JUSTICE INVOLVED BEHAVIORAL HEALTH

Psychiatric Labels in the New York City Pre-Trial Criminal Legal System: What Really Happens

Report from the First Annual Symposium of the Justice-Involved Behavioral Health Workgroup

June 13, 2023

New York State Psychiatric Institute

COLUMBIA

COLUMBIA UNIVERSITY
DEPARTMENT OF PSYCHIATRY

JUSTICE INVOLVED BEHAVIORAL HEALTH WORKGROUP

Mission

The NYSPI/CUIMC Justice-Involved Behavioral Health Workgroup aims to improve the care of individuals with behavioral health needs who are or have been involved in the juvenile and/or criminal legal systems. Through collaboration with those most impacted, the group leverages its research, clinical, and training expertise to raise awareness, enhance understanding, and improve treatment.

Goals

1. Collaborate with affected communities to generate awareness while maintaining cultural humility.
2. Develop and evaluate collaborative data-driven projects to improve clinical services, education, training, and policy related to behavioral health treatment in juvenile and/or criminal legal settings.
3. Tailor initiatives to the needs of impacted individuals, incorporating their skills and perspectives at every stage.
4. Use findings from these projects to advocate for system reforms that reduce initial or recurring legal involvement through person-centered care.

Special thanks to the following for their assistance in the preparation of this document:

Nedyah Alexis
Joseph Alli
Tonie Dreher
Kate Elkington
Elizabeth Ford
Harun Khan
Leah Pope

TABLE OF CONTENTS

Executive Summary 4
I. Introduction 5
II. Assessment for mental health needs by professionals in the criminal legal system 6
A. Observation – Appearance and Behavior 6
B. History 7
C. Engagement 8
III. Challenges of diagnosis in criminal legal settings 9
A. Time 9
B. Environment and access to care 10
C. "Serious Mental Illness" (SMI) 11
D. Bias and stigma 12
E. Proposed solutions 13
IV. Research and training 13
V. The inclusion of voices of lived experience 15
VI. Recommendations 16
VII. Conclusion 16

Acknowledgments

This report and the symposium on which it is based are the result of contributions from multiple individuals for whom we are grateful. We would like to thank the Justice-Involved Behavioral Health Workgroup Steering Committee, which has dedicated countless hours to building the Workgroup over the past two years, and which planned and executed the first symposium. We thank all the speakers, moderators, and panelists who participated in the symposium and shared with us their varied life and professional experiences. We also thank all the attendees who actively engaged in the discussion and deepened our understanding of the critical overlap between mental health and criminal legal systems. We are grateful for ongoing support from the New York State Psychiatric Institute, the Department of Psychiatry at Columbia University Vagelos College of Physicians and Surgeons, and the New York State Office of Mental Health.

Executive Summary

This report summarizes the proceedings of the Justice-Involved Behavioral Health Workgroup's symposium, "Psychiatric Labels in the New York City Pre-Trial Criminal Legal System: What Really Happens," held on June 13, 2023. The event brought together people with lived experience, mental health providers, advocates, law enforcement, legal professionals, family members, and researchers to discuss an early intersection between the mental health and criminal legal systems – the point at which a person under arrest is labeled as having a mental illness.

Keynote speakers Dr. Ann Marie Sullivan, Commissioner of the NYS Office of Mental Health, and Judge Toko Serita, Statewide Coordinating Judge for Problem Solving Courts in the New York State Unified Court System, opened the symposium, followed by panels covering three key pre-trial settings: police involvement, arraignment, and pre-trial detention in jail. Panelists explored the central question, "What behaviors suggest someone might have mental health needs or be in crisis?"

The event's discussions illuminated the complexities of how psychiatric labels are assigned, communicated, and acted upon across various stages of the criminal legal process. Recommendations and reflections emerged throughout the day, contributing to an ongoing dialogue about the impact of these labels on people and how the system can better serve those with mental health needs.

Key themes:

- The difficulty in assessing mental health needs in pre-trial settings, where operational and clinical judgments are often based on superficial observations.
- Barriers to diagnosis, including time constraints, environmental factors, and stigma associated with psychiatric labeling.
- The need for expanded research to inform best practices for mental health assessments in the criminal legal system.
- The critical role of incorporating the voices and expertise of people with lived experience at all levels of decision-making.

