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The Enhanced Pre-Arrest Screening Unit

Improving Health Services, Medical Triage, and Diversion
Opportunities in Manhattan Central Booking

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From the Director

The New York City jail system—with more than 60,000 annual admissions and an average daily population of 9,400 people in 12 facilities citywide—is among the largest in the nation.

A high percentage of people incarcerated in this vast correctional system have serious behavioral and physical health issues that require monitoring and treatment—often most effectively addressed outside of a jail. Yet historically, the criminal justice agencies entrusted with deciding which arrested people wind up in the city's jails have had little health history information to consider when making decisions about whom they should divert from jail to community-based treatment programs.

Since the early 1990s, the city has assessed arrested people at pre-arraignment screening units (PASUs) for health conditions prior to arraignment at its central booking facilities. But the process has been limited by the cursory nature of the evaluation and the absence of staff trained to detect and treat common medical conditions prevalent among the population of arrested people. As a result, the police routinely take anyone with the appearance of an active behavioral or physical health problem to a city hospital's emergency room for assessment and, if necessary, treatment. These hospital evaluations eat up hours of police officers' time spent in ER waiting rooms and often prove to be unnecessary. Furthermore, the PASUs collect information in paper records that are unconnected to the rest of the city's public health infrastructure, including jail medical facilities. This fragmented process has led to missed opportunities to triage people appropriately as they travel through the criminal justice system.

The financial and human cost of the inefficient, inadequate PASU system led New York City's Correctional Health Services (CHS) to partner with the Vera Institute of Justice (Vera) in creating and launching a pilot program in Manhattan Central Booking, known as the Enhanced Pre-Arraignment Screening Unit (EPASU). CHS, a division of NYC Health + Hospitals, the country's oldest and largest public health care delivery system, provides medical and behavioral health care, dental care, social work services, discharge planning, and re-entry services in the city's jails. The goals were to increase the capacity to deliver medical care to people pre-arraignment, improve coordination across correctional and community health providers, and bolster diversion efforts for people with behavioral health needs.

This report examines the EPASU's first year, identifying its successes and challenges in performing more rapid, accurate health assessments of people prior to arraignment, delivering needed treatment, communicating with correctional healthcare providers, providing defense attorneys with health screening summaries that aid them in arguing for their clients, and when appropriate, diverting arrested people from jail. The lessons learned suggest that the EPASU is one important tool for eliminating health disparities across the justice continuum and reducing the overrepresentation of people with behavioral and physical health disorders in New York City's jails.



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Introduction

In the United States, people involved in the criminal justice system have higher rates of chronic, infectious, and behavioral health problems than the general population.¹ As a result, police, criminal courts, and correctional agencies routinely function as default providers of primary care and behavioral health services for some of society's most underserved, uninsured, and impoverished members.² Each year, correctional health providers working in New York City jails contact incarcerated people approximately 750,000 times to provide medical and mental health services. More than 40 percent of people in the city's jail system receive some type of behavioral health service, of which 23 percent meet diagnostic criteria for a serious mental illness and 47 percent have a diagnosable substance use disorder.³ People in the city's jails experience higher rates of chronic and communicable diseases than other New Yorkers.⁴

In response, policymakers in New York City have adopted strategies to improve the quality and coordination of correctional health care and reduce the overrepresentation of people with mental illnesses and substance use problems in custody. For example, in 2011, the city implemented an electronic health record system to enhance healthcare services for people receiving care while incarcerated and promote care continuity for those transitioning between correctional and community settings.⁵ In recent years, public health and criminal justice agencies in New York City have been collaborating to increase diversion opportunities for people with physical and behavioral health issues. For instance, in 2014, the NYC Mayor's Office of Criminal Justice developed a citywide action plan that included a range of strategies to steer people with substance use and mental health disorders away from jail and facilitate access to psychiatric services, treatment for addiction, and social services in community settings.⁶

Diversion opportunities at various stages in the criminal justice process—before or after arrest, at first court appearance (known as arraignment), or as part of or in lieu of formal sentencing—can contribute to downsizing correctional populations and promoting access to community-based health and social services.⁷ Yet, in New York City

and elsewhere, diversion efforts have not traditionally taken advantage of a standard component of booking protocols, in which a healthcare professional screens newly arrested people to determine if they require immediate medical attention or transfer to a hospital prior to consulting a defense lawyer and proceeding to arraignment.⁸

Arraignment is a critical juncture in the adjudication process. Following a brief consultation with a lawyer—a public defender, for those who cannot afford a lawyer—defendants must quickly decide how to plead to the charge or charges just moments before their arraignment. Arraignments generally result in a defendant’s release to the community—for example, when a judge dismisses the charges; releases the person on his or her own recognizance; assigns time served or issues a community-based sanction if the person pleads guilty for minor crimes; sets bail that the person pays; or adjourns the case in contemplation of dismissal with the consent of the prosecution.⁹ Less frequently, an arraignment results in jail confinement. People may be held in custody because they lack the financial means to post bail, because the judge determines that they are unlikely to appear at the next court date and denies bail, or because they plead guilty at arraignment and receive a jail sentence. While timing varies by jurisdiction, New York law requires arraignments to occur within 24 hours of an arrest, unless there is an “acceptable explanation” for a delay.¹⁰

In 2014, recognizing the potential to build upon existing pre-arraignment booking procedures, New York City Health + Hospitals’ Division of Correctional Health Services (CHS), in partnership with the Vera Institute of Justice (Vera), began planning the Enhanced Pre-Arraignment Screening Unit (EPASU) pilot with support from the Jacob and Valeria Langeloth Foundation. The EPASU pilot launched in May 2015.¹¹ The screening unit is based in Manhattan and has introduced a new approach and set of resources in the borough’s central booking facility, including an electronic screening tool, connection to electronic health records, and a designated diversion liaison. The EPASU aims to: (1) increase Manhattan’s capacity to deliver medical care to people moving through the arrest-to-arraignment process; (2) improve coordination of health services between correctional and community providers; and (3) bolster diversion efforts for people with behavioral health needs.

This report describes the results of a process evaluation—covering the period between May 2015 to November 2016—conducted by Vera and CHS to assess the EPASU’s implementation and successes as well as the challenges in meeting these aims.

The arrest-to-arraignment process in New York City

In 2016, the New York City Police Department (NYPD) arrested more than 22,000 people each month, including a disproportionate number with mental illness and a range of other chronic and acute health needs.¹² If an arrested person reports or displays a health problem, the arresting officer immediately takes him or her to a hospital emergency room. There, physicians evaluate the person's health to determine whether he or she is stable enough to proceed to the central booking facility or requires admission to the hospital. Barring any immediate sign of a health problem, police bring newly arrested people to the precinct station house. Unless the arresting officer issues a desk appearance ticket (meaning that the arrested person is ordered to appear in court at a later time), the officer confirms arrest charges with a supervisor and then takes the person to the central booking facility in the precinct basement or adjacent to the courtroom in the borough of arrest to await arraignment.¹³ It generally takes about four to six hours at the precinct station before the arrested person goes to central booking.¹⁴

There are four central booking facilities in New York City—in Manhattan, Brooklyn, Queens, and the Bronx—where most people are held prior to arraignment.¹⁵ Once a person arrives at central booking, he or she is searched, fingerprinted, photographed, and undergoes an iris scan. The arresting officer next takes the person to the booking facility's pre-arraignment screening unit (PASU), where an emergency medical technician (EMT) screens him or her for a variety of health needs. Then staff from the Criminal Justice Agency, a pretrial service provider, conducts an interview to collect information on family and community ties, housing, employment status, and any other information that informs recommendations for bail and pretrial release.

The city originally established the screening units after a 1993 settlement (*Grubbs v Brown*) required the city to assess and treat the acute and chronic health needs of arrested people passing through booking facilities. Responding to overcrowded and dank conditions in the city's booking facilities, with poor air flow that turned holding cells into vectors for spreading tuberculosis and other communicable diseases, the settlement

ordered city agencies to create a process for screening the health needs of all people awaiting arraignment.¹⁶

The original PASU model, still operating in Brooklyn, the Bronx, and Queens, has several limitations. First, the EMTs who staff these units are neither credentialed nor equipped to diagnose or treat the most common ailments that people present in central booking, such as asthma, alcohol withdrawal, and hypertension. They cannot prescribe or administer prescription drugs, and can give patients aspirin and Tylenol only on request. As a result, EMTs typically ask police to transport anyone reporting a health problem to a hospital emergency room.¹⁷ Police officers taking patients to the hospital frequently spend their entire shift in the hospital waiting room, which reduces the department's ability to respond to 911 calls. Because officers frequently stay at the hospital with the arrested person awaiting evaluation after their shift has ended, the practice also results in significant overtime costs to the NYPD. And in extreme cases, the central booking facilities' minimal medical capacity has had tragic consequences. For example, in 2013, Kyam Livingston, a mother of two, died from alcohol-related seizures in Brooklyn's central booking facility, after reportedly complaining of stomach cramps and requesting medical attention for more than seven hours. The incident spurred public protests and a wrongful death lawsuit against the city.¹⁸

Second, the PASUs' paper-based medical screening protocol is outdated, limited in scope, and requires EMTs to quickly determine people's health needs based solely on self-reports, with no access to health records. This system lacks a process for detecting the full range of health problems that are common among people encountering the justice system.

