people with mental illness. The study is based on 2013 data, when the homeless population was smaller than current levels. A 2017 estimate would be even higher, said Kristin Miller, director of the Corporation of Supportive Housing’s New York Program, one of the researchers behind the study.

“There are 60,500 people in the New York City’s shelters, and not all them need supportive housing for sure,” Miller said “But you can see that we have a tremendous need for housing and within that supportive housing in New York.”

So far, supportive housing has been funded through city and state contracts, the so-called New York, New York agreements. There have been three agreements since the 1990s. The third one expired in 2016, and advocates want the program to continue.

Gov. Andrew Cuomo and Mayor Bill De Blasio have not reached an agreement on a fourth. However, De Blasio committed last year to creating 15,000 new supportive housing units within the next 15 years, and in April Cuomo said the State will create 20,000 new units within the next 15 years.

“It will certainly go a long way,” said Catherine Trapani, executive director at Homeless Services United. “But I imagine, frankly, that we could probably fill even more than that. But let’s start with what was pledged because right now we have very few vacancies.”

BARBUTO

From her window in South Bronx, Cherita Barbuto, 56, can see straight to the jail at Rikers Island. The view reminds her of a past she does not like to recall. Barbuto, who suffers from PTSD and bipolar disorder, has been in and out of jail so many times she stopped counting.

“They know my name in there,” she said. “When I walk in they say ‘Ms. Barbuto, what did you do now?’ When they know your name when you are going to a jail, I think you’ve been there a bit too much.”

The first time Barbuto got arrested was in 2002 for selling a bag of heroin to an undercover cop, she said. Barbuto was a substance user, and selling drugs was convenient in terms of earning money and satisfying her own needs.

She was sent to drug rehabilitation. After two years in rehab, Barbuto went home to her apartment in Brooklyn. But after a short time Barbuto and her husband, who had custody of their children, split. Like many other mentally ill New Yorkers, Barbuto started cycling between jail and the city’s homeless shelters.

In October 2015, she moved into an apartment in a supportive housing building in the South Bronx. Supportive housing is permanent affordable housing combined with support from professionals such as social workers and mental health staff. Residents like Barbuto pay one-third of their income. The purpose is to keep mentally ill homeless people able to maintain their apartments, and manage the challenges that left them homeless in the first place.

Barbuto, who is now sober, shares a one-bedroom flat with her black cat, Sugar. The walls are decorated with photos of her adult children.

Barbuto thinks she has one of the best apartments in the building. The apartment is placed in the corner of the building so it has two windows, which makes the apartment seem less like a prison, she said.

“At first it kind of bothered me,” Barbuto said of her view of Rikers. “But then I said to myself ‘Girl, remind yourself you don’t want to go back over that bridge.’ So it’s more like a blessing reminder. You don’t want to go back that way.”

--

Adult Group Homes: Prevented from Leaving

By Mary Hanbury

Thousands of New York City’s mentally ill are housed in privately owned adult group homes, legally free to leave – but a court-appointed monitor said many facilities improperly pressure residents to stay.

Some group homes deploy scare tactics, mislead residents about their options and prevent independent counselors from even meeting with the mentally ill to discuss housing, according to a 2016 report by monitor Clarence Sundram.

A mentally ill person at one home was told that if he left, “no one will care about him,” Sundram reported.

A 73-year-old ex-Marine who lives in a Queens group home told the NYCity News Service charged he was subjected to such tactics – leaving him feeling stuck in a “hellhole.”

Advocates who sued and got the oversight monitoring say the reason for these pressure tactics is clear: money. Group homes get reimbursed from Medicaid and other programs for every person they house, so losing residents means losing revenue.

“They are profit businesses and they want to make as much money as possible,” said Jota Borgmann, a lawyer with MFY Legal Services, whose attorneys were part of the legal actions over treatment at adult group homes.

ABUSES LEAD TO COURT SETTLEMENT

Several decades ago, adult group homes were seen as a humane answer to large psychiatric wards. In the wake of deinstitutionalization, thousands of mentally ill were dispersed into smaller adult group homes, in the hope of providing better conditions and integrate them into neighborhoods.