Recommendations:

1. Practice empathy to better understand the experiences of others.
2. Reevaluate the necessity of psychiatric diagnoses or classification (e.g., "serious mental illness," or "SMI")for accessing support and services in the criminal legal system.
3. Prioritize research on evidence-based best practices for diagnosing mental health conditions in the pre-trial legal context.
4. Implement cross-system training for mental health providers and criminal justice professionals
5. Include people with lived experience at all levels of research, education, policy development, and clinical care

Click here for the full program

I. Introduction

On June 13th, 2023, the Justice-Involved Behavioral Health (JIBH) Workgroup hosted its inaugural city-wide symposium. Based on months of conversations with people with lived experience, advocates, mental health providers, judges, lawyers, family members, educators, researchers, and others, the symposium focused on one of the earliest points of intersection between public mental health and criminal legal systems – the identification of an individual as having a psychiatric diagnosis or being labeled in some way that identifies them as mentally ill. This “labeling” was repeatedly raised as a critical process determining the course of a person’s path through the criminal legal and behavioral health systems, a process that is obscure to many.

The police are typically the first point of contact with the criminal legal system and are therefore most likely to form the first impression about an individual’s behavioral health status. Impressions at arrest can inform subsequent assessments, evaluations, diagnoses and treatment in emergency rooms, interactions with legal personnel, proceedings at arraignment, and clinical interactions in the pre-trial space, including detention in the New York City (NYC) jail system on Rikers Island.

Being perceived to have, or labeled as having, a mental illness can affect the way people are monitored, processed, and cared for in the criminal legal system, and can impact them in ways that may be both helpful and, unintentionally, harmful. For example, inclusion in many alternative-to-incarceration programs and problem-solving courts requires a mental health diagnosis, while a diagnosis of serious mental illness is an exclusion from solitary confinement in the jail system. Adding complexity, accurate identification and diagnosis is inherently challenging in criminal legal settings. Most existing literature related to mental health in the criminal legal system describes the prevalence, program development, and healthcare needs of people who have already been identified as having a mental health diagnosis. However, acknowledging that psychiatric diagnoses are dependent on observed and reported symptoms and behavior, are known to be subject to provider- and systemic bias, and may be carried from one criminal legal setting to another without adequate re-assessment, we are missing the critical impact that mental health providers play in the trajectory of an individual's path through and, hopefully, out of, the criminal legal system.

The choice of symposium topic was informed by conversations of the JIBH Workgroup, invited speakers, and, most importantly, the input of many people with years of experience being treated in, subject to, and/or working within or alongside the New York criminal legal system, and their acknowledgment of the incredible power that psychiatric diagnoses hold in that system. The symposium, focused on the pre-trial components of the police, courts, and jail detention, sought to bring together people with lived experience, criminal legal and behavioral health practitioners, and policymakers to engage in open dialogue and knowledge exchange about how each component identifies and communicates about mental illness. The goal was to develop a shared understanding of practices across systems to inform efforts at improving the continuity of person-centered and justice-informed mental health care.

Each of the panels represented a different pre-trial setting – public safety, arraignment (initial court appearance in NYC), and jail detention. Each panel was moderated by a mental health professional with expertise in the respective pre-trial setting and included two panelists who experienced that pre-trial setting first-hand and two panelists who work in that setting. For example, the public safety panel included representation from the NYPD, the arraignment panel included a prosecutor and defense attorney, and the jail panel included representation from the

NYC Department of Correction. The voices of system-impacted people were intentionally elevated.

As a first step to understanding how mental health diagnosis informs practice in the criminal legal system, we asked one unifying question across all panels: "What behaviors indicate to you that someone might have mental health needs or be in crisis?" This question sought to unravel the intricacies of labeling – how we label, who we label, and what we do with the label. We recognized that before any meaningful progress can be made in this space, we need to come together as a collective of people with different ideologies, professions, backgrounds, skills, and interests. This report is a summary of the proceedings of the day-long symposium, divided into major themes, and ending with recommendations for future work.

The day was planned to foster conversation not only amongst the panelists but the symposium attendees as well. For that reason, and to protect those who may feel uncomfortable sharing their truths and experiences more publicly than in a closed conference space, we have identified speakers only by their profession and/or experience.

II. Assessment of mental health needs by professionals in the criminal legal system

Although the assessment, diagnosis, and treatment of mental health and substance use disorders are not part of the education or expertise of professionals in the criminal legal system, police, judges, attorneys, and correctional officers frequently find themselves assessing whether people in their custody or the courtroom have mental health needs. Given the stigma and public misconceptions of mental illness, how do criminal legal professionals make such assessments? And how do those assessments align with the experience of the people being assessed?

A. Observation – Appearance and Behavior

Many of the participants representing criminal legal professions noted the importance of a person in custody's appearance and behavior in prompting inquiries about their mental health, just as they cautioned against the risks of assumption and judgment based on observation. Representatives from the New York Police Department (NYPD) noted that in response to a police dispatch call, "when we engage someone on the street, we're looking at appearance. Are they keeping themselves properly groomed, maintained…are they making eye contact? Basic body language can give you a good example of how they're engaging with people around them, with their environment." They also spoke about the importance of being precise in observation and trying to avoid interpretation about what a person's appearance might say about their situation.