Third, the PASU clinics are isolated from the rest of the city's public health infrastructure, including jail medical facilities. There is little or no communication between EMTs screening patients, clinicians conducting medical intakes on Rikers Island, and community providers. As a result, medical information the PASU EMTs collect is not typically used to ensure that people with health problems who are incarcerated after arraignment are swiftly triaged to the appropriate medical settings within the jail system. In the worst-case instances, failure to communicate with city jails' medical intake staff about serious health conditions such as chest pains or signs of heart failure gathered during pre-arraignment screening has resulted in otherwise preventable deaths within the first few days of incarceration. Finally, the PASUs have untapped potential as settings for gathering comprehensive health information about defendants that could

be used to advocate for diversion or to link people with chronic physical and behavioral health needs to community mental health care, primary care, housing, and harm-reduction services.

Rethinking Manhattan Central Booking

To address these shortcomings and missed opportunities, Vera and New York City Health + Hospitals' Division of Correctional Health Services (CHS) established a pilot program to test an enhanced pre-arraignment screening unit (EPASU) model, designed to improve the ability of the courts to identify health needs, facilitate diversion, and triage healthcare services. After a 12-month planning process, the EPASU was launched in the Manhattan Central Booking facility in May 2015. The NYC Task Force for Behavioral Health and Criminal Justice, spearheaded by the Mayor's Office of Criminal Justice, played an instrumental role in the pilot's launch, by adopting EPASU as part of a citywide action plan for addressing the overrepresentation of people with behavioral health needs in the city's criminal justice system. Since its launch, the EPASU pilot has operated from 6 a.m. to 2 p.m., Monday through Friday.¹⁹ In November 2016, CHS received additional support to expand the EPASU model to operate around the clock in Manhattan. The principal components of the EPASU are as follows:

A new electronic screening tool. The EPASU's health-screening tool is more comprehensive than the PASU model in several ways. It includes a wider range of questions for detecting the physical and behavioral health needs of people awaiting arraignment in central booking, notably additional questions to identify signs of psychosis and withdrawal from alcohol, opiates, or other narcotics. The new screening tool is also web-based, which allows EPASU staff to more easily share information with healthcare providers in the jail or the community.

Increased clinical capacity and care coordination. A patient care associate (PCA) a nurse practitioner (NP), and a licensed social worker staff the EPASU, giving it a greater capacity to detect, diagnose, and respond to common medical problems than the PASU. Each person entering the EPASU

receives a preliminary health screening from a PCA—a caregiver who works under the direct supervision of a registered nurse or nurse practitioner and is trained and certified to assess vital signs, collect health history information, and assist in delivering care. The purpose of this Level 1 screen is to ascertain acute medical and behavioral health needs and identify anyone who may require a more thorough assessment. PCAs refer those patients to the NP for a more in-depth Level 2 screen.²⁰ NPs are licensed to diagnose and treat a range of common medical conditions and trained to make informed judgments about whether it is necessary to transfer patients to a hospital for further evaluations or care prior to arraignment.²¹ They can also prescribe medications for medical conditions common among patients in central booking.

Access to electronic health records. EPASU clinicians can access two electronic health databases that include detailed information on prior symptoms and diagnoses for people coming through booking: e-Clinical Works (ECW), the jail's electronic health record system, which includes information on prior diagnoses, prescriptions, radiology images, and allergies for any patients who have been through the city jail system in the past five years, and the New York State Office of Mental Health's Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) database, which provides historical and current information on diagnoses and service use among Medicaid beneficiaries. With the patient's consent, EPASU staff can search PSYCKES to learn about any recent hospitalization for a psychiatric condition and find contact information for current outpatient service providers. The health data in ECW and PSYCKES allow EPASU clinicians to make informed treatment choices, triage medical services with community and correctional providers, and decide who is a candidate for diversion.

A diversion liaison. The EPASU's licensed social worker (known as the "diversion liaison") identifies people with behavioral health needs and, with the person's consent, shares the relevant information with defense counsel prior to arraignment. While each person meets with the nursing staff, the social worker searches ECW and PSYCKES for any evidence of a behavioral health problem. Evidence of a psychiatric need triggers a conversation between the diversion liaison and the patient about current or past treatment contacts, the patient's desire for treatment, current housing status, health insurance, and other indicators of psychosocial instability. The liaison then prepares a clinical summary and, with the patient's consent, shares a paper copy with the relevant public defender agency prior to arraignment (in Manhattan, these agencies include Legal Aid, New York County Defenders, and the Harlem Neighborhood Defenders). By the pilot's design, the public defender is the gatekeeper of the

clinical summary. In consultation with their clients, defenders have the discretion to use the information in the summary to advocate for the client at arraignment or at a later stage in the case.

Systematic medical triage. Routine, rapid communication between the EPASU and jail medical intake personnel is critical for preventing illness and death among people sent to city jails. Thus, a main objective of the EPASU is to promptly share important medical information collected in central booking with clinicians on Rikers Island or the other city jails. Whenever a patient discloses or a clinician detects symptoms of an underlying chronic illness or warning signs of an adverse health event, such as a heart attack or stroke, that requires follow-up assessments, the clinician enters a triage flag in the jail's electronic health record (ECW). The aim is to alert healthcare providers to expedite medical intake for any jail-bound person who needs immediate attention. Additionally, with a patient's permission, the diversion liaison or NP can contact community health and social service providers to inform them that their client has been arrested and to make post-release referrals. Communicating with community providers can be especially important for people who live in homeless shelters and are at risk of losing their bed if they fail to arrive or notify the shelter of their incarceration. For people actively enrolled in a Medicaid health home, the diversion liaison may also be able to contact their care manager, who can reestablish adherence to previously prescribed medication, counseling, and symptom-management regimens for chronic health conditions.²²

Aims and methods

Vera and New York City Health + Hospitals' Division of Correctional Health Services (CHS) conducted a process evaluation of the EPASU pilot from May 2015 through November 2016 to assess its implementation and understand whether it achieved its principal aims: increasing the capacity to assess and treat health problems in central booking, improving medical triage and care coordination, and facilitating diversion opportunities. As described in more detail below, Vera and CHS used a mixed-methods

Table 1

PASU limitations vs. EPASU components

PASU limitations	EPASU components
EMTs not trained or credentialed to diagnose or administer medications for common ailments.	Employs a patient care associate and a nurse practitioner who is able to diagnose and prescribe medications for common ailments.
Relies on hospital emergency room to prescribe and administer medication.	Avoids unnecessary hospital runs by prescribing commonly needed medications on-site.
Relies on paper-based screening that includes cursory assessment of behavioral health needs.	Uses revamped, electronic health screening instrument that includes a new instrument for assessing mental health and substance use symptoms.
EMTs have no accessibility to city’s electronic health database systems and must rely solely on self-report.	Clinicians have access to many people’s health histories in the jail’s electronic health record system (ECW) and Medicaid claims database (PSYCKES).
No process for facilitating jail diversion.	Employs a social worker (diversion liaison) to identify people with behavioral health needs, conduct outreach to community providers, and compile clinical summaries. With consent, clinicians can share clinical summaries on clients’ behavioral health needs with public defenders in advance of arraignment.
No systematic process for coordinating care with medical intake staff in the jail system.	Uses electronic system for creating a triage notification in a patient’s medical record, when necessary, to expedite medical intake at jail admission.

approach that combined quantitative and qualitative research strategies, drawing on analyses of administrative data, in-depth interviews, surveys, and focus groups with key stakeholders to answer the following questions related to the pilot's aims:

1. Increasing clinical capacity

- > How many patients did EPASU clinicians screen over an 18-month span?
- > What were the most prevalent physical and behavioral health problems reported, identified, or diagnosed?
- > What medical treatments and services did nurse practitioners deliver most frequently on-site in the EPASU?
- > How many unnecessary hospital trips did the EPASU prevent through its expanded capacity to prescribe medications for common medical ailments in Manhattan central booking?
- > How did NYPD officers and hospital emergency room physicians view increasing the capacity to assess and treat health problems in central booking?

