CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HEALTH JOINTLY WITH COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITY, ALCOHOLISM, SUBSTANCE ABUSE AND DISABILITY SERVICES, AND COMMITTEE ON FIRE AND CRIMINAL JUSTICE SERVICES

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May 26, 2016
Start: 10:15 a.m.
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HELD AT: Council Chambers - City Hall

B E F O R E: COREY D. JOHNSON
Chairperson

ANDREW COHEN
Chairperson

ELIZABETH S. CROWLEY
Chairperson

COUNCIL MEMBERS: Rosie Mendez
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A P P E A R A N C E S (CONTINUED)

Patsy Yang, Senior Vice President
Correctional Health Services
New York City Health and Hospitals

Homer Venters, Chief Medical Officer
New York City Health and Hospitals

Patrick Alberts, Senior Director
Policy and Planning Department
New York City Health and Hospitals

Levi Fishman, Associate Director
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Elizabeth Ward, Director
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Ross MacDonald, Chief of Medicine
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Dr. Nicole Adams, Deputy Commissioner
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Elizabeth Ford, Chief of Service for Psychiatry
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Gary Strong (sic), Assistant Chief
Commanding Officer
NYPD Criminal Justice Bureau

Lillie Carino Higgins
SEIU 1199

Riley Doyle Evans
Jail Services Coordinator
Jail Services Division
Brooklyn Defender Services

Jennifer Parish, Director
Criminal Justice Advocacy
Mental Health Project
Urban Justice Center

[sound check, pause] [good morning]

COMMISSIONER CHANDLER: Good morning and welcome to today's joint hearing on evaluating recent changes in the delivery of health care in the City Correction facilities. I'm Council Member Elizabeth Crowley, the Chair of the Fire and Criminal Justice Services committee, and I'm joined today by Council member Andy Cohen, who is the Chair of Mental Health, Development Disability, Alcoholism, Substance Abuse and Disability Services Committee, and soon we will be joined by Council Member Corey Johnson, who is the Chair of the Health Committee. This is the third hearing on correctional health this term. The first was held in June of 2014 and the second of March 2016. So it is fitting that we have a hearing today on this topic. I'd like to also recognize other council members who have joined us. We have Council Member Rosie Mendez, Council Member Peter--sorry--Council Member Peter Koo, Council Member Paul Vallone, and one of our newest Council Members Mike--Joe Borelli. Please forgive me. In addition to this oversight portion of the hearing, we will also be hearing a package of legislation related to delivery and effectiveness of health and mental health

services in city jails, as well as a resolution calling on the federal government to continue Medicaid coverage for individuals while they are incarcerated in correctional facilities. The committees would like to update--would like an update on the transaction and the transition of medical service providers, which up until December 31st, 2015 have been provided for by a for-profit company under contract with DOHMH, and which are now managed by New York City Health and Hospitals. The committee--the committee is also interested in learning about the new role of a safety operations officer, the coordination between H & H and the DOC, and the extent to which health information is shared between the two agencies. The committees are also interested in discussing how the proposed legislation will help address these important issues. Today we look to examine and evaluate how such changes have affected the quality of healthcare in city jails as well as impact-impacts felt throughout the Criminal Justice System. Proposed Intro 852-A, which I sponsored addresses a troubling problem reported in the DOC facilities, inmates not receiving access to necessary care. This bill would require DOC to escort inmates

who have requested sick call to a medical clinic within 24 hours of the request and ensure inmates wait no longer than two hours to receive medical care. Intro 1013 and Intro 1014 are both sponsored by Council Member Johnson and Council Member Johnson will speak to those bills when he comes. Intro 1064 is a bill that I also sponsored, which will require the DOC to conduct a yearly evaluation of the effectiveness of any inmate programming it utilizes, and to submit a summary of this evaluation to the Council and to the Mayor that would include the data on the amount of funding such programs receive, the number of individuals served, a description of the services provided, and the data related successful completion and compliance rates where applicable. Council Member Laurie Cumbo has introduced 1144, which we'll also hear today. Introduction 1183 is sponsored by Council Member Cohen, who will speak about that introduction, and lastly Resolution 461, which I sponsored calls for a change in the federal law that prevents Medicaid from covering health costs incurred during incarceration. There is no reason that a person whose medical costs are covered outside the confines of a correctional facility should not be

covered inside as well. I look forward to today's testimony from the Department of Correction as well as Health and Hospitals, and I now would like to recognize Council Member Cohen for his opening remarks.

CHAIRPERSON COHEN: Thank you, Chair Crowley. [coughs] Good morning. I'm Council Member Andrew Cohen, Chair of the Council's Committee on Mental Health, Developmental Disabilities, Alcoholism, Substance Abuse, and Disability Services. I am pleased to be holding this join hearing today with Council Member Crowley, Chair of the Fire and Criminal Justice Committee and Council Member Johnson, Chair of the Health Committee. My fellow co-chairs and I held our last oversight hearing on Rikers Island and Healthcare Services in city correctional facilities over a year ago. Since then, there has a seismic change in the administration of-- of care on the Island. Thus, today is our second oversight hearing on healthcare services in city correctional facilities, but the first with New York City Health and Hospitals as the provider. We are eager to discuss how those services have changed since New York City Health and Hospitals took over

the responsibility, and how the future of Health and Hospitals' Plan to provide health care at city jails. I'm looking forward to learning how Health and Hospitals intends to improve the care for the mentally ill and those suffering from substance abuse issues. New York City Health and Hospitals has spoken before about a five-year capital plan for correctional health that they will make available to this Council. I am hopeful that this plan will prioritize the mental health of individuals in city jails as well as those individuals suffering from addiction. Today, we are also hearing a bill that I am sponsoring, Intro 1183. Intro 1183's goals are threefold. First and foremost is to ensure individuals who are entering the justice system are treated in a humane and sensitive way. To that end, this bill would require the DOHMH to ensure every arrestee brought to a criminal court for arraignment is screened for possible mental health issues prior to being arraigned. The agency will create a report for any arrestee so identified. The agency would also be required to request the health information of any arrestee treated by any healthcare provider while in NYPD custody. Additionally, legislation would

require the NYPD to create a report whenever a person under arrest either exhibits symptoms of mental illness or is treated by a healthcare provider while in police custody. These reports are to be transferred to DOHMH in a timely fashion. Such information, mental reports and mental health reports created by NYPD would all be sent to the Department of Corrections to ensure the continuity of care for inmates admitted to the custody of the Department of Corrections. I think Council Member Crowley has acknowledged all the members except we've been joined by Council Member Grodenchik. Lastly, I want to thank the Committee staff and Nicole Aberdeen (sic) our Legislative Analyst; Michael Benjamin who's around here some place, and Janette Merrill our Finance Analyst, and as always, my own Legislative Director Kate Diebold. Thank you.

CHAIRPERSON CROWLEY: And--and before we ask the departments and the Administration to give their testimony, we have to swear you in. So anyone who is giving testimony, you could raise your right hand. Do you affirm to tell the truth, the whole truth and nothing but the truth in answering

questions that Council Members pose to you, and in your testimony today?

PANEL MEMBERS: [off mic]

CHAIRPERSON CROWLEY: Okay, and please being once you're--

DR. PATSY YANG: Sure. Good morning, good morning Chairpersons Cohen, Crowley and Johnson and members of the Mental Health, Health and Criminal Justice Committees. I'm Patsy Yang. I'm Senior Vice President for health--Correctional Health Services at New York City Health and Hospitals. I'm joined at the table by Homer Venters, who's our Chief Medical Officer, and to my right Patrick Alberts who heads up our Policy and Planning Department, and to his right Levi Fishman who heads up Public Affairs in Correctional--

COUNCIL MEMBER VALLONE: [interposing] If you could just get closer to the mic that would be a big help. Thank you.

DR. PATSY YANG: And I also want to recognize the very distinguished and committed members of our senior team are in the next few row in the audience. In the five months between the time Health and Hospitals assumed responsibility for--for

CHS on August 9th of 2015, and the December 31st, 2015 expiration of the Corizon contract, we successfully created new division of Correctional Health Service or CHS. That's a $235 million program with 1,500 employed and 24/7 operations in 12 jails citywide.

CHAIRPERSON CROWLEY: I'm sorry. I'm-- I'm having a hard time hearing you. If you can pull the microphone closer that would be great.

DR. PATSY YANG: I'm going to be very close. [laughs] Okay, is that--is that better? Okay. [coughs]

CHAIRPERSON CROWLEY: [off mic]

DR. PATSY YANG: I'll try. Is that better?

CHAIRPERSON CROWLEY: [off mic] Just-- yes. Give me one moment and then we'll see.

DR. PATSY YANG: Okay.

CHAIRPERSON CROWLEY: [off mic] That's perfect.

DR. PATSY YANG: Good. Thank you. During this transition period, there were no lapses in coverage and no disruptions in patient care. To achieve this, we worked closely with representatives

from the Mayor's office and City agencies to clarify governing structures, resolve legal liabilities and ensure a budget neutrality to Health and Hospitals. Furthermore, really great personnel and credentialing license and files are--and conducted background checks for each of more than 1,200 Corizon employees. Simultaneously, we negotiated with each of our four union partners, Doctors Council and NYSNA, 1199 and DC37 for the smooth transfer of nearly 300 staff by August 9th, and for the employment by January 1st of over 1,000 Corizon staff to whom we offer jobs beyond December. At the time of both transitions, all union staff whom we selected to retain, were covered by collective bargaining with salaries, leave balances, pensions and health benefits preserved. Despite the complex challenges presented by the transfer to Health and Hospitals and disengage--disengagement from Corizon, we didn't want to miss an opportunity to begin building the framework for our service. An immediate and fundamental change has been to unify all management from senior executive to jail site leadership into one team with Health and Hospitals. This replaces the previous model of an oversight agency and an entire separate vendor. This sets new

expectations and replaces a culture of inherent distrust with a new culture that emphasizes that we're all in this together. Moving away from the for-profit vendor to a public healthcare system has also enabled us to recruit and retain more mission driven professionals. To that end, we brought psychiatrists, psychologists and social workers who devoted their professional lives working in the field of correctional health in institutions such as Sing-Sing, Bridgeport Community Correctional Center, Lincoln Hills Juvenile Justice facility and Bellevue Hospital. We've integrated our mental health and discharge planning staffs into one professional psychiatric social service--sorry--social work service. This service is led by a newly hired licensed clinical social worker with psychotherapy background. These changes have already resulted in positive outcomes from the quality of discharge readiness services and connections with community agencies to our ability to recruit high quality staff. In addition, we've--we've ensured that we now have deputy medical and nursing directors responsible for specific jails and site medical directors each of whom perform some patient care. We've also created

and filled key leadership position. Heading up the new Department of Substance Abuse Services will be an addiction medicine physician who's working an academic affiliate caring for homeless patients. She will help optimize the clinical efficacy of our extensive substance abuse treatment programs, and keep the care that we provide on the cutting edge.