Attorneys who work at arraignments similarly noted the importance of observation – "clues" in one's appearance at arraignment such as the person seeming to be "unkempt or malnourished;" "plenty of times that people may be rambling or incoherent or talking about other things" – and the challenges. "One of the things I find particularly challenging is [that] I cannot just look at this individual and [see] their clear needs…Most defendants have an incentive to pull it together and be their best selves in front of the judge."

Participants with experience working in the NYC jail system also used appearance and behavior to make assessments about a detained person's mental health. "Is he sleeping? Is he eating? What are his interactions with others? Is this person arguing with others? Giving away property? Basic hygiene. You don't have to go to graduate school to observe behaviors." One

participant described several examples in his career about how behavior can be misinterpreted: an elderly man admitted to the jail who was "highly aggressive" because from the time of arrest until days into his detention, no one had spoken to him in his native Chinese language, only yelling at him in English; a person in alcohol withdrawal, which can present with severe behavioral disturbances and even death, being referred to a mental health clinic rather than receiving urgent medical attention.

The many system-impacted people who participated in the conference as panelists and symposium attendees provided evidence and support for caution in making assumptions about a person based on their appearance and behavior. "I'm tall…my voice is very boisterous," said one woman. "I'm very outspoken. I always [got] a ride to the psychiatric hospital. It wasn't my intention to be in a psych ward, but people take one look, and all [they] hear is the loudness of me. [They] don't know that I haven't slept in like a week because I'm homeless." Another system-impacted professional described a situation he encounters in his work. "If a person tells you, 'I woke up on the train this morning, somebody stole all of my stuff. The police tapped me and said I had to get off the train. I've been diagnosed with schizophrenia. I have opioid use disorder. I'm going through withdrawal. I haven't eaten in days. I haven't showered. People look at me and they scream…my body is screaming on the inside.'"

Assumptions based on observation can also miss important mental health needs. "I present well," said one participant with years of experience in jail and prison systems. "I don't speak out of turn…I don't have those kinds of outward signs. They say in the medical profession that high blood pressure is the silent killer. Well, so is mental illness for a lot of people. Nobody at my job realized that I had a mental illness and how I was suffering."

Another noted that every time she was arrested, because of her substance use and behaviors to obtain drugs, she was "disheveled, mumbling, [couldn't] stay up, stinking, and all I want[ed] was food and water…That should point out to someone that maybe there is something going on here that we need to take a better look at." She then highlighted the difference between one's appearance and behavior upon arrest and later, at arraignment. "Back in those days, [after arrest], you stayed in that bullpen. [You could] pull yourself together to get some sleep, to eat…sandwiches…to wash up with the little bar of soap. So, when you presented in the courtroom, you definitely did not look how you look when you got arrested. The first time that we see our public defenders, [they] are looking at a façade."

A system-impacted panelist reminded symposium attendees, "What you see on the outside…it's not really what is going on on the inside."

B. History: What is known and unknown about someone's mental illness

Given the flaws inherent in observation, especially in arrest, arraignment, and jail environments in which a person is almost certainly not at their best, the participants noted the importance of collecting as much additional information as possible to help inform decision-making A community psychiatrist highlighted, regardless of setting, the importance of talking with others, such as family members, community supports, and other treatment providers, in gathering information to inform a diagnosis, as well as making sure to pay attention to the impact of trauma on a person's presentation.

At the point of police contact, a member of the NYPD spoke about the importance of giving as many details as possible when someone calls 911, 1-800-NYC-WELL, or 988, all emergency mental health phone numbers in NYC. "The more information that you give to the 911 operator, the more information they can relate to the officers, which can help when the

officers respond to the scene." For example, if it's known that the person in crisis doesn't like female officers, the NYPD will try to send only male officers. "Anything that you can give us will help, anything that we can do to make that person feel a little bit more comfortable…A lot of that can be mitigated by the information that you give to the 911 operator…so when [the police] get there, they can adjust the way they approach that person."

Various courtroom staff all spoke about using an individual's rap sheet (i.e., a record of arrest and prosecution) as a potential source of information, noting that "it's typically the worst parts of someone's life that we [the prosecutors] see, at least initially. And by that, I mean, their criminal history, their rap sheet, and then the instant case facts." A public defender said, "One of the first things I look at is their rap sheet...I look to see if there's any past psychiatric history…[was] the person [ever] incompetent…if the person has gone to prison before, have they had contact with the [New York State] Office of Mental Health [the mental health care provider in New York State prisons]. I also look to see what the accusation is. Is it bizarre in nature? Is it random? Is it something separate from maybe what their history may show?"