2. Improving triage and care coordination

- > How frequently did the NP flag patients for triage and what were the most common reasons for doing so?
- > Did EPASU clinicians successfully connect patients to healthcare and social services in the community?

3. Facilitating jail diversion

- > How many EPASU patients were identified as potential diversion candidates?
- > How many clinical summaries did the diversion liaison share with public defenders prior to arraignments?
- > Did the pilot help public defenders divert people with behavioral health needs from jail at arraignment or later stages in their criminal case?
- > What suggestions did public defenders and social workers offer for improving the EPASU's ability to facilitate jail diversion?

Administrative data analysis

The research team compiled administrative data from EPASU health screens, weekly performance metrics, and the jail electronic health record system to describe the first 17.5 months of program operations, from May 18, 2015 through October 31, 2016.²³ The health screening data included self-reported information on people's physical and behavioral health symptoms, diagnoses, and treatment histories. Vera and CHS developed a performance metrics database for monitoring a range of outputs, such as weekly volumes of patient encounters, arrest charges, people identified as potential diversion candidates based on the diversion liaison's assessment, and clinical summaries shared with public defenders. As described above, CHS's electronic health records system (ECW) provided supplemental health information on all EPASU clients with a history of incarceration in New York City. The research team matched EPASU screening records with ECW data to describe services provided upon jail entry, diagnostic information, and previous jail-based care.

Interviews, surveys, and focus groups

Researchers conducted interviews, surveys, and focus groups with key stakeholders to monitor the pilot's progress in achieving its objectives and address challenges arising during implementation. These included semi-structured interviews with nine stakeholders: a patient care associate; a nurse practitioner; the diversion liaison; psychiatrists from the Comprehensive Psychiatric Emergency Program at Bellevue Hospital; and supervising attorneys from the Legal Aid Society, New York County Defenders, and Neighborhood Defender Services. Interviews focused on the features of the EPASU compared to the PASU system; the challenges experienced during start-up; how public defenders use the information EPASU clinicians collect; and recommendations for improvements.

In the first few months of implementation, the research team also conducted structured interviews with a convenience sample—a sample drawn from those on hand—of 45 police officers using the EPASU to assess their perspective on how the pilot procedures affected the booking process. Vera and CHS distributed 417 surveys to public defenders working in the court arraignment parts during the hours that the pilot was operating. A total of 145 public defenders completed surveys, a response rate of 35 percent.²⁴ These short, paper-based surveys were attached to each clinical summary defenders

received at arraignment. The survey included a combination of closed-response and open-ended questions. It sought to document how frequently and in what ways public defenders used the information in the clinical summaries to advocate for their clients at arraignment and at later stages in a case.

In August 2016, Vera researchers conducted two focus groups, one with public defenders from the Legal Aid Society and one with those from the New York County Defenders offices. Working with supervising attorneys, they recruited focus group participants who were familiar with the pilot and had received clinical summaries from the EPASU diversion liaison prior to arraignment.²⁵ Vera researchers asked participating public defenders to discuss a range of topics, including examples of receiving clinical summaries on their client's behavioral health needs that helped with advocacy strategy and outcomes at arraignment and post-arraignment stages, as well as instances of the information not helping clients. The researchers also asked for general feedback and assessments of the pilot, including suggestions for improvement. The research team asked defense attorneys about their experiences working with an EPASU diversion liaison and the utility of the information that the liaison provided.

Findings

Vera's analysts distilled the EPASU's successes and challenges in achieving its principal aims.

Identifying the physical and behavioral health needs of EPASU clients

Prior to the EPASU, New York City lacked a system for collecting and reporting data on the health profiles of people held at central booking pending arraignment. Creating a more comprehensive, electronic screening instrument, coupled with access to historical medical records, gave the city's public health administrators a vital resource for monitoring the prevalence of symptoms, diagnoses, and health service needs among the pre-arraignment population. As the findings below describe in more detail, this data revealed that people passing through Manhattan's central

booking experience a significant burden of physical and behavioral health needs. They also demonstrate that people who were identified as having a behavioral health need experienced more frequent negative health and criminal justice outcomes than people without a behavioral health need.

EPASU screenings found high levels of medical needs

EPASU clinicians saw 10,796 patients during the first 18 months of the pilot's operation. Patient care associates and nurse practitioners (NPs) screened an average of 149 patients a week. Only 1 percent (n=101) refused to answer any screening questions or engage in a clinical assessment. The pilot's clinicians completed a total of 10,695 Level 1 screens and 3,053 Level 2 screens. A Level

✂ **People passing through Manhattan's central booking experience significant physical and behavioral health needs.** ✂

1 screen is the initial questionnaire that all people passing through the EPASU receive. If a person discloses a behavioral health issue or a medical condition that requires a more thorough evaluation, then he or she is referred to a nurse for a Level 2 screen. The Level 2 screen contains more detailed questions about a person's substance use and mental health needs. The Appendix contains a complete summary of self-reported health needs from all 10,695 people who were screened by the EPASU during the 18-month pilot.

The most commonly reported physical illnesses and symptoms included breathing problems, mostly related to asthma (772, or 7 percent of all patients screened); heart problems (422, 4 percent); diabetes (260, 2 percent); and seizure disorders (147, 1 percent), as shown in the Appendix. Patients reported high rates of recent hospital or emergency room treatment, measured as police-escorted visits prior to their arrival at central booking or any encounter in the week prior to arrest. In the week prior to arrest, 1,532 patients (14 percent of all patients screened) reported having been in the hospital or emergency room; 71 percent (1,087) of those visits arose from medical complaints, 16 percent (240) from psychiatric concerns, and 13 percent (202) from both medical and psychiatric concerns.

Table 2

Self-reported behavioral health indicators in Level 1 screens

Self-reported behavioral health indicators	N (Total n = 10,695)	% of total patients screened
Prescribed any psychiatric medications in the past three months	418	3.9%
Currently enrolled in drug or alcohol treatment	352	3.3%
Currently enrolled in mental health treatment	164	1.5%
Drink alcohol every day or most days	951	8.9%
Risk of withdrawal from alcohol	224	2.1%
Use anti-anxiety medications (such as Xanax, Ativan, Klonopin) every day or most days	311	2.9%
Risk of withdrawal from anti-anxiety medications	170	55%
Ever treated for alcohol or benzodiazepine withdrawal	389	3.6%
Suicidal thoughts within past three months	197	1.8%
Received Level 2 behavioral health assessment	2,788	26.1%

EPASU patients reported significant behavioral health needs

EPASU screening data revealed high frequencies of self-reported substance use and mental health needs among patients. Table 2 summarizes self-reported indicators of a behavioral health need from Level 1 screens, including frequency of alcohol use, use of benzodiazepines, use of prescribed psychiatric medication, enrollment in substance use treatment, and enrollment in mental health treatment. Of all screened patients, 3.9 percent (n=418) reported having a prescription for a psychiatric medication in the past three months. Additionally, 3.3 percent (n=352) reported current enrollment in drug or alcohol treatment, and 1.5 percent (n=164) reported current enrollment in mental health treatment. Nearly 9 percent of patients reported daily alcohol consumption (n=951). Risk of drug or alcohol withdrawal was common, with one quarter of daily alcohol drinkers reporting withdrawal symptoms when ceasing alcohol use (24 percent or 224/951), and over half of patients on anxiety medications (such as Xanax, Ativan, and Klonopin) reporting withdrawal symptoms upon cessation (55 percent or 170/311).

A subset of patients received Level 2 screens and provided more in-depth information on their behavioral health needs. More than 600 of these patients reported currently being in mental health or substance use treatment (n=601 or 5.6 percent of all patients seen). When asked if patients have “ever done anything, started to do anything, or prepared to do anything” to end their life, 181 patients responded affirmatively (1.7 percent of all patients seen), with nearly one-third (n=57) of this group indicating suicidal behavior within the prior three months. Forty-eight patients reported current suicidal thoughts (0.4 percent), and 46 patients reported currently hearing voices (0.4 percent).

Information-sharing and continuity of care

Increasing the capacity to share information between clinicians working in correctional and community settings was a primary goal of the EPASU pilot. NPs working in the EPASU used existing patient health information in ECW and PSYCKES to confirm self-reported symptoms, diagnoses, and medications; uncover preexisting health problems that may have otherwise gone undetected; and create triage flags to expedite medical intake procedures in the event that the patient was sent to jail post-arraignment. However, although ECW and PSYCKES are critical sources of information for diversion liaisons in identifying people who may be appropriate for diversion, challenges remain in using this information to successfully link EPASU patients to health and social service providers in community settings.