We've created a new position for clinical quality improvement to singularly push us constantly to improve the quality of care we provide. Under his guidance, we've overhauled our quality assurance and quality improvement structure and processes and we're integrating that into the robust quality assurance structure of Health and Hospitals

We've recruited a Director of Clinical Education who will train medical staff and promote a culture of continuing education. A medical expert in Geriatric and Quality of Care who will manage the care of our elderly patients. We have a designated nursery coordinator who meets with every pregnant woman at the Rose M. Senior Center. She pre-screens all pregnant women for eligibility for nurse replacement and reinforces the importance of prenatal care and breast feeding. We've increased our

education efforts establishing medical and mental health programs, and for continuing education credits across multiple disciplines, and we're working to expand with a academic--we're working with academic partners to expand educational collaborations for trainees. The opportunity to create a unified approach in one of the nation's largest correctional health services has also attracted professions with expertise in administration operations of correctional health. These are areas previously managed by Corizon. On the administrative side, we built our in-house system of employee review and tracking to ensure that anyone who is working at CHS has the requisite credentials, licenses and background clearances.

We've created a new Department of Policy and Planning comprised of epidemiologists, data analysts and patient relations experts who coordinate incident complaint investigations responses to external inquiries ranging from patient requests to federal requests and data collection analysis and reporting. Policy and planning also guides the implementation of key initiatives involving external partners including our enhanced pre-arraignment

screening at Manhattan Detention Center, our collaboration with Health Home citywide, and our efforts to ensure Medicaid coverage for CHS patients. Our Operations Department led by a recently recruited professional with significant administrative and nursing experience in correction settings is rolling out new standards and systems for every aspect of the operation that supports the provision of clinical. Everything from staff and patient scheduling to inventory management is being overhauled to increase accountability and productivity. Our Operations team--sorry--that's better. Okay. Our Operations team has spearheaded critically important improvements to staff safety in the jails. Earlier this year we conducted the first every safety survey of every clinical space in the jail system to create baselines for necessary improvements. We are working with DOC and the health unions to determine how we can operationalize improvements to safety. With the assistance of the City's Office of Labor Relations, we've convened a pioneering Workplace Safety Committee that includes DOC, COBA and the four health unions, and focuses on creating a safer work environment for all staff in the jails.

Additionally, operations has designated a CHS Safety Officer and has set up CHS Safety Report Line in the clinic area so that staff concerns can be directly communicated to us for follow up. Safety in the jails cannot be discussed without acknowledging our central the Department of Correction at an executive recruiting our strategic directions and critical matters and the weekly to jointly plan and problem solve. With the direct support of Commissioner Ponte, DOC and CHS staffs at our most challenging jails meet daily to discuss the most pressing issues surround safety and patient reduction. Weekly meetings of custody and health and jail leadership are also held to review and plan for the management of the most challenging patients system wide.

We also established the Joint Assessment Review or JAR process to foster better coordination with DOC or in significant incidents that affect staff, patients and facilities. Under the JAR, each agency conducts its own investigations, but then we come together to share respective findings and identify opportunities to jointly reduce the--the likelihood of recurrence. Collaboration with DOC and the JAR process has already resulted in policy and

operational changes that should help improve access to care and reduce the likelihood of bad outcomes. As with our workforce and infrastructure, we also began making improvements in service delivery even while we were managing the transition. We worked with the Health and Hospitals Health Plan, Metro Plus to establish the presence at the Visit Center on Rikers Island. Each Friday since mid-December, last mid-December, people who are leaving jail or visiting someone at Rikers can stop at the Metro Plus for assistance in getting health insurance. In the 17 weeks since we began this collaboration, 77 of our patients or their families got health insurance coverage with 96% of those individuals choosing to enroll in Metro Plus.

Last month, we launched a Telehealth pilot program, which is the first ever in the Health and Hospital system. In collaboration with the infectious disease service at Bellevue Hospital, CHS now offers audio-visual consultation to patients at jail locations. Telehi--Telehealth sites have been established and tested in three jails, and physicians at Bellevue sites have the ability to view the CHS

Electronic Health Record to facilitate clinical consultation.

Also, last month, we launched Safe Landing, a new reentry group for sentenced individuals with mental health needs. The groups providing opportunity to discuss challenges people may face as they reenter their community such as stress related to reuniting with family or friends. Led by our Psychiatric Social Work Service, Safe Landing helps patients learn how to identify triggers and develop mechanisms so that they have the best chance of bringing positive change for themselves when they leave jail. [coughs] I'm very excited to announce that this coming Wednesday, June 1st, we will be opening our new Correctional Health Services Assistance Center located in part of our facility across the street from the Rikers Island Bridge. The center is a one-stop location to help people who are leaving jail and their families get connected to services in their community. Initially, the center will be staffed by representatives from CHS' Reentry and Continuity of Services, Health and Hospitals MetroPlus, Gotham Health and the Health and Hospitals Health Home. Over time, they expect to expand beyond

these four anchor programs to include key city and private agencies to improve the transition of our patients into the community.

Being part of the nation's largest public healthcare system offers many opportunities to improve the continuity of and access to care. For example, we've been working with Gotham Health on a number of fronts including connecting patients to Gotham providers when they are released. We strengthened our relationship with the Health and Hospitals Health Home by exchanging information about known patients and dedication resources to facilitate care coordinate--coordination for eligible Medicaid patients who are dealing with multiple health issues. Most recently, the team at Bellevue Hospital Center is granting us direct access to its clinic scheduling system so that we can streamline the process [coughs] for getting our patients appointments for world class specialty care. [coughs] Excuse me. All the important structural and systems improvements I described so far were accomplished with existing resources. In the coming fiscal year we will continue to examine existing processes and pilot new strategies particularly around patient production.

We will keep pushing ourselves to try different ways to address longstanding problems. Additionally, we have another transition ahead of us, namely, the disengagement from Damian Family Health Center, which is a contract service provider with the Lindsey Bain Center in the Bronx. The process will be similar to that which we undertook with Corizon, although on a smaller scale. It is our intention to ensure a smooth transition by the expiration of the Damian Contract on October 1st that results in no disruption in patient care. We are very excited that FY17 brings opportunities to bring significant changes in the we provide care. We are gratified to see that Mayor de Blasio's Executive Budget includes a commitment to change the way we care for incarcerated person. This five-year commitment will help us achieve our two main goals: To achieve--to increase the quality of and access to care we provide our patients while reducing challenges to and demands on security, and to increase continuity care during and following incarceration.

The Program for Accelerate Clinical Effectiveness or PACE units are housing units for inmates with serious mental health issues that

resulted in increased adherence to medical regimes, reduce injuries to patients and fewer uses of force. As with the first four PACE Units, these newly funded treatment units will be designed to bring high level behavioral services to specific cohorts of patients. PACE Units operate at annual cost of about--approximately $2 million, and the cost the new--new units will be equal to or less than each of the current units based on the blend of services in each setting. We're scheduled to open two PACE units each year, each fiscal year through 2020. Our Enhanced Pre-Arraignment Screening Unit, or EPASU, opened last may, and currently operates Mondays through Fridays from 6:00 a.m. to 2:00 p.m. in Manhattan Central Booking.

In the 11 months of operation almost 7,3000 individuals were screened for acute medical and behavioral health needs. Approximately 28% of those were referred to our nurse practitioner for more in-depth assessment and 3% or 59 of these 2,020 individuals were sent to the hospital for emergency treatment. Notably, 338 individuals with acute medical needs were treated by our staff on site at Manhattan Central Booking avoiding the need to

transport patients to the hospital and conserving important hospital, EMS and NYPD resources. Increased funding will allow us to cover all three shifts, and weekends at Manhattan Central Booking. Thanks to the Executive Budget, for the first time we'll have dedicated resources to ensure that we're able to treatment patients with Hepatitis C who are most in need. The prevalence rate for Hepatitis C in our--in our New York City Jails is estimated to be 12%, and this funding will allow us to treat more patients who are tested positive for the disease while with us, or her continuing treatment who--that was initiated in the community prior to their incarceration. We will also be able to [coughs] to significantly increase the number of mini clinics we currently operate close to or within housing areas. These satellite clinics bring our services closer to where the patients are thereby increasing access to needed services particularly in our larger jails. This--these units also reduce the challenges of patient movement and patient waiting.

Telehealth funding in the Executive Budget will allow us to greatly expand our pilot to sites, services, and uses of technology that increase

access to care and--and reduce the need for resource intensive and disruptive patient transportation. Our hope is to expand to other services within Bellevue as to other health--as well as to other Health and Hospitals locations. While Telehealth may not be appropriate for every patient, service or encounter it can offer greater access to urgent, specialty and routine care among the jail clinics as well as between the jails and the hospitals and even within a single facility where patient movement may be a challenge. [coughs]

Earlier this year, hundreds of CHS staff responded to an employee engagement survey that we sent out. The survey was conducted so that we could take the temperature of our work staff immediately after the transition where there had been a tumultuous and uncertain time for 1,500 individuals both personally and professionally. Of the hundreds of our staff who responded, 91% feel that the work they do is important and fully 93% are confident that CHS will be successful in coming years. I was and remain inspired by this level of shared optimism, commitment and determination that what we do is so important and that we can do things better. Leading

the charge were given in June of 2015 and achieving the transition without disrupting services are detrimentally affecting patient care, required Herculean efforts from our staff and all our partners both within and outside Health and Hospitals. At the same time, we also managed to lay groundwork for fundamental change in how we care for our patients. We very much look forward to building upon the changes that we've made to date, none of which could have been possible without the leadership and unwavering support of President Raju and the team at Health and Hospitals, the Department of Correction, this Administration and this Council.

Although this concludes my formal testimony, we were asked to provide feedback on some proposed legislation, and my colleagues from other affected agencies who are here and I would give additional feedback on the bills on today's agency. But first, I just wanted to briefly comment on the three bills that directly pertain to work that CHS currently performs. One is Intro 1064, and this bill would require DOC to report on providers delivering inmate programming, which is defined to include education, training or counseling regarding drug

dependencies. The substance abuse treatment services that current--that we currently offer CHS are among the most extensive that are offered by a correctional health system in the nation.

Intro 1013 would require DOC and the Department of Homeless Services, DHS, to place inmates who have been identified as having multiple arrests and have lived in a shelter into appropriate treatment, health and mental health programs immediately after discharge. As a part of our discharge planning activities, CHS already works with DHS as well as other agencies, some of whom are here, regarding the placement of a domiciled person who is being released into--from the jails.

Finally, Intro 1183 would require NYPD staff to observe and report on symptoms of mental illness and require DOHMH to conduct pre-arraignment mental health screening. As noted earlier, we, Correctional Health Services at Health and Hospitals currently run and will be expanding the enhanced Pre-Arraignment Screening Program at Manhattan Detention Center, which enables us to screen patients for medical and behavior health needs. For patients who don't go through our enhanced Pre-Arraignment

Screening program, Correctional Health Services currently operates comprehensive--provides comprehensive clinical evaluation on admission, which allow us to screen, diagnose and then often initiate treatment for a variety of medical and mental health issues. We're happy to discuss further how these services that we provide now could help address some of the issues that are raised the bills. I say thanks.

CHAIRPERSON JOHNSON: Thank you, Patsy. Thank you for the testimony. It's good to be with Chairs Crowley and Cohen chairing this hearing. I apologize that I was not here for the beginning of it. I am not going to read my opening statement, but just say that, you know, I'm really--I think we have a lot of tough questions for you. But before we get to those, I want to say that I'm really grateful that the city made a--a proactive decision about a year ago to end Corizon's contract when it--when it was completed, and to transfer this to New York City Health and Hospitals, HHC at the time. And so the--the work that you outlined I think is really good work that you've been able to do in a short amount of time. But I do think that there are some things that

we have some pretty serious concerns about, and some of it may be DOC related. Some of it may be related to the Public Benefit Corporation. So I want to get into some of those questions, and then I want to turn it over to my colleagues who I'm sure have questions as well. So you talked about some of the priorities that you have that you've been working, the expansion of PACE, the Pre-Arraignment Screening, Hepatitis C expansion. Did Health and Hospitals identify other areas for improvement in Correctional Health Services? Where can you guys do better? Where are things lacking? Where do you need more funding?

