COUNCIL OF THE CITY OF PHILADELPHIA

COMMITTEES ON THE DISABLED AND

SPECIAL NEEDS AND PUBLIC SAFETY

Room 400, City Hall
Philadelphia, Pennsylvania
Friday, March 20, 2015
10:35 a.m.

PRESENT:
COUNCILMAN DENNIS O'BRIEN, CO-CHAIR
COUNCILMAN CURTIS JONES, JR., CO-CHAIR
COUNCIL PRESIDENT DARRELL L. CLARKE
COUNCILWOMAN JANNIE BLACKWELL
COUNCILMAN DAVID OH
COUNCILMAN MARK SQUILLA

RESOLUTION 150131 - Resolution authorizing Council's Committees on the Disabled and Special Needs and Public Safety to hold joint public hearings investigating the barriers faced by people with serious mental health issues who are transitioning from incarceration to the Philadelphia community.

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COUNCILMAN O'BRIEN: Good morning. This hearing is called to order. This is a joint public hearing of the City Council Committees on the Disabled and Special Needs and Public Safety. The purpose of this public hearing is to hear testimony regarding reentry from incarceration in Philadelphia for individuals with serious mental illness authorized by Resolution 150131.

Does anyone have any opening remarks?

(No response.)

COUNCILMAN O'BRIEN: I'll just open with a few remarks.

I want to thank everyone for being here today as we examine the barriers faced by people with serious mental health issues who are transitioning from jails and prisons to the Philadelphia community.

Here in the United States, approximately 2.5 million people are

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incarcerated. Ninety-five percent of them get released within 12 months. Of this 95 percent, two-thirds of them are rearrested within three years.

Studies have consistently found elevated rates of mental illness in prisons, approximately 16 percent and sometimes higher. Yet data shows that the prevalence of mental illness is only 6 percent among the general population.

Community reentry is not as simple as just leaving an institution and picking up right where you left off. Individuals with psychiatric disabilities released from correctional facilities have many needs that require a multi-systemic approach.

In addition to mental health treatment, many individuals with psychiatric disabilities confront structural barriers such as limited access to food, clothing, shelter, transportation, healthcare, and personal identification. An inability to address

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these most basic needs can lead individuals to return to criminal activity.

Additionally, many returning citizens often lack social capital to help them successfully reintegrate back into their communities. They've often returned to broken or non-existent family ties and friendships. They lack high school diplomas, employable skills, and other valuable social supports to steady themselves. They rely on their providers and other professional workers, including the witnesses presenting here today, to help them get back on their feet.

We already know that community reentry can be extremely challenging for anyone, but when an individual also has an underlying mental health issue, reentry can be that much more difficult. This is an important issue to examine, not only because of the impact it has on the welfare of the community at large, but because addressing the needs of

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individuals with psychiatric disabilities is the responsible thing to do.

It is in everyone's best interest if we are able to help people with serious mental health issues successfully return to the community to become productive, law-abiding citizens. We're hoping to begin the conversation here today to discuss how we could be more supportive of this population and ensure their transition into the community after incarceration is successful.

So I would like to bring up the first panel. I would like to ask Ray Zeigler, who is a certified peer specialist and a returning citizen, to come and present testimony.

Mr. Zeigler, if you can make yourself comfortable at the table and if you can identify yourself for the record and then proceed with your testimony.

(Witness approached witness table.)

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MR. ZEIGLER: Good morning, Councilmen and Councilwomen.

COUNCILMAN O'BRIEN: Good morning.

MR. ZEIGLER: Good morning. Yes. My name is Raymond Zeigler and I'm a returning citizen.

I had wrote something down to give you a brief biography of who I am.

COUNCILMAN O'BRIEN: Take your time. Can you just pull the microphone closer to you.

MR. ZEIGLER: Sure. Sure.

My name is Raymond Zeigler and I have been in and out of prison since I was eight years old. I was released from SCI Graterford Prison in 2010 after serving 20 years for a crime I committed while under the influence of crack cocaine. I have been using drugs and alcohol for close to 40 years, and every time I used, the end result would be prison.

In 1981, I was sent to SCI Camp

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Hill Prison for voluntary manslaughter. While I was there, I learned that I could not read or write, not even at a third grade level. I learned this when I took the GED testing, which I flunked twice and only earned it by two points the third time.

While serving the 20-year prison sentence, I enrolled in a business management course with Montgomery County Community College, which lead to achieving an Associate's Degree. I was informed by other men in prison that Villanova University was giving out scholarships. So I took the test with them and earned one of the scholarships. In 2010, I received my Bachelor's Degree and am now working on a dual Master's Degree with Eastern Mennonite University. The degrees are a Master in Divinity and the other one is in Conflict Transformation. In addition, I have received two journeymen's electrical and electronics training.

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Upon my prison release in 2010, my mother suggested I should talk to someone in mental health. I took her advice and learned that I am bipolar and have trauma that stemmed from my youth and prison experiences. I am in treatment for both. With the help from the Department of Behavior and Health Intellectual disAbility Services, I received training as a certified peer specialist and forensic specialist, among other trainings, to better help me in supporting other men and women who want to live a life of recovery. Today, I am employed at Greater Philadelphia Asian Social Services, GPASS, working as a certified peer specialist. My responsibilities include weekly drug and alcohol outpatient group sessions, IOP and OP; writing drug and alcohol progress notes, DAP; helping men and women with employment and peer support. As needed, I also do intensive outpatient sessions.

These are just a few of the

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duties that I do with GPASS. But apart from GPASS, I go around the City and I speak at different providers' facilities and just whether I can plant a seed of hope in the men and women who are on this journey to get back -- to regain their life.

COUNCILMAN O'BRIEN: Does that conclude your opening remarks?

MR. ZEIGLER: Well, I don't know exactly the protocol as to how things are done. I just wanted to read my biography first.

COUNCILMAN O'BRIEN: That's fine. If you don't mind, we may have a few questions for you.

MR. ZEIGLER: Sure. Sure. Sure.

COUNCILMAN O'BRIEN: How supportive do you think, with the recidivism that you had with the correctional facilities, how supportive was the mental health system to you when you came out of prison?

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MR. ZEIGLER: Well, if I may say --

COUNCILMAN O'BRIEN: And you were not diagnosed until recently as having a mental health issue.

MR. ZEIGLER: Correct. And that was only through the help of my state parole officer and my mother. He was very supportive, and he suggested, him and my mother, suggested that I look to that area, because he kept asking me the question, what is it about prison you like so much? What was it about every time you get out, you go right back? What was it about the street life that I liked?

Well, I'm one that was in the street. I was the street. I loved the street more than I loved my life. I now understand that. Now, as I look at a lot of these other young men and women who are in the street, yeah, they come from a different era than what I come from, because when I was out in the street, how

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distorted this may sound, there was a code of ethics among such criminals, and we respected each other as opposed to not killing each other and all the stuff that they doing today.

Well, while in Graterford, I began to work on myself and ask questions, what's going on with me, and I learned some things about myself that, you know, I had low self-esteem. You know, I didn't want to grow up. I was immature. I thought the world owed me something, because I was angry. But I wasn't angry at the world. I was really angry at me, because I wanted to be successful. I wanted people to see me as equal, but, however, I wasn't doing things to allow people to see me in that light.

As I talk to a lot of men and women today through counseling over at GPASS, that's me. Many of the men and women, these young men and women, they want to be heard. They have a say, but,

however, one contradicting aspect that I see in their lives, they get out of prison and when they get out of prison, they are stipulated with house arrest. Then they got to stay at a program for three days - Monday, Wednesday, and Friday. And then when they want to get -- they looking for employment, they want to make a contribution back into their baby mother lives with their kids, but they are held back by the system because of house arrest and other things.

Now, I know that I'm not naive that men and women commit crimes, because I was that man and I was that woman, because I committed crimes. I made it do what it do. I'm not going to lie. That's who I was. Today, I'm no longer that person, but I do know what will drive a person into trying to get a couple dollars in their pockets, and they going to get it any way they could, sadly to say.

So a lot of men and women I'm

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talking to, they come in the facility and they're angry. Well, Zeig -- they call -- my nickname is Zeig, short for my last name Zeigler. So they say, Zeig, when -- they say, Zeig, how can you tell me you're going to help me with a job when Probation and Parole won't let me get a job? My parole officer or my probation officer is on my top. They won't even let me out the house to go to the library to do research on the computer.

So I tell them about CareerLink. I tell them about the Urban League. I tell them about the NAACP. I tell them, get the support of a bigger establishment that has the network ability to really help you, because the only thing I can do is go on the Internet, help you do some research where I'm at at GPASS, and that's it. They can't even do that, so they become angry. They become angry. And a lot of them do have trauma in their lives.

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And I must add this, is that many of our young men -- many of our children, babies, because of the crime that's happened in our community, they walk out their front door, these little kids, and they may see a crime scene - blood, cops, yellow tape, the whole nine yards. What does their parent do? Put them right in the car, take them to their get-set center or school or whatever. But what happened to that processing and talking to these kids so when these kids as they grow, to me, they become immune to hurting people or being hurt. And it's -- to me, I don't have the words to say, because I'm passionate about planting the seed of hope in children as men and women planted the seed in me.

I remember Councilman Curtis Jones and I remember Councilwoman Mrs. Blackwell, and I know her husband. I was applying for a job before I got locked up during the 20 years at the DoubleTree, and Mr. and Mrs. Blackwell was just

leaving for lunch and they stopped. The remarkable thing, they stopped and had a conversation with me, and this was over 20 years ago, and I remember that. Just by them stopping, having that -- just that word or two with me empowered me. Even though I continued on my life of crime, but I didn't forget that. And when they came to Graterford, Senator LeAnna Washington and many others, Shirley Kitchen, I was right there, because I wanted to be seen as equal as opposed to someone who has been discarded by society.

Now, looking at what's going on today, many of the young men and women, they have that same mindset as I do. They want a chance. I think if they had other options or other alternatives, because I don't think no one wake up and say, I want to go to jail today. You know, even though their actions show it that they going to jail today, because they get up and they want to go back out

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there to the corner and they want to sell their drugs or do what they do, you know.

Peers such as myself, because -- and I must say this too. We have a lot of programs that's operating today. A lot of these programs really is nothing but frauds, because what they do, they teach the men and women that's getting out of prison how to fill out an application, how to do a resume. Well, many of the men and women in prison already know some of this stuff. They don't need to be sitting up in these programs for four and five months while the program collecting all of this cash. They need some type of job or some type of stipend to say, Okay, while you're here, we going to support you. And I remember there was programs like that back in the day that helped me.

So I don't have any answer. The only thing I can do is give you my life's experiences and know what worked for me and I know will work for other

young men and women in my same situation. Yes, I take my medication, which I don't like to take, you know. Because of my passion, sometimes my mouth get me in trouble, but that's everyone, you know. We're passionate about something.

So I just know it can work. It can work if a lot of these agencies and programs be more genuine to the men and women and have more peers, a lot of them such as myself. There's a lot of young men and women out there who are certified peer specialists or who can be a good peer to a lot of these young men and women and say, Hey, look, man, if I can do it, I know you can do it. I've seen it. I've seen it.

COUNCILMAN O'BRIEN: I have a couple questions, but I think your testimony has substantially responded to that. I want to thank you for sharing your personal life experience. You're an accomplished certified peer specialist. You've touched on the supports that you

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as an individual and others like you who have mental illness, specifically the supports that you need and the supports that you already have, and that's helpful to us to know what supports are successful and what supports you, who have successfully reentered the general population, are advocating for others to have.

The other thing that's remarkable and maybe I'll prey upon your privacy for a moment just to share with us if you had an earlier diagnosis that you were bipolar, how do you think that would have changed the events of your life?

MR. ZEIGLER: When I was younger, my mother and father like in the late '70s, we used to have family treatment over at Einstein on Broad and Olney, and we used to have family therapy there, and I recall they was giving me these anti-depressant pills. I can't think what it was. They was giving them

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to all the kids, because we was too hyper.

COUNCILMAN O'BRIEN: Prozac?

MR. ZEIGLER: Not Prozac. There was another one. I was on Prozac, though. That was one of the pills I did used to take later on, but I forgot the pill they used to give kids -- anyway, I was too hyper. I was hyper, I admit. I couldn't stay still. But I was never diagnosed as bipolar or I never knew anything about bipolar. Even up at Graterford talking to the therapists up there, never knew. Never, never knew until I got out and my parole officer, Brian Faver, state parole, he a good dude and he took an interest in me. He seen something in me that I didn't see in myself, and I really give him his props for that.

I've come across many probation and parole officers today, and it's just a job to them as opposed to looking at the person first, not as crime, not his

mental illness or whatever it may be, but look at the person as a person. That was looked at at me, and, no, I never was diagnosed as bipolar. I don't know what they diagnosed me with, but I know that I didn't like taking those pills, because every time I went to voice or speak up against something I felt was wrong, my mother used to say, All right, it's time for you to take a pill, and I remember that as a little boy. So when I got out this trip and now was prescribed medication, I started taking it. My mind races at times. The medication calms me down. Today, I'm married, and my wife monitors and watches me.