Access to health databases enabled EPASU clinicians to verify self-reported symptoms or preexisting diagnoses and identify undisclosed health needs.

EPASU clinicians looked at ECW for all patients screened and found that 31 percent had an existing ECW record (meaning they had been in jail in New York City since 2011). Among those with records in ECW, 23 percent (n=771) had previously received mental health services while in New York City jails, which is representative of the overall level of identified mental health need for people entering city jails. Moreover, 12 percent of patients with an ECW record had a prior diagnosis of a serious mental illness, such as schizophrenia, bipolar disorder, and major depression (n=393 patients). Two-thirds of patients with an ECW record had a prior substance use disorder diagnosis (66 percent, n=2,210).

Nearly a quarter of EPASU patients received medical triage flags in their electronic health record to alert physicians conducting jail medical intake.

Nurses entered a triage flag into CHS's database for 15 percent (n=1,577) of all EPASU patients, and for 52 percent of those who received a Level 2 screen.²⁶ Nearly a quarter (23.7 percent, n=545/2,298) of people sent to jail post-arraignment received a triage flag in their health record. The researchers could not determine whether patients with triage flags in fact received expedited intakes or recommended treatment upon incarceration.

Behavioral health conditions were the most common reason that NPs entered triage flags in the records of patients sent to jail post-arraignment.

Over two-fifths of triage flags (43 percent, n=236) indicated a need for a mental health status assessment, and another 37 percent (n=200) indicated needs related to alcohol withdrawal. The third most common reason for applying a triage flag was for diabetes (13 percent, n=72), indicating the need for an immediate finger-stick test upon arrival at jail.

Table 3

EPASU triage flags assigned to released patients vs. jailed patients

	Patients released to community (n=3,053)	Patients sent to jail (n=2,298)
<i>Any triage flag</i>	1,577 (52%)	545 (23.7%)
Triage flag type		
Mental health assessment	909 (29.8%)	236 (10.3%)
Alcohol withdrawal	552 (18%)	200 (9%)
Diabetes	226 (7.4%)	72 (3%)
Initiate suicide watch	41 (1.3%)	16 (1%)
Other	395 (13%)	148 (6.4%)

Having access to electronic databases in EPASUs provides social workers with valuable information on patients' behavioral health histories and social service needs used to facilitate diversion.

Having the option to query ECW and PSYCKES provides diversion liaisons with timely information on patients' diagnoses, medications, and service used for facilitating diversion decisions. During the pilot's first 18 months, liaisons searched ECW a total of 9,625 times (or for 90 percent of all EPASU patient encounters) to identify people with behavioral health needs who might benefit from diversion and to supplement health screening information with historical information on diagnoses and service use. They identified an existing patient health record from a prior incarceration



**EPASU diversion liaisons
can use city and state
public health databases to gather
data relevant to diversion decisions.**



in ECW for 35 percent of these queries (n=3,333). Among patients with an existing health record in ECW from a prior incarceration, nearly half had a mental health diagnosis (47 percent, n=1,576) in their medical file, 12 percent (n=393) had a serious mental illness, such as schizophrenia, bipolar disorder, and major depression, and 66 percent (n=2,210) had a substance use disorder diagnosis. During health screenings, approximately 8 percent of people (n=664) reported being homeless, and on average, each week social workers encountered 28 people reporting that they were homeless.²⁷ The liaisons were also able to verify patients' recent or current engagement with community-based health and social services using ECW and PSYCKES.²⁸ For example, they identified 386 people as actively or recently enrolled in Medicaid health homes—12 percent of all patients with an existing ECW health record.

Retrieving patient information from PSYCKES requires a different, more stringent informed consent process than ECW.²⁹ Therefore, during the first six months of the pilot's implementation, CHS was unable to retrieve information from PSYCKES unless there was an existing documentation of patient consent

in ECW. This requirement limited social workers' ability to retrieve important information on patient diagnoses, medications, hospitalizations, health home status, and participation in outpatient psychiatric services. Therefore, in January 2016, the diversion liaison was trained to ask patients who reported or displayed behavioral health needs for consent to access PSYCKES. Over a six-month period (January 4 to June 30, 2016), the diversion liaison asked 76 people who reported significant symptoms of a mental illness for their consent to query PSYCKES, of which 62 percent (n=47) gave authorization. They located psychiatric information from Medicaid claims for 79 percent (n=37) of patients who authorized them to search PSYCKES for health records.

Diversion liaisons had trouble communicating with community-based providers and expressed a need for additional social workers to focus on connecting patients to healthcare and social services.

Community-based treatment providers can help facilitate pre-arraignment diversion by responding to requests from the EPASU diversion liaison to verify a patient's prior or current enrollment and by confirming their commitment to providing supports in the community. However, establishing effective communication between the EPASU diversion liaison and community providers was challenging. The EPASU liaison, with patients' permission, contacted community behavioral health providers 178 times during the pilot's first year (existing providers for 28 percent of patients who self-disclosed receiving community-based treatment were contacted). EPASU staff said that additional social workers were needed to focus mostly on health promotion and referring people to community-based health and social services providers. One staff member stated:

There are some days where I think that it would be great to have another social worker down there or a case manager or something whose job it was to just make referrals and connections to actual programs.... I can say, 'Oh, this person would be a good fit for Phoenix House or Odyssey House or whatever' and name a program but it doesn't mean that anything's going to happen ... I went to the midtown community court and they have a resource coordinator who sits in the courtroom and can make referrals right there and I think that would be really helpful.

During the evaluation period, EPASU clinicians identified 17 patients currently enrolled in an assertive community treatment (ACT) program, which is an evidence-based, recovery-based approach for delivering case management, care coordination, rehabilitation, and support services, for people diagnosed with a serious mental illness). But, during the pilot's first 18 months, liaisons had limited success in engaging ACT teams. EPASU clinicians and ACT team case workers do not have a history of working together or established channels of communication for coordinating care or making referrals; many EPASU patients were currently disengaged from ACT team services at the time of their arrest; and most of the city's ACT teams are not formally involved in jail diversion.

To gain more perspective on this challenge, Vera researchers asked the Comprehensive Psychiatric Emergency Program (CPEP) psychiatrist about city emergency rooms' experiences trying to identify and reengage people in need of care with their ACT team, which may be analogous to the challenges of coordinating care with ACT teams from the EPASU. He said:

I can't think of cases for us where somebody has come in and we have kind of been the one that reconnected them with the ACT team, and sometimes it's serving the end of putting pressure on the ACT team to do some more or come to the ER to see them and make another effort to kind of manage the situation. That's more commonly what we can do, but again usually in that case for us, we're kind of holding them overnight and making a plan for the ACT team to come in the morning, and it takes some time.

Expanding access to treatment

Another goal of the EPASU pilot was to increase the capacity to deliver basic medical care in Manhattan Central Booking, by hiring more credentialed medical staff licensed to diagnose, prescribe, and administer medications for common ailments. It was hoped that expanding the array of medications and services available in central booking would result in significant reductions in the number of unnecessary visits to city emergency rooms. As reported below, the pilot succeeded in cutting ER visits among patients whose medical ailments were addressed by an EPASU NP.

The EPASU facilitated timely treatment for patients who previously would not have received care while in central booking and would be transferred to the emergency room.

NPs treated EPASU patients for common ailments with prescription and over-the-counter drugs. Over the first 18 months of the EPASU's operations, about 7 percent of its patients, or 26 percent of those referred to the NP (n=794), received some type of clinical treatment (such as prescription or over-the-counter drugs) in central booking, with NPs administering a total of 931 doses of medication. The most common type of care was the distribution of inhalers (Albuterol and Ventolin) to treat asthma, which comprised 45 percent of total treatments (n=414). About 13 percent of on-site treatments involved prescription drugs for patients with high blood pressure. Approximately 4 percent of medications administered were for the treatment of HIV (n=37) and 3 percent for the treatment of seizures (n=26). NPs also routinely distributed over-the-counter pain relief (33 percent of all medications administered, n=308).

The EPASU's increased capacity to deliver medical care prevented an estimated 601 trips from central booking to a hospital emergency room from May 2015 to October 2016.