DR. PATSY YANG: Thank you for the question. Our priority focus with--with--on our end and with DOC remain on production and--and safety, and there are number of--of pilots, for example, that we are currently operating. We're planning to--to try. We don't quite know whether they'll be successful or sustainable or replicable, but we are again trying and pushing ourselves to--to try different ways to address longstanding problems. We--we are examining our processes and seeing where our resources are, and where we can match them best with--with priorities. The funding that we've gotten

beginning in '17 will allow us to replicate known successes, and I'm hopeful that as quickly as we can get them up and running, and continue--continue to demonstrate their efficacy, that we can continue to work with the Administration to do additional changes.

CHAIRPERSON JOHNSON: So you can't tell me any specific area that you think there needs to be improvement on that you inherited? I'm not even blaming that on you guys. You guys inherited a really large complex difficult system that you and your team spent an enormous amount of time preparing for. People weren't happy with Corizon, which is why we stopped the contract with them. You can't give me any specific areas where you think we need to be doing better?

DR. PATSY YANG: We definitely can be doing better in many ways. Patient product--production is the--the biggest issue for us, and we're working with DOC on a--in an unprecedented level I think to--to address both safety issues and production. The--as a result of the job, which I had mentioned earlier, which is a joint review of our findings and processes, there hare have been changes

in the way DOC is handling lockdowns and notification to us. Working with us so that when we know that--and--and isolating us so that an entire facility doesn't need to lock down, that patient movement is still possible despite a lockdown, that when an area is locked down we are being notified by DOC, which gives us an opportunity for example to review who we were not able to see and prioritize them.

CHAIRPERSON JOHNSON: Speaking of--of--of DOC, in--during the March 2016 Board of Correction meeting, it was revealed at that meeting that healthcare staff are not provided with a complete list of people who are seeking medical attention. They only know about people who the DOC staff bring to the clinic. Is that accurate?

DR. PATSY YANG: It varies by jail. It's definitely gotten better. We are working DOC and Commissioner Ponte has--has asked that all his staff and all the housing units produce the so-called list. We're also about to launch another pilot.

CHAIRPERSON JOHNSON: Hold on, but ask or demand. I mean it doesn't make any sense--

DR. PATSY YANG: [interposing] Right.

CHAIRPERSON JOHNSON: --to me that why wouldn't the healthcare staff have at the beginning of every single day a list of people that need to be seen? Is that currently not the case, or is it--is it the case?

DR. PATSY YANG: It--we are getting lists, and the Commissioner required his staff, each housing unit to provide that. But the list is really--it's--the list is not necessarily the issue so much because it's--there are people who can ask for--to be seen in a clinic who don't sign up for the list. We're actually work with the--with the Commissioner and with DOC to try another way, another pilot on sick call where people will actually be signing up on--on a--not a list, but actually explaining what their request is and what their need is so we can triage that, and make sure that people who do need to be seen are seen, and that people who are asking for other things like lotion or replacement eyeglasses can be dealt with by other staff and not necessarily produced at a clinic.

CHAIRPERSON JOHNSON: But wouldn't it make sense for Health and Hospitals to have control over the sick call process so that you know who needs

medical care, and for what reason even if they don't get an escort to the clinic for some reason?

DR. DR. HOMER VENTERS: Yes, and so [coughs] that's actually--that's exactly the direction we're moving in. Right now, when we schedule somebody for a follow-up appointment, we know that that person is scheduled to come for an appointment, and then we can then work with Corrections to make sure that they come. Similarly with the sick call process that Dr. Yang just referenced, we're moving towards a model whereby we take the DOC officers out of the equation in terms of having to produce a list. So in many jails around the country you'll see sick call boxes where the patient puts a slip in themselves, the health staff get that slip and then you don't have to ask the correction officer to do the same level of work that happens now. That's--that's exactly what we're going to do.

CHAIRPERSON JOHNSON: When will that be fully up--implemented?

DR. HOMER VENTERS: I don't know. We're working with Corrections on the first jail to try to

pilot this, and so that pilot has not started yet, but that's the direction we're moving, and that's just getting going in the current weeks, the--planning the pilot in the first jail to do that.

CHAIRPERSON JOHNSON: But why do we have to do a pilot? Why can't--if we think this the best thing to do, why can't we just do it? Why do we have to test it out? I mean this is a process issue on trying to ensure that people who are sick are seen in a timely manner, and that healthcare staff have more ownership and decision making authority in getting people treatment they need instead of corrections officers.

DR. PATSY YANG: Yeah, so we share that commitment both to make sure--our one goal is that--that any--anybody who needs to be seen gets seen, and that we have greater ownership of that clinic and the health process, and I want to introduce Beth Ward. She is actually the one who was in my testimony who we--we recruited to head up our new Operations Department, and this pilot is--is hers.

ELIZABETH WARD: Hi, good morning I'd just like to explain what we're doing moving forward. My name is Elizabeth Ward, and I've worked in

Corrections now for 15, 20 years, and this is a project that I have pulled--put out on--in a number of prisons in the past, a number of jails in the past. What this is, is and what I've identified as a problem is a lack of relationship between us and our patients. And this would enable us to have a one-on-one relationship with our patients. The idea is yes, to have a process where a person upstairs signs a sheet, says I have a headache. I need my lotion, and these requests to be in locked boxes up on the housing units. The OC not having anything to do with this process. One of our employees going up on probably the 4:00 to 12:00 shift picking them up, bringing them down, bifurcating them. If someone has a headache, and we look and see they have hypertension, we need him down here. If someone is saying I want I my glasses fixed, he's in the other pile.

CHAIRPERSON JOHNSON: So, why are we piling it? Why are we piling it?

ELIZABETH WARD: Well, we're starting this because we right now, the Chief and the Commissioner have allowed the maintenance supervisor to order the supplies for the boxes. So that's where

we are. The minute we have the boxes, we have sheets, we have everything in place.

CHAIRPERSON JOHNSON: And it's only to be done in one jail?

ELIZABETH WARD: We're probably going to be doing it in two for two reasons: We have to educate. There's an education piece on our side, on the DOC side, and on the patient's side.

CHAIRPERSON JOHNSON: So how long--how long will it take to implement this throughout all of Rikers?

ELIZABETH WARD: In my last time--the last time that I did this personally, it took at least seven, eight months to really get this on board. It takes time, but to start it--

CHAIRPERSON JOHNSON: [interposing] That seems like far too long.

ELIZABETH WARD: --it's a very, very quick turn around. The results are quick, and I have no reason to believe that won't be the same.

CHAIRPERSON JOHNSON: [interposing] People are not seeing doctors in many instances in a timely manner because of our inefficient systems that have lingered for far too long. Corizon had a

horrible track record where people were losing their lives and dying in many instances because of how horrific they were. We cancelled that contract. Patsy and I team I think have done a very good job as has Homer coming and trying to change things. But it doesn't matter about the quality of care if people aren't care in a timely manner. So, for you to tell me it may seven, eight, nine months to get this fully operational--

ELIZABETH WARD: [interposing] Oh, no, it will be operational, but you won't be developed

CHAIRPERSON JOHNSON: [interposing] But all jails--

ELIZABETH WARD: You will not see results--

CHAIRPERSON JOHNSON: [interposing] Okay.

ELIZABETH WARD: --for a number of months.

CHAIRPERSON JOHNSON: So--

ELIZABETH WARD: [interposing] But it will be truly operational.

CHAIRPERSON JOHNSON: Okay. So at the--I just have a couple more questions, and then I want to turn it over to the chairs. I mean I have a lot of

questions, and I'll come back for a second round. Does the Rose M. Singer, the women's jail currently have a female gynecologist on staff?

[pause]

DR. HOMER VENTERS: The--let me just confirm with Dr. MacDonald, who's our Chief of Medicine. We have a Reproductive Health Specialist who--

DR. MCDONALD: [off mic] And an obstetrician.

DR. HOMER VENTERS: And an obstetrician that are--that are female.

CHAIRPERSON JOHNSON: So how is that different from a gynecologist?

DR. HOMER VENTERS: Well, no that--that--that is a gyne--OBGYN. It's the same thing. Yes.

CHAIRPERSON JOHNSON: And what role does that person play? I mean if someone needs to see a gynecologist, they need to see a gynecologist.

DR. HOMER VENTERS: Sure. All--all the primary OBGYN care is occurring with that provider--with the providers I mentioned in the facility, and then if they're a specialty like a high risk patient for instance, they may need to go to the Elmhurst

Hospital and they may see a male or a female provider there.

CHAIRPERSON JOHNSON: How many women are in that facility currently?

DR. HOMER VENTERS: About 600.

CHAIRPERSON JOHNSON: And there's one gynecologist for 600 women?

DR. HOMER VENTERS: So just to clarify, the--

CHAIRPERSON CROWLEY: The swearing in.

ROSS MACDONALD: I'm sorry. Ross--Ross--

CHAIRPERSON CROWLEY: You haven't taken the oath, and we have

ROSS MACDONALD: Sure.

CHAIRPERSON CROWLEY: -and we have to it, and Mr.--Ross, we need to know your name for the record.

ROSS MACDONALD: Sure.

CHAIRPERSON CROWLEY: Do you affirm to tell the whole truth in answering any of the questions, the questions that are posed by Council Members?

ROSS MACDONALD: I do.

CHAIRPERSON CROWLEY: And your name?

ROSS MACDONALD: My name is Ross MacDonald. I'm the Chief of Medicine for the Division of Correctional Health Services. So within obstetrics and gynecology, which are generally a field that is combined, there's--there is OB care, which is for the pregnant patients in our women's facility of which on a given day we have about 40. We have one dedicated obstetrician for that work. Over the last year we've implemented in response to qualitative research that looked at the experience of our patients with their reproductive health services a clinic that focuses on reproductive health. So that is also in the field of obstetrics and gynecology that looks at particularly treatment around long acting reversible contraception. So procedures to do--

CHAIRPERSON CROWLEY: [interposing] Just to--one for clarification, the long-acting LARC as it was known or IUD. So are you installing them?

ROSS MACDONALD: Yes.

CHAIRPERSON CROWLEY: Yes. Okay, and you're keeping track on how many?

ROSS MACDONALD: Yes.

CHAIRPERSON CROWLEY: And so many have been installed?

ROSS MACDONALD: So the latest numbers we'd probably have to get back to you, but we have outpipe--outpaced--In--in this year program, I believe we've outpace any other correctional facility in the country in implanting long-acting contraception.

CHAIRPERSON CROWLEY: That's goo and--and was this procedure done prior to H&H taking over healthcare?

ROSS MACDONALD: So, it was done prior to H&H taking over healthcare It's a--it's a program that Home and I implemented in the last year of the Corizon contract. So, just to round it out. So the routine gynecologic services, which would include pap smear and women's health visits as well as colposcopy, which is a higher level quasi surgical intervention that's done Riker's Island. The primary person who does that work is a--is a male gynecologist. So really three--three providers, two of whom are female and--

CHAIRPERSON JOHNSON: [interposing] Is that enough for 600 women?