It didn't always work out that way.

Investigations in the past two decades uncovered abuse, neglect and poor oversight in New York City's group homes. That included a 2002 Pulitzer-winning investigation by The New York Times, lawsuits and a state inquiry.

A group of mentally ill residents sued New York state in 2003 to enforce rules that give the mentally ill a choice of where to stay. The federal government joined the litigation. Under a 2013 federal court settlement, the mentally ill are supposed to be able to choose whether to reside in more independent living situations, like apartments where social workers could check on them and help them out.

As part of the settlement in 2013, counselors are supposed meet with the mentally ill and their families to explain housing options. Group homes could not interfere with the consultations and were told not to stymie any resident who opted to move. Court-appointed independent monitoring was set up to track whether the state and private adult group homes were living up to promises.

In New York City, the settlement covered 4,300 mentally ill residents in 23 different adult group homes. The plan is to relocate anyone who wants to move within five years, though efforts are behind schedule.

While some group homes appear to be meeting the spirit of the agreement, the inspectors found other homes have used scare tactics and prevented counselors from meeting with residents.

“It's the nature of the beast,” said Geoff Lieberman, executive director of the disability advocacy group Coalition of Institutionalized Aged and Disabled, which helps adult homes residents with the transition.

He said it is not unusual for residents to stay in adult homes for more than 10 years, and the effects of living in an institution where you are unable to do anything for yourself takes a toll.

DOCUMENTING DISCOURAGEMENT

Sundram, who has a long history of working with the disabled, released his most recent annual report in April 2016. Among his findings:

- Caseworkers counseling the mentally ill “talk of the subtle and not so subtle influences that they feel the adult group home administrators and staff have on the process.”
- Caseworkers advising about housing options faced difficulties in getting into the homes and setting up counseling sessions. In one instance, counselors arrived at a group home before 10 a.m. but staff at the front desk did not call any of the residents down for another hour, leaving time to meet only one person.
- Housing counselors tried a mass mailing to residents at an unidentified group home, inviting them to an event. No one showed up.
- At one unnamed group home, counselors opted to meet with the mentally ill in the laundry room, sometimes having to talk over the noise of the machines. The alternative was to meet in a small room with a camera and where the group home’s staff could overhear their conversations.
- As of March 2016, almost 90 percent of those in adult group homes had been advised about housing options. But compared with the previous year, the number who said they would be interested in moving had dropped from 60 to 46.8 percent.
- The process to move out is taking longer than it should: only 15 percent of the 1,600 who said they want to relocate have actually done so.

Among the cases at city group homes named in the report:

- Mermaid Manor in the Rockaways section of Queens faced four allegations of “discouragement” between September and November 2015. The state Department of Health substantiated all of the claims, the most of any group home in the report. One resident said Mermaid Manor administrators told him “no one will care about him and no one will take care of him” if he left, a caseworker reported. **Those who said they wanted to relocate from Mermaid Manor plunged from 70 percent a year earlier to 40 percent.**
- At New Haven Manor in the Far Rockaways, independent housing counselors were prevented from talking with mentally ill residents about their options for several weeks. New Haven Manor compiled a form letter for residents to sign saying they did not want more independent housing. Seventy-four letters were sent by residents. Monitors found some signed the letter mistakenly believing they were writing to say they did not want to move immediately, not that they were uninterested relocating later to supported housing. **In addition, the percentage at New Haven Manor interested in moving plunged from 79 percent a year earlier to 52 percent.**
- At Central Assisted Living, also in Far Rockaway, counselors have talked with 169 residents and 53 said they would leave – posting a 31 percent rate of those interested in

leaving. That was the lowest level for any group home in the report. Still, no one had actually moved out in two years.

- At New Gloria's Manor in Rockaway Park, the number of residents who said they wanted to move fell from 46 percent to 40 percent. In all, 42 people said they would relocate. But only two have done so.