Bipolar I did not understand. You go from one extreme to the other, with no medium. Today, I understand that I must have a medium, and this is what I pass on to a number of the men and women, because they get out of prison and they want to get out that gate running and they want to give themself a chance, many

of them, but soon -- the first hurdle they hit, boom, they bounce back and go back to that life of crime.

So I was not diagnosed as a youth, I don't believe, as bipolar, but about two or three years ago, yes, and I have a better understanding as to my triggers. I know my demarcation line, how far to go. I know how to pump my brakes now.

COUNCILMAN O'BRIEN: Thank you.

Chairman Jones.

COUNCILMAN JONES: Thank you so much, Mr. Chairman, and thank you for bringing this issue to this Chamber to talk about it. You've been on the forefront of all types of critical disabilities and challenges that our citizens have, and I just want to publicly put on the record thank you for bringing that forth in a courageous way.

I want to say to you, I'm going to call you Mr. Zeigler today.

MR. ZEIGLER: Yes, sir.

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COUNCILMAN O'BRIEN: I'd just like to add the real courage our witnesses --

COUNCILMAN JONES: That's what I was going to say.

COUNCILMAN O'BRIEN: -- like Mr. Zeigler to come forward.

COUNCILMAN JONES: So I'm going to call you Mr. Zeigler. I met you before.

MR. ZEIGLER: Yes, sir, Mr. Jones.

COUNCILMAN JONES: I know your name, but I'm going to give you the due respect of being in that seat and also recognize your courage, as well as our Chairman asked, for coming forward and sharing with us things that are or have been like taboos that we don't talk about in the community and to be able to let us kind of address it in a public policy way. So I want to thank you for that.

MR. ZEIGLER: Thank you, Councilman.

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COUNCILMAN JONES: I have some questions, because I don't know, but I can tell you this, some of the things you describe some of my members have. So we don't know barriers. We don't know -- we can go from zero to 60 on some things too. So we got more in common than probably people give credit for.

And the questions I ask aren't just directed to you. It's directed to anyone who can answer them in a way that will come up and testify after you. I'm just trying to get more clarity about this issue.

So the first question I'll ask you is, in your opinion -- and there's no A answer, B answer or true/false or whatever you can be helpful with.

How many people in your time in prison do you think in that population had mental health issues?

MR. ZEIGLER: Seventy-five percent.

COUNCILMAN JONES: You're

saying to me that you think 75 percent of the people you came in contact with in the general pop had some type of mental health issue?

MR. ZEIGLER: Yes, because we all suffered. We used to have a focus group and --

COUNCILMAN O'BRIEN: Can you pull that just a little bit closer.

MR. ZEIGLER: I'm sorry.

We used to have a group up at Graterford. That's where I did my 20 years at. And I met some remarkable men in there. Some of the men you have mentored. And we learned that we all suffer from some form of trauma from our community, which led us to our distorted thinking that led to crime. That's why I would say 75 percent, because 75 percent of Graterford were black and they came from the Philadelphia area. Maybe that number could be a little too high, but I'm just, you know -- it could be lower, I would assume. It could be lower. But

I know that there was a number of men, they suffered with the same things that I suffered from.

COUNCILMAN JONES: So in your contact with the population -- and I know you're not a certified psychologist. I'm not holding you to -- but just from your observations, if I were to say a spectrum -- and I learned this, there are degrees of mental health issues. From a spectrum of that, how many of them had the mild to the more severe, and what happens when you hit that tipping point and you realize that one of the other individuals in population has a problem? How was that identified and then treated in Graterford?

MR. ZEIGLER: It wasn't treated. They was taken straight to the hole, solitary confinement, go down solitary confinement, sometimes for two, three years.

COUNCILMAN JONES: Two or three years?

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MR. ZEIGLER: For two or three years, yes. Sometimes psychologists will come down or the counselor will come down and talk to the individual through the door while they're at solitary confinement. How I know that, because they did it to me. I was a solitary confinement boy, you know.

I mean, it's sad, bringing back memories back, how I used to respond to the officers because how they responded to me. Again, because of my mental illness, I seen things right as wrong and I seen wrong as right. So when they came down to talk in the hole, they talk, How you doing today, Mr. Zeigler? And they talk through the door. Are you good? This, that and the other, you're being treated okay? Yeah, yeah, yeah. Well, we going to prescribe such-and-such, boom. And many of the men and women -- or many of the men, I'm sorry, that was there, we just wanted the medication because we know it put us to sleep,

because in that environment, it was a jungle and it was constant hollering and banging on the door. You know, so you couldn't really sleep, but when they came down to give you medication, you knew that that pill will put you to sleep and allow you to get some type of rest while you was down there.

So I don't think or I don't believe that it was really addressed up at Graterford like it should have been addressed.

COUNCILMAN JONES: So it leads to my next question. Remember, these questions are for everybody. You're just the first one up to bat. So this way, I won't have to ask them again and they can proceed with it.

But once identified that there was a problem, to what degree was it medicated versus therapy? Like you didn't get the prototypical, Come into my office, sit on the couch, what's wrong, or did they throw a pill at you?

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MR. ZEIGLER: They throw a pill at you. And the medication line, you know, we used to line up in the hallway, you know, as you're going down -- coming down the corridor at Graterford once they let you through the sally port, and as you come down the hall there, it's a long walk, and right where they have commissary, there used -- well, they used to be the old 69. They call it old bubble. That line be all the way down the hall, the corridor with people trying to get their medication. That's all it was. People were still living in their addiction too. I can't look past that, because a lot of the men that was up there too, they was under the influence of some type of drug and alcohol for many years. So a lot of the men still was playing games. So a lot of the men used to go to the doctor, to the psych, just so they could get the psychotropic medication, you know, either for personal use or to sell.

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COUNCILMAN JONES: So during that process, fast forward to the time where the window of opportunity to come home opens, how did they prepare you for that reentry?

MR. ZEIGLER: That's funny that you ask. It was a joke, because what they do, they would have you go down to school to meet parole eligibilities. You had to go -- you had to have your GED or be working on your GED. However, they have a long list of people trying to get into school, because they only have a certain amount of people that can enter the school. So when they parole date come up, they may be on the list to take the class for GED and that's it as opposed to being actually in the class.

COUNCILMAN JONES: I think my question speaks more to if an individual has an issue, mental health --

MR. ZEIGLER: Oh, mental health, okay.

COUNCILMAN JONES: So you've

been medicating throughout your time of incarceration.

MR. ZEIGLER: Not the whole time.

COUNCILMAN JONES: So let's say you were, let's say you weren't, on and off. Addressing whatever those issues, those drivers, those triggers are, was there any coaching, any therapy --

MR. ZEIGLER: None.

COUNCILMAN JONES: -- any preparation --

MR. ZEIGLER: None.

COUNCILMAN JONES: -- for you to come home --

MR. ZEIGLER: No.

COUNCILMAN JONES: -- to say, You're going to need to monitor this or take care of that or seek help in this area?

MR. ZEIGLER: None, Councilman. None.

COUNCILMAN JONES: So they gave you car fare home and said, Good luck

with that?

MR. ZEIGLER: Yes. Yes. That was it. None. Well, they sent me to the halfway house and they sent me to the halfway house with a bag of drugs. They gave it to the correctional officer. He had dropped me off at the halfway house and that would be it. No type of followup on the street. Nothing. Nothing.

COUNCILMAN JONES: Thank you, Mr. Chairman.

Thank you, Mr. Zeigler.

MR. ZEIGLER: Yes, sir, Councilman.

COUNCILMAN O'BRIEN: Councilwoman Blackwell.

COUNCILWOMAN BLACKWELL: Thank you. Thank you, Mr. Zeigler, and God bless you. Lucien Blackwell has been gone over 12 years now, and I'm always encouraged when I hear people remember him for his life and service, and thank you for what you're doing to help other

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people who pass this path.

MR. ZEIGLER: Yes, ma'am.

COUNCILWOMAN BLACKWELL: God bless you.

MR. ZEIGLER: Thank you, ma'am.

COUNCILMAN O'BRIEN: Thank you for your testimony and thank you also. I'll echo what Councilwoman Blackwell just said. I'm always thoroughly impressed with her brand and the recollection of so many people recognizing the Blackwells' random acts of professional and public kindness. So thank you for sharing your life experience, and we wish you continued success.

MR. ZEIGLER: Thank you. Can I just add one more thing, Councilman?

COUNCILMAN O'BRIEN: Yes.

MR. ZEIGLER: Employment. That's another major, major hurdle. You know, I recall when our honorable Mayor put out that tax, job tax thing, tax incentive for companies to hire

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ex-offenders or returning citizens, and I was blown away how -- I don't think it was -- it was only like one or two, if that, that was -- it was none, Councilman?

COUNCILMAN OH: Zero.

MR. ZEIGLER: Zero that latched on to that, that tax incentive. So it's not only -- it's society. It's society as to how they're seeing men and women who have made bad choices. Because we all make bad choices. I don't want to get on my soapbox, but we all make bad choices, but yet a lot of the men and women are not allowed to redeem themselves and given another opportunity.

Again, thank you for allowing me to testify, and in closing, I would like to just say that I thank my organization, my agency I work for, GPASS, who have given me an opportunity, because like they believed in me. Even the training that I received from the Department of Behavior and Health, and I

did an intern over at MHA, the Mental Health Association, over four months over there, but yet -- they was paying me a stipend, but yet when a job opened up and I met the requirements for that job, they would not hire me, but yet you let me work here for three, four months, the same way with the Department of Behavior and Health.

So it was a blow to me, but how many men and women who -- and I had -- that was an experience for me, because it was a blessing for me, but I was kind of blown away. I wanted to -- before I got where I'm at today, I wanted to go back out there in them streets. I got friends that still doing they thing out there. And, Councilman, I really, really wanted to go back out there, because nobody would give me a shot. But I stayed steadfast and I didn't want to continue to hurt my family, friends, and loved ones, people who had invested in me. And I believe that if we continue to invest

in some of the men and women today, it will change their way of really looking at themselves. And I think that, you know, they'll have a better chance than what they did have and they could see that they got some gifts in them that they can give back, such as myself.

So thank you again for allowing me to, you know, just give you a piece of who I am.

COUNCILMAN O'BRIEN: Thank you very much. The last thing that you just said reminds me of a program or a strategy that we have in the City of Philadelphia called Focused Deterrence, and part of that is to take those most likely to shoot or be shot and if they -- and incarcerate them or take a closer look at them for the infractions and parole and probation violations, but the key part of that also is for the community and the family and friends to come forward and say that you matter, we don't want you to go to jail, we don't

want you to go to prison. And a lot of those individuals are leaving that life and taking jobs at Payless Shoes and Goodwill and other places. So it is that opportunity and the support that the community brings forward that can make a difference. And thank you for that testimony. Thank you for --

MR. ZEIGLER: Yes, sir.

COUNCILMAN O'BRIEN: -- informing us of the importance of certified peer specialists. So thank you very much --

MR. ZEIGLER: Thank you, Councilman.

COUNCILMAN O'BRIEN: -- for sharing your life story with us.

We will now ask Jeff Draine, a Professor and Chair of the Social Work Department at Temple University, to come forward.

Doctor, could you please state your name for the record and proceed with your testimony when you're ready.

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(Witness approached witness table.)

DR. DRAINE: My name is Jeffrey Draine. I am Chair of the School of Social Work at Temple University, and thank you for the opportunity to come here, Councilmember O'Brien and other Councilmembers. I think it's probably -- maybe it's part of the ritual to begin with a Lucien Blackwell anecdote. My first week living here in Philadelphia in 1989, I remember it was in the midst of a mayoral campaign, and that's when I first saw Lucien Blackwell leading what amounted to a parade as part of his campaign, and that memory is still in my head as my introduction to Philadelphia.

COUNCILWOMAN BLACKWELL: Thank you.

DR. DRAINE: It made me happy to be here that something like that would happen.

COUNCILWOMAN BLACKWELL: Thank you.

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DR. DRAINE: I would like also to thank Mr. Zeigler for his words this morning. I would say that as someone who is a researcher, has been working for 25 years on the issue of mental illness in the criminal justice system, that any source or information that I provide is secondary to the primary source, which is the lived experiences of people who have experiences similar to Mr. Zeigler. So I just want to make sure that that's how I prioritize the sources of information I have.

Let me begin with a bit of an anecdote and then some content.

My interest again during my earlier days, interest in this area, was as a full-time volunteer for a religious community working to address homelessness in my hometown of Richmond, Virginia. The state prison, which is now demolished, sat across the street from the place where we worked, and the men -- it was a men's prison -- would use our

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street address, 308 West Canal, as their discharge address and would walk across the interstate bridge and into our front door. The one time I've ever been physically hit in this business was when one of those men walked through the front door and had to hit someone to vent his anger over lost time to prison. True to our way at the time, we logically made him our cook and a role that he filled for years following.