However, despite the recognition by professionals of the importance of gathering collateral information to help guide decision-making, those who were system-impacted describe a different experience, whereby frequently their mental illness was overlooked or missed, resulting in criminalization as opposed to treatment and intervention. A system-impacted participant noted that, in her personal experience, her mental health history was not going to be found in her criminal records because "What is my criminal record going to show about a mental health condition that was never recognized by the NYPD or the Department of Correction? Every time I came in, I came in homeless, addicted to drugs, suffering from an unchecked mental illness. And I was always criminalized. I was always put in the jail. There was never anything in my records about mental health because that just wasn't recognized."

C. *Engagement*

Professionals working in or alongside the criminal legal system recognized the importance of engaging with individuals in their care to more fully understand their experience and to permit more effective movement through (and hopefully out of) the criminal legal system. These professionals shared the importance of engaging with people in custody as fellow human beings to learn more about them and any potential mental health needs. A public defender said, "I go in and talk to the person and introduce myself and try and get as much information as I can about them. I start with as early as I can, where they were born, how they grew up, [asking] about their parents and their siblings."

A system-impacted mental health professional replied that, as a provider in an alternative-to-detention program based out of the NYC criminal court system, the path to effective engagement as a provider is being transparent, patient, and utilizing the help of peers. "I want individuals that are just like me to know it doesn't matter where you come from, it doesn't matter what you've been through. Take a leap of faith with me."

However, several symposium attendees recognized that successful engagement required trust on the part of the system-involved person, acknowledging the imbalance of such a request in the context of the criminal legal system. A judge noted about engagement procedures in the criminal court parts: "We expect vulnerability [from people being evaluated] in a way that is not reciprocated. We ask of them what is almost unreasonable, which is to take a leap of faith on systems that have historically not necessarily worked in their interests…How might we begin to

reciprocate vulnerability and to appreciate that…we're asking people to kind of take a leap of faith in us that we're going to get them what they need?”

Similarly, several system-impacted participants described a potential disconnect between how providers think they are engaging, and what the people who are being “engaged” think of the process. “It frequently amazes me,” said one, “[that] we don't talk to people and ask them where they come from. We don't talk to people and ask them what happened to them.” Another emphasized that the best way to understand a person and their needs is to “have a conversation with the person, talk to them. That's how you should know, not any visible things on the outside. Have a conversation.”

III. Challenges of diagnosis in criminal legal settings

It is the responsibility of the police, attorneys, judges, and correctional officers to refer a person with known or suspected acute mental health needs to a mental health provider, for whom the assessment for a psychiatric diagnosis is critical. As one psychiatrist noted,
“Diagnosis is a way to identify an illness. It guides the way we treat people; it guides the therapies we might suggest; it guides the medications we might use; and it guides the research into looking at how can we do better. It is also a communication tool, a way to say to someone and let others know what you're thinking in a succinct way.” She also stressed that it must be a “partnership” between the person being diagnosed and the person doing the diagnosing.

Amongst the participants who work as mental health providers, some with personal experience in the criminal legal system, there were different opinions about what the process of assessment and diagnosis should/could entail. However, all agreed about the importance of a diagnosis in the current system for accessing care, including hospitalization while in police custody, an alternative-to-incarceration program through the criminal courts, and treatment while detained in jail. All also agreed that the current practices do not provide enough time, engagement, or human resources to maintain a person-centered approach.

A. Time

A forensic psychologist reminded symposium attendees, “Many times the issue is that all of us who work in the public health care system [may] only have 20 minutes, 30 minutes if you're lucky. We don't have all the tools [or time] that we need to really look into a person and into a person's background and provide the right diagnosis.” A community psychiatrist agreed, noting,
“Where we fall short sometimes is we do a diagnosis based on immediate contact with someone…and we don't look at what was going on in that person's life to the depth that you often need to, to truly understand what you're diagnosing. What you see are symptoms, symptoms are not a diagnosis, symptoms are just what someone is displaying at that moment. Maybe [someone is] very angry, maybe they're upset, maybe they're screaming. What does that all mean? That takes time to figure out. I think under pressure we sometimes make those diagnoses too quickly…Diagnoses can sometimes legitimately look different at different points in time, just like any other illness can look different at different points in time."

Several psychiatrists with experience working in the psychiatric emergency rooms to which people under arrest in NYC are brought by the police in case of a known or suspected

mental health crisis highlighted the difficulty of trying to have a person-centered focus in a crowded, busy, and stressful emergency setting.