NPs working in the EPASU sent less than 1 percent (n=90) of all patients screened directly from central booking to the hospital. Prior to the EPASU, prescription drugs were only administered in central booking facilities if the person had the bottle with valid labeling in their possession at the time of arrest. If a patient reported a need for a medication, then he or she would be immediately sent to the hospital. Thus, researchers used the quantity of prescription drugs administered in the EPASU as a proxy for the number of avoided hospital runs. This measure is a conservative indicator because it only captures hospital visits averted directly from central booking, and does not count instances in which police with knowledge of EPASU medical services decided to bring a person directly from the police precinct to central booking, rather than escorting the person to the hospital for clearance, or situations where EPASU nurses perform basic psychiatric evaluations that previously would have taken place in a hospital.³⁰ Using this proxy, researchers estimated that by increasing the capacity to treat patients for common ailments on-site, during the lowest volume, eight-hour tour, Monday through Friday, the

EPASU pilot prevented 601 unnecessary hospital visits in its first 18 months of operation—an average of 6.5 hospital runs averted each week.

Preventing unnecessary hospital runs also reduces burdens on city emergency rooms. A senior CPEP psychiatrist explained that the presence of defendants and police officers in crowded hospital emergency rooms can cause discomfort and insecurity among patients and medical staff. As one emergency room physician explained, “We get many patients sent to us—who are in police custody—for reasons like a patient has taken anti-depressant medications or some type of psychiatric medication in the past. These types of cases would be flagged for a hospital run. That’s when a [EPASU] nurse practitioner may intervene and say, no, that’s not an acute hospital run-level need. Those are the kind of examples, and that’s not a small volume—we have many, many, many, patients like that.”

Police officers’ perceptions of EPASU

As mentioned, during the pilot’s planning stages, NYPD leaders offered their support for the EPASU based mainly on its potential for reducing the time officers spend escorting people to emergency rooms between arrest and arraignment. While some police officers were concerned that implementing the EPASU’s comprehensive health screening procedures would interrupt booking procedures, significant delays attributable to the EPASU did not materialize. Police officers interviewed for the research and completing the officer survey mentioned a number of benefits of the EPASU, with some officers advocating for its expansion.

Overall, police officers expressed favorable views of the EPASU.

During the early stages of implementation, Vera administered a semi-structured survey to 45 NYPD officers to assess their perspective on the advantages and disadvantages of the EPASU pilot compared to the PASU model. About 61 percent of police officers reported being “very satisfied” with the pilot. The most common reason for this response (cited by 59 percent of respondents) was the EPASU’s ability to avert police-escorted trips to hospital emergency rooms for minor medical ailments (see Table 4).³¹

Describing the benefits of treating minor medical conditions on-site in central booking, one officer stated: “It’s quicker. It prevents us [from going] to the hospital, which is often for a minor concern . . . way better than going to [the] hospital for a headache.” Another officer described his first experience with the EPASU: “It saved me four to eight hours. They treated him right

Table 4

Benefits of EPASU cited by NYPD officers (n=45)

Survey response	Percent of NYPD officers endorsing response
Allows police to avoid hospital runs	59
Saves time/is faster	36
Can distribute medications	36
Can treat minor medical problems	20
Collects more thorough health history	16

here. Hospital trips are a long process.” During interviews, NPs observed the positive experiences for police as well. “So far the NYPD have been very cooperative and appreciative. They like the program...because it saves them time, it saves them hospital runs, and many of the prisoners, they love it too.”

Officers specifically noted the advantage of the EPASU in averting emergency room trips with asthmatic patients. One officer stated that having the ability to prescribe and administer patients inhalers on-site in central booking is “much faster in any scenario where they need [an] inhaler... it avoids five-to-six-hour trips to the emergency room, which is definitely a plus.”

Police officers said EPASU health assessments took too long, but also recommended expanding its hours and the number of medical treatments.

While most officers spoke favorably about the pilot, others highlighted its limitations and made suggestions for improvements. For example, about 13 percent of survey respondents noted the pilot’s limited hours of operation, and about 22 percent flagged the need for the EPASU during higher-volume shifts, especially on nights and weekends. For instance, one officer noted: “If they could do 4-10 and midnights, it would help... cops on all tours should get it... it makes us feel better knowing we’re going to be dealing with the nurses. It’s less likely [patients will] get turned away [and sent to the hospital].” About 27 percent (n=12) of officers responding to the survey expressed discontent with the lengthier EPASU assessments. For example, one interviewee said, “The

process needs to be sped up. If I bring someone to the unit, it sometimes takes 15-20 minutes to complete the interview. If they already went to hospital, then they do not need to go through program [EPASU]”.³² Additional suggestions for improvement included increasing the staffing levels, treatments, and medications available on-site. One officer suggested that the EPASU should offer methadone or other medication-assisted therapies to alleviate discomfort and prevent withdrawals for people with opioid dependencies.

Gauging the value of EPASU clinical summaries for public defenders and facilitating jail diversion

A principal aim of this process evaluation was assessing the utility of providing clinical summaries of people’s diagnostic, medication, treatment, and/or housing information to public defenders prior to arraignment. In surveys, in-depth interviews, and focus groups, public defenders described the benefits and limitations of using the clinical summaries to advocate for the health and fundamental rights of clients, both at arraignments and later stages in a criminal case. As the findings below demonstrate, defense attorneys largely found value in having reliable background information on their clients’ health prior to arraignment and, although their decision to use that information in court depended on multiple factors, they viewed it to be an effective advocacy tool in certain circumstances at both arraignment and at later stages of adjudication.

Most EPASU patients with behavioral health needs were arrested for misdemeanors, nonviolent felonies, or noncriminal violations.

Diversion liaisons documented the top arrest charge for each EPASU patient considered for a health-related diversion based on health screen information and any supplemental information found in ECW or PSYCKES. The charging patterns for EPASU patients with substance use or mental health symptoms reflected citywide trends, with most of this group facing charges for low-level offenses: Most arrests for this group were for misdemeanors (55 percent), nonviolent felonies (17 percent), and violations (10 percent). About 14 percent of these arrests (n=235) were drug-related.³³ Unfortunately, information on district attorneys’ charges was not available in the data.³⁴

People with identified behavioral health needs experienced negative health and criminal justice outcomes more often than those without these problems.

For a subset of EPASU patients (n=3,968), researchers matched EPASU health screening records with ECW data, using arrest identification numbers, to compare criminal justice involvement of EPASU patients with and without indications of a behavioral health need (BHN).³⁵ As Table 5 shows, people with a BHN experienced higher frequencies of negative health and criminal justice outcomes, compared to those without a BHN. EPASU patients with a BHN had more prior contacts with the New York City criminal justice system on average and experienced worse outcomes compared to those without an identified BHN. For instance, patients with a BHN went to jail at nearly double the rate of patients without a BHN: Thirty-five percent of patients identified as having a BHN went to jail after arraignment, compared to 18 percent of those without a BHN, which includes people who could not afford bail and those receiving a jail sentence.³⁶ A quarter of EPASU patients with a BHN had been in jail within the past 12 months, and had an average of 10.1 arrests in the past five years. By contrast, only 7 percent of patients without a BHN were incarcerated in the past year and had an average of 3.7 prior arrests in the previous five years.

Slightly less than half of potential diversion candidates consented to share their clinical summaries with a public defender prior to arraignment.

Diversion liaisons must obtain informed consent before sharing patients' clinical summaries with a public defense agency. During the pilot, liaisons approached 24 percent of the patients they researched in health screening, ECW, and PSYCKES to interview as potential diversion candidates (n=2,113).³⁷ About 44 percent (n=924) of patients approached were interviewed and agreed to share their information with defense attorneys prior to arraignment. Social workers shared an average of 19 clinical summaries with public defenders each week.³⁸

Defense attorneys reported that clinical summaries gave them insights into clients' behavior and helped to establish trust and rapport with their clients.

As part of interviews, surveys, and focus groups, the research team asked defense attorneys about their experiences working with an

Table 5

Comparison of health and criminal justice indicators: people with and without behavioral health needs identified in EPASU screenings (October 2015 to June 2016)

	Total	Behavioral health need			
		No		Yes	
		N	%	N	%
TOTAL	3,968	2,879	72.6	1,089	27.4
Male	3,384	2,405	83.5	979	89.9
Female	584	474	16.5	110	10.1
Mean age		34.2 years		39.3 years	
Refused EPASU screen	53	38	1.3	15	1.4
Sent to jail	901	517	18.0	384	35.3
Incarcerated in past 12 months	471	203	7.1	268	24.6
Mean number of arrests in past five years		3.7 arrests		10.1 arrests	
Currently reported being sick or injured	189	115	4.0%	74	6.8
Has been in the hospital or ER in past week including since arrest	513	252	8.8	261	24.0
In hospital since arrest	480	241	8.4	239	22.0
Received Level 2 screen	1,088	582	20.2	506	46.5
Sent to hospital from EPASU prior to arraignment	20	6	0.2	14	1.3
Received triage flag (any kind)	569	200	7.0	369	33.9
Treatment administered in EPASU	288	168	5.8	120	11.0

EPASU diversion liaison and the utility of the information that the liaison provided. Participating attorneys said that receiving background information on a client's diagnosis, clinical history, and acute needs yielded valuable insights into the person's state of mind prior to arraignment and informed how they approached their clients, helped build trust, and strengthened their legal strategy. One survey respondent remarked, "Although bail was set, aspects of your report [clinical summary] did prove helpful in allowing me to get background information about the client before sitting down and speaking with him. At the time of my interview, he was in an agitated state and just having some familiarity with his issues helped me to connect with him at the outset." Similarly, another attorney noted: "It [clinical summary] gives us background. It gives us a perspective. It helps definitely with the interviews, in terms of the services they've received, and that helps with the bail application if we think we should mention it to the judge."