We had built a coalition in Richmond that provided physical comforts, mental healthcare, and advocacy for the welfare of people who came to us. We were not naive about our guests. Many were tough characters, hardened by life on the street. A third to a half of those who came through our doors were living with serious mental illness. We gave them things to do and things to aim for - school, jobs, and relationships. And I begin with this anecdote to paint for you the perspective I have on this

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issue that is treated too often as a clinical issue. It is first and foremost an issue of human dignity.

I now want to focus on some of the terms that people use around this, all which happen to start with R-E. It just happens to be the way things are named around here.

First I want to talk about the term "rehabilitation." And we talk about rehabilitation in the context of mental illness in one way and we talk about rehabilitation in the context of the justice system often in another way. My understanding of the term "rehabilitation" from my training and my experience is that it is preparation and accommodating for a person to live a full life in the community. And in my years of experience going in and out of jails and prisons and working and talking to people, that it is very difficult to achieve that inside jail or prison, because it's an unnatural environment.

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It's an unnatural way for people to associate with one another.

The preparation for living a life comes from living a life in the community where you're going to live and have relationships and fully integrated in that community. So whatever services or treatments or helps that are provided inside that are called rehabilitation should be things that also continue and accommodate care and support for people on the outside, just like anyone else, to the fullest extent possible.

Removal is the second word. Todd Clear is a visionary criminologist who works at Rutgers University-Newark, and he insists instead of calling this issue reentry, he calls it removal. And it is an interesting term of a phrase, because he says that's the real issue, and I see it that way too ever since I heard him frame it this way, because the issue is that people have been removed from their communities. People have been

removed from their family, and their family members have been removed from one another. And it's a fissure in families and it's a fissure in neighborhoods, especially in neighborhoods where there is a greater likelihood that a significant number of people who may be parents are removed from those neighborhoods, which not only affects the fabric of families, but affects the fabric of whole communities. And I think if we don't see this as a removal issue that affects all levels of a community and a person's life, that we're missing something.

The next word I have is the one that we are using most often, which is reentry. Reentry is really a vaguely defined term. It's actually a very vague phrase. Those of us that do reentry work, we use it all the time and we assume, first of all, that we're all meaning the same thing. When I talk to people outside the field, the specific

field of criminal justice or reentry, one of the most common questions I get when I say reentry, they say, Reentry to what? And I say, Well, that's a really good question. That's also the question we ask when we ask about diversion. Diversion to what? Where are we diverting? What are people reentering? And when we talk about reentry, we need to talk about once again that end of the equation, which is often really more important than the equation of what are the mechanics of how someone is released from jail or prison.

One of the things that I -- concerns I have about reentry programs is -- the concern I have is whether or not they are scaled up to an extent, that they not only are big enough in their vision to have an impact on individuals' lives and also if they're big enough in their scale to really be able to provide those kind of services to everyone who is affected. So I've been thinking about

the capacity of these programs to actually provide comprehensive support and services that are most affected is an ongoing issue, and I don't think we realize how big that may be. I think we need to make decisions about the resources that we're going to devote to this.

I think one of the ways to do this, to talk about impact, is -- the other R-E word I'm going to introduce is restoration, to think more about restoring people to communities. If we think of it instead as reentry, but what do we do if we want to really restore someone to the communities? What does that look like that's different than if we just think about someone leaving jail or prison, which is a traumatic experience, as expressed to me by a lot of people, that one day -- actually, let's say one moment you're on one side of the door. This is an expression I hear quite often. And you're thinking

everything is going to go right this time, and then you step outside the door and often the first thought is, Oh -- enter your favorite expletive -- what am I going to do now. And the services that meet you there are really what meets that. But too often that's the biggest step people take and the biggest gap there is in our services.

We need to aim for -- I call this, we need to aim further down the road than just reentry. We need to aim further down the road than just focusing on recidivism. If we just focus on recidivism, the only expectation we're having for people is that they stay out of jail. We need to focus on how people are restored to community.

I think there's an approach that is largely untapped on this issue with people with mental illnesses that are leaving jails and prisons, and, that is, the use of evidence-based practices from psychiatric rehab for people to be

able to return to communities with the supports they need in housing, in work, in schools like anybody else. Evidence-based practices such as supported employment, integrated drug dual diagnosis treatment, self-advocacy, and those treatment services and rehab services have practice histories and evidence for their effectiveness, to relative degrees. We're still learning about all these practices in the mental health community. And they're not implemented enough on the outside, in the general community outside that, but it would definitely be an advantage to be using these intervention models specifically for these populations, because they target the specific things that are the main impediments to staying in the community for a longer period of time. Because even among a population of people with mental illness, the main impediment is not the mental illness. The main impediment is the lack of

education and the lack of employment and the lack of housing. Those are the things that trip people up, not the mental illness, and there's data to show that.

I've been preaching this, and my colleague Mark Salzer is behind me somewhere, and, you know, we've been writing about this since 2002, that the issue with this population is not the mental illness. It's the policies that surround the criminal justice system, including policies around incarceration, including policies like probation and parole.

You know, a lot of the things that we suggest, for instance, around probation and parole, around some of the things that Mr. Zeigler mentioned that inhibit the ability to get a job, that inhibit the ability to participate, we propose this, and the response we get generally is along the lines of, Well, why are you going easy on people who have

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done crimes, who have committed aggravated assault crimes, who have robbed people? Why are you going easy on them?

I see it completely differently. It's not whether or not we're hard on people or easy on people. This criminal justice system in the U.S. is hard on everybody, trust me. My question is, what is your aim? Is your aim to punish or is your aim for these people to return to the community with the supports they need? What looks easy to you or someone else, to me looks like the best way to solve this problem. And I'll end my comments there and take any questions you have.

I also have written down the questions that you -- the homework we had all along the way.

COUNCILMAN O'BRIEN: Thank you. I was remiss in not inviting Sandy Vasko, who is the Director of the Office of Mental Health, Department of Behavioral

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Health and Intellectual disAbility Services, to come forward and join the panel. Would you please come up at this time.

COUNCILWOMAN BLACKWELL: While she's coming, let me say thank you too. So thank you for your kind remarks and your memories.

DR. DRAINE: Thank you.

COUNCILWOMAN BLACKWELL: Thank you. About Lucien Blackwell. Thank you.

(Witness approached witness table.)

DR. DRAINE: Sandy Vasko will correct anything I said that was wrong.

COUNCILMAN O'BRIEN: Ms. Vasko, you can identify yourself for the record and proceed with your testimony.

MS. VASKO: Good morning, Chairman O'Brien and Chairman Jones. My name is Sandy Vasko. I'm the Director of Mental Health for the Department of Behavioral Health and Intellectual disAbility Services.

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I'm appearing on behalf of Arthur E. Evans, the Commissioner of the Department of Behavioral Health, and Dr. H.J. Wright, who is the Director of our Behavioral Health and Justice Related Services. Unfortunately, Dr. Wright was unable to be here today and he asked me to represent his comments to you today.

Individuals reentering society from custody who suffer with a serious mental illness, or what we refer to as SMI, have formidable challenges, as you just heard from Dr. Draine. Individuals diagnosed with an SMI such as schizophrenia or, as Mr. Zeigler identified earlier, bipolar disorder, major depression disorders, psychotic disorders suffer from impaired mental, emotional, and behavioral functioning to the extent that they require supportive treatment services if they are to successfully remain functioning to the extent that they require supportive treatment services and functioning in the

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community.

The national average for incarcerated individuals diagnosed with an SMI is 9 to 18 percent. Recent data from the Philadelphia Prison System is on the lower end of this estimate. As of January 2015, the PPS census had an average daily population of about 8,150. Nine hundred and fifty-nine of those individuals, only about 11.8 percent, had been diagnosed with an SMI. Additionally, it was noted that between 30 to 40 percent -- I believe someone had asked that question -- of incarcerated individuals have received behavioral health services. In total, according to PPS admission release data, the yearly average is about 37,000 admissions, 33,000 unduplicated individuals. Of those, SMI admissions at PPS average about 4,200 a year, or 81 per week. Individuals released from the Philadelphia Prison System with an SMI average about 12 per day, or 84 per week.

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For individuals diagnosed with an SMI, emphasis must be placed on substance use, dependence, and mental health treatment. Those individuals with co-occurring behavioral health challenges are four times more likely to violate parole and/or return to jail within the first year after reentry than persons with no SMI or substance use dependence history.

Given the significant number of people with SMI reentering the community every week, the challenge to remove the barriers that impede successful reentry require collaborative efforts basically involving City agencies that serve in this role. Collaborative across disciplines and jurisdictional boundaries is at the core of jail reentry. Recent years have seen a national explosion of creative and productive partnerships among jails and law enforcement, probation and parole, faith-based organizations, mental health clinics,

victim advocacy groups, the business community, and a variety of other social service and community providers.

Fortunately, in Philadelphia we've had quite a bit of cross-systems collaboration among justice partners and the behavioral health system. We've had much in the past approximately ten years. The behavioral health system actively participates on the Criminal Justice Advisory Board and meets regularly with the courts, Philadelphia Prison System, District Attorney's Office, Philadelphia Defender's Association, and Probation and Parole, focusing on implementing the evidence-based practices for planning and implementation of reentry strategies. Two current behavioral partnerships or initiatives specifically address reentry while the third example that I will reference for you addresses both diversion and reentry.

The first initiative that we are involved in has been -- DBH has been

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an active participant in the First Judicial District Mental Health Court since its inception in about 2009. This is the first reentry mental health court in Pennsylvania in which sentenced individuals who are diagnosed with an SMI are released from custody into the community to court-ordered housing, treatment, case management, and other support services. The DBH is currently working with the First Judicial District Mental Health Court through a U.S. Department of Justice Office of Justice Programs grant to provide comprehensive assessments for placement and services behind the walls. The scope of this grant is to implement a comprehensive assessment which encompasses the clinical needs of the court participant and addresses the risk of re-offending. This grant has just been awarded as of October '14 and we will have the benefit of that for the next two years.

The second initiative that we

are working with is the Philadelphia's Veterans Court through two Substance Abuse and Mental Health Service Administration grants, one of which we will focus on in this testimony. The four-year grant project diverts U.S. military veterans with trauma-related disorders from the criminal justice system and incarceration in local jails to programs that address their behavioral health and recovery needs. The veterans diverted from the criminal justice system receive trauma-specific treatment and support services within a trauma-informed integrated services system. This project's goal is to facilitate the healing process for men and women who have suffered from the acute stress and trauma of war and to assist them with reintegration into the community. This project is a pilot here in Philadelphia. We share the project with Allegheny County, and the hope is that this will be replicated across the Commonwealth.

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And then the third, I'd like to reference the work of our Office of Addiction Services Department, which has been effective for the past 22 years. They have worked in partnership with criminal justice agencies, including the First Judicial District, Court of Common Plea, Municipal Court, Adult Probation and Parole, and Pretrial Services, the District Attorney's Office, the Defender's Association, the Philadelphia Prison System, and 70 addiction treatment programs to develop a network of justice behavioral health projects. These projects work to either divert non-violent substance abusers from jail as well as promote community reentry activities to link inmates to services when they return to the community.

Some of the initiatives that they outline and include are the Forensic Intensive Recovery Program, or otherwise known as FIR; Drug and Alcohol Restrictive Intermediate Punishment

Program, the IPP program; Philadelphia Treatment Court; the Driving Under the Influence, or DUI, Court; Accelerated Misdemeanor Program, or the AMP Program; Domestic Violence Court; Dawn Court; Family Court Adult Evaluation; Juvenile Treatment Court; and Youth Violence Reduction Program.

During Fiscal Year 2014, a total of 7,000 individuals were served by these initiatives. The problem-solving courts that I mentioned such as Treatment, DUI, Domestic Violence are all programs designed to divert or prevent individuals from entering the Philadelphia Prison System. FIR and Intermediate Punishment programs are early release or parole programs that offer reentry support and alternatives to local incarceration. Approximately 3,200 individuals are in licensed treatment programs in lieu of incarceration annually.

This is by no means an

exhaustive list of collaborative efforts between justice partners and behavioral health to mitigate the effect of risk factors and promote protective factors for returning citizens with SMI and co-occurring challenges. Successful reentry is a shared challenge. We believe it requires creative shared collaborative solutions. Needless to say, we have much work ahead of us.

I appreciate the opportunity to speak with you and to offer this testimony here today.

COUNCILMAN O'BRIEN: Thank you both for your testimony. Chairman Jones has a question. I'm going to ask one question first of Dr. Draine. You use a lot of words that begin with R-E, and I'd like you just, because there were so many -- and I'll just mention a few -- rehabilitation, removal, reentry, restoration, and you talked about the evidence-based practices, including, but not limited to, housing, education,

employment. Can you please again just summarize how that affects another R word, recidivism.