ROSS MACDONALD: I think that's something we're evaluating. We're considering whether--

CHAIRPERSON JOHNSON: [interposing] But based on your experience right now, do you think that's enough?

ROSS MACDONALD: I--I think it's enough. I think that there is--I think it's enough for a--a high standard for jails where we have a transient population. The truth is that most jails don't do a great job of focusing on this work. So it's definitely enough to keep us ahead or in the middle of the pack in terms of national standards. I think that we could do more, and we are looking at potential options for that.

CHAIRPERSON JOHNSON: [interposing] Yeah, I mean I--I--not to--not to any way degrade what you just said. I don't really care that much about national standards. What I care about is are people getting seen and getting provided quality culturally competent safe healthcare when they need it.

ROSS MACDONALD: Yeah.

CHAIRPERSON JOHNSON: And if--if we need more physicians for the women in that facility to be able to give a pretty strong yes to that question, we

should be doing that. And so if women who are currently incarcerated are saying that it's taking longer or they're not seeing people in a timely manner, it seems to like we need more staff, and that's what I was trying to get to.

ROSS MACDONALD: Yeah, so I--I appreciate that, and I think we are very much on the same page. We're also engaging in a--so I mentioned a qualitative analysis that was done with some of our academic colleagues to talk to 20 women and get their opinions about the healthcare delivery reproductive health. So we are engaging in a follow-up study, and really trying to engage community partners to help us push the level of care. So I think that we absolutely have--it's an area of focus that we've identified, and we'll be able to have further discussions about that.

CHAIRPERSON JOHNSON: Thank you. I just want to ask one last question to Dr. Venters, and then I'll turn it back to the Chair. I think there are other council members that have questions as well. So, I've mentioned this to you before, but I always find that it's worth repeating given how strongly I feel about it. The United Nations Mandela

Rules to which the United States is a party established that prolonged solitary confinement greater than 15 consecutive days is cruel, inhumane and degrading treatment, and it's harmful to an individual's health. Why are New Yorkers being subjected to a practice that is deemed torture by the international community and the United States' own correctional health authority?

DR. HOMER VENTERS: So I appreciate you raising the issue. It's something we care deeply about. Importantly, the National Commission on Correctional Healthcare recently promulgated a position statement for the entire country, and so this is a critical development because it's not simply the United Nations. It's a---it's an American accreditation body for jails and prisons identify that solitary confinement past 15 days also constitutes cruel, unusual, degrading treatment. When that came out, I was actually with Juan Mendez, who is the Special Rapporteur who wrote the report, and so he and I talked about this quite bit. [coughs] We--I will say two things: We have worked and made tremendous progress partnering with the Department of Corrections using data about the

health, adverse health impact of solitary confinement to dramatically reduce the number of people on any given day who are in solitary confinement. There has also been a dramatic reduction in the length of time people go into solitary confinement. We have more work to do. I will say that we remain committed to keeping our patients safe, and that includes any environment risk, health risk that they encounter in the jails including solitary confinement. So we're--we have made a lot of headway, but we still have quite a ways to go.

CHAIRPERSON JOHNSON: That position paper advises quote, "In systems that do not conform to international standards healthcare staff should advocate with correctional officials to establish policies prohibiting the use of solitary confinement for juveniles and mentally ill individuals. It eliminates use to less than 15 days for all others. That's what the position paper says.

DR. HOMER VENTERS: And that's what we've done since 2012.

CHAIRPERSON JOHNSON: Are you--so you guys are telling DOC that?

DR. HOMER VENTERS: We--in 2012, we published the data showing the health impact of--of serious and mentally ill people going into

CHAIRPERSON JOHNSON: No, Homer, I know you're committed to this issue. You and I have talked about it. So why isn't it less than 15 days. Who makes that decision?

DR. HOMER VENTERS: That is a custody decision.

CHAIRPERSON JOHNSON: That's a custody decision by the Department of Correction?

DR. HOMER VENTERS: Yes.

CHAIRPERSON JOHNSON: So who here from the Department of Correction can speak to this? [pause]

CHAIRPERSON CROWLEY: Do you swear and affirm to tell the whole truth when answering the questions that Council Members pose to you today?

DR. NICOLE ADAMS: Yes. I do. My name is Dr. Nicole Adams. I'm the Deputy Commissioner of Health Affairs with the Department of Corrections. So to answer your question, we absolutely. I was at the conference with Homer. We were discussing these changes that have been made in looking at looking at

solitary confinement and I also spoke with Juan Mendez, and had at lengthy discussion with him about how horrible this is, and the changes that need to be made. We absolutely I would H&H more so now than ever truly comes to the table, and we have discussions weekly on the individuals that are placed in solitary confinement, and the reasons behind it. And that meeting actually includes many DOC bureau chiefs that are looking at the security issues, which--which drove the rationale for this type of placement, and I'm also in agreement. We're committed to making change.

CHAIRPERSON JOHNSON: How many people are currently serving more than 15 days?

DR. NICOLE ANDERSON: A lot. I don't have the number. I can get back to you.

CHAIRPERSON JOHNSON: We should have that number. What's the number.

DR. NICOLE ANDERSON: I don't have it. I can get back to you.

CHAIRPERSON JOHNSON: Homer--Homer, do you know what the number is?

DR. HOMER VENTERS: No, I don't.

DR. NICOLE ANDERSON: I can--I can get back to you with it.

CHAIRPERSON JOHNSON: [interposing] Is there anyone here who knows what the number is? this is an important thing. People should know this. How many people are currently being subjected to cruel and human--and inhumane treatment being locked up for more than 15 consecutive days right now in the system?

FEMALE SPEAKER: [off mic] This isn't something that you see everyday, and the in system, the average sentence is 15 days. (sic)

DR. NICOLE ANDERSON: About 160.

CHAIRPERSON JOHNSON: 160 people.

DR. NICOLE ANDERSON: Yes.

CHAIRPERSON JOHNSON: Okay, 160 people are currently being tortured by the Department of Corrections. I turn it back to the chair.

DR. NICOLE ANDERSON: The average sentence in punitive segregation itself is 15 days, and there's 165 individuals right serving that current sentence. It is constantly under review, because we are aware that it is not the ideal situation. It's not changing behavior, and that's

ultimately what we try to--you know, the thought behind punitive segregation was that it was going to change behavior. We know that doesn't work.

CHAIRPERSON JOHNSON: Even with the PACE expansion we still don't have enough units for people who are mentally ill. I want to come back for a second round. Homer, I appreciate your work on this. I think we need to be advocating in a much louder and stronger way to ensure that we stop this practice. I'll give it back to Chairs Cohen and Crowley.

CHAIRPERSON CROWLEY: How many psychiatrists are working full time on the island or in the--the correctional facilities?

DR. HOMER VENTERS: For the exact number, I'm going to ask Dr. Ford to come up, Dr. Elizabeth Ford who came over from Bellevue to run our mental health service. She can introduce herself and be sworn in.

DR. DR. ELIZABETH FORD: Good morning.

CHAIRPERSON CROWLEY: Do you affirm to tell the truth in answering the questions the council members pose to you today?

DR. DR. ELIZABETH FORD: I do. My name is Elizabeth Ford. I'm the Chief of Service for

Psychiatry for Correctional Health, and your question is how many full-time psychiatrists do we have?

CHAIRPERSON CROWLEY: Yes.

DR. ELIZABETH FORD: At this point I believe we have seven.

CHAIRPERSON CROWLEY: Seven?

DR. ELIZABETH FORD: Uh-huh.

CHAIRPERSON CROWLEY: Is any of the seven an expert in juvenile adolescent psychiatry?

DR. ELIZABETH FORD: Yes, we have two psychiatrists who are both child and adolescent trained. One of them is also forensically trained.

CHAIRPERSON CROWLEY: Okay, and how long do inmates have to wait to see a psychiatrists if they need to see one?

DR. ELIZABETH FORD: Typically, it depends on the severity of the request. So an individual who is seen and referred through many sources. If the issue is sig--significant, they're seen within 24 hours, although usually they're seen within a couple of hours. For individuals who have requests that are not as urgent, they are seen no later than three days later.

CHAIRPERSON CROWLEY: Have there been any suicides since H&H took over?

DR. ELIZABETH FORD: Yep, there have been two, one in January and one in March.

CHAIRPERSON CROWLEY: Were either of the two under the watch of a psychiatrist

DR. ELIZABETH FORD: Both of the individuals were on the mental health service. One of them had been seen, and was in general population. The other had yet to be evaluated by a psychiatrist. It was very early on in his incarceration.

CHAIRPERSON CROWLEY: Well, how long does it take on average before an inmate is seen by a psychiatrist to establish whether they have mental health needs?

DR. ELIZABETH FORD: Yeah, so do you want to take that?

DR. HOMER VENTERS: So the--actually a mental health clinician, as Dr. Ford just mentioned, a patient with an urgent need will be seen with hours immediately during the intake process. So that--that clinician who could be a social worker may determine that the patient also needs to be seen by a psychiatrist.

CHAIRPERSON CROWLEY: But--buy you said within an hour, but what happened with this case where an individual took their own life, and they hadn't seen a mental health clinician or doctor?

DR. HOMER VENTERS: They had seen a--they had been referred for mental health services, and I guess the other thing is I want to caution about not talking about specific cases in an open forum, but I will say that one of the things that's--that improved in the last three months really is that some of the critical access concerns that come up around when there's a security even in a building. So let's say we schedule, we identify that we want to see somebody whether it's in an hour or a day or three days. We all know that there have been challenges to getting the providers together with the patients. One of the things that's categorically improved just in the last couple of months is that the Department of Corrections is now notifying our operation staff whenever there's a lockdown in a building, and that's important because it means that our staff, if they know that there's going to be a lockdown in a given jail, they can identify which of these patients do they most need to see, and then corrections will

bring those patients to them. So the notification about lockdowns without getting into the specifics about any one case has been crucial in allowing us to connect with the patients that we say need, whether it's a psychiatrist, a mental health clinician or another medical providers. So that's a--a really important improvement, but we probably shouldn't get more into detail about a specific case.

CHAIRPERSON CROWLEY: And you have a psychiatrist up there 24/7?

DR. HOMER VENTERS: We have psychiatrists [coughs] psychiatrists at present 24/7 in the Mental Health Center at AMKC. So, as you know, we have 12 jails that we operate so we don't have the capacity to have a 24/7 psychiatrist there. However, if there's an emergency, we can have a patient transferred over or there can be an emergency consultation. We do have doctors and nurses in every jail 24/7.

CHAIRPERSON CROWLEY: And since H&H took over, are you doing the physical changes as to where the healthcare facilities are located in the various and separate jails, and does every jail some type of clinic, doctor, medical care office?

DR. HOMER VENTERS: Every jail has one, and actually ever jail has more than one clinic setting, and so one of the really important bits of work that Elizabeth Ward has done, our Senior Director of Operations is to look at all those physical spaces, and figure out are they adequate and are they safe. Because as you know and you've heard from our staff it doesn't do much good to have a clinic if the staff don't feel safe there, and the correction officers don't feel like it's a safe setting. So her team's assessment of the physical plant, the clinics and the safety has really been crucial to our staff feeling more comfortable doing these jobs we're talking about.