Related to the court space, one of the judges in attendance asked about incorporating trauma into the diagnostic process, recognizing that trauma responses can sometimes appear as volitional behaviors that lead to misinterpretation and provider bias. A social worker with incarceration experience replied, “I don’t think too many places in New York City, particularly the judicial department, are really capable of digesting that [trauma] narrative because of the amount of time they have with this person in court…If the judge opens up a can of worms with the trauma narrative, then the case of going to be prolonged. If I said what was really happening behind the scenes, then I risk [my client] getting remanded or they may get removed from the household.”

A social worker who experienced incarceration recalled his admission to Rikers Island and the requirement, because of past lawsuits related to overcrowding, to get a bed in jail within a certain amount of time. This necessarily limited the time available for diagnostic assessment. A psychiatrist currently working in the NYC jail system acknowledged that “although we focus on identifying people who have mental health needs early in incarceration, that may sometimes not be the best time for individuals to be assessed and want to speak.”

B. Environment and access to care

The criminal legal system, especially in the pre-trial phases, creates an environment that encourages people in custody to do whatever they can to obtain their freedom, treatment, or even to survive. This can complicate current diagnostic evaluation procedures that rely heavily on clinical observation and a patient’s description of their symptoms. There are no blood tests or instruments that can diagnose mental illness.

According to a psychiatrist with experience working across various settings in the criminal legal system, "behavior may look like illness, but is in fact, a survival strategy.” This may lead to providing a diagnosis when one might not exist. Another psychiatrist noted, “Oftentimes we may not be aware of what someone is going through because [in the jail environment], people may not feel comfortable [sharing].” This may lead to missing a diagnosis that could lead to beneficial treatment.

According to an experienced psychologist, "Receiving a psychiatric label can mean several different things for people involved in the court system. For some people, it might be positive because…New York City is lucky to have a lot of alternative-to-incarceration options…a specific label might make you eligible or ineligible for some of those options. For some people, it might mean you get out of jail sooner, but for other people, it might mean that they stay in the system longer…There are incentives to want to have a [psychiatric] label or not."

A system-impacted professional agreed that categories and labels, like diagnoses, are used to make consequential decisions about the life of a person in custody. A symposium attendee noted that “diagnosis is becoming a gatekeeper in deciding who does not get services versus who does.” A system-impacted professional noted that from her personal experience and those of the people she supports, “there are people in these systems coming through today that are undiagnosed and because [they] are undiagnosed, [they] never get a chance at treatment.” A psychiatrist from the jail system agreed that “there is a real spectrum [of behavioral health needs],” and that it is important to recognize all suffering, not just symptoms that form a specific diagnosis.

C. *“Serious Mental Illness” (SMI)*

In the criminal legal system of NYC, not all diagnoses are treated equally. A person diagnosed with SMI, not a formal psychiatric diagnosis but a frequently used classification of mental illness, is offered many more services than someone who has a “less serious” mental illness or no illness at all. Adding further complexity, the New York state, NYC jail health service, and the NYC criminal legal definitions of SMI do not perfectly align.

Most of the conference discussion related to SMI highlighted the flaws of the label and the potential inequities in access to and quality of care that result. One of the symposium attendees asked, “If you [don’t] have a severe mental health [illness], you can be excluded from the benefits of diversion…Who makes that determination [about] what’s severe and what’s not? Because to me, my mental health [needs are] severe.”

According to a forensic psychologist, “The concept of serious mental illness is not clinically very useful. It really doesn’t tell you much about what someone is going through. It’s typically a term that’s used by systems to identify a group of people that are thought to have more functional impairment…and that need enhanced support. But it’s not an actual diagnosis, it’s not in the DSM, [and] it’s defined very differently in the research. I’ve had patients who didn’t have a diagnosis that [were] label[ed] serious mental illness that struggled so much and had so much functional impairment and clinical distress and suffering, compared to others that were doing okay on medication and had the SMI label.”

An attorney said, “We see people who are feigning certain illnesses or behavioral health needs so that they can avail themselves of a treatment court.” They went on to add that, paradoxically, when they see someone with a diagnosis of schizophrenia, "it feels somewhat reassuring. And by that, I mean, there are clear places that an individual who is struggling with a serious mental health condition can go. They are not all great, but there are clinicians who can offer psychotherapy. There are psychiatrists who can offer medication…When I see that label, it feels like I [can help], compare[d] to someone who maybe doesn't have a diagnosed behavioral health need, but appears to be [ill]."

A judge from a specialty court said that many of the participants were also interviewed for mental health court, “but they were often not eligible because they did not have a serious mental illness…But they were victims of severe trauma, and they didn't fit easily into a [diagnostic] box. That was very problematic for us…sometimes people who have experiences don't necessarily fit into easy categories.”