Defense lawyers said that knowing whether a client is currently taking or has stopped taking prescribed psychotropic medications can help them prepare when conducting an initial interview or discussing legal strategy. If necessary, such information provides defense attorneys grounds for arguing that the court should allow a client to receive medication before arraignment to ensure that he or she can communicate and participate in the proceedings in his or her own best interest. As one supervising defender explained:

When you walk into the interview booth, it's very hard to tell and sometimes... the clients don't trust you right away. Is this client off his meds, is he on meds, or is he just belligerent? Is he just angry because of the system and the process? And depending on their mindset, of course, it varies your approach. If a client needs their medication, I refuse to interview them and I tell NYPD, you need to take him to the hospital, he needs to get medicated because he's not going to be able to speak to me or tell me what's going on.

Public defenders found EPASU clinical summaries to be useful for helping their client at arraignment and later stages of adjudication.

Public defenders described how the usefulness of clinical summaries at arraignments and later stages of adjudication depended on a range of factors, such as the severity of the client's current charges, criminal history, and current

or recent engagement with substance use and mental health treatment. More than half of the attorneys who responded to the survey (53 percent) reported that the clinical summaries were useful in post-arraignment stages, while more than a quarter (28 percent) found them useful at arraignments. Fifteen percent found them useful at both stages. Only one respondent found the summary to have no value in the defense process. In that case, the defender reported using the clinical summary at arraignment, but indicated that it didn't succeed in improving the client's outcome.

At arraignment, public defenders used clinical summaries to improve arraignment outcomes.

Based on available data, researchers could not determine frequencies of specific arraignment outcomes for all people screened in the EPASU during the pilot's first year. However, approximately 45 percent of defenders who completed surveys (n=65) reported using the clinical summaries at arraignment. Among this group, 62 percent (n=40) said the information in the summaries improved their clients' arraignment outcomes. The most frequent arraignment outcomes in these cases involved defendants pleading guilty and being released to complete a program or community services (35 percent, n=14); having bail set (20 percent, n=8); receiving time served (17.5 percent, n=7); and being released on their own recognizance (17.5 percent, n=7).

Defense lawyers suggested that having information on contacts with community-based health or social services was particularly important.

Defense attorneys interviewed for this research, focus group participants, and survey respondents commented on the value of having timely, validated information on a client's recent or current participation in community-based treatment programs. They said that giving a judge evidence of the client's recent or current enrollment in a mental health or drug treatment program can be pivotal in successfully advocating for bail, diversion, or dismissal to help clients avoid going to jail, while helping ensure that they are connected to appropriate supports. For example, one attorney stressed the importance of having EPASU clinicians verify treatment engagement:

If we have background information on programs that the client was involved in, we can use that to show ties to the community, that the client is familiar with certain programs, he has participated or successfully completed certain programs. It shows a sense of responsibility. We can use

this [clinical summary] to argue for community service or for another program. Usually these programs are lifelines for the client. It's their connection to their housing, it's their connection to their public assistance, it's their connection to getting their medication. That's how it usually helps us.

Survey respondents described cases in which they helped clients reconnect to alternative-to-incarceration programs in lieu of jail by using information from the clinical summaries. One defense attorney said, "For the client, the specific program recommendation (Bridge Back to Life) in the clinical summary was very helpful. It became part of the CD [conditional discharge] the client received in lieu of 30 days in jail." Another defense lawyer who used the clinical summary at arraignment said that her "client took a plea to CASES [an alternative-to-incarceration program]."

Without corroborating information, judges are less likely to trust defendants' own statements that they are in treatment or participating in a program. A clinical summary issued by NYC Health + Hospitals staff that is based on detailed clinical records of a person's recent or current engagement in treatment can ease a judge's reservations about releasing a person to the community. One focus group participant stated:

...in an arraignment situation where everything's happening fast, it's night time, we're not in a position to be able to figure out where [a client is in treatment]. And then you go in front of a judge, and you say, 'Judge, my client is in a drug program.' [And the judge replies] 'Well, who told you that?' [The defense attorney answers] 'My client.' Well...you know the judges aren't putting a lot of faith in that. Really what the clinical summary provides is the ability for you get up there and say, 'The Department of Health has confirmed [client's self-reported information]' and it absolutely made a difference.

Public defenders also said that in cases that resulted in a conviction, clinical summaries mitigated sentencing decisions. One defender recounted that she had used the clinical summary when advocating for a conditional discharge to show that the client could quickly reconnect with a community treatment program, despite the prosecutor's argument for jail time. The "DA [district attorney] would offer jail time on a case, but if we can convince the judge that the client is actively participating in a program and this has

been verified by an independent agency, the judge sometimes takes that into consideration and may release the client on a conditional discharge.”

Another attorney described an instance when she used information from a clinical summary to help influence the arraignment outcome:

I had a misdemeanor case where basically all I had to do was reiterate what was in the clinical summary... that my client has participated in this program, successfully completed this program, he's dealing with these issues, he's on these medications, he goes to counseling ...and I was able to present that to the judge to show that he's trying to stabilize his life, and he does have human connections and people...and people are there to help him.

Most defense attorneys who completed surveys (53 percent) reported that clinical summaries were especially useful at later stages in a case. As one supervising attorney put it:

At arraignments, they're [prosecutors] pretty much reading a script. Either the recommendation is already written down in the file or they have their guidelines. If you have a more experienced prosecutor, they could vary the offer if they hear something compelling, but I would say that happens a minority of the time. Now at post-arraignment you are dealing with the prosecutor who is now in charge of that case for the next several months, and so certainly I think that it should have an impact on them and certainly it can't hurt.

Another public defender said that information from clinical summaries saves defense agencies time and resources otherwise expended to gather background information on the clinical needs and treatment service histories of their clients for post-arraignment negotiations with prosecutors:

And if you're talking about a case where a person's held on bail and you have to go back to court five days later for the [Criminal Procedure Law Section] 170.70 date, or the [Criminal Procedure Law Section] 180.80 date [for a preliminary hearing], having that information already identified, now you're using it to negotiate with the prosecutor, you know... now you're one leg up in terms of being able to identify and get more records. So, it's absolutely useful information.

A different public defender reported a case in which the information in the clinical summary helped mitigate a jail sentence for a client with a lengthy criminal record and created an opportunity to connect him with mental health services:

This person had a horrible record, long criminal record... and the prosecutor, on a misdemeanor, was offering a year in jail. It was a judge who was not the most defense-oriented judge. This was a case where without the summary, they thought the judge would have offered about 90 days in jail...and instead got 15 days in jail. And it was 100 percent based on being able to say, 'The Department of Health has confirmed...' that despite the person's long history of drug use and long misdemeanor criminal record that the person was trying. That the person as recently as a week earlier was still trying to get help.... And it had an impact.

Defenders' use of clinical summaries depends on a number of factors.

In cases involving minor misdemeanors or low-level offenses that are likely to be disposed at arraignment, public defenders said they rarely introduced information from the clinical summaries. In some situations, bringing the client's mental health problems to a judge's attention at arraignment makes it more likely that the person will be denied bail or detained post-arraignment. For example, a supervising attorney overseeing large numbers of arraignments for low-level offenses said, "Lots of times, I handle minor cases that get disposed of at arraignments, like consumption of alcohol or walking between the train cars, things like that. Those cases get dismissed or dismissed and sealed in six months, and having the information [clinical summaries] served really no purpose." In contrast, another lawyer stated, "In the assault context, the criminal contempt context, maybe if it's a sex-related misdemeanor...lawyers are gonna be very careful about sharing that kind of information. So I think it's driven more by the charge."