DR. ELIZABETH FORD: Do you support and does the Administration support all of the bills that are getting heard today? [pause] And one of the has to do with an escort, one of those that I supported because in the past there have been numerous cases where inmates have gone unattended into a clinician's office space, and we've seen some get injured or--or, you know, attacked by an inmate with the protection of an officer nearby. So I think that it is important to address that but, you know, what--what

are you doing to make sure that one, do you support that--that all of the inmates be escorted into a healthcare setting so that your staff is safe?

DR. HOMER VENTERS: So just to the operational issue, we obviously work closely with DOC and support any venture that increases the likelihood that patients actually come to clinic. But I think it's important also to point out that [coughs] the innovation that we've received some early funding for that we've referenced, Dr. Yang referenced, and what we've actually tried to do without new funding is to get our staff together with patients even if it doesn't mean a patient coming out of their housing area to the clinic. So setting up these mini-clinics, thinking about telehealth. We want to reduce the burden of demand for correction officers in moving patients around if we can safely provide the--the care without moving a patient back and forth.

CHAIRPERSON CROWLEY: So you support the bill?

DR. HOMER VENTERS: I think that the--I'll let Dr. Yang.

DR. PATSY YANG: It's okay, I--we support the--the concepts. I think the specifics of the bill involves more than just us, and I think we all would welcome discussion with you on that.

CHAIRPERSON CROWLEY: Okay, I'm going to recognize Council Member Cohen who has questions, Co-Chair Cohen.

CHAIRPERSON COHEN: Thank you. Thank you for your testimony. I just want to take a step back for a second. If can just kind of briefly--and briefly describe maybe the--you know, the top two or three motivating factors in Health and Hospitals taking over from Corizon. What were the most significant areas that you thought that this needs the city to be hands-on and--and take this project over?

DR. PATSY YANG: You know, I--I think one really fundamental issue was that Correctional Health Services provides healthcare, and we are among the largest, if not the largest one--correctional health service in--in the nation, and right here in the heart of New York is the country's largest public healthcare system. We share the same mission. We share the same goals, deliverables, operations. We--

we share a percent of the population, probably, you know, Correctional Health is--is seeing the same people who in a community before and after incarceration are--are coming to Health and Hospitals facilities. It just made a lot of sense in terms of everything from operations to legal responsibilities, professional development, recruitment or quality, everything that--that we do it's--it's the same, and so that also brought the opportunities to leverage a lot of the--the programs and services that this huge 42,000 person system provides to 8.5 million New Yorkers. So some of those I mentioned earlier and I think well, even without new resources, we were able to have early wins in terms of linking up and leveraging those--those Health and Hospitals systems and programs to ensure that people who are leaving our care have a place to go, for continuity of care, completion of treatment in a community, have Medicaid--have a plan to go to, have care coordinators who are assigned to them to help them stay in--in the community. Those are I think the--the primary ones.

DR. HOMER VENTERS: I just wanted to quickly reference two aspects that--that from the

inside leave. One is that we have really amazing, amazing staff who have worked on Rikers Island in the health service for a long time, just incredibly dedicated staff. We, however, have done them a disservice by having them working in this construct whereby they work for a staffing company, and that has one set of management, and they're really part of one family that's a mission driven organization. They are now, and they feel it, and we feel it from them that being part of and having agency, an--an organization that has not consecrated a profit or any other stay--

CHAIRPERSON COHEN: [interposing] How--how do you know they feel it? I mean are--are--

DR. HOMER VENTERS: Well because we just--Dr. Yang referenced we did an employee engagement survey recently where we got in--incredibly positive results from the staff. Also lots of ideas about what to improve on, but we ask them. We don't know any of this without data.

CHAIRPERSON COHEN: And--and the--the percentage of staff that stayed that was formerly Corizon or formerly part of that that system to now

part of your system? How--how many people are--what is the percentage in who those people are?

DR. PATSY YANG: It was 83% of--of people who were on the Corizon payroll were people who we individually vetted, interviewed and selected.

CHAIRPERSON COHEN: So approximately 83% of the staff hasn't changed that?

DR. PATSY YANG: Right, right. What we--what we wanted to do was as--as Dr. Venters referenced earlier is--is they're so--they're incredibly committed intelligent people who have been working in the jails for years in some cases, and--and not being part of that team being in this sort of inherently distrustful relationship of--of a vendor versus an oversight agency in the city was difficult, and--and I think we've already-- Some of the changes we've made in the infrastructure already are to improve supervision systems, all those things that make people function best in their jobs.

CHAIRPERSON COHEN: As--as an example, can you tell me how many people worked for Corizon and I guess in--in healthcare at Rikers before, you know, on December 31st, and how many healthcare

employees there are as of today or since the takeover?

DR. PATSY YANG: I think it was 1,036 or something. It's 83--there were 1,249 people at--at the base, and we selected 83% of those.

CHAIRPERSON COHEN: But are they--so did--did you hire any people, hire additional, bring in additional people.

DR. PATSY YANG: Yes, yes.

CHAIRPERSON COHEN: So the staff--are the staffing levels comparable to Corizon to now?

DR. PATSY YANG: The core staffing levels in the jails are because we didn't want to disrupt patient care even while were are reassessing not only assignments, but shifts and--and configurations of disciplines.

CHAIRPERSON COHEN: [coughs] You--you say you're assessing. How long will that take, and when do you think that will be done?

DR. PATSY YANG: We--we--we've--we actually started ground running before we started hiring so that we were--we were offering positions to people who were--who we selected to retain from Corizon. We were giving them their new assignments.

So we've already restructured. We created middle-management and--and senior level changes already. Some of the things that we've talked about already is also even while in place change what your job consists of. So that under [coughing] Dr. Richards' leadership, you know, we have--you have people who are in the jails who are in--it's like leadership positions that are also now doing patient care. Those are important things.

CHAIRPERSON COHEN: So I'm--I'm not sure that that answers in terms of staffing levels, are you--are you covered--are you done reviewing and saying that these are appropriate staffing levels or are you still--

DR. HOMER VENTERS: No, we're still in the middle of reviewing the current staffing levels, and part of that is because we have reorganized the most--the biggest parts of our service. So for instance I referenced earlier that in Mental Health Service we used to have a huge team that was just discharge planning and worked on the discharge planning for the folks and the--and the patients in there also. Then we had a mental health service, and so we've integrated those two groups together, but

that integration is happening right now. And as we do that, we're--you know, that is the right thing to do for our patients and for those staff. We still haven't fully assessed the implication of that integration or consolidation on the staffing levels, and that will take a couple more months for us to do.

CHAIRPERSON COHEN: I apologize for hopping on our budget. The Corizon budget, as I recall from the past hearing was approximately $140 million and that was--that was Rikers alone or--or--?

DR. HOMER VENTERS: That was for all the--all the jails that Corizon had. So that was nine jails on Rikers and two of the borough houses because Damian most recently has--had the VC--VC (sic) contract.

CHAIRPERSON COHEN: And--and what are we anticipating for a budget now?

DR. PATSY YANG: So I can ensure that was reviewed and that they're not comparable because what we did do in the restructuring from the get-go was in unifying the management team and not having this two-party system was a lot of the people who were--who were supervisory or--or site leadership in the jails who were in Corizon we brought in house. So they're

part of Health and Hospitals' payroll. So the contract itself is smaller because it's more of the front line people who were--who were hired on our affiliate, our academic affiliate at this point in time, our academic and professional affiliate. And--and the--the entire supervisory structure is at Health and Hospitals. So I can give you the specific numbers, but they track one for one, but there was no--there wasn't a change in what was basically the Corizon core matrix and the dollars that are associated with it.

CHAIRPERSON COHEN: I--I--I hear you, but I--I think it is important that we be able to compare, you know, the--the services that Corizon provided in terms of the budget, and--and the services that are being provided now. So even if the model is changing I think to the extent that we can track what was and compare it to what is I think is really--it will be valuable to the agency, and I think it will be valuable to--to us.

DR. PATSY YANG: Right.

CHAIRPERSON COHEN: Safety is--is there any data on I guess since January 1st assaults on medical staff do we--have--have there been any

incidents? How many incidents have there been, and have they been serious? [pause]

DR. HOMER VENTERS: So since I guess in 2016 we've had 17 staff assaults.

CHAIRPERSON COHEN: 17 on medical staff?

DR. HOMER VENTERS: Right. That--it's been--it's been--it's been kind of a downward trend the past couple of years.

CHAIRPERSON COHEN: Can you say like for the first quarter of 2017--of 2016 how that compares to 2015?

DR. HOMER VENTERS: So 2015 at 43 going back, 74 in 2014. So that was--that was pretty much the peak.

CHAIRPERSON COHEN: Absolutely.

DR. HOMER VENTERS: Right.

CHAIRPERSON COHEN: How many PACE beds are there?

[background comments, pause]

CHAIRPERSON COHEN: You're going to get it right on. (sic) [laughter]

ELIZABETH WARD: I'm sorry. That's not that helpful. We currently have--hold on, I'm doing some quick math here--71 PACE beds open.

CHAIRPERSON COHEN: 70 and how many additional units did you hope to open and how many does--how many beds does that translate to?

ELIZABETH WARD: Sure. So we have one unit that's due to be open fairly short. That will be 35--30--sorry, 30 additional beds, and then we received funding for 8 additional PACE units.

CHAIRPERSON COHEN: Eight--

ELIZABETH WARD: [interposing] Eight.

CHAIRPERSON COHEN: --additional units?

ELIZABETH WARD: Uh-huh, yep. Because that will be approximately 300 more beds.

CHAIRPERSON COHEN: So around 375 is the goal?

ELIZABETH WARD: Yeah, well it's--let me just let you know. So we anticipate that after the eight units open in addition to the four that we already have planned, we'll have 368.

CHAIRPERSON COHEN: So, and when--approximately when do you think those beds will all be online?

ELIZABETH WARD: That's a good question.

DR. HOMER VENTERS: So we're planning for two--putting inside the fourth PACE unit, which we

already had received funding for and should open imminently. The additional newly funded units, two per year. So in the next four years we would have completed a rollout of eight more units.

CHAIRPERSON COHEN: Can you just briefly explain this. I mean I've been to--I think that's something with the CAPS, but the important--I think that it's vitally important that we get these--these units up and running as fast-- Can you just tell us briefly some of the challenges and barriers now that we have the funding in place to try to get them?

DR. HOMER VENTERS: Sure, I think that the--one of the core issues is with each of the first four units, including the one that hasn't been opened, we've identified a--a patient cohort that we think is vulnerable. So we started with the most vulnerable, people just coming back from Bellevue Hospital, and then we've rolled out--the PACE Unit is looking at patient cohorts that are identifiable and that we have an intervention for. As we go forward, we're going to continue this process to find specific patient cohorts that need a higher level of care than we provide them. But then we identify programs and staffing levels, and we hire staff, but then we also

work together with the Department of Corrections to find a physical plan that's appropriate. And I think that that's a place where the rollout of these units is required. As we increase the footprint it's required more innovation and more effort, and I'll defer to Dr. Ford to see if she has anything else to add.

DR. ELIZABETH FORD: No, I agree with that, but I would--I would add that for the additional units, DOC has been working very hard I think to renovate some existing mental health units. And so I do think moving forward some of the construction issues will be less cumbersome than they have been in the past.