DR. DRAINE: Yes. That's the other R-E word.

COUNCILMAN O'BRIEN: Just pull it a little closer, because the stenographer and others have trouble hearing.

DR. DRAINE: Okay. The impact on recidivism is -- the evidence for that is mixed, largely because I think a lot of the interventions that have been tried have focused more on the treatment access side of the intervention and not address also the other aspects as thoroughly.

The evidence that there is -- for instance, we have some conversation here about problem-solving courts and mental health courts.

COUNCILMAN O'BRIEN: I'm glad you picked up on that because I heard that in your original testimony.

DR. DRAINE: Yes. The one

trial that shows significant effect in this was for mental health courts, with some strength to the effects, was one that also offered housing. Others tend to not have as effective of an outcome. So those basic support services seem to be key to reducing recidivism.

In terms of special problem-solving courts generally, one of the issues in the evidence is, it's difficult -- it's one of these things that looks really easy initially but actually gets really complicated real fast, because you have the number -- you have to closely examine who is coming into mental health courts and how. So the whole population might come into mental health courts. The process -- depending on the process -- and there's a lot of variability depending on what courts they're in. The process of how someone graduates through that process or makes it all the way through the Mental Health Court program, a lot of people

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fall off either by being asked to leave or being told that they haven't met requirements or by dropping out. And it depends on where the evidence is collected, whether it's collected following the whole population in or it's just the people who have stayed in the program long enough to have data collected about them.

I have to say, I don't have specific information about the Mental -- data on the Mental Health Court here in Philadelphia. Like most researchers, I'm most naive about my hometown.

COUNCILMAN O'BRIEN: That's interesting. We have some of the most enlightened and forward-looking epidemiologists in the country right here, and perhaps we can take another closer look at that data.

I'm going to recognize Chairman Jones for a question and then I'll have some other questions for you, if you don't mind.

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COUNCILMAN JONES: Thank you so much for your testimony. It is enlightening from both of you. A couple of questions, and feel free to answer any of the other ones that I've asked before, but one that is intriguing to me is that you mentioned the population that has been diagnosed as having some type of mental illness, a range of about 9, I believe it was, to 12 percent?

MS. VASKO: Nine to 18 percent.

COUNCILMAN JONES: Nine to 18 percent. When Mr. Zeigler testified, in his non-clinical diagnosis, walking those tiers, he said it was more like 75 percent had some type of visible, recognizable issue. Why do you think the disparity is so great between the two observations and diagnosis?

Pull that mike to you, though.

DR. DRAINE: So I think there are a number of reasons for that. One is depending on how you are assessing mental illness or observing mental illness. If

you are observing mental illness in the general environment where there is a lot of -- there's a fair amount of mental illness to begin with and also a fair amount of trauma and people responding to different experiences, you might observe a higher number than is usual in the general population.

Also, this is a tricky thing to measure, to actually look at what you're talking about. A lot of people can come in to jail or prison with mental illness, but not having been diagnosed. People can be misdiagnosed. So all those issues come into play in terms of the error that comes in to making these kind of estimates.

There also -- there's using diagnoses that are in charts in jails and prisons and there are other ways in which researchers use research-based diagnosis, which are standardized instruments they use. And the most reliable numbers for jails in particular -- and this would be

most relevant to your purview in Philadelphia jails as opposed to prisons -- is using these reliable instruments for people coming into jail systems. It's about 7 percent of men and about 15 percent of women show signs of having serious mental illness coming into jails.

Now, that also is problematic because there may be -- and there's some speculation from me here based on experience and based on the fact that I have spent a fair number of years actually administering these standardized instruments. There may be some bias to the differences in how men and women respond to it. I think men are less likely to admit to depression, for example, in the same way than women do, and that's just an observation that may explain it, or it may be actually true that it's about twice as many women as men.

But those are the numbers that

we have with the most reliable, valid procedures and methods coming into jails, and that was done in New York. We do have similar numbers from data that we used in Philadelphia around 11 or 12, which is very close to the numbers that Ms. Vasko provided, and we didn't even talk ahead of the meeting. And what's interesting about those data and is a project in which we followed people who left Philadelphia jails and would explain whether or not people came back into jails and that the individuals that were more likely to recidivate, which was consistent with evidence at large, is that people with substance use disorders, with co-occurring substance use.

But what was really interesting about the data we had was, we saw little to no effect for uncomplicated mental illness. And even -- and this may get into like some peculiarities about analyzing data. Even in some cases, depending on how you analyze the data, it

looked as if mental illness could even be a factor that keeps you out of jail, uncomplicated mental illness. And my read of that about the mental health system generally is a competent and capable mental health system is probably pretty good, like the one in Philadelphia, is probably pretty good at treating uncomplicated mental illness and addressing it in a way that keeps someone out of jail. It's the co-occurring substance use that's difficult and challenging, not just as a clinician to know how to treat it, but to have a sufficient number of providers that are trained in -- that are thoroughly trained in doing co-occurring treatment, that treating both mental illness and substance use, and the resources to back it up.

COUNCILMAN JONES: So if I understood what you said to me, you said that people in that diagnosed population, 9 to 18 percent, sometimes have a greater

chance of not coming back than the regular general population?

DR. DRAINE: I think -- let me just word it this way. This is probably the most valid way I can say it, is that the factor that is the largest contributor to recidivism and to entry into jails from general populations in prisons is substance use, co-occurring substance use with the mental illness.

COUNCILMAN JONES: All right. I stand corrected.

The other question I have is, during the '80s, late '90s, there were a number of standard institutions that were closed.

DR. DRAINE: Yes.

COUNCILMAN JONES: What impact did that have on the prison system?

DR. DRAINE: So that is a very complicated question for a number of reasons, and that's actually the issue that I've written about to some extent, because of the extent to which people

make the direct connection from the closing of large custodial psychiatric institutions and the increasing number of people with mental illnesses in the criminal justice system. The reason it's complicated is that during that time period was also the time period where the war on drugs began in earnest around about 1973, '74 when sentencing standards were changed to be much more tougher on drugs. People were sentenced more certainly for drug crimes and for longer periods of time, and that sort of collects more and more people into jails and prisons and keeps them there for longer periods of time. So that's part of what explains that.

Also, it was the baby boom aging into the early 20's, which is the usual age frame when people have first break of most of the illnesses that we're talking about here. So the population of people that were at risk for mental illness was growing. The population of

people getting arrested for drug crimes was growing. It's just one of those perfect storm things. You can't attribute it solely to psychiatric hospitals closing.

In fact, I think there's some evidence, some historians of mental illness claim that psychiatric hospitals closed largely because state officials, not to blame everything on elected officials, but state officials became very wary of being able to pay for large custodial institutions that were just going to get larger and larger. And that's part of the history of large custodial institutions. That also applies to past institutions such as almshouses and orphanages.

COUNCILMAN JONES: Conversely, out of -- and this is my last question, Mr. Chairman.

Out of that 9 to 18 percent of the population that you diagnose coming in the door as having some type of issue,

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what is the percentage of that same population coming out with an improved circumstance mentally?

DR. DRAINE: That's a very good question, and I'm not going to be able to answer it probably to your satisfaction. But I will say that I think the way to answer it is examining the role of different interventions and different models of providing support services as people leave jails and prisons. You know, for instance, right now we've just completed data collection of a large study of critical time intervention as a method -- as a potential method for keeping people with mental illnesses who leave prison -- and this was specifically prison -- from returning. And we're just analyzing the data now, so I can't tell you anything definitive from that right now. It does appear that people are more likely to be engaged with providers, but that doesn't mean that following from that that less return to the justice

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system.

I think the answer is more and more people taking time -- I mean, the way we get break-throughs in science around issues such as this or anything is by trying any plausible idea that could possibly help. And, for instance, criminal time intervention. My idea was that this was an intervention that had a strong evidence base for helping people stay out of homeless shelters. There's actually a very strong evidence base for that. It could apply to people leaving jails and prisons, and we're hoping that that's true.

Housing does seem to be the key. I keep harping that point because that's actually where we have strong evidence. We have strong evidence from Lamberti in New York. We have strong evidence from mental health courts in California and in other locations that -- and from the evidence we have generally on the strength of supported housing as

the key element to people's recovery generally, is definitely key to improved health and improving all the factors that contribute to recidivism.

COUNCILMAN JONES: So going forward, I would encourage all here to understand that whether you come here to save souls or to save dollars, you have to measure what good costs, and that's something that we've been faced with in our budgeting process, that everything costs money and we need to know that is this ounce of prevention costing us or saving us a pound of cure.

DR. DRAINE: Yes.

COUNCILMAN JONES: So where to apply limited resources will depend on should we build another institution that segregates that population out to give them a better outcome. Should we incorporate these treatment processes within existing institutions, and which one of those are more cost effective and which ones of those are more efficient in

improving outcomes.

DR. DRAINE: We do have evidence that it is more cost effective to provide support services to people in their own homes. It is more effective to actually pay for that housing and provide support to people in their own homes than to use traditional institutional-based treatment. Dennis Culhane at University of Pennsylvania, my colleague at the University of Pennsylvania, has done extensive work on this, run the data through New York City, New York, New York study, and it's conclusive evidence that supported services in people's own homes, even to the extent of actually providing the housing, is more cost effective to society, not just to the one provider or one set of providers, but to society, because hospital emergency room use, homeless shelter use, hospital use is all reduced by the fact that people have a stable place to live.

COUNCILMAN JONES: Thank you,

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Chairman O'Brien.

COUNCILMAN O'BRIEN: Thank you.

I would just like to expand on the recommendation that my colleague Chairman Jones just made, and I think you're very supportive of it. We have to commit to a new way of policymaking, and that's reflective in the outcomes-based requirements that the federal government is now insisting upon. But, again, I would reiterate that we have epidemiologists here that are leading the way, and they drill down inside the data and it points to new directions and in supporting those outcomes, because we take -- they take the data, they strip it of its bias, and when they drill down inside, it projects a new direction that we would never have been aware of before.

So committing to that new type of process is something that I think would reenergize the effective use of our resources, and then this whether we should tax. Once we are aware of that

kind of evidence, we have a responsibility to act.

But, again, I would just like to talk to Ms. Vasko. You mentioned the Forensic Intensive Recovery, the FIR, Program. We hoped that we would have somebody here today from that program given the important work that they do. We know that they deal mostly with individuals coming out of jails that have substance abuse issues. My question is, does the FIR program and the other addiction initiative that you mentioned address the needs of those who are duly diagnosed? Because my understanding is that the mental health diagnosis can sometimes exclude these individuals from those programs, and, if so, what can we do with co-occurring mental health and substance abuse issues for individuals that are eligible to participate in so they take full advantage of these programs?

MS. VASKO: First, I'd like to

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say that Laurie Corbin is in the audience and she is the Forensic Intensive Service Program Director. So if there are any questions, I'm sure that Laurie would be willing to comment.

But just to speak to the co-occurring, I think one of the things that is happening within the Department currently is that there is an increased effort to have more collaborative discussions between the Office of Mental Health and the Office of Addiction Services, because we clearly are realizing planning for services sort of in a siloed approach is no longer meeting the needs of the majority of the individuals that are coming through the system.

We've recently piloted some case management efforts around providing supports and services, access to services, from a co-occurring approach, and we have found that at least to date that it has been effective with the small

population that we have piloted it with. We're hoping that as we expand our look into how to create more co-occurring access, that we will be able to tackle that issue. Unfortunately, I don't believe we have done enough of it, but the fact that we are in the process now of talking and planning from that perspective, hopefully we will be able to address that issue.

COUNCILMAN O'BRIEN: I just think it's a really challenging issue for my individuals with disabilities for many, many years who we chemically restrained them instead of providing the behavioral analysis that was necessary to identify the underlying treatment issues that were required.

I also would like to redirect a question to you, Doctor, and there's a second part to it. First, if you can identify some of the creative initiatives that I think are housed at Temple that we can build partnerships with the City.

But specifically given that question and also with my guys with autism and other disabilities, I think it's critical that we use our schools of pharmacology to identify this integration and look at how to properly use those drugs specifically for a diagnosis and also the interaction of those drugs. And I know in our programs for autism, we have limited it to a certain number of medications, because beyond that no one can predict what the interactions of those chemicals may have.

But if you can just speak to the collaborations that could be enhanced between Temple University and this conversation.

DR. DRAINE: Surrounding individuals on --

COUNCILMAN O'BRIEN: Well, two issues - the best practices, the evidence-based practices that you were testifying to before, and also perhaps some of the issues around the dual

diagnosis issue.

DR. DRAINE: So we have a center, the TU Collaborative, on inclusion of people with psychiatric disabilities, and that center is devoted to knowledge development and distribution on evidence-based practices and implementing and testing interventions, particularly around some of the outcomes I mentioned around use of supported housing, supported employment, supported education, and that's a strong collaboration we have with the Department of Behavioral Health and with other agencies within the City as well and across -- collaboration with other universities as well, and all those resources are available for collaboration with our colleagues at the City.