"Owners scare residents into thinking that if they hospitalized they will be put back on the street," Borgmann said.

"There is a lot of skill that is required in getting them to move," she said. "It's not a simple question of 'Do you want to move?' It is a more intensive process than that and requires more intensive interviewing."

To be sure, Sundram noted in his monitoring report that there have been improvements. All but 10 percent of the mentally ill in New York City's group homes have met with counselors about moving, a vast improvement from a year earlier, when only a third had met with independent housing advisors.

The report does document several who moved out but did not transition well at first. One unnamed person neglected to take his medication regularly, mismanaged money, disturbed neighbors and even was found once having smeared feces in his apartment. Yet with additional support he was able to try again in a studio apartment in the Bronx and, with increased support, is doing well, according to the report.

Those "who have made the transition are, with few exceptions, generally doing well in their new homes and are happy to have made the move," according to Sundram.

STUCK IN A 'HELLHOLE'

In 2009, Ronald White, suffering from depression and grappling with chronic lung disease, said he was giving a choice when being released from a hospital: Go to a group home for the mentally ill or face homelessness.

The ex-Marine reluctantly moved into New Gloria's Manor in Rockaway Park.

"I have been wanting to move out of here since I moved in," said White, 73. "I wouldn't wish this place on my worst enemy."

The facility was described in a 2016 an independent court monitor report as an "outlier" because so few residents left. The report found that some group homes use pressure tactics to keep residents from moving – charges echoed by White.

He said a director for the group home frequently listens in on conversations. "Every now and then he will have a member of staff come through, trying to hear what is going on, even though

they are not supposed to be doing that,” he said. “These people are so afraid of him that they believe he can put them on the street.”

“It’s a business,” said White, “that’s all this is, and they look at us and see dollar signs.”

White has shared a bedroom and bathroom with another resident with mental illness. He has a bed and side table, chest of drawers, and chair to himself. In this box-like space he houses all his possessions.

He said the worst part of being in a group home is losing his independence. He hasn’t cooked himself a meal in years.

In June 2016, White said he was told he would be moving to his own apartment. “They build me up, saying: ‘You are going to be moving out soon,’” he said.

“If I get out of here I am definitely getting myself a bike,” White said. “In the meantime I am stuck in this hellhole. I am tired of this place and if anyone says they are not, they are out of their minds.”

--

Detention in the Emergency Room

By Michael O’Brien

On Halloween 2013, Amber Decker’s then-8-year-old son was rushed by ambulance to the emergency room. He was not deathly ill, hadn’t broken his arm at the playground or slammed a door on his fingers.

He’d thrown a tantrum.

It started when his teacher asked him to take off his Halloween mask. “He was the Lizard from ‘Spider-man,’” Decker said, “in a little foam outfit with a plastic mask.”

It can take her son, who is autistic, a while to follow directions. But he’s smart and high functioning, Decker said, which is why he was enrolled at Public School 120 in Flushing, Queens, instead of a special education school.

The school was aware of his condition and employed a school psychologist, Decker said. But like many psychologists at New York public schools, he split his time between schools and wasn’t at P.S. 120 that day. Decker said a guidance counsellor couldn’t handle the 8-year-old’s outburst.

So someone at the school dialed 911 for an ambulance.

Decker’s son is far from the only city school-kid sent to the ER for acting out. Some [1,447](#) students were taken to the emergency room for an “emotional/psychological condition” during the 2015-2016 school year, according to city [data](#) recently made available.

Even the city has cast doubt on whether most of these ambulance calls are necessary. Child psychologist Charles Soule [testified](#) in [May 2012](#) before New York City Council that the city's School Based Mental Health Committee, an advisory body to the NYC Department of Health and Human Hygiene, found that in 97 percent of such cases the students did not require immediate hospitalization.

The New York Civil Liberties Union concluded in a 2013 report that uniformed school security officers on campus regularly failed to distinguish tantrums from actual emergencies. A year later, a federal judge ordered the city "avoid unnecessary emergency room visits for students experiencing emotional, behavioral or psychiatric events."