Reflecting on his time at Rikers, a system-impacted social worker said, “If you had SMI, then you would get…immediate services. But all those other people that were suffering, they didn’t get any services and that was why we had all the violence.” He said that the only time people in jail were seen by clinical staff when he was incarcerated, if they hadn’t been diagnosed with a mental illness, was “if you try to kill yourself or create some sort of violence.” Another system-impacted participant agreed. "You have to admit to a serious mental health disorder to be seen consistently.”

Another participant with lived experience echoed this sentiment. “Are we going to gatekeep services based on whether you have a higher diagnosis? What makes yours so higher than mine or anybody else's?”

D. Bias and stigma

Not surprisingly, the stigma associated with psychiatric labeling was a central theme. This is, of course, not unique to the criminal legal system. According to a psychiatrist participant, "It is just a sad fact of our society that we are not yet able to get past that." She noted how a cancer diagnosis used to be something "nobody ever wanted to talk about. And that's not the case anymore. Now, people are very open about it. And it's helped tremendously in terms of people getting the services and the care that they need. I just hope someday we do the same thing with mental health diagnoses."

Several of the psychiatrists and psychologists focused on the specific stigma attached to a common diagnosis in the criminal legal system, antisocial personality disorder, one that they believed should be more correctly described as complex trauma. While not typically classified as SMI, antisocial personality disorder (ASPD), defined in the DSM-5 TR as a "pervasive pattern of disregard for and violation of the rights of others that begins in childhood or early adolescence…Individuals with ASPD fail to conform to social norms with respect to lawful behavior [and] tend to be consistently and extremely irresponsible…frequently deceitful and manipulative in order to gain personal profit or pleasure [and] tend to be irritable and aggressive…", was noted throughout the conference as a diagnosis that reduces the chances of someone accessing care.[1] Describing his time in jail, a panelist noted, "I did not tell the mental health staff what my symptoms were. I didn't discuss it. And so right away they gave me the standard diagnosis that is given out: antisocial personality disorder…That diagnosis was given to me after about a five-minute conversation with a therapist…I could have gone to the mental health unit on Rikers Island, but [that diagnosis] disqualified me from going there…They won't let you into a mental health unit because they think you're violent, they think you're dangerous. So, you're too dangerous for treatment."

A psychologist agreed. "The systems that we use to classify psychiatric disorders are not perfect and they are also filled with some significant racial biases. She noted that court and jail personnel can see [antisocial personality disorder] as automatically dangerous, and "then everyone expects certain behaviors of you."

Many of the system-impacted panelists shared experiences related to the stigma of being labeled with a psychiatric diagnosis in jail. "I did go to [mental health] callouts, but when you go to a call out on Rikers Island immediately you hear the cry 'Bug out.' You know, this person is crazy." This panelist said that he stopped seeking care in jail because "I didn't want anyone to know that I was involved in the mental health program. I didn't want anybody to know when I took psych meds. That was automatic grounds for you to become a target for every predator in your housing unit." Another panelist described a similar experience: "I didn't want to be on medication…I didn't ever want that because people always made fun of them [people on medication]."

He continued, "There is a fear that's very real about an assessment being done on you." He described his experience of being arrested at age 16 and going to prison at age 17 for a 20-to-life sentence and being asked by the person doing the mental health assessment whether he had ever thought of killing himself. "Hell yeah, who wouldn't think about ending their life after they've done the most horrible thing that they can possibly do? When I said that, I was put in a strip cell. I don't know what the policy is now, but [back then], you get thrown in a cell…you're

---

[1] American Psychiatric Association. (2022). *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR). American Psychiatric Association Publishing. https://doi.org/10.1176/appi.books.9780890425787

butt naked with the ID that says inmate. That's the only property that you have until the doctor says you are okay to [leave]. There is a punishment for [saying that you are suicidal]. Why would I speak to [a mental health professional] and tell [them] what is really going on in my mind? Why would I do that when you're going to take over my body?"

E. Proposed solutions

A symposium attendee suggested an alternative approach. "How about just treating the person and the intersectionality that comes with them? We all come from different backgrounds with different experiences, with different traumas, with different success stories and failures. And how about treating the intersectionality of an individual first instead of approaching things with fear and then labeling [people]?"

A symposium attendee from the District Attorney's office noted that the approach [at one of the city's mental health courts], "which we're constantly evolving…is maybe somebody has substance use and various mental health needs that don't fit neatly into certain categories…there is space in the court system for this idea and this approach that perhaps we can start to think about treating people without these labels."

A psychiatrist working in the jail system described the medical perspective in the jail system. "The medical frame is such that when you go to the doctor's office you need a label, for billing. When you are seeing someone in jail, you need a label for the assessment form, you can't just leave it blank [or the form will not be saved]. [Despite that,] I think it's important to recognize that we all exist in the gray areas." He said that more important than putting a label on someone is having curiosity about them and trying to understand them. He emphasized the need, however challenging given the threats to safety in the jail environment, to "create a culture where people want to share, speak about their narrative, and feel comfortable doing that."