COUNCILMAN O'BRIEN: Thank you.

Councilman Oh.

COUNCILMAN OH: Thank you very much.

So I'll have some questions

just for my curiosity's sake. I'm curious, what is the difference between serious mental illness and mental illness in terms of this topic? Because from what I'm reading on the mission statement, 6 percent of the population has serious mental illness. Once you get in the prison population, it rises. So the difference between serious mental illness and mental illness when it comes to our discussion today.

DR. DRAINE: Broadly defined -- and I say that because if we get three mental health experts together, we'll have five opinions. But there would be reasonable agreement to a diagnosis that is in the serious diagnostic categories of schizophrenia or serious emotional disorder such as bipolar disorder or major depression, and that would be agreement on those in particular. And other people may add other disorders as well such as trauma-based disorders and things, depending on how the people's

perception of those is serious or not may develop.

Actually, what's more important in terms of defining something as serious mental illness is looking at the extent to which the disorder is debilitating or actually inhibiting a person from leading a life that is included with everyone else in their day-to-day life, the extent to which is actually inhibited in their participation of day-to-day life. That's actually more important in defining something as serious mental illness.

Unfortunately, it's easier just to use a diagnosis as a shorthand because that's easier -- often easier to access and often that's -- I know the City respects the fact that functioning is also included with diagnosis in terms of defining serious mental illness. So that's the definition of that category.

People will use the frame -- the term "mental illness" which will refer to anything -- can refer to any

emotional or psychosocial problem that someone is having that is disordered in some way. So that's a much broader category.

MS. VASKO: And I think you have to take in to consider the acuity level. Unfortunately, sometimes from a federal and a state perspective, they define -- they are very prescriptive about what falls in certain categories. We tend in the Department to push the parameters a little further and tend to go with something more on the acuity or the level of impairment that it has in a person's life.

So while -- for example, one of the diagnoses that often straddles the mind is borderline personality disorder. Not necessarily recognized as a serious mental illness; however, has severe impact on an individual's -- often on a person's functioning level, ability to interact with others in a socially appropriate manner, and oftentimes has

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much more of an impact in terms of a person's success coming out of jail, integrating back into the community, successfully living and managing their apartment, but yet would fall more in the category of just a mental illness categorization when you look at it from a state perspective.

COUNCILMAN OH: Okay. So for the purposes of providing a better mental healthcare system for those that are incarcerated and those who leave incarceration, I understand that there is a serious mental illness that has a kind of a definition that we would consider kind of grossly abnormal to the functioning capabilities of the society. You are identifying mental illness as a general term that many people may have, and somewhere in the middle is this mental illness that is debilitating in having a full life's enjoyment type of thing. Is that correct?

DR. DRAINE: So I think that,

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yes, part of the mental illness is the diagnosis, the acuity level, how serious the illness is, as well as the impact it has on someone's functioning. I would hasten to point out that in terms of the implications for jail and prison services, that the jail is responsible for treatment of any mental illness, not just serious mental illness. They're actually constitutionally obligated to provide effective treatment from mental illness, from the most serious mental illness to -- probably from my experience -- and it's been a long time since I've actually seen the data from the prisons, but I can imagine it's still true. The most common diagnosis is adjustment disorder, and largely from people -- or major depression and depression, which could be -- is exacerbated by coming into jail.

COUNCILMAN OH: Okay.

DR. DRAINE: And that needs to be treated as well. Even if you see like

an adjustment disorder in jail, it's still mental illness. It's still -- because that's the nature of mental illness, is the interaction with stressors.

MS. VASKO: And I think that's the other piece that I think you heard Mr. Zeigler speak so well to, which is we've yet to truly understand the influence and the involvement of trauma as well that is often, quote/unquote, undiagnosed, but is very, very prevalent in many of the inmates and has a significant impact in functioning level and does exacerbate conditions. So an individual could go into prison not diagnosed, maybe never accessing behavioral health services, and with the onset of that traumatic experience could trigger and then it becomes evident whether it's exhibited in behaviors or some level of symptom that hopefully someone in the prison system is going to take note of, connect with our Mental

Health Unit in the prison and get treatment for the individual.

COUNCILMAN OH: Well, I certainly agree with that and all that's in that statement about we should and do treat any mental illness and should provide those services. The reason I'm asking is because of the use data, rehabilitation, reentry, restoration, and it would seem to me that trauma is very broad. In other words, there's the trauma of being incarcerated. There's the trauma of having raped someone or murdered someone or broken in their house. There's the trauma of having been burglarized or assaulted or raped or had your child killed. So you have a population that's traumatized. And then you have those who got caught and those who didn't get caught who do the same thing, live in the same neighborhood. And so you're doing a reentry, restoration in an environment or a circumstance typically where the person

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is leaving a place where that is a condition of the environment and reentering that location.

I would say that I don't know -- are we still using the McNaughton rule? Do we have a DA in the room? Yes, still McNaughton.

So the McNaughton rule is that regardless of mental illness, you are a criminal if convicted not because you're mentally ill, but because you evidenced your ability to recognize that what you did was wrong and you had ability to control yourself. We typically say the person who stabs someone in the middle of the street and stands there with a knife in their hand is not able to control themself, but one who stabbed one in secret, hides the knife, and creates an alibi while mentally ill is criminally responsible.

So taking that legal standard that law enforcement, prosecutors, judges, you know, applies to the mentally

ill and perhaps a seriously mentally ill, although we would try to weed them out of this process, I would think, for those clinical reasons, how then do you do -- how then do you apply the restoration, rehabilitation, reentry under those circumstances for the person returning but also recognizing that there's a whole population who didn't get services? We typically, when I was in the DA's Office, had an offender and a victim. The victim got raped and would have no services. The offender would have services. So, you know, what is the -- how do you identify the serious mental illness services from the ability to reenter and be fully engaged services?

DR. DRAINE: So you're talking about the issue largely -- you're bringing up the issue of culpability.

COUNCILMAN OH: No, not culpability. Regardless of culpability, they were found guilty, not guilty. The issue is one has what you would say,

every doctor would agree is serious mental illness, inability to control themselves, or if they were convicted, they are recognizably unable to function within the normal set of circumstances. The other one may be able to function, though debilitated by the experience of being in jail, whatever happened in jail, the life that they led prior to being convicted and sentenced, returning to a neighborhood where that kind of experience is not unique. Other people share that experience. I could give an example that many times we have people that are in the military and they seem to function fine. When they are suddenly discharged from the military, they come into the civilian world and they experience depression and other things. They're outside of an environment that they were familiar with. But in this case, you're taking a person who is in prison, incarcerated, and trying to reenter them into a location that they

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aren't familiar with and others are familiar with them as well. And the recidivism, does that come from the fact that they reenter -- are they depressed? Do they -- what's the restoration that you are seeking?

MS. VASKO: Well, I think some of that is true. If you're not correcting or you're not improving or offering change to the public health of a general neighborhood population and you are reentering that individual into a neighborhood with familiar people, familiar things that put them back in touch with a prior drug history that they've had or a drug use pattern that they've had, then you can almost anticipate that the person will gravitate back to that.

I mean, one of the things from a reenter perspective that we are looking at is not only looking at the individuals that are in, but where they came from and beginning to do more of a knowledge base

on what is -- what do our neighborhoods look like, what do our neighborhoods need, where are those hotspots in the system where you may see a larger percentage of individuals that are recidivating back into the prison system, and begin to do public health initiatives around those areas so that you're bringing a general positive, whether it's a training opportunity or you're bringing an ability to unite different services together to establish collaborative efforts to improve the neighborhood, so that you're increasing the likelihood that someone coming back into the neighborhood would stand a better percentage of success than they might have had you not done those interventions.

So while we're simultaneously doing an array of things with prison reentry, we're also attempting as a department to do a number of initiatives in terms of just general educational,

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incentivizing with small projects and small programs with faith-based initiatives, business owners to improve hiring opportunities for individuals and trying to pilot those kinds of things as well. So public health becomes as critically important as some of the initiatives that are geared specifically to the mental ill or the seriously mentally ill coming out of the jails.

So that's one approach that we've taken to attempt to improve the quality of what a person is moving back into.

COUNCILMAN OH: So what I'm taking from this is that we have the seriously mentally ill that need better treatment, better healthcare services both in and outside of the prison, in addition to which we have a population of folks that have not been recognized as needing the services in a kind of a more broad spectrum of housing, social services, support mechanisms, although

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they return to an environment where their behavior is not unusual, but they need to have services to help them to adjust into a life that while it may not be the normal life in -- there may be high unemployment, high drug use, high crime, but there is an effort to restore them into a sense that they could achieve this type of life and to stay away from the other elements that drew them back into prison, exacerbated by their mental illness and depression and trauma and other things. Is that kind of the program that we are talking about implementing or enhancing for those who are identified as having that need?

DR. DRAINE: That's the kind of program that I think we would encourage for anyone with mental illness or psychiatric disability, that they have access to the support services to the extent that it can help them remain in the community. The models are out there to do it.

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COUNCILMAN OH: I should stop here, but I have just one more, because I hate to lose the opportunity to talk to experts.

So out of the blue, nothing to do with this conversation, if I were to categorize -- I'm not saying this is correct -- that people that may be in prison will consist of five categories of people - the brutal, the criminally committed, the weak, the victims of life and circumstances and whatnot, and then those who have made a mistake. The ones who made a mistake, once they're out they don't want to come back. The ones who are victims, they're the low-end criminals of the neighborhood who always get caught and get arrested again and again. The weak, they're just always revolving around low-end crime and they want to hang around the bigger criminals. The criminally committed, smart or otherwise, they are devoted to a life of crime, drug dealers, organized criminals,

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the lucrative whatever they are, and then just the plain old brutal.

In terms of population in our prisons, do we kind of know how many or percentage of what is what, how much of our space is taken up by those who are just brutal to other people, rapists and murderers, aggravated assault, mayhem, what percentage are like organized criminals, what percentage are people who made a mistake, you know, just shouldn't -- abnormal for them. You identified those low-level drug dealers, war on crime, happened to be out there selling some cocaine, they got the long sentences. They're just replaced by others. They make up a large portion.

Do we know the population of the people in prison in some kind of category like that?

DR. DRAINE: I don't know the -- Councilman Oh, you sound like you'd make a decent criminologist.

COUNCILMAN OH: No, no, no.

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The reason I'm asking is because as the --

DR. DRAINE: That was -- I would probably use different terms, but that was a relatively decent classification. But the thing we know in terms of how people see and examine the criminal justice system and who goes through the criminal justice system and how, what we know is that the number of people who commit crime is much huger than we can imagine and we could ever capture, because if you include any crime, we'd include, you know, jaywalking, you know, where it's a crime and things like that. So it depends on what classifications that you're going to use. And you go from that, which is the broadest category, all the way down to the very small categories.

COUNCILMAN OH: Let me --

DR. DRAINE: Which largely are the ones -- I would probably put them in the single digits percentage-wise.

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COUNCILMAN OH: Let me hone down my question, because I wasn't just trying to categorize people. The reason I was asking it is because when you're talking about serious mental illness and mentally ill and where the program is going to be effective, who it targets, who wants to be part of the program, and then we look at, okay, so of this -- so let's say they all suffer some type of abnormality that we would say in society is some mental illness, some trauma in their life, but there's a portion that can benefit from this restoration, reentry, and they're looking to reenter, be restored, have a productive life. And so the issue is not everybody may want it or be part of it. So what is -- how do -- what is the cost? That's something we have to always consider. We don't have a dollar, what's the program, what's the cost, how do we prioritize something like this to make it other than a discussion. How do we bring it into

reality of funding, prioritization, those type of things?

DR. DRAINE: Right. So it probably is a matter that people that recidivate the most who are more committed, as you frame it, committed criminals -- I understand what you mean by that -- are the people that cost us more than other people in the criminal justice system. If they also have a mental illness that needs to be treated while they are inside, it costs there as well. I would add, though, another dimension to that, and I would add the dimension --

COUNCILMAN O'BRIEN: If I could interrupt for one second. I'd just like to take care of a couple housekeeping issues. I'd like to recognize the presence of a quorum and recognize that with us today are President Clarke, Councilwoman Blackwell, myself, Councilmen Jones and Squilla, and Councilman Oh. I'm sorry. And if the

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Clerk would read the resolution.

THE CLERK: Resolution No. 150131, authorizing Council's Committees on the Disabled and Special Needs and Public Safety to hold joint public hearings investigating the barriers faced by people with serious mental health issues who are transitioning from incarceration to the Philadelphia community.

COUNCILMAN O'BRIEN: Thank you.

You can continue with your answer. Thank you.

DR. DRAINE: The other dimension I wanted to add is time, that one of the things that we know -- one of the new things we know about mental illness is that it is not an "and" crime, and criminal behavior, that it is not a permanent condition or a permanent label that we attach to someone, that people change over time, particularly as they get older.