The de Blasio Administration's mental health plan, launched in November 2015, called for expanding instruction to help officers respond more appropriately to special needs students. This includes fewer 911 calls, fewer suspensions and training on how to de-escalate crises.

A RUSH TO THE ER

Tens of thousands of city students have mental health and behavioral problems. The city [Department of Education](#) estimates [9 percent of children ages 6 to 12](#) year olds have ADHD, depression, anxiety, depression, bipolar disorder and/or other psychological difficulties. [Eight percent](#) of the city's high school students have attempted suicide, according to the city.

Still, it's difficult to determine how many of the city's 1.1 million public school students, from pre-kindergarten through high school, are grappling with mental health issues.

About 18 percent of students have an individual education plan on file. This classifies them as students with disabilities, according to the city Department of Education, though the numbers aren't broken down to distinguished between children with physical or mental difficulties. City schools are required to integrate all but the most disabled kids, who are placed in special schools covered by District 75.

On paper, New York schools appear to have a robust program for addressing students' mental health needs. But, advocates say, a lack of resources and proper training leads educators and staff to too often rely on punitive measures.

Advocates say city schools began calling more for ambulances for psychologically challenged youth when schools embraced zero-tolerance suspension policies in the 1990s.

In the case of Amber Decker's son, someone ignorant of his diagnosis might conclude his trouble understanding instructions can make it seem like he's being "mischievous or not listening," the mother said. When her son didn't take off his beloved Halloween mask, the situation escalated. By the time his mother arrived at the school, her son was locked in a room with a security officer.

An ambulance arrived, she said. Decker was told by the school her son would not be allowed back in class unless she went with him to the hospital. They spent the day in a hospital emergency room. He was evaluated and sent home with a [doctor's note](#) stating that he was "currently able to return to school at this time."

This would not be the first time EMS would be called in to deal with her son's tantrums. It happened again, at another school, she said.

The boy didn't only lose schooltime: It cost his family money. Parents are expected to pay for for the trip to the hospital – the average cost for an ambulance ride is \$800, plus medical fees that range from \$700 to \$1,700, said Nelson Mar, an attorney with [Legal Services NYC](#).

The [NYCLU](#) reported in 2013 that special needs students were suspended twice as often as other students. Over 10 days in 2012, according to the report, one Bronx hospital received 58 emergency psychiatric calls from area public schools.

During the 2011-2012 school year, a 5-year-old kindergartner was sent to the emergency room involuntarily at least five times, according to Legal Services NYC. The group, which lobbied on the boy's behalf, the school required a guardian to sit with the child or he would not be allowed in class.

Another kindergartner at Harriet Tubman Charter School was banned from school until receiving a "psychological clearance, as well as a neurological and behavioral assessment" for yelling and throwing chairs, according to a letter from the school to the child's guardian.

In the 2015-2016 school year, police were called to assist with 1,262 suspensions for students with disabilities. This was out of the total 3,437 suspensions involving police.

This data is publicly available largely due to a lawsuit brought by Legal Services NYC, which sued the city on behalf of 11 children with behavioral issues varying from ADHD to autism and their families. Amber Decker and her son were on the list.

"Having these emotional crises in schools has a serious ripple effect. This is part of the reason why we have the achievement gap," said Mar. "Schools are unable to address it and it spirals out of control."

REFORM EFFORTS UNDERWAY

An additional \$150 million dollars was set to spent on school children under the de Blasio administration's Thrive NYC plan between 2015 and 2019, with the extra funding proposed afterward, according to the Mayor's Office of Management and Budget.

This would eventually provide mental health training for 9,000 teachers and staff in classrooms with the youngest students. The city would also train an undetermined number of middle and high school staff. According to the [Mayor's Management Report](#), as of October 2016, 30 mental health consultants had been hired for 206 schools to identify students most in need of care.

There are still [900 school campuses](#) without additional mental health resources.