A licensed clinical social worker with lived experience in the criminal legal system shared his approach to diagnosis, one that focuses on time spent getting to know a person and developing a therapeutic relationship. "If we have space for people, eventually, they'll start to trust us, hopefully, and tell us their stories." A mental health specialist encouraged symposium attendees to practice empathy during assessment. "How can we look at each person as an individual and understand that my perspective of the world and my worldview might be slightly different than their perspective of the world and their worldview? Both worldviews are important and should be respected."

A psychiatrist with experience across criminal legal settings noted that he "often conceptualizes access to care as making sure that there are enough clinicians to see people. But I think [what's been discussed today] demonstrates that access to care is also creating pathways to care. So people want to seek it."

IV. Research and training

Panelists and symposium attendees alike agreed that there was not enough of an evidence base, either through research or large-scale programs, to develop a best practice standard concerning the assessment and diagnosis of mental health needs for people in the pre-trial criminal legal system. "I don't know that we have a whole host of best practices about how to work in the very best way with [people in the criminal legal system]," said one psychiatrist. "We still need better research. We have some ideas and we're doing some work and certainly, peers

are important, but when it comes to issues like diagnosis [and] therapies, I think we need some help to better understand what's the best practice. And we're not there yet."

One of the symposium attendees, a defense attorney, spoke about the dearth of research on the impact of incarceration because of the restrictions on studies of vulnerable populations, including the "doubly vulnerable" populations of people with mental health needs who are incarcerated. This leads to treatment and interventions that are not evidence-based. "I don't mean to be depressed about the situation, but it is really depressing for someone who has worked in the criminal legal system since the 1990s…I'm not going to say things aren't better, they're better, but they're not much better."

"Researchers inform doctors and clinicians, [who] inform legal counselors, [who] inform judges," said one of the panelists. "[We must] educate…politicians about what's really going on and [help] politicians [avoid] making decisions based on fear and ignorance."

Despite limited data on best practices, panelists described organizational efforts to improve on-the-job training. A member of the NYPD said, "[Police] officers get a lot of training. It starts in the academy and continues when they're assigned to their commands. We work with many different providers, and they give us very good training. The only thing is, NYPD is a very large organization. So, by the time you get to the end, that first group of trainees have gone through that training maybe two or three years ago." He emphasized that the issue was less about different or more training, but about increasing the frequency of training so that officers stay up to date. "We practice, quite often, how to use the instruments on our belt, but we don't practice that often with how to deal with mental health crises." Another member of the NYPD added that even for the many crisis teams being created to respond to the city's mental health emergencies, "we really haven't set good benchmarks for engagement. We don't know what we don't know in terms of how we best engage someone who may be likely to tell us to [get lost] when we arrive."

One of the attorney panelists was very clear: "They do not teach this stuff in law school, I can promise you that." A judge reminded symposium attendees that judges are not trained to make diagnoses. "One of our challenges, and one of the things that I would certainly like to see is a base level understanding about all of these issues for any judge who comes into the system…" A psychiatrist who opened the conference noted that "academic psychiatry has not prioritized the mental health of the many millions and millions of people in this country who have been involved in the criminal justice system, despite our awareness that social factors such as poverty and racism have greatly contributed to that involvement."

A retired member of the NYC Department of Correction said that he was never trained in mental health, "but we actually worked with the psychologists and clinicians [on the mental health units at Rikers Island] to look for certain behaviors." He described this as a successful initiative, one that benefited both correctional officers and mental health staff, but more importantly, the people in custody. He described the process of CIT (Crisis Intervention Team) training in the NYC jail system, training both mental health staff and correctional officers at the same time. "We'd pick a subject, like terminology. Ask a CO [correctional officer] or a cop what malingering is, what do you think they will tell you? Loitering. In the inmate rulebook, malingering means not complying with an order in a timely fashion. That's not malingering clinically. So we weren't even speaking the same language."

His comments picked up a theme raised earlier in the conference about potential effective education strategies across the two systems, including joint training that involves both clinical providers and criminal legal personnel. "If you could do that jointly so that we understood each other and we understood each other's systems," said one of the psychiatrists, "I think that that

would be tremendous…A joint effort is something we haven't really done…that would be really great to do.” A judge concurred. “We're definitely going to make that happen…I feel like I'm here as an ambassador of goodwill and also to encourage everybody who's going to be attending the symposium today to really think outside of the box and think about collaborations and how we can spread the word and how we can educate one another.”