I have seen in my time in

working in this area and interviewing people and talking to people, I have seen -- and I can imagine any number of people that I know who have lived lives like you describe and, as they grew older, reached out for compassion for their illness and compassion for life, because they may have eliminated options along the way, but they are still in our community with an illness suffering from that illness as anyone else who would have that illness and deserving of compassion because of their dignity as a human being and as a citizen.

COUNCILMAN OH: Thank you very much. Thank you.

COUNCILMAN O'BRIEN: Are there any other questions?

(No response.)

COUNCILMAN O'BRIEN: Seeing none, I would just like to go out of order and thank the witnesses for testifying today, and I would like to ask Bill Hart, the Executive Director of the

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Mayor's Office of Reintegration Services, RISE, and Mike Resnick, the Director of Public Safety, to come forward.

Thank you so much.

(Witnesses approached witness table.)

COUNCILMAN O'BRIEN: I appreciate you being here today, and I know you have a very busy schedule. Would you please identify yourselves for the record.

MR. RESNICK: Sure. Michael Resnick, Director of Public Safety for the City of Philadelphia. With me is Bill Hart, the Director of the Mayor's Office for Reintegration Services for Ex-Offenders, and it's my privilege to introduce you to our newest Deputy Commissioner for Philadelphia Prison System, Deputy Commissioner Blanche Carney, who is charge of Restorative and Transitional Services.

COUNCILMAN O'BRIEN: Thank you very much for being with us and welcome

to this conversation.

I just have one question for Mr. Resnick and Mr. Hart. Would you tell us a little bit about the pilot initiative that the City is undertaking regarding the support of people with mental health issues who are reentering into the community from the Philadelphia prisons, and specifically what are you trying to accomplish with this initiative, what partnerships and collaborations and how would you sustain it?

MR. RESNICK: Sure. I'll let Mr. Hart take that one since he has been spearheading the initiative. He's been doing some great work on it as well.

MR. HART: Bill Hart, the Executive Director --

COUNCILMAN O'BRIEN: Could you please pull your microphone a little closer.

MR. HART: Bill Hart, the Executive Director of RISE. I offer this

testimony as a reentry professional, not necessarily a clinician about behavioral health issues.

But with that said, the genesis of the SMI pilot came from us looking at recidivism at the PPS system, and as we looked at the three-year rate of recidivism, it became very clear to us that it's that first year where we have the highest level of recidivism. And as we start to drill down on what cohort groups fit into that category for the first year, it became glaringly visible that our mental ill and our seriously mental ill population are our frequent flyers. We release, they come back, we re-release.

So that said, the impact was to how do we reduce recidivism, how do we reduce the cost of the taxpayers' burden for the work that we do around public safety.

So our goal is to maintain a continuity of care from treatment and

detention and post-release treatment. Specifically, how do we remove some of the barriers, the immediate barriers that face the SMI population.

So to answer your question about the collaborative partners, our task force team consists of at this moment the PPS system, our social workers, our medical staff, RISE, the Department of Behavioral Health --

MR. RESNICK: Pennsylvania Department of Behavioral Health.

MR. HART: Pennsylvania Department of Behavioral Health, PHMC, DHS, the Office of Supportive Housing, PennDOT, and our academic partners from Temple University.

We looked at it at first as how do we train the partners that are involved in this engagement. It became very clear that we need to be better trained to better understand the challenges of the SMI population. So most of the partners have gone through

the trauma of informed care. I'll say more specifically most of the partners also have gone through the COMPASS training with the Department of Human Services, with the goal of connecting, I'll say, our guys and our ladies to medical benefits immediately.

The workflow with what we do sounds something like this. Our partners are obviously the PPS system, it's RISE, it's our forensic peer -- our certified forensic peer specialists, and then further out, our providers in the world who do services for the behavioral and intellectually challenged population.

So the workflow starts with an evaluation and assessment of sentenced clients. We've identified a cohort group of 117 that fit into what's been diagnosed as the seriously mental ill population. We're beginning 120 days out with engagement, with the evaluation, and working on just cultivating the relationship with the clients that we'll

be serving not only in detention but post-release. We're working on their discharge plans. And additionally, we're reaching out to the family support system that they may or may not be returning home to. That is also accompanied with the COMPASS application. The COMPASS application is simply an application that will turn on their medical benefits. We partner up with the Department of Human Services that now we have a central point of contact that all of our applications are submitted five days to release, with the goal and the objective is that medical benefits are turned on immediately upon release, so there is, again, that continuity of care from incarceration, detention to post-release.

MR. RESNICK: And that's important -- not to interrupt, Bill -- because when someone is incarcerated, their benefits are turned off. When they're discharged, it's a process to have them reapplied and turned back on

again. And if a person doesn't have access to their benefits, they don't have access to their care and their medication, they quickly decompensate, they re-offend, and they're right back in our custody. So this is an important part of the program, to make sure that an individual is released with access to their benefits.

COUNCILMAN JONES: I don't want to interrupt your testimony. For the record, could you let us know when people are released from State Road, how much medication are they given to transition to turn on their benefits?

DEPUTY COMMISSIONER CARNEY: There's 14 days medication and a script that is given to the returning citizen. So they have their medication or any blister pack medication that they can take with them, and then that script is recognized by our health centers. And the crucial part with this piece is, once the application and the benefits are

turned on, they can then get that script filled promptly and continue on with the medication, so there's no interruption.

COUNCILMAN JONES: What's the average time? And this is not in your wheelhouse, not in your responsibility area, but what's the average time to turn on the benefit? So if we have 14 days worth of medication, what's the average time of reigniting a benefit?

MR. HART: I'm going to take an attempt to answer the question. It depends, Chairman. It depends on the returning citizen's ability to, one, have identification that's appropriate to get the application turned on. That's, just a sidebar, one of the other relationships that we brokered with the Department of Transportation for this pilot. They're offering up 120 state-issued driver's license or non-driver's license. So it's a valid piece of identification to help with that application process.

Also residency becomes another

issue. If in fact in their home plan, their discharge plan, there isn't a place where mail can go to, that creates another barrier that lengthens that time as to when the benefits are turned on. One of the things that we have done is now we're using RISE as a central point of contact for our guys and ladies that may not have permanent resident addresses and that as a, I'll say, drop point to receive their mail so it's a central location. It's another touch point for us post-release for the clients that we serve.

COUNCILMAN JONES: So there are a number of factors, I get it, but what would be helpful to me when you come back by way of budget, if you could take a little bit of research time to find out what the average time of a returning citizen's benefits are. So that if we can reach out to our friends -- I say that sparingly sometimes -- in the State Legislature, we might be able to help or

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ask them for help to have that looked at.

MR. RESNICK: We'll look into that.

COUNCILMAN JONES: Thank you.

MR. HART: Chairman, also what's fun about, I'll say, about this workflow is the way that we have it positioned right now, there are touches/engagements with our clients 120 days out, 90 days out and what I call zero day, which is the day of release. Then there's a warm pass-off to our certified peer specialist. In the ideal world, we will be waiting for our clients as they walk out of detention from State Road and that pass-off will either take them to residential treatment, non-residential treatment. So there's, again, that continuity of care.

As the process plays out with the forensic peer specialists, then we engage our partners in the mental and behavioral health community to connect them with resources.

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So, again, the goal is how do we continue the care, how do we remove the barriers for this population in particular for that first year where we see the recidivism rates at its highest.

COUNCILMAN O'BRIEN: Could you please go back to the point that you identified PennDOT's participation in non-driver's license identification. Did you say up to 120?

MR. HART: Yes.

COUNCILMAN O'BRIEN: Why is there a numerical ceiling on that?

MR. HART: Now, I'm going to answer the question as best I can. The Department of Corrections has a relationship with PennDOT that every returning citizen leaving state detention will walk out with a state-issued ID. However, it has not been offered up to the counties. So for the past three years, we've been attempting to negotiate with PennDOT to open up that resource to returning citizens in the county, and

they've pushed back. So we repackaged the ask and now put it in the form of an ask for identification for a pilot program that we're going to serve 120 people. So from my perspective, it was just an inroads into solidifying that relationship that hopefully we can grow and to be able to offer up state-issued ID's for everyone returning out of the county systems.

COUNCILMAN O'BRIEN: And that can be done administratively?

MR. HART: Yes.

COUNCILMAN O'BRIEN: It doesn't require any act of the Legislature to do that?

MR. HART: Yes.

COUNCILMAN O'BRIEN: I'd like to follow up with you on that. Thank you.

COUNCILMAN JONES: Ma'am, welcome to City government.

So as we start to look at what we can do to smooth that transition out

from incarceration to our streets, do you have any suggestions on that by way of what we can do also particularly for our people with mental challenges or physical disabilities, anything that we can help you do?

DEPUTY COMMISSIONER CARNEY:

Yes. The process would have to be streamlined. Oftentimes for the sentenced population with the SMI diagnosis, we're working with First Judicial District, Mental Health Courts, FIR, Department of Behavioral Health. That population has been diagnosed. There's a treatment plan in place and there's an engagement process pre- and post-release. For the larger population for those folks that may not be sentenced as of yet in our system but come in and out of our system, have mental health issues, a streamlined approach whereby there's a centralized process, someone coming out that we've identified as having a mental illness. They can be

engaged pre-release. That's the key, because once folk that have mental health issues, they're navigating a system or attempting to or not. So having after care, case management engagement, reconnection with intensive case management or an agent or the capacity-building for agencies that are currently doing the work in the system, in the communities, it has to be an integrated approach. Right now pretrial folk that come in and out of our system, we're seeing them. We know the diagnosis, but if they're getting out, they're not sentenced. That approach, there's a disconnect. It has to be a hand-off and that the agency engaging the returning citizen has to come behind the walls to start that process. Because you lose in that first 30 days, whether it be medication continuation, filling a script, engagement with medical assistance reactivation, and then continuity of care. That's crucial. So

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establishing how we look at funding and building capacities for agencies to do the work post-release.

COUNCILMAN JONES: So is there a benefit bank system 20 days, 50 days before a person is scheduled to be released that says you are eligible for the following benefits should you choose to accept that? Is that process happening inside?

DEPUTY COMMISSIONER CARNEY: Not currently. This pilot project that Mr. Hart spoke of is to hopefully build upon that. So with the demonstration, if we're engaging this SMI population now, starting that COMPASS application, hopefully that would inform an expansion and that process would then expand across anyone coming out of our system.

COUNCILMAN JONES: So in a perfect world, 30 days before they're released they go down, see their social worker, case worker, and they are codified as to mental, drug treatment

kind of services that are available to them, housing services, whatever, and then they're given that package, that health package. I'd be interested from the time you start to next budget year, see if that impacts the number of returning citizens, if it helps at all. Because if I'm struggling with a whole range of issues, you know, some of the little things -- it's not the mountain that you have to climb. It's the pebbles that get in the sand on the way up the mountain that can trip you up.

So if we can measure that to see if a little bit of help on the front end stops the recidivism, I think that might go a long way to taking a stab at putting more resources to a particular service or program. All right?

Welcome on board.

DEPUTY COMMISSIONER CARNEY: Thank you.

COUNCILMAN JONES: Mr. Chairman.

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COUNCILMAN O'BRIEN: Thank you all for testifying today and thank you for your patience.

(Thank you.)

COUNCILMAN O'BRIEN: At this time, I would like to ask Matt Tice, who is the Director of Forensic Liaison Program, Pathways to Housing, come forward.

(Witness approached witness table.)

COUNCILMAN O'BRIEN: I'm sorry. I'm sorry. I'm going to -- I'd like to ask Eric Stryd, who is the Assistant Chief of the Diversion Courts Unit, District Attorney's Office, and Jeanette Palmer, the Supervisor of the Mental Health Unit, Adult Probation and Parole, to come forward. Pardon me.

COUNCILMAN JONES: One other question. I'm sorry. You can be seated, but one other question.

The Pennsylvania Commission on Crime and Delinquency, to what degree do

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you guys interact with them?

MR. HART: Chairman, we work --

COUNCILMAN JONES: You got to say your name, come to the mike.

(Witness approached witness table.)

MR. HART: Chairman, again, Bill Hart, the Executive Director of RISE.

We're working pretty closely with PCCD on multiple levels. From a policy perspective, we engage them actively with the Reentry Coalition. I'll say closer to home, PCCD has been one of our guiding resources as we look at some of the housing initiatives that may be able to, I'll say, impact the, I'll say, that barrier of coming home, having stable housing, what some of the other alternatives will be. So we're working very closely with PCCD.

COUNCILMAN JONES: So you work very closely with them and -- okay. That will do.

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MR. HART: Thank you, Chairman.

COUNCILMAN JONES: Thank you so much.

Good afternoon. Is it afternoon? Let me check. Yes, it's afternoon. Good afternoon.

MS. PALMER: Good afternoon.