CHAIRPERSON COHEN: I guess that goes to the heart of my next point, but maybe you could just sort of--I'm concerned about the integration between DOC and--and Health and Hospitals in making like--so Corrections will build out the--how is that just in terms of getting the PACE units up, how does the integration work there?

DR. ELIZABETH FORD: In terms of--do you want that?

DR. HOMER VENTERS: Well, I mean it's what we've done with the--the units already. So have a track record of being about to do it, but you can talk just a little bit about the specifics of how do we identify a unit and get it ready?

DR. ELIZABETH FORD: Yeah, so we look at a number of things including which jail has the highest need. We'd like to reduce transfer of--of mental health patients between units because that can be problematic. We look at the staffing that are available and those who are trained. We look at--on both sides, custody and health, and we look at physical space.

CHAIRPERSON COHEN: But after your evaluation, is that the end of the line and what if Corrections says--

DR. ELIZABETH FORD: [interposing] Yes.

CHAIRPERSON COHEN: --that there's no space at that facility for you. We nee it for whatever we're doing there.

DR. ELIZABETH FORD: Fair enough. So we actually every week, and have--this has been in place for 18 months. The Department of Correction and Health and Hospitals speaks specifically about PACE

units. The ones in existence and planning for those that are--are online and--and heading towards completion. (sic)

CHAIRPERSON COHEN: [interposing] I guess that gets me to my last point is 1183. I mean the goal of this legislation is to try to create the--the best integration of information ultimately so that an inmate who has mental health issues is--is not running up into, you know, with these constructs. The barriers between agencies ultimately shouldn't impact healthcare. And like I'm even wondering if like, you know, around these mini clinics. Like if we could--what if we could put the, you know, the prisoner's cell in relation to--like their proximity to healthcare services. In other words we have an--an inmate who we think is going to be a high need user, they should--their cells should be close to the facilities, and I don't know how--how we do that.

DR. HOMER VENTERS: So we do that I think that the--so we do it--I think the most overt example is for the mental observation areas where in those clinics we actually pushed clinical services into some of those places. So having a nurse there for instance, a medical nurse. Bringing services to the

patients is critically important. In other areas we do this routinely. So for patients that need air conditioned housing, we not only have place--you know, housing areas with air conditioned housing for people with chronic diseases, but then it will--

CHAIRPERSON COHEN: [interposing] Who makes the decision, though, whether the inmate ends up in an air conditioned unit or not?

ROSS MACDONALD: We do and then we also push clinical services into those areas. So some of the most important mini-clinics that are functioning today are in the air conditioned housing door--housing areas where we have people with chronic disease, and so--but as we contend with the physical plan limitations across the board, putting the patient together with the appropriate services is, you know, it's a very, very complicated game, and it's not a game. It's a very complicated endeavor, but that's why since the day or the week we got the first PACE forming, Dr. Ford has had a weekly call, a meeting with Corrections about the project plan for PACE implementation because it--it requires constant, constant vigilance.

CHAIRPERSON COHEN: Right, could you tell me how many--many clinics there are.

DR. PATSY YANG: There are current 16.

CHAIRPERSON COHEN: Sixteen.

DR. PATSY YANG: And we're adding 12.

CHAIRPERSON COHEN: And you're adding 12 more?

DR. PATSY YANG: Right.

CHAIRPERSON COHEN: And--and again going back, the--the enhance. I mean it seems to me that we're in agreement that these Enhanced Pre-Arraignment Screenings like trying to identify people as early on in their contact with the system, I think, you know, just and obviously you agree because you're implementing this. But it's important and I think system wide that we identify everybody coming in, and I think it will-- You know as there are a certain number of inmates who are, you know, frequent, you know, reoccurring inmates, and having those people all lined up so that we know right away when--when this person, you know, enters into the system that there is this integration of services that we--you know, that will hopefully get the person

out and not have-- You know, as we reduce the overall population at Rikers--

DR. PATSY YANG: Yeah.

CHAIRPERSON COHEN: --you know, people with the mental health challenges are the people who are not getting out as fast, who are really having the most trouble navigating it.

DR. PATSY YANG: So--

CHAIRPERSON COHEN: Yes.

DR. PATSY YANG: So one of the--our Enhance Pre-Arraignment Screening not only earlier on identifies people who need attention and care at a higher level than--than EM--that EMS is prepared to do because we have practitioners and clinicians there. It--it avoids those unnecessary hospital runs. It saves resources on the hospital side, EMS and the NYPD side. If people do get moved on to--to jail in intake we know people who are at risk, and we can pluck them out earlier, and move them out of intake sooner to get attention, which they may need. But another key part of it is that our Enhance Prevention Screening program gets information that with patient consent can be handed over to defense, which has the possibility of increasing the

opportunity to use diversion as an alternative to incarceration. And I think I wanted to hand it over to--I don't know if you want to talk about that.

[pause]

ASSISTANT CHIEF STRONG: Hi. I'm--I'm Assistant Chief Gary Strong (sic) I'm the Commanding Officer of the NYPD Criminal Justice Bureau. We are responsible for pre-arraignment prisoners, roughly 24 hours and then we--we turn them over to the DOC. We just wanted to comment on one point in the intro that we would very respectfully--we have concern about and we would oppose, and that's just the one portion that would require an arresting officer or police officer to document a symptom that prisoner, an arrestee a newly arrested person is exhibiting that might be a mental illness symptom. We don't feel that a police officer is qualified to make that determination. If a prisoner in our custody requires medical attention for any reason--any reason whatsoever we do document it. We document it in detail, and that--that document, the medical treatment of prisoner form would eventually find its way to the Department of Corrections in the event that the prisoner was released and arraigned.

CHAIRPERSON COHEN: If you're doing it already, I'm little puzzled as to why you would--

ASSISTANT CHIEF STRONG: The--the distinction, sir, would be whether they are getting medical treatment or not. If we take the person to a hospital, we would document it. If they're treated by EMS and no further is necessary, we would document it. What we would be concerned about would be a situation where someone in custody is acting out in some way, but not to a level where they need medical attention, and to have our police officers document that the person is--whatever--be ag--agitated because we would have no--they would not be in a position to make that assessment the staff. Behavior is attributable to some sort of mental illness, or if the person is just upset finds things because they're arrested. That--that would be our only concern with--with the intro.

ROSS MACDONALD: And if I might add, that's--this is the perfect segue back into pre-arraignment screening because that--that is exactly what we're there to do as a resource and he is there to do this behavioral health screening to be able to identify those kind of issues that you're talking in-

-in the law. Does this person need to go to the hospital, yes or no. No, then they should probably talk to our social worker who has a direct line into the defense agencies who will be hearing this arraignment case in--in a few hours. That information with consent can make it right over to those attorneys, and we've been in communication with all of the defense agencies operating in Manhattan just to make sure that we have those lines of communication open, an we're getting feedback, too, that-that this a useful resource for them. So, you know think about pre-arraignment screening, it does all of these--these things. One is medical treatment on the spot. One is triage for when people go--come into jail. So it's kind of the ultimate information sharing within Correctional Health. It's kind of our view into what's happening to everybody who gets arrested, which is about 80% of the people that get arrested don't go to jail. So we're kind of getting a view into that population. For those 20% that do come to jail, we kind of--we have the workup on them already that we can share with our clinicians that are going to be doing intake, and they can use that information, you know, as a triage flag to say this

person needs to be seen immediately. They've go an urgent medical health need or, you know, they use it while they're--while they're in jail further down the line so--

CHAIRPERSON COHEN: I appreciate that, and we--I know we've been talking offline about trying to make this a better bill, and we should continue to do that. Thank you, Chair.

CHAIRPERSON CROWLEY: I'd like mention that we are joined by Council Member Vacca. Council Member Lancman was here as well as Council Member Barron. We're also joined by Council Member Van Bramer and Council Member Cabrera and Council Borelli has questions.

COUNCIL MEMBER BORELLI: All right and thank you for coming. I just have some questions for you regarding the cost of operations in the 12 jails on Rikers. Do you have an estimate of how much it costs in total? [pause]

DR. PATSY YANG: Hi, our--our--our FY16 Budget is $235 million. That includes that entire operation. It includes salaries for providers.

COUNCIL MEMBER BORELLI: That's just--just the Rikers?

DR. PATSY YANG: It's the entire jail system. So it's the 12 jails including the nine that are on Rikers.

COUNCIL MEMBER BORELLI: So how much-- what is the agency's overall budget?

DR. PATSY YANG: Our division is $235 million.

COUNCIL MEMBER BORELLI: All--all of HHC?

DR. PATSY YANG: Oh.

COUNCIL MEMBER BORELLI: Can you estimate.

DR. PATSY YANG: I will have to get back to you.

COUNCIL MEMBER BORELLI: [interposing] As you know, is I probably should know so I'm not-- you know, I'm certainly judging you guys.

DR. PATSY YANG: Mr. John, do you want to just get this.

JOHN JURENKO: [off mic] It's more than $7 billion.

DR. PATSY YANG: We're told it's more than $7 billion.

COUNCIL MEMBER BORELLI: More than $7 billion. So it's--

DR. PATSY YANG: [interposing] More than seven.

COUNCIL MEMBER BORELLI: Okay, how much do you guy spend on Staten Island? [pause]

JOHN JURENKO: I'm John Jurenko, Vice President at Health and Hospitals. I can get you those--I don't have those numbers on me right now, but I can get--get those back to you today.

COUNCIL MEMBER BORELLI: Okay, so the 1,500 employees that deal with the jail system, healthcare system, how many employees do you have on Staten Island. [pause] I think you see where I'm going because obviously I'm trying to paint a picture that I think you guys do a better job. [mic static] Oh, that was--that was God judging you guys.

JOHN JURENKO: Oh, I may have unplugged this.

COUNCIL MEMBER BORELLI: So out of--

JOHN JURENKO: [interposing] I don't have it.

COUNCIL MEMBER BORELLI: --you have 1,500 in the prison healthcare system. How many employees does HHC have on Staten Island.

JOHN JURENKO: I'll have to get you that information.

COUNCIL MEMBER BORELLI: Do you think it's more or less than 1,500?

JOHN JURENKO: I don't want to speculate.

COUNCIL MEMBER BORELLI: Okay. Do you have a department or a division of substance abuse on Staten Island?

JOHN JURENKO: We have- we have Seaview, which is a long-term care facility. We have two-

COUNCIL MEMBER BORELLI: [interposing] For elderly mostly, though. I mean it's--it's a facility.

JOHN JURENKO: It's for persons who need long-term care, and then we have Mariner's Harbor Clinic. We have the Stapleton Clinic, and we have the Mobile Medical Office, and we're building a diagnostic and treatment center on--it's going to be a 155 Vanderbilt.

COUNCIL MEMBER BORELLI: Okay. The--the seven psychiatrists and four PACE Units, do you have anything similar like that in Staten Island?

JOHN JURENKO: Again, I--I didn't bring the Staten Island information with me, and I'll get back to you on it.

COUNCIL MEMBER BORELLI: I--I think--I think there's not much information. To be honest, I think you don't have the information because there's not much information to be given. My district is more than the entire--in--in area, it's larger than the entire Borough of Manhattan, and would you be willing to tell me whether you have any type of facility in--in the 51st District?

JOHN JURENKO: I'll get back to you.