V. The inclusion of voices of lived experience

The strongest theme throughout the symposium, described further in each of the sections above, was the need for the voices, skills, and expertise of people with lived experience to be at all the decision-making tables related to policy involving the care of people at the intersection of the mental health and criminal legal systems. One system-impacted panelist noted that “[Peers] need to be incorporated on all levels. We can do more than just be peers. We need to have people with lived experiences in these research entities working on research projects, building the questions, building the focus groups, and building everything from a lived experience point of view, not from an academic or a clinician point of view… So, before you build the next research project, before you think about putting policy into place, you need to incorporate the voices of those who are the subject matter experts."

This was supported by all, including those in the room in leadership and policy-making positions. "If you're going to really do it right, then [peers have] to be a part of your policy-making, part of your decision-making...It must be a part of how you make your decisions within your systems of care.” It was noted that since peer services in OMH-licensed outpatient clinics are now reimbursed by Medicaid, there should be increasing opportunities for people with lived experience to work in these spaces. It was also noted that the Office for Justice Initiatives, which oversees all of the problem-solving courts in New York State, focuses on access to equal justice and that increasing roles for peers and people with lived experience in those court spaces “would fall very, very nicely in that category.”

In addition to inclusion in decision-making, the perspectives of people with lived experience are crucial in the education of mental health providers in all settings, particularly the complex and opaque criminal legal system. One system-impacted professional did not mince words about the experience of meeting with mental health providers. “If you gave me a certain look, I wasn't coming back for your services. If you made me feel some sort of way, I wasn't coming back for your services because I felt like you were judging me. No one could judge me more than I judged myself.”

These perspectives provide insight into the mismatch between a person’s lived experience and assumptions made by others. Said one symposium attendees, "I think part of the problem is understanding different cultures and how they handle mental health. For the longest as a kid, no one considered mental health [in my behavior]. They automatically thought…he's an at-risk kid. He's a problem kid. He's a thug. That's how my behavior was addressed for almost 50 years until someone finally met me where I was at. Looked at the situation, got as much information about my background as they could. And I was finally given an understanding of what was going on with me and I was diagnosed with complex post-traumatic stress disorder. I'm now 60 years old. This just happened to me five years ago. So, I've spent all this time living under people's judgment about what was going on with me and no one really cared enough to meet me where [I was].”

Another person with incarceration experience, now a mental health provider, said, “If somebody [had] sat me down when they were taking me to a psychiatrist or psychologist when my father got murdered and understood what I was saying, then I might have not [done] 25 years because they would have understood that I was trying to unpack some stuff and I was feeling very scared in the neighborhood that I had to live in with my family. But that's not the assessment [they] did.”

VI. Recommendations

Throughout the day-long symposium, the following recommendations emerged for people working in the criminal legal and mental health systems:

A. Practice empathy in trying to understand the experiences and behavior of other people.

B. Consider whether a psychiatric diagnosis or classification (e.g., SMI) should be required to access person-centered support and services in the criminal legal system.

C. Prioritize research that seeks to identify evidence-based and best practice standards of care regarding the accurate diagnosis of mental health disorders for people in the pre-trial criminal legal system.

D. Implement initial and refresher cross-system training approaches that educate mental health providers about the behavioral impact of criminal legal involvement, and that educate criminal justice professionals about mental health.

E. Include system-impacted people with lived experience at all levels of research/education/clinical care/policy development.

VII. Conclusion

The labeling of people with a mental health diagnosis presents opportunities for targeted interventions and service referrals, but also comes with limitations in communication; concerns about privacy, bias, and stigmatization; reliance on observable behaviors; possibilities for misdiagnosis; and differential access to care. The imperative for innovation and change was evident throughout the symposium. As stakeholders navigated this intricate landscape, the goal emerged to foster a more equitable, compassionate, and effective mental health support framework for individuals within the pre-trial criminal legal system.

This conference served as a critical first step aimed at breaking down professional silos, reducing otherness, and identifying shared goals for a meaningful and transformative future. There may be no better summary of the symposium than the words of one of the Workgroup’s Steering Committee members:

> *“Think of this room right now, think of the amazing integration that you're seeing: legal counselors, psychiatrists, psychologists, mental health counselors, social workers, people with lived experience, administrators, judges. What an amazing group. Talk about*

integration. And it cannot be done without everyone being in the same room thinking, collaborating, talking to each other." He reminded symposium attendees that "many people in this room have the power [and privilege] to change a person's life completely," and with that power and privilege comes the responsibility to be sensitive to the person in front of you, to their story, and their interpretation of their needs. "We've been working on harm reduction for over 35 years and as clinicians, we're still struggling. These things are not easy. But the conversation has to happen. So, let's begin."