MR. STRYD: Good afternoon.

COUNCILMAN JONES: Welcome. Thank you for your patience. You can begin your testimony in any order that you see fit. State your name for the record and begin your testimony. Pull that mike a little closer to you.

MR. STRYD: Good morning, Chairman O'Brien, Chairman Jones, and members of the joint Committee. Thank you for inviting me to testify. My name is Eric Stryd. I am the Assistant Chief of the Diversion Courts Unit at the District Attorney's Office. As Assistant Chief, I am responsible for running a number of reentry and diversion programs, including County Intermediate Punishment,

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State Reentry Court, MENTOR, and Mental Health Court. Prior to becoming the Assistant Chief, I was in the Trial Division for over six years handling non-fatal shootings and other violent felonies in South Philadelphia. Many of these non-fatal shootings and violent felonies involved defendants from the Focused Deterrence program. Prior to joining the District Attorney's Office, I worked for a year and a half as an Assistant Public Defender in Missouri.

The First Judicial District Mental Health Court was Pennsylvania's first reentry mental health court and was started in 2009 under the leadership of Judge Sheila Woods Skipper and has processed over 3,000 cases since its inception. Mental Health Court is a post-sentence reentry program designed to provide specialized services to those who struggle with mental illness. It provides an alternative to incarceration for non-violent offenders with mental

illness and co-occurring disorders by preparing those individuals for reentry into supervised communities. The goal of Mental Health Court aims to reduce the jail population and criminal justice costs by balancing justice, treatment, and public safety.

Now, defendants can be referred to Mental Health Court through a variety avenues. Cases can be identified by judges, defense attorneys, probation officers or assistant district attorneys. Once a defendant is identified as a possible candidate for Mental Health Court, a formal referral is submitted to the Program Coordinator, Patricia Wilson. Ms. Wilson then reviews the application and the defendant's mental health history to determine whether the defendant is a good fit for the program. I also review the defendant's application, his mental health history, and also the facts of the case to determine whether he or she is eligible for the program. If both the

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District Attorney's Office and Ms. Wilson agree that the applicant is an appropriate candidate, the defendant is accepted into Mental Health Court.

Now, when the defendant enters the program, President Judge Woods Skipper explains the program in detail and also explains what our expectations are for that participant.

Once the defendant enters the Mental Health Court, he or she will be required to follow all the conditions of the program, which include attending mental health treatment, remaining medicine compliant, and meeting all other conditions set forth by the Mental Health Court probation officer.

Mental Health Court has a number of built-in rewards and sanctions for its participants. If the participant is doing well, he or she will receive applause in the courtroom, see a decrease to the probation reporting requirements or a lowering of the probation

supervision level and ultimately a reduction in the sentence. If the defendant does poorly or violates the rules of the program, sanctions include writing an essay, having to sit in the jury box, increased probation supervision, jail time or ultimately expulsion from the program.

Now, when I review an application for Mental Health Court, I usually focus on three things. First of all, does the defendant have a serious mental illness. The program is designed for defendants who are suffering from bipolar, major depressive disorder, schizoaffective disorder or schizophrenia.

Second, what are the facts of the current case. We are targeting individuals with non-violent offenses. So defendants with sexual assault cases or other violent cases will be rejected.

And, third, what is the defendant's prior criminal history. If

the defendant has a history of violent behavior, he will be rejected from the program.

Now, we are not bound by these three areas, as every defendant is always looked at on a case-by-case basis. However, they provide guidance to us as we try to seek consistency in both our referrals and approvals.

Serious mental illness affects a large segment of our general prison population and remains a problem for our society and our prison system. Our prisons often do not have the ability to provide the necessary services to a defendant who suffers from a serious mental illness. When a defendant does not receive treatment for his underlying problems, it often leads to rearrests for new charges. This harms not only the defendant, but the victim of the crimes and the community at large. Mental Health Court makes a difference in these defendants' lives by providing intensive

supervision, case management, and treatment in order to help the defendant reenter society. When a defendant does not re-offend, he saves taxpayers money, reduces risks of harm to his community, and also helps himself.

Now, while providing services and treatment to participants in Mental Health Court is much more cost efficient than incarcerating them, it is also very time-consuming and labor-intensive. Mental Health Court requires many groups and agencies to work together for the betterment of the individual and society. In order for Mental Health Court to continue to be successful going forward, I see two immediate concerns.

One is bed space. While we have many wonderful partners in Mental Health Court, we often run into the problem of not having enough beds for our participants. Our city needs to increase the amount of beds for people who need in-patient treatment for their mental

illness. This includes more beds at secure facilities and also more beds at non-secure facilities. To give you an example, Norristown State Hospital currently has a waiting list of 99 individuals for the male population and an approximate wait time of one year. This is unacceptable.

The second point would be resources required to keep the program running.

COUNCILMAN JONES: Excuse me. Can you stop there. Did I hear Norristown wait time of a year?

MR. STRYD: Yes.

COUNCILMAN JONES: Yes.

MR. STRYD: Resources required to keep the program running. Mental Health Court requires much more time than merely trying a case. That is in fact one of the primary purposes of Mental Health Court, to ensure that the offenders in the program receive the time, programs, and followup necessary to

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help them avoid committing new crimes and to help treat their underlying conditions. As you know, the savings associated with Mental Health Court such as reduced prison costs are significant. Unfortunately, the caseloads are often unmanageable. With more investment, the system will yield even better results.

Now, we believe that we have the tools and the knowledge to deal with the growing mental health population in the criminal justice system. Mental Health Court is an effective alternative to the revolving door of custody for mentally ill offenders. This is a special population that requires a specialized approach.

I want to thank Council for its interest in this subject, and I'm happy to answer any of your questions.

MS. PALMER: Good afternoon, Council.

COUNCILMAN JONES: Can you pull that mike a little bit closer.

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MS. PALMER: Good afternoon, Councilman Jones, Councilman O'Brien, esteemed panelists, and guests. I would like to thank you for this opportunity to speak with you regarding this very important issue.

My name is Jeanette Palmer and I can attest that I have worked for the First Judicial District of Pennsylvania, specifically the Probation and Parole Department, proudly for over 27 years. I am currently the Supervisor of the Mental Health Unit of the Philadelphia Adult Probation and Parole Department. This is one of two units specifically designated to supervise offenders with mental illness. The other unit, the Specialized Court Unit, including the Mental Health Treatment Court, Veterans Court, and Dawn's Court, is supervised by Christine Carassai, who is present with me today.

I personally supervise 11 probation officers and oversee 1,450 probation and parole offenders who have

been court ordered to have specialized probation officers to assist them with successfully completing their period of supervision.

I was transferred to the Mental Health Unit on February the 10th of 2014 and immediately began the process of communicating with as many mental health partners that I could to assist our population. I may add that prior to supervising the Mental Health Unit, I supervised the Forensic Intensive Recovery Unit, or FIR, of the Probation Department where I've gained experience and knowledge in the funding process for offenders who have drug and alcohol addictions as well as mental health issues related to the use of drug and alcohol.

From 1999 through 2002, I was employed with Horizon House, Incorporated. This organization specifically assisted people with mental health disabilities. While working with

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this organization, I gained the love, respect, and admiration of people in general who suffer with mental illness.

In December of 2014, the Mental Health Unit of the Probation Department supervised 1,481 active offenders, with a total of 2,423 active cases. Three hundred and sixteen, or 21 percent, of our offender population was incarcerated. The Mental Health Unit received 40 new offenders in this month, with a total of 103 new cases. The average caseload size of the Mental Health officer is 135 offenders. The probation officers had face-to-face contact with 1,189 offenders during this month, which equals a 77 percent face-to-face contact rate. The total number of phone contacts made by the officers to the offenders or related parties to the offenders was 1,404 calls. I have provided you just a few of our year-end statistics, but I must state this, by far, was the least busy month of the year.

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The probation officers are responsible for ensuring that the offender complies with the rules, regulations, and the direct order of the court. Essentially we follow the direction of the judge's court order. The Mental Health Units of the Probation and Parole Department are very unique in that their officers must request and want to work with this very challenging population. Yes, we are stern, but we are compassionate. We wear the hat of counselor, law enforcement officer, mediator, therapist and, yes, we are confidants. We meet with the judge, the attorney, the family, the therapist, the treatment providers in general. Many times we are all things to our offenders.

I am here to make a passionate plea for your assistance. The Probation and Parole Department needs housing programs, in-patient programs, more intensive case managers for the mentally ill offender. Have you ever gone to work

and happen to see a man or a woman talking to themselves? Or perhaps you have seen a person swinging at the air? Or maybe you just watched a man lying on the church steps eating out of a paper bag? Chances are that this individual may be one of our offenders assigned to the Mental Health Unit of the Probation and Parole Department. The lack of resources for this population is growing every day.

Our offenders are being released from custody, jail or prison, with nothing. In most cases, if they have not been court ordered to a specific program or transported by the Philadelphia County Sheriff's Department, they are sent to the City shelter system. This more times than often leaves the offender vulnerable, as the shelter system is not always available and suitable for locating housing for this population. Because the offender has no proper identification, no medication, and

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sometimes no family contact information or family to assist them, they are forced to live on the street. We will always attempt to have an offender 302'd for safety purposes, but in most cases this is not an option for the Probation Department.

Secondly, when medication is not available for the offender, and this could be for any number of reasons. They have lost their benefits due to not completing necessary paperwork for the Department of Welfare, they have lost their identification. Sometimes our offenders lose their medication and cannot get a refill. They have no one to assist them and no one often to help them at all and they are left to spiral out of control. Due to the arrest record and often violent offenses of the individual, it is not appropriate or they will not accept them into many mental health housing programs. When the offender reports to the Probation Department, we

are left with no choice but to remand this individual into custody. While in jail, they can have a warm bed, so to speak, medications and some stability. We will request a court-ordered mental health evaluation for the purpose of an updated diagnosis and competency. This solution, as you can envision, is never a solution.

Earlier in my testimony I provided statistical information to give you an idea of how many offenders we supervise and the high number of issues that we are confronted with daily. If we had programs, case managers, beds, nurses, and staff that would willingly accept the mental health offender, we could reduce the number of offenders who are incarcerated. While incarceration is, so to speak again, is better than being on the street, mental health therapeutic treatment is unavailable. Statistics have proven that all recovery and mental stability works best when

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combined with treatment and medications. This begins with stable housing, food, and clothing.

In closing, yes, we supervise offenders. They are people who have broken the law. They are often unstable, often without family. However, they are people in need. The Probation Department cares. We care about the City of Philadelphia and its citizens. We care about ensuring the court order is honored and obeyed, but we also care about our offenders. They are in need of our assistance and they are in need of our care and our expertise. Availing affordable housing to this population as well as Social Security benefits, I might add, would save our city from housing offenders in custody wandering the streets of Philadelphia or not being properly supervised in general. This is an important issue.

I thank you for this opportunity and your consideration of

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this matter.

COUNCILMAN O'BRIEN: Thank you so much for your testimony.

Mr. Stryd, some mental advocates have concerns about Mental Health Court's emphasis on medication compliance and treatment adherence. How would you say the DA's Office addresses these concerns to ensure that all rehabilitation options are being explored?

MR. STRYD: Well, I'd say we're part of a team for Mental Health Court. That's one of the beauties about Mental Health Court, is that we're working in conjunction with the public defenders, with Judge Woods Skipper, with everyone. So if there became a concern over whether someone needed medication or did not need medication, we would leave that up to the professionals.

I don't know as much about certainly medication and mental health as people who were trained to do it every

single day. So while entering into the program, defendants need to sign a list of things that they must do to enter the program. One of them is to be compliant with their medication. But if the team and the court decides that medication needs to be stepped down, lowered or changed, taken away completely, that's something we usually will work out amongst ourselves, and it's not a requirement if the professionals are saying you don't need it.

COUNCILMAN O'BRIEN: And, Ms. Palmer, we've heard a lot of testimony today about individuals with psychiatric disabilities leaving prison. Can you speak to the adequacy or lack of appropriate services --

MS. PALMER: Yes.

COUNCILMAN O'BRIEN: -- from your lens.

MS. PALMER: From our perspective, we know that prisons are not designed to necessarily therapeutically

help people with mental illness. So where you spoke earlier of not having places like Byberry or Woodhaven or because of the violent offense of the person, they're not able to enter into a particular mental health program, they're left on their own. There isn't a real treatment option while incarcerated for the mentally ill. I mean, the treatment option is medication. Mr. Zeigler testified earlier that person may be placed in the hole. The modification is to curtail the behavior.

COUNCILMAN O'BRIEN: Mr. Chairman.

COUNCILMAN JONES: Yes. Thank you.

So you work with Focused Deterrence?

MR. STRYD: I previously did. Prior to becoming the Assistant Chief of the Diversion Unit, I was assigned to South Division to handle a lot of the shootings and violent offenses. So I

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did --

COUNCILMAN JONES: Non-fatal shootings.