COUNCIL MEMBER BORELLI: It's a mobile office. I--I have an app. I'm asking rhetorically the mobile office that's--that's there it's--it's actually the address that's given is right across the street from my office and I've never--never seen it once. I guess just in sum, the question I'm asking is does HHC do a better job with care of prisoners, and I'm not painting the picture that you shouldn't be doing a good job, but I'm asking a question: Do you do a better job or have a more robust operation for the 10,000 daily prisoners on Rikers Island than

you do for the 7% of the city's population on Staten Island?

JOHN JURENKO: Yeah, we strive to have high quality care at all of our sites across this. We--we've correctional health for 5-1/2 months now.

COUNCIL MEMBER BORELLI: Okay, thank you.

CHAIRPERSON JOHNSON: Council Member Ca--Cabrera.

COUNCIL MEMBER CABRERA: Thank you so much to all the chairs. Welcome. Let me focus on mental health here for a second. I'm curious to know at the--at the facilities, are--they are when you're dealing with suicidal are you as quick to deal with suicidal kinds as you would in a hospital setting? If, for example, Bellevue?

DR. ELIZABETH FORD: Hi, so I have--I do have experience working at Bellevue for 14 years prior to coming here. So we are extremely quick in this jail system, and I know national numbers may not be important, but quite quick compared to other jails in terms of identifying suicide risk, and it happens really the second someone is booked into custody and the Department of Correction works to--very hard to identify those who are at risk of suicide and refer

them to us quickly. So it happens really immediately and then once that risk is identified, also immediately interventions are made, and that can be a range of things from a referral to the hospital to placing someone on suicide watch to do an intense monitoring in the MO Houses. So it's very quick.

COUNCIL MEMBER CABRERA: So, help me understand. So you said--let's say I'm on Rikers. I've been identified as suicidal, and express the desire to kill myself, what happens? If you can guide me through that process real quickly I--I'm taking him to who, to see who? Would--do I stay overnight?

DR. ELIZABETH FORD: Sure, so and I will- there are also interventions here that the Department of Corrections staff help with as well. So if Dr. Adams wants to weight in, but essentially depending on the housing area. So if someone is in general population housing, and they express to anybody suicidal thinking or if we are notified from family or other inmates or advocates about a suicide risk the individual is taken immediately to the clinic, and evaluated for intervention. So that happens right away. If someone is on mental health housing

and they express suicidal thinking or again if we get referrals about that because the clinicians have much greater access to that population they're seen in their housing area very quickly, and then removed if necessary to a higher level of care.

COUNCIL MEMBER CABRERA: And he higher level of care what I'm trying to get to then is--it goes--where do they go? Do you have a special unit? Do you place people with a psychiatric disorder-- My experience dealing with hospitals is that they--they place everybody whether you're schizophrenic whether--whatever disorder you have they place them altogether. Is that the same case that we find at the facilities?

DR. ELIZABETH FORD: So we're very fortunate to have been funded for these PACD Units, which actually address that very specific issue. So if someone is again in general population or in some cases mental health housing, and they need a higher level of care, we now have an additional option other than sending someone to the hospital. Obviously, that's the highest level of care, but these PACE units are designed to address specific risks and to place patients together who have similar treatment

needs. So that the--the staff or the custody staff and the health staff can really focus their interventions.

COUNCIL MEMBER CABRERA: So when you say that they crew together are this--are there in the same floor, and interacting with other people with different disorders?

DR. ELIZABETH FORD: Well, so in any mental health--it's a great question--in any mental health setting you will have individuals who have a wide variety of illnesses for sure, but we do try to cohort patients who have similar needs together.

COUNCIL MEMBER CABRERA: [interposing] You know, I never-

DR. ELIZABETH FORD: That's--that's the standard of care.

COUNCIL MEMBER CABRERA: --I've never been a--a fan or had the unfortunate opportunity to go there to go see people on psychiatric--you know, on the suicidal watch floor, and when you have everybody mixing their, I mean it just--sometimes it makes you more depressed, to be honest with you. I'm sure you know better than I do what that--that that feeling is like. And sometimes I wonder how much

help can you really get when you're surrounded with other things that does not provide a sense of peace or tranquility, focus, stability. So I'm--I'm hopeful that in the future there will be consideration having just one complete unit that is just dedicated to, you know, to clients like that. The--the other thing I was going to ask you is, and to whoever can answer this question, what would--you--you mentioned there were two unfortunate cases of--of--to pore (sic) over unfortunately, successful in committing suicide. What would you have done different? What could have been done different?

DR. ELIZABETH FORD: So again, I'll defer to Dr. Venters. I think his comments will--

DR. HOMER VENTERS: [interposing] Sure. So, [coughs] again each--any suicide in jail or prison reflects really a tragedy for the patient, the family, but also I think should push the Correctional Health and Security staff to examine everything they do, every part of the system that interacted with the patient. I think that without getting into specifics of one case, I can tell you that one of the really important areas for improvement that we have identified recently is what I referenced earlier,

which is that when a lockdown occurs in a jail, ant this happens routinely whether it's a security event and there--there might--it might be hard for patients to get to services that are needed. But now the Department of Corrections has started notifying our operations staff the second the lockdown starts, and that's crucial because what that does is it lets the health staff identify who are the patient that most need to be connected with their care right now in the next hour or two. That's an improvement that's new, and that has helped our mental health service because if they hear about a lockdown halfway through they may not have gone through the list to see who's showing up today, who's not showing up today and they're kind of playing catch-up. So that innovation actually has been crucial for connecting the patients with the highest need with the--the clinical staff that are there to take care of them.

COUNCIL MEMBER CABRERA: So the suicides took place, the--the two that took place this year, and I'm sure you could look back to the previously, previous year, they took place during lockdown? Is that--?

DR. HOMER VENTERS: We've had--in the last several years we've had like there have been suicides that occurred where the--the delivery of care that we were trying to get connected with the patient did occur during a lockdown.

COUNCIL MEMBER CABRERA: Okay. I only have two more quick questions. First--second to last, secondary trauma to your staff. Dealing with--I can imagine with all of these cases, what do you do for your staff so they can debrief themselves? Do you have daily debriefings? What exactly is in place to help people with that?

DR. HOMER VENTERS: [interposing] Sure so we actually have--there are several levels of intervention, and I'll let Dr. Ford mention one of them, but something we started about two years ago is this notion of dual loyalty that is a human rights concept. When you work in a jail or a prison as a health person, your ability to provide care to the patients in front of you is impacted by the security system, a constant everyday. They may be small, but they're important pressures of your deliver of care. So we started actually doing dual loyalty trainings for all the staff whether you're a driver, a

pharmacist, a doctor, a couple of years ago. And when we do those trainings, we also elicit stories from people or feedback. We give them scenarios. We say have you ever encountered this type of scenario? What would you do to improve this? How would you handle it? Engaging with the staff around the realities. of their--their work part of which is the trauma, but part of which is these pressures is you cannot do this work without engaging with the staff, and I'll let Dr. Ford mention some of the other efforts that she's initiating.

DR. ELIZABETH FORD: Thank you, by the way, for bringing up that issue. It's one I'm well familiar with and I think is probably one of the biggest factors for working in this environment. So thank you for that. The--some of the best things to help with secondary trauma include just letting people know that it's--it's something that exists, and that we can work to change. It's allowing people to learn in their roles. So education and supervision is a critical part of preventing burnout and trauma. It's allowing, just as you mentioned, opportunities to debrief and talk about these things with colleagues. And also something that we are

exploring is to debrief in a setting where you don't have to worry about whether your boss is listening to you, or the custody staff or any of that stuff in a very safe space. So we're working on that. We're also working very hard to bring academic relationships into the jail because diversifying what people do also helps them and alleviate some of the--some of the burnout that develops. So it's--thank you again for bringing up.

COUNCIL MEMBER CABRERA: I appreciate that you have something in place. Having worked as a licensed mental health counselor and working in a lot of critical incidents scenarios like 587, et cetera. I don't want to get into it right now, but you--you're working with a critical incidents level that very few I think psychologists, psychiatrists, social workers get to experience in--in that setting I think is important that they have that. My last question is do you have chaplains that you work with so you could deal with the spiritual aspect? I know that spirituality is an agency of change, an opportunity for changes in the lives of those inmates.

DR. ELIZABETH FORD: Yes, the answer is yes, we do, and I do think in terms of room to grow,

I think this is true for the psychiatric community general. We can involve spiritual resources a little bit more robustly, but yes, there are chaplains, and we work as closely as we can.

COUNCIL MEMBER CABRERA: How many do you have?

DR. HOMER VENTERS: Those are the Department of Correction staff and so there Chaplaincy program is incredibly robust, and we should let them. If they want to answer any specific questions, it's a very important partnership.

DR. NICOLE ADAMS: [off mic]

COUNCIL MEMBER CABRERA: I'm sorry. You have to---[pause]

DR. NICOLE ADAMS: This is Dr. Adams again. In each jail we have a chaplain assigned for each religious--religious group that exists, and if the inmate would like a specific religion represented, we have a chaplain available for them, and with that they only have to ask.

COUNCIL MEMBER CABRERA: So you--you only have one per religion? Is that what I hear you saying?

DR. NICOLE ADAMS: No, no, we have--

COUNCIL MEMBER CABRERA: So--so how many do you have? So what do you have in total?

DR. NICOLE ADAMS: Total on staff?

COUNCIL MEMBER CABRERA: Yes.

DR. NICOLE ADAMS: We--we--we haven't--actually, I don't have the exact number. I know in each specific jail they do have chaplains available on a regular basis on Sundays, on Saturdays, even on Fridays, but after this I can get you the exact number.

COUNCIL MEMBER CABRERA: All right, I want to encourage you to reach out also to volunteer chaplains that we have different chaplain organizations whether it's Lockout, United Chaplains. There are many that you could basically get on for free.

DR. NICOLE ADAMS: Yes. So as a part of the Thrive NYC Initiative, we've actually had much more relationship with various houses of worship. As a correction facility, we actually have been going to those houses of worship. I went actually this past Sunday, developing more robust relationships so that we can have more individuals, and so many people have volunteered, and asked to be a part of that. So

we're actually developing those relationships in a more intense fashion.

COUNCIL MEMBER CABRERA: That's great. I'm looking forward to you expanding that, and to make it broader so they could be impacted especially when there's mentorship taking place. Thank you so much, Chairs. Thank you for the extra time.

CHAIRPERSON COHEN: Thank you, if you don't mind. I just have a--I just want to follow up on--on the--on the safety of the healthcare staff. Could you--I understand obviously you can't go into specifics, but just generally because you just talked about briefly the range of the kinds of assaults that we're talking about, the seriousness?

ROSS MACDONALD: So can get the--the exact numbers of them on types. So we kind of strategy in each one of the--each one of the incidents by the seriousness of the staff member. You know, can I just take--take a step back a second. We have work place violence committee along with the coordinator that's part of the board staff who was just up here as well. We have the Health and Hospitals and the Corporate Workplace Violence oversight, which--which is kind of new to the--to

Correctional Health. So we--we report all these statistics upwards as well, but we have everything from kind of splashing to attempted assaults to actual striking of the work--of the--of the staff that work in the jails. So it kind of ranges--

CHAIRPERSON COHEN: [off mic] Of the 17--[on mic] Of the 17 that you document in the first quarter, are--are they in that range, striking? Has anyone been hospitalized and, you know, just kind of again without talking about the specific--the specific cases, I'd--I'd like to know the severity of--of the incidents.