Dawn Yuster, an attorney with Advocates for Children of New York, is heartened that the city is attempting to tackle the problem, but noted that too many schools are lagging.

"it's commendable what the city is doing," she said. "But it's just not nearly enough."

--

In Prison: Suicides and Missed Appointments

By Anthony Izaguirre and Michael O'Brien

In November, a mentally ill inmate held at the Manhattan Detention Complex punched an assistant warden in the face during a brawl that injured at least seven other jail workers.

In January 2016, a Rikers Island detainee hung himself with his shoelaces. A city corrections board member attributed his suicide to a lack of mental health care, including missed psychiatric appointments.

These incident occurred in a city jails system system where 42 percent of inmates suffer from mental illness. That amounts to roughly 4,000 detainees – about the same number as all those housed across the state in psychiatric hospitals. Of those 4,000 inmates, 400 are classified as having [debilitating](#) psychiatric problems as of Fiscal Year 2016.

Meanwhile, more than [three-quarters](#) of the violent incidents inside the five city jails involve inmates with a history of psychiatric illness, according to a city report.

Jails are ill-suited to provide mental health care, advocates say: Inmates are promised appointments with mental health care staff, but sessions are missed one-third of the time. Jail guards are calling for special mental health facilities to handle these detainees, who often end up behind bars because there's nowhere else to send them.

"We have so little mental health services in the community, the only way to get any care at all is in a prison setting," said Dr. Bandy X. Lee, a Yale psychiatrist who completed a residency at the city jail on Rikers Island, said jails have become a place where the mentally ill end up because of threadbare public services. "What we are doing with jails and prisons is the exact opposite of what we should be doing."

MISSED OPPORTUNITIES FOR HELP

Promised care frequently does not happen. The city began publicly tracking missed visits with psychiatric staff in April 2016. Between April and October, reports show, inmates missed close to [70,000](#) mental health clinic visits. They continue to miss one-third or more of appointments every month, mostly due to a failure of having enough guards to [escort](#) them to clinics.

To be sure, jails are not designed primarily to provide mental health care. Guards, charged with maintaining security, face a difficult task. Getting inmates to mental health visits can be complicated by frequent security lockdowns

"Corrections institutions are so gravely not designed to meet the needs of those who need mental health care," Lee said. She added that the number of inmates with psychological problems may be much higher since prisoners try to hide symptoms from police, lawyers and guards.

Mayor Bill de Blasio's administration plans to spend more than \$33 million to construct and staff new clinics: Psychiatric clinics inside jails are slated to triple from [four to twelve](#), according to city records.

Existing units will take on more mentally ill prisoners. Guards and jail health care workers have begun to undergo specialized training, including a week-long course on how to diffuse psychiatric episodes like the Nov. 6 fracas at the Manhattan Detention Complex.

The union that represents corrections officers quickly blamed the city's mental health care agency for endangering the guards hurt in that incident.

"The question we have is where is the Department of Health and Mental Hygiene?" the Corrections Officers Benevolent Association wrote in a [statement](#).

"How many more assaults on staff committed by inmates who require mental health treatment have to occur before the DOHMH intervenes and removes the mentally ill and puts them in mental health facilities instead of using Rikers Island and the City's jails to house them?"

In July of 2015, City Council Member Elizabeth Crowley (D-Queens) proposed a [bill](#) that would require the city Department of Corrections to escort inmates psychiatric appointments within a "reasonable period of time." The measure also would require the DOC to make public the waiting times that inmates face getting care. The proposal is currently before a committee. She hopes it gets a hearing soon.

Since data on the number of missed appointments became public, the percentage of missed visits have [gone down](#). In August, inmates only made it to 60 percent of their mental health visits. By October, inmates were making it to 67 percent of those appointments. Still, that represents more than 7,000 missed appointments.

Dr. Robert Cohen, who sits on the [Board of Correction](#), which helps oversee city jails, is well acquainted with medical conditions at Rikers – he worked there as a doctor for 17 years. From 1982 to 1986 he was the director of its medical center. He blames Department of Correction policy for the missed appointments.