A supervising attorney described a situation where it is not useful to raise mental health issues contained in the clinical summaries to judges during arraignment:

If we have a transitional homeless person, charged with assault of a stranger and the write up is talking about his mental health

problems, that's probably something that my lawyers aren't going to want to use at arraignment, because quite frankly the judge may say 'Oh, so not only did he get into a fight with a stranger but he's mentally ill. I think I'm gonna send him to jail.'

Another lawyer described how evidence of a client seeking treatment for a substance use disorder is more likely to mitigate sanctions for property crimes than for violent crimes:

These things are very charge-specific. A substance abuse history, or a documented effort of trying to get help for your addiction goes a long way toward the property crimes and toward drug crimes. [But] in the context of a domestic violence case, probably not.

Furthermore, several attorneys said that they were reluctant to bring up a client's mental health issues to prosecutors or judges without evidence of a viable option to connect a client to community treatment services. One defense attorney stated, "Having a written-down diagnosis so early on is very helpful if the case is going to go forward. But if you bring up mental health as a mitigating circumstance [at arraignment] but don't have a solution, that can actually be problematic."



Conclusion and future directions

Each day, hundreds of people with acute and chronic behavioral and physical health conditions are arrested and booked into the city's justice system, often for low-level, quality-of-life offenses. Whereas traditional procedures in the city's central booking facilities result in cursory assessments of health needs and overreliance on emergency rooms to treat common medical ailments, this evaluation demonstrates that the EPASU has created new opportunities to meet the health needs of people passing through Manhattan criminal court. In particular, creating

Connecting the city's and state's health information technology infrastructure allows nurse practitioners to confirm self-reported health issues, uncover undetected health problems, and triage medical care with providers in other community and correctional settings.

new capacity to identify, diagnose, and treat common ailments in central booking helps ensure that people who are arrested receive thorough clinical assessments and timely access to care prior to arraignment. Connecting the city's and state's robust health information technology infrastructure, ECW and PSYCKES, allows nurse practitioners (NPs) to confirm self-reported symptoms, diagnoses, and medications, uncover health problems that may otherwise go undetected, and triage medical care with providers in other community and correctional settings. Having NPs in central booking who are licensed to dispense medications for prevalent chronic conditions, such as asthma and high blood pressure, allows them to promptly alleviate patients' symptoms and discomfort and reduces the burden on police and city hospitals associated with unnecessary

hospital visits. And having social workers on-site to identify people with a mental illness or substance use disorder and transmit summaries of their diagnostic, treatment, and social service information to their attorneys prior to arraignment is one tool that can help divert people with behavioral health problems away from jail and into community-based treatment.

However, the findings also revealed a few strategies for city officials to consider that could improve the model in the future. First, although the EPASU was envisioned as an intervention to connect people to community-based care and supports, including primary care, mental health and substance use treatment, and housing services, more can be done to make the EPASU an effective outlet for health-promotion interventions and to strengthen linkages between the EPASU and community providers. Increasing the number of staff devoted to these goals may be a necessity. EPASU NPs, diversion liaisons, emergency room physicians, and public defenders alike stressed that having more social workers or community health workers based in central booking would translate into greater success in helping people to access health care, housing, and other vital social services regardless of the outcome of their case. Currently, the social worker's focus is identifying people who are candidates for jail diversion. Employing another social worker or community health worker devoted to strengthening EPASU capacities for outreach, communication, and referrals from central booking to healthcare and social service providers in New York City neighborhoods could improve other outcomes.

Second, there is work to be done to increase the EPASU's ability to serve as an effective conduit for diversion opportunities. Public defenders widely endorsed the usefulness of having clinical summaries on their clients with a mental health or substance use problem. Further research could determine why only half of people identified as having a behavioral health disorder consented to sharing a clinical summary with their public defender prior to arraignment. It could also shine light on whether there are significant differences between people who consent to share their information and those who do not.

Third, given the many benefits associated with expanding the capacity to diagnose and treat common ailments, such as asthma, alcohol withdrawal, and hypertension in central booking, the EPASU is limited by its inability to treat certain medical conditions that high numbers of EPASU patients report, such as diabetes and opioid dependencies. However, the EPASU as currently structured is still not equipped to treat such medical conditions. NPs and police officers voiced strong support for continuing to expand the types of

treatments and medications available in central booking to alleviate patient suffering and further reduce unnecessary transports to hospital emergency rooms. More specifically, they stressed the importance of investing in equipment and medication for treating symptoms of diabetes, and the potential benefits of being able to continue patients on medication assisted therapies such as methadone and buprenorphine to alleviate discomforts associated with opioid withdrawal. Relatedly, another area of potential growth for the EPASU is to forge partnerships with harm-reduction organizations to develop strategies for distributing educational materials and making referrals to people who use drugs on where to find syringe access programs, drug treatment, naloxone, HIV and Hepatitis C testing and treatment, and assistance with housing, employment, and health insurance enrollment. Continuing to expand the array of clinical services, medications, diagnostic tools, and technological options (such as telemedicine) will further enhance the improvements introduced in the pilot.

Eliminating health disparities across the justice continuum and reducing the overrepresentation of people with physical and behavioral health needs in city jails requires unwavering commitment from public health and justice leaders. The EPASU is one important tool for advancing this mission and exemplifies the benefits of focusing on the mutually reinforcing goals of health promotion and jail diversion in the pre-arraignment setting.

Indeed, until recently, the time a person spent pre-arraignment in Manhattan had largely been overlooked as an opportunity to increase access to healthcare despite the fact that thousands of people pass through the city's central booking facilities—gateways to both jail and the community—every year. By prioritizing the physical and mental health needs of people swept into the city's criminal justice system before first court appearance, policymakers can change the trajectory for people who would otherwise languish in jail without alleviation of their suffering or return to the community without connection to needed services and supports. Continuing to strengthen the capacity of the EPASU will not only improve outcomes for many people but can also ultimately help reduce the harmful use of the city's jail system as a de facto holding area for some of the city's most vulnerable residents.

Appendix

Table 6

Summary of EPASU self-report data May 18, 2015 to October 31, 2016

	N	Percent
Total number of patients seen	10,796	
Weekly average number of patients seen	149	
Refused any screening	101	1%
Total number of Level 1 screens	10,695	99%
Total number of Level 2 screens	3,053	29%
Currently sick or injured	727	7%
In hospital in past week or prior to booking	1,532	14%
for medical reason	1,087	71%
for psychiatric reason	240	16%
for medical and psychiatric reason	202	13%
reason missing	3	
Current medical problems		
Breathing problems	772	7%
Dialysis	2	0%
Hepatitis C	88	1%
Seizures	147	1%
Diabetes	260	2%
HIV/AIDS	108	1%
Heart problems	422	4%
Behavioral health questions in Level 1 screening		
Prescribed psychiatric medications in past three months	418	5.0%
Drink alcohol every day or most days	951	8.9%
Withdrawal symptoms when stop drinking alcohol	224	23.6%
Use antianxiety medications every day or most days	311	2.9%

	N	Percent
Behavioral health questions in Level 1 screening (continued)		
Withdrawal symptoms when stop taking antianxiety medications	170	54.7%
Currently in drug or alcohol program	352	4.0%
Currently in mental health program	164	2.0%
Currently living in supportive housing or residential program	687	9.0%
Ever treated for alcohol or benzodiazepine withdrawal	389	3.6%
Suicidal thoughts within past three months	197	1.8%
Behavioral health assessment conducted	2,788	26.1%
Behavioral health questions in Level 2 screening		
Currently taking any psychiatric medications	760	7.1%
Ever done anything to end life	181	1.7%
Ever done anything to end life in past three months	57	0.5%
Current suicidal thoughts	48	0.4%
Currently hearing voices	46	0.4%
Currently in treatment	601	5.6%
Triage information		
Number of people sent to jail	2,298	
Total number who received triage flag	545	24%
Type of triage flag:		
Diabetes	72	13%
Alcohol withdrawal	200	37%
Stat mental health assessment	236	43%
Intent to hurt someone	6	1%
Initiate suicide watch	16	3%
Other	148	27%