MR. STRYD: Non-fatal shootings.

COUNCILMAN JONES: I remember that.

COUNCILMAN O'BRIEN: And we want to expand that program, by the way.

COUNCILMAN JONES: Yeah, we do want to expand that program, by the way.

So in your experience now, both of you, the closing of Byberry that arguably was a focused kind of treatment center, some people -- there's varying report cards on how effective and how efficient and how cost effective they were. As we've evolved into in-patient treatment in the system, if you were to give it a grade, A to F, what would it be?

MS. PALMER: At best I would give it a C. There are programs that will accept our offenders, and I don't

have the legality and the exact laws on this, but some of the things that caused Byberry to close was the idea that the offender has the right or any individual has the right to participate in their own wellness. And so some of that also triggered the closing of some of these institutions.

Some of the offenders -- the offenders that we supervise in my unit and that are supervised in some of the other -- not necessarily the Treatment Court, but definitely in the normal Probation and Parole Mental Health Unit, the offenses can be very violent. Our offenders are on probation for aggravated assault. They're on probation for, some of them, for murder. We have very serious offenses, and our offenders, again, are mentally ill. So being able to go into a program like Byberry or some place where they have round-the-clock supervised -- trained, supervised staff that can administer medication, that can

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designate when the medication is altering the personality negatively or positively, that's necessary for this particular oftentimes violent population. The people that we see walking around downtown are often that population, and as you all know yourself, that population is increasing. There are more and more people not medicated.

COUNCILMAN JONES: If I recall your testimony, it's about a thousand plus.

MS. PALMER: I supervise 1,480 offenders.

COUNCILMAN JONES: One thousand.

MS. PALMER: Four hundred and eighty active.

COUNCILMAN JONES: More like 1,500.

MS. PALMER: Yes.

COUNCILMAN JONES: So how many staff -- what is the case ratio per --

MS. PALMER: I have 11

probation officers that I currently supervise. I should have 12. We're short one, but that person will be replaced eventually. So right now the average case of the size is 135 offenders.

COUNCILMAN JONES: So 135 offenders. How often, in a perfect world, should we be interacting with that person? At least once a month?

MS. PALMER: Yes. We see our offenders no less than monthly. Depending upon what's going on with them, the reporting for my unit is often increased. I would say we rarely see anyone monthly. Our people have too many needs, and some of the -- you asked earlier about the mental health disorders. I mean, we do have people with, as you heard, bipolar and schizophrenia, PTSD, ADHD, personality disorders. Oppositional defiance disorder is also coming into my unit at a rapid rate. So we're supervising people

with serious mental illness. A lot of our offenders are at home. A lot of our offenders are between the ages of 18 and 26. More and more you'll find this population growing in paranoid schizophrenia and schizophrenia, oppositional defiance disorder.

COUNCILMAN JONES: So how can we help?

MS. PALMER: We need one -- I mean, almost all of our issues have been at least brought before you this morning. We need housing. We need when a person is released from the Probation Department, when a person is released from custody, that information should begin at the prison. They should know whether or not they're going to be released with identification. They should have a housing plan. And if there isn't a housing plan, then we just need to be presented with that information. It would help if a person is eligible for Social Security income or Social Security

disability, that that application is begun before they're released. It's very difficult to catch up with a body that's not mentally competent.

COUNCILMAN JONES: And I don't know if it's SSI or whatever that federal Social Security designation is, the average time for a decision is a year.

MS. PALMER: A lot of our defenders -- I cannot give you the percentage -- have already had that income allotted to them. When they go into custody for any variety of reasons, a new offense, a new arrest, non-compliance of the conditions of the court's order or if the person falls into a state of incompetency and we may have to remand them into custody, if they're in custody for longer than 30 days, they will lose their benefits. And so the process has to begin once they're released.

COUNCILMAN JONES: So it starts all over again?

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MS. PALMER: It starts all over again.

COUNCILMAN JONES: Okay.

MS. PALMER: And at that point if they've lost their identification, if mom has called me or mom has called the District Attorney's Office and we're instructed by the judge to remove that person, they can't go back to that home. The parent, unfortunately, depending on what's going on with that individual, they may have discarded all of their relevant information or they can't find it or the person moves, they're transitional. So, again, the body is released from custody with no means of us or PHMC or anyone being able to help them.

COUNCILMAN JONES: So I had a client come in my office, Mr. Chairman, who will remain nameless and came in and said, Please, please, please have someone come and arrest my son. And I have to believe that's one of the most difficult

statements a mother will ever have to make about their child. Because the young man because of issues, mental issues, was going around touching people, and often inappropriately, and some of the adult males in the neighborhood, they understood his condition, but at some point, you know, your wife, your sister, your mother, your daughter becomes the priority over that. But she knew that left untreated, left unaddressed, that -- and so I had to call individuals to come and do an assessment. But you shouldn't have to know somebody to get some help, and it just -- so she was trying to prevent her son from getting really hurt.

So this is a touchy issue, and we have to put the resources to it so that we can adequately monitor it. If your individual managers have 135 individual clients that some of them have to be found, traced down, dealt with, you're not going to average, what, close to five a day, that's not realistic.

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MS. PALMER: More than five a day.

COUNCILMAN JONES: More than five a day.

MS. PALMER: Absolutely more. Some of our officers, they will see up to 20 people a day. Definitely a day in -- and I was the supervisor of the Specialized Courts prior to moving here. Definitely the District Attorney and the Treatment Court, they will see a large number of people in a day.

MR. STRYD: Typically for us on a Thursday with Judge Woods Skipper and Mental Health Court, we're going to have 120 cases on the list.

COUNCILMAN JONES: We have to stop being penny wise and pound foolish. At the end of the day, we're going to pay for this, and the proper allocation of resources in the right way may prevent us a pound of foolishness.

MS. PALMER: Exactly. If I would add, I couldn't tell you how many

times -- I mean, if my boss were here today, he could tell you how many times he's received a call from Councilwoman Blackwell's office, Councilman Jones' office, Councilman O'Brien's office where a person is calling us saying this person is disrupting the community, what are you going to do, this person has broken out windows, this person is running around naked, this person is any number of things, what are you going to do. And we do not want to take people into custody. I'm sitting here with the District Attorney. That's not our first choice, but often we are left with no other choice. We are left with no other choice. And I've heard testimony today saying the Probation Department wants to. Our goal is to be a cohesive working organization that helps people first, but our primary responsibility is to help the community, to protect the community. We are sworn officers and we are compassionate people, but we need your

help, because we need resources, again, for housing. We need you to help the District Attorney's Office so we can find a way to keep this particular population safe. They're not safe for themselves primarily and they're not safe for the community at all. And when we receive those phone calls, we have to respond.

COUNCILMAN JONES: Thank you, Mr. Chairman.

COUNCILMAN O'BRIEN: Thank you both very much for your informative testimony and for your dedication to the system.

At this time, we would like to reintroduce Mr. Matt Tice, who is the Director of Forensic Liaison Program for Pathways to Housing.

(Witness approached witness table.)

COUNCILMAN O'BRIEN: Mr. Tice, if you can state your name for the record and proceed with your testimony.

MR. TICE: Good afternoon,

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Chairman O'Brien and Councilman Jones.

Thank you for the opportunity to testify.

My name is Matt Tice. I'm the Clinical Director of Pathways to Housing PA.

We're a non-profit organization here in Philadelphia. I'm here as a licensed social worker who has been in the field for the last ten years. Over this time, I've worked with many men and women who have struggled to land on their feet after reentering communities from circumstances like incarceration. Since coming to Pathways to Housing, I've gotten to know and serve an incredibly resilient group of individuals living with severe mental illness who have lived with chronic homelessness due to a wide variety of complications in their lives, including reentry. People come to us with difficult histories, and through a "housing first" model, we offer them their own apartment in locations spread across the City with no other pre-conditions.

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The people my agency serves do not generally come directly from prisons. Often instead they are the people who find themselves leaving institutions like prison and not knowing where to turn, how to properly access care, deal with addiction or find adequate housing. Our program participants describe confusing or unsympathetic systems, with long waits that do not seem to thoroughly consider mental illness when they return.

Because of a combination of individualized behavioral challenges and outside institutional barriers, they find themselves homeless, and not just for short stints. We exclusively serve chronically homeless individuals. So they need to have been on the street or in and out of shelters for at least a year to qualify for our program. Our job is to help pick up the pieces when it all goes wrong. Many have been outside for decades. We've also seen homelessness and other resulting nuisance crimes

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contribute to incarceration. These concerns become deeply engrained issues that our staff later need to work with participants to resolve.

We come to you today to ask for your continued support for person-centered holistic care that offers easy and open access to all individuals passing through our jails and prison systems. Foster an environment where reentry is supported by more productive discharges. Often individuals leave jails in the middle of the night and their only option is, if they don't have family to take them in, is to go to street or shelter. This is the first step in a cascade of problems where many feel like they are set up to fail. We need an environment where people are valued both inside and outside of prison walls and transitions between are made as smooth as possible.

The exciting thing about this group of people is that we know that they

can get better. I've helped individuals who have spent upwards of 30 years either on the street or in prison move into their own apartment. Through our supportive housing program, we serve the whole person, including medical, therapeutic, and behavioral interventions. We routinely watch them maintain their housing at an unheard of rate of 89 percent retention. They reintegrate with neighbors and communities and connect with family members. For those who want to access drug and alcohol treatment, we help open that door, and for those that are not ready, we continually offer access. We make sure healthcare is easily accessible, user-friendly, and are happily amazed when people's health improves even in light of chronic conditions. We also offer support as our participants reconnect with faith communities and other spiritual endeavors.

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Right now Pathways to Housing and Horizon House, as mentioned earlier, are the only programs in the City that utilize full adherence to the housing first model. Other programs are starting to follow suit, but it is a slow, hard climb from graduated models that expect behavioral and psychiatric concerns to be settled before housing is offered. We ask you to support developing initiatives that foster this kind of movement. Philadelphia needs more housing first services.

We fully support the Mayor's Office of Reintegration Services and some of the other services that have been mentioned here as great examples of how the City is turning toward preventing reentering individuals from ending up in situations like chronic homelessness, but we need more. With the amount of people who pass through the prison system every year with serious mental illness, we need the voices of our leaders such as

yourselves to champion interventions that are geared towards wholeness, informed by the trauma that so many have experienced, and welcome them right where they are. The flow of individuals into homelessness can be staved off, but it won't happen with quick fixes. It will take the dedication of caring individuals informed by the voices of those on the streets.

We thank you for listening to those voices.

COUNCILMAN O'BRIEN: Thank you so much, Mr. Tice. Where does your funding come from to provide housing for your program participants?

MR. TICE: We get it from wherever we can. We get funding from private donors, from grants, from -- we actually get a good amount of money from the City. We get money from HUD. They subsidize a lot of our housing programs. So we look for any possible option. We also have two large programs working with veterans, and so we get funding through

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the Veteran Administration Department as well.

COUNCILMAN O'BRIEN: Thank you. You've given us the retention rate for your program. Has this changed at all for individuals with mental health issues involved in the criminal justice system?

MR. TICE: So as mentioned before, so I also have a group of service coordinators or case managers that work with a forensic liaison or that they are forensic liaisons, and they're designated individuals to work with that system, and with their help, they have -- they've turned around quite a bit and been able to produce some really great results with this group and this population. And so we've seen some really good results with them.

COUNCILMAN O'BRIEN: And one final question. What kind of support do you think would be useful from this City Council in terms of supporting the housing first model so it can be

implemented more broadly throughout the City?

MR. TICE: Well, there's been a lot of programs that have been talked about and kind of housing first is a buzz word right now. I'm hearing that a lot of non-profits, a lot of other organizations are starting to embrace it, but encouraging that as an environment, looking to housing first as a model that really does work and that is actually cheaper than most other models. There's a lot more dignity in empowering people right where they are, allowing them to have a lot more choice, but also it's cheaper, and that's great for the bottom line too.

COUNCILMAN O'BRIEN: I want to thank you for your testimony. I don't see Chairman Jones. So is there -- so I will thank you for your testimony and ask, is there anyone else that wishes to testify on this resolution?

(No response.)

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COUNCILMAN O'BRIEN: Seeing no one else is here to testify regarding Resolution 150131 and there being no further business before this Committee on the Disabled and Special Needs and Public Safety today, the public hearing on Resolution No. 150131 is recessed until the call of the Chair.

I want to thank you all very much for your attendance.

(Committees on the Disabled and Special Needs and Public Safety concluded at 1:15 p.m.)

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CERTIFICATE

I HEREBY CERTIFY that the proceedings, evidence and objections are contained fully and accurately in the stenographic notes taken by me upon the foregoing matter, and that this is a true and correct transcript of same.

MICHELE L. MURPHY
RPR-Notary Public

(The foregoing certification of this transcript does not apply to any reproduction of the same by any means, unless under the direct control and/or supervision of the certifying reporter.)

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