"The NYC Department of Correction decided to require escorts for almost all mental health appointments and knew that it did not have the staff to provide the escorts," he said in an email. Inmates began missing appointments. The department of mental health notified the corrections department "immediately," Cohen said. This was several years ago. The corrections department took no action, he said.

QUESTIONS OVER RIKERS SUICIDES

Cohen charged that the two inmate suicides on Rikers island in 2016 came after the "Department of Correction failed to provide detained men with access to scheduled mental health appointments"

One of the men, Angel Perez-Rios, was arrested in 2013 for fatally stabbing his girlfriend in the neck while her three young children watched in their Queens apartment. Perez-Rios, who had a history of mental illness and domestic violence, "snapped" the day of the murder, said his lawyer, Jorge Santos.

After Perez-Rios was arraigned, his lawyer filed a 730 exam – a request for a psychiatrist to determine whether a defendant is mentally fit to stand trial. Santos said he does not believe Perez-Rios understood the proceedings.

“I was trying to get him to take a plea,” said Santos. “‘Give me the death penalty,’ he would tell me.”

On Jan. 24, Perez-Rios hung himself in his cell.

He entered a coma and died a few days later.

At a public meeting held after the death of Perez-Rios, a representative from the city Health and Hospitals Corp. said the agency would review the suicide and make any needed make recommendations to the corrections department. But Health and Hospitals officials declined to say whether the review was completed and would not disclose any recommendations, citing concerns about Perez-Rios’ privacy.

The other Rikers inmate who hanged himself in 2016, Jairo Polanco Munoz, was arrested in March for stealing a cellphone, according to the [Daily News](#), and was sent to Rikers.

After a routine examination, it was determined that he should undergo a thorough psychological assessment. His first appointment was cancelled when there was a lockdown. Three days after being placed in Rikers, he committed suicide. He had a history of serious mental illness.

The Department of Correction said it would conduct an investigation. But DOC investigations are confidential and there are no public findings in this case.

Santos said the criminal justice system is ineffective handling mentally ill defendants. “You can’t go to a judge and say, ‘Judge, put him there in a hospital, he needs medicine, he needs doctors, he needs real care,’” said Santos, a lawyer for 27 years.

“You’re asking lawyers like myself and corrections officers who have a high school diploma to deal with this,” Santos said. “It’s easy to indict corrections. We ask a lot of these guys and I think it’s unfair.”

FALL DOWN ON FOLLOW-UP

The Department of Mental Health and Hygiene was supposed to help ensure release inmates mental illness get proper care.

But it had a poor track record.

A [2014 audit](#) by the New York City Comptroller found that “despite spending nearly \$10 million dollars,” over a three-year period to create mental health treatment plans for released inmates, the city’s health department “has limited assurance” the formerly incarcerated followed through on their treatment plans.

The report found the agency failed to “conduct required follow-up” for 11 percent of “severely and persistently mentally ill” inmates after they were released from custody.

During the 2012 and 2013 fiscal years, the department neglected to check-in on 165 of the 1,521 severely mentally ill whom were released from jail with a treatment plan. During the same period, an additional 3,880 inmates were released from jail with treatment plans but without being classified as severely mentally ill. The mental health department was not required to follow up with those patients

When there was required follow-up, it lasted no longer than 30 days after the person was released from jail. The comptroller recommended that the department follow up on every patient released from jail with a mental health treatment plan, regardless of severity.

In June 2015, the de Blasio administration [announced](#) responsibility for health care in city jails would shift from two private contractors and the mental health department. Instead, it would be handled by the city's Health and Hospital Corp., which includes Bellevue. The shift includes care inside jails and follow-up for released prisoners.

Levi Fishman, of the Correctional Health Services division of Health and Hospitals, said the city has "undertaken a number of proactive initiatives to improve mental health services for inmates." These include the tripling of mental health units in jails, hiring additional "expert clinicians" and adding more services for young adults and others with "serious mental health issues," he said.