Endnotes

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- 8 Medical clearance procedures are a standard component of booking procedures that take place after an arrest and before an arraignment. Depending on the jurisdiction, nurses, technicians, or law enforcement officers administer a brief screen to determine whether a person has an urgent health problem that requires transfer to a hospital prior to their first court appearance.
- 9 New York Criminal Procedure Law Section 170.55.
- 10 Criminal Procedure Law 140.20 requires police to present arrestees to the courts "without unnecessary delay"; see *People ex rel. Maxian v Brown*, 77 N.Y. 2d 422 (N.Y.1991). Hospital escorts, especially for people experiencing psychosis, are a common "acceptable explanation" for a delay in the arrest-to-arraignment process. Police routinely escort people who are exhibiting signs of psychosis or emotional stress to a comprehensive psychiatric emergency program (CPEP) for an evaluation. NYC Health + Hospitals have reported that 5 to 10 percent of people escorted to CPEP by law enforcement for an evaluation are ultimately determined too sick and unable to proceed through central booking to arraignment. Typically, male patients are civilly committed to the Bellevue Jail Psychiatry Service (BJPS) in Manhattan and women are admitted to Elmhurst Hospital in Queens for treatment. While hospitalized, these patients fall under the legal supervision of the public hospital and the Department of Correction, rather than the NYPD prior to arraignment. Eventually, these people are arraigned in one of three ways: hospital arraignments, video arraignments, or discharge from BJPS custody to the NYPD (in which case they return to central booking and are arraigned in the courthouse). See Susan M. Gray, Christopher W. Racine, Christopher W. Smith, and Elizabeth B. Ford, "Jail Hospitalization of Pre-arraignment Patient Arrestees with Mental Illness," *Journal of the American Academy of Psychiatry and the Law Online* 42, no. 1 (2014): 75-80.
- 11 Mayor's Task Force on Behavioral Health and the Criminal Justice System, Action Plan, New York City (2014), <https://perma.cc/9SUK-MHKS>.
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- 13 In Staten Island, most people are held in a pen at the police station house. During some hours, police bring people arrested in Staten Island to Brooklyn Central Booking Facility.

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- 14 All New York City boroughs except for Staten Island have central booking facilities.
 - 15 People waiting in central booking are legally under the jurisdiction of the NYPD until they are arraigned. At that time, if they are detained, they are transferred into the legal custody of the Department of Correction (DOC). However, in all central booking facilities except for Brooklyn, DOC officers supervise people waiting to see the judge after the arresting NYPD officer escorts them through fingerprinting, the health screen, and an interview with pre-trial services. Often, DOC refuses to supervise a person if he or she is known to have a psychiatric problem or other medical condition. In these instances, these people are held in cells that are overseen by the NYPD until arraignment. People arrested in Staten Island are booked and held in custody at a police station prior to arraignment, or at times taken to Brooklyn's central booking facility.
 - 16 *Grubbs v Brown*, No. 92 Civ. 2132 (S.D.N.Y.); cited by Legal Aid, who brought the case, <https://perma.cc/FPR5-5PAE>. Note that the final legal settlement does not list Brown as a party. Eran Y. Bellin, David D. Fletcher, and Steven M. Safyer, "Association of tuberculosis infection with increased time in or admission to the New York City jail system," *JAMA* 269, no. 17 (1993): 2228–2231.
 - 17 During the planning stages for the EPASU, Vera and CHS learned that most patients brought to the emergency room are not admitted and are discharged. Everyone cleared to proceed is subsequently returned to central booking, where they provide PASU clinicians with documentation of their hospital clearance.
 - 18 Charisma Miller, "Conditions at Brooklyn Central Booking, lack of medical attention blamed for woman's death," the *Brooklyn Daily Eagle*, August 26, 2013, <https://perma.cc/4A5H-2D2R>.
 - 19 This period of the day was selected because it is a lower-volume tour when there are fewer arrests. At the outset, it was imperative to ensure that more thorough health screening procedures would not cause delays in the arrest-to-arraignment timeline. During the planning stage, Vera and CHS analyzed average arrest-to-arraignment times for different tours using data derived from the Court-Stat System—a tool that allows the judicial system to monitor daily averages in the timing from arrest to arraignment. This system was spearheaded by Judge George A. Grasso as a measure to address systemic problems in court processing in recent years.
 - 20 Patients not disclosing any health problems to the PCA are cleared to proceed and escorted to a holding cell overseen by the DOC until arraignment. When the volume of people being booked into the facility is high, then the NP and PCA may both conduct Level 1 screens. Only the NP conducts Level 2 screens.
 - 21 Under New York law, NPs must be a registered professional nurse who has completed graduate training and is certified by the New York State Education Department. NPs are licensed to diagnose medical conditions, prescribe medications, and deliver certain treatments.
 - 22 Health homes, created through the Affordable Care Act (ACA), are virtual entities comprised of multidisciplinary professionals across the healthcare field to deliver personalized, comprehensive care to Medicaid beneficiaries with chronic and acute physical and mental health problems. Health home care managers coordinate tasks and referrals among provider networks and community institutions to help Medicaid beneficiaries navigate the complexities of the healthcare system. See Patient Protection and Affordable Care Act, Section 2703.
 - 23 CHS received additional funding to expand the EPASU pilot to 24 hours, seven days a week in Manhattan. Therefore, this process evaluation includes analysis of the pilot up until the program expansion on November 1, 2016.
 - 24 Defenders completed and returned 145 of the 417 surveys (a 35 percent response rate). Seventeen respondents who completed surveys reported not receiving a clinical summary for a client. Three public defense agencies represent indigent defendants at arraignments in Manhattan's criminal courts: The Legal Aid Society (LAS), New York County Defender Services (NYCDS), and the Neighborhood Defender Services of Harlem (NDS). Our sample is representative of the percentage of defendants that each agency represents on average: 79.3 percent LAS (n=115), 13.8 percent NYCDS (n=20), 4.1 percent NDS (n=6), 2.7 percent (n=4) unknown or missing.
 - 25 Focus group participants stated that eight out of 50 attorneys handling arraignments for one of the agencies reported having received or used the clinical summaries. At the outset of the process evaluation, the researchers had difficulty getting survey responses from attorneys regarding the utility of the clinical summary in advocating for their clients.
 - 26 NPs are not able to determine who will be sent to jail, and therefore enter a triage flag for anyone who would benefit from expedited medical intake or has a medical condition that needs follow-up if sent to jail post-arraignment.
 - 27 Diversion liaisons did not begin collecting data on patients' housing status until July 2015. The reported estimate of homelessness is an average that includes data from 43 weeks out of the year.
 - 28 In March 2016, diversion liaisons began searching PSYCKES in addition to ECW to identify health-home patients. With patient consent, liaisons can contact care managers. Otherwise, the liaison enters health home status into the EPASU database.
 - 29 CHS is not legally required to ask permission of people seen in the EPASU before searching ECW for existing health records from a prior incarceration, because CHS oversees medical services in all city jails and in the EPASU, and accessing patient records is necessary for care coordination. In contrast, unless CHS can confirm that a patient provided its clinicians with prior authorization to access their information in PSYCKES, EPASU clinicians must obtain each person's consent before querying that database.

Endnotes

- 30 During the planning stages for the pilot, CHS and Vera learned that approximately 60 percent of patients escorted to a hospital prior to arraignment do not receive any care and are quickly discharged.
- 31 As described earlier, in the traditional PASU system, police officers frequently spent an entire shift waiting for the person they arrested to be evaluated and cleared to proceed through arraignment; this often diminished the capacity of the police department to respond to other 911 calls and also resulted in overtime pay.
- 32 While planning the pilot, Vera and CHS examined data from E-Arraignments, a citywide data system that measures the average time from arrest to arraignment in each borough to ensure that increasing the length of health screening procedures would not lead to significant delays in court process times. This database includes time stamps for events that take place from the time of arrest through arraignment. Using this system, the researchers conservatively estimated that people spend about eight to 10 hours in a holding cell after being screened in the PASU, waiting to be arraigned. Therefore, expanding the length of the health screening process will not breach legal requirements that arraignments occur within 24 hours of arrest.
- 33 This reflects the arrest charge and not the prosecutor's filed charge.
- 34 As the result of changes in data collection protocols, we did not collect arrest charge information on every patient identified as a potential diversion candidate. These distributions are based on a subsample of 1,506 cases.
- 35 EPASU patients included in this subset included a convenience sample of those with an existing record in ECW, which meant they had at least one prior incarceration in New York City since 2011. Every person admitted to New York City jails receives a medical intake and therefore has a record in ECW. Moreover, ECW includes data on individual arrest and jail incarceration histories, in addition to health-related information. Thus, for this analysis, CHS researchers compared all EPASU patients with an ECW record who could be successfully matched using the current arrest identification number.
- 36 This was derived from ECW jail admissions.
- 37 There were several weeks from May 15, 2015 to October 31, 2016 where a diversion liaison was not present in the EPASU because of staff vacations and temporary staff vacancies. For instance, diversion liaisons did not conduct interviews with EPASU patients from December 7, 2015 through January 4, 2016 because of personnel changes.
- 38 Diversion protocols began approximately one month after the pilot launched in May 2015. Additionally, for a five-week period at the end of 2015, there were no diversion activities as the result of personnel changes among the liaison staff.

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