HOMER VENTERS: And I'm not speaking with any specific--we can get to the specific numbers but [coughs] my experience since 2014 where we really had the highest rate, the rate of--of assault on staff was double that year than--that it was in 2015 and the first quarter of--of '16, but most of the incidents involve splashing or--or less serious. It's--it's the--the physical striking of a health staff member. It's incredibly traumatizing and serious, but it's representing a small fraction of--of the incidents over the years, but we can get you the--

CHAIRPERSON COHEN: Well, that's--that's exactly what I want to get at, though. I want to know specifically.

HOMER VENTERS: Right. So I will get-get you that number on the--on the type of incidents that--

CHAIRPERSON COHEN: I'd appreciate it, if you could get it like last, you know, maybe '14, '15 and '16-

HOMER VENTERS: Sure.

CHAIRPERSON COHEN: --that would be helpful.

HOMER VENTERS: Right.

CHAIRPERSON COHEN: Thank you very much.

CHAIRPERSON JOHNSON: Thank you, Chair Cohen. I want to come back to some things I wasn't able to ask before. So the National Commission on Correctional Healthcare Position Paper again advices--[coughs] excuse me--that in quotes, "Principles of respect and medical confidentiality must be observed for patients who are in solitary confinement. Medical examination should occur in clinical areas where privacy can be ensured. Patients should be examined without restraints, and with the presence of

custody staff unless there is a high risk of violence. In situations where this cannot occur, the patient's privacy, dignity and confidentiality should be maintained as much as possible. If custody staff must be present, they should maintain visual contact but remain at a distance that provides auditory privacy. I wanted to ask that in the restrictive units, does mental health rounding occur cell side or are people taken out of their cells into a confidential setting.

ROSS MACDONALD: Sure. So I want to make [coughs] an--an important distinction that the NCCHC also in their standards makes distinction I'm about to make. [coughs] Rounding is not the same as a clinical encounter. [coughs] So rounding is a surveillance too--tool to make sure basically nobody is in distress or dying or in serious need of, you know, going to the hospital. Rounding is a cell side function by definition. Someone is going around looking in the cell, are you okay? That does not replace, nor should it ever constituted a replacement for actual healthcare encounters, which have to be in a clinic setting, which have to be private except for in the rare instances you just referenced. That is

our approach in the city jail system. When somebody is in solitary confinement or even in one of these intermediary units that are somewhat restrictive, if they have a mental health encounter, if they have a medical encounter they need to come out of that cell, and come into a clinical setting. This is also why the expansion of many clinics is helpful because if there's a concern [coughs] by the custody staff if they don't want to--and people, you know, patients going across the jail, having a mini-clinic there that's a real clinic, where we can have a real encounter is easier for them. But that is the standard that we follow.

CHAIRPERSON JOHNSON: And do you believe that the standard that you're following complies with the NCCHC Standards?

ROSS MACDONALD: Yes.

CHAIRPERSON JOHNSON: So most hospitals in New York City have Sexual Abuse and Violence Intervention Programs and SAVI programs and provide in-person rape crisis counseling services, and advocacy through the staff and volunteer that are part of the hospitals. NYC Correctional Health Services is now part of H&H. Is there a similar

program in the jail system where is well--where there is currently a well documented epidemic of sexual violence. Not too many months ago my colleagues on the Council on Women's--the Committee on Women's Issues investigated this during a hearing I believe in December. So I wanted to see are SAVI programs up and running in the jail system as well?

ROSS MACDONALD: So the resources that you just referenced the SAVI programs, those are particular in H&H to hospitals, what--what happens in an emergency room or in an in-patient setting when somebody reports an allegation of sexual abuse. We have--the Department of Correction has engaged the services of a consultant group, Moss Group, which is assisting in bringing both DOC and Correctional Health into PREA compliance so the Prison Rape Elimination Act is the legal construct that we're proceeding with. Part of that is if somebody makes an allegation of sexual abuse, we don't actually think that the jail is the appropriate place to load in forensic examination resources. So we have--we actually have staff that are trained in forensic examination for--to do a rape kit, but we don't think the jail is the right place. We think that actually

that patient if they need a rape kit, for example, should go to the hospital and should get examination like everybody else would. Now, you reference in another area, which is the provision of counseling services. So that's an area where we, the Department of Correction, the Moss Group and the Board of Correction are working to--right now there's a--a partnership with Safe Horizon to provide remote counseling services. I think we're also discussing whether or not there's a potential to deliver in-person counseling services because the jail mental health service is really not an NCCHC. Also, the jail mental health service shouldn't stand in for real rape crisis counseling services. And so we need dedicated rape crisis counseling services like you would have in a hospital, and so we're working together with our partners in DOC to [coughs] make that a--a reality.

CHAIRPERSON JOHNSON: So is there an epidemic of sexual violence in our jail system?

ROSS MACDONALD: The number of incidents in the last five years that reported has gone up dramatically.

CHAIRPERSON JOHNSON: So is there an epidemic?

ROSS MACDONALD: I don't know what--I don't know what the true number of cases was five years ago because to be honest we did not do a very good job assessing it, but I think that the number of cases is alarming.

CHAIRPERSON JOHNSON: [interposing] What's that number?

ROSS MACDONALD: I'll have to--we have the numbers here with us. So this year there's been--so we--we track reports. So when patients report to us that they've been sexually assaulted or there a suspicion that a sexual assault or sexual abuse occurred, we track that essential through this PREA compliance reporting notifying DOC and DOI, and right now this year we had 118 reported sexual abuse.

CHAIRPERSON JOHNSON: 118?

ROSS MACDONALD: Right.

CHAIRPERSON JOHNSON: And I would assume like we do generally even outside the jail system that there is a lot of unreported cases that go on? Do you guys make that same assumption?

ROSS MACDONALD: We do and the--and the standard requires this as well. So if--if we suspect that someone has encountered--has been sexually abused, we start the reporting apparatus right away, which includes medical and mental health response. But to your point that's exactly what that process is set up for is the fact that it's embarrassing to bring this up, and essentially live with everyone in the jail in including all of the DOC officers that you see all the time. So it's difficult to make these reports. Our staff are supposed to be vigilant and be proactive in reporting.

CHAIRPERSON JOHNSON: And out of that was the number 119?

ROSS MACDONALD: 18.

CHAIRPERSON JOHNSON: 118. Out of that 118, how many of those reports were against DOC staff?

ROSS MACDONALD: I will have to get back to you on that number?

CHAIRPERSON JOHNSON: It was a significant number? Do you know?

ROSS MACDONALD: It wasn't--it was not the majority, but I'll have to--I'll have to get back to you.

CHAIRPERSON JOHNSON: You know, I'd like that information. That would be helpful. So, if we have this level of sexual violence [coughs] are we doing enough to take care of it?

HOMER VENTERS: Sorry, we--I do have that number. It's--it's 40.

CHAIRPERSON JOHNSON: 40?

HOMER VENTERS: Right.

CHAIRPERSON JOHNSON: 40? 40 instance of individuals who were supposed to be taking care of inmates have sexually assaulted them. How many of those instances out of the 40 do you know are rapes?

HOMER VENTERS: So these are--these are reports, and--

CHAIRPERSON JOHNSON: What and so the--the--those 40 allegations or sometimes they have actually been adjudicated or they're not allegations any more, but we know they actually happened, what's happened to those officers? Are those officers no longer working in DOC facilities?

HOMER VENTERS: So we--we take every report that we have to DOC, and they investigate these--these cases. We handle the medical side, and they handle the security and--

CHAIRPERSON JOHNSON: [interposing] But, when an allegation is made against an officer, does that officer then put--is that officer then put on leave until information is sorted out?

HOMER VENTERS: I'll have to defer to DOC for that.

CHAIRPERSON JOHNSON: Excuse me?

HOMER VENTERS: I'll have to defer to DOC for that.

CHAIRPERSON JOHNSON: If DOC could answer that. [pause]

DR. NICOLE ADAMS: The Office--this Dr. Adams again. They're immediately removed from working with that individual where the allegation was made while the investigation is happening.

CHAIRPERSON JOHNSON: Just that individual or the entire general population? Because typically people that sexually assault or rape one person go on to do it to other people.

DR. NICOLE ADAMS: Okay.

CHAIRPERSON JOHNSON: Just that one person or the entire general population?

DR. NICOLE ADAMS: Well, while it's--it's an allegation, the--the officer that was accused of whatever the allegation is, that person is removed. And then at that point the chief will decide what type of assignment they will have whether it's still working in the population or doing something different there.

CHAIRPERSON JOHNSON: [interposing] That's outrageous. That is--so someone has been accused of potentially raping an individual, and they are still allowed to work with inmates while the investigation is going on?

DR. NICOLE ADAMS: It depends on the type of allegation, but I think it's the type of allegation--

CHAIRPERSON JOHNSON: [interposing] Well, what type of allegation gets them--what type of allegation in regards to sexual violence gets them taken out of working with the general population?

DR. NICOLE ADAMS: It depends on each individual case. So for example, if there is a concern that this person could potential victimize

other individuals, they're not working with the population any longer, but that's really a decision made by the Chief of the department at that end of the--

CHAIRPERSON JOHNSON: [interposing] How long do--how long do investigations take?

DR. NICOLE ADAMS: It varies.

CHAIRPERSON JOHNSON: What's the average length of time that an investigation takes to be completed?

DR. NICOLE ADAMS: I don't think there is an average length of time because they vary as they--

CHAIRPERSON JOHNSON: [interposing] Well, we need an average length of time. I want to know because if someone has been accused of rape or sexual violence, and the investigation takes six months, eight months, nine months, ten months, however long, that's far too long while other people could be victimized.

DR. NICOLE ADAMS: Fair enough. I just think there are many competing factors that factor into that decision about the investigation, and getting some more information.

FEMALE SPEAKER: I don't if you can [off mic]

DR. NICOLE ADAMS: So, what I was going to begin to elaborate on is this PREA, these--these PREA policies we're--we're beginning to work on in conjunction with H&H. It talks about what is the timeline, and how do we standardize that timeline moving forward. So I think everyone understands the sense of urgency associated with these allegations, and responding in a timely fashion to make sure everyone that's potentially touched by this is safe. And so, I think working with PREA is going to going to get us a place where we have better timelines that we can about.

CHAIRPERSON JOHNSON: Doctor, no disrespect to you, that--that is a very feel good statement that you just made, but that does not answer the questions that we have on the length of time of how people are being handled when allegations are made on the epidemic of sexual violence that are--that is on Rikers Island right now. That sounds nice, but in real world application, where people are being sexually assaulted, sexually abused, victimized and taken advantage of either by other inmates or by

the staff that there's to protect them, that's not an answer.

DR. NICOLE ADAMS: Staff is

CHAIRPERSON JOHNSON: [interposing] So I--I want an answer on the length of time investigations take. What triggers someone being removed from the general population, and when you will be fully PREA compliant.

DR. NICOLE ADAMS: So in talking about real time and a real answer, from working in the jail I can talk about specific instances where I was made aware when an allegation was made. If an--if an inmate or patient came to me and said, I was sexually assaulted, which happened in my experience, immediately the officer was no longer on the unit, and the investigation process started.

CHAIRPERSON JOHNSON: But they were still allowed to work with other--other inmates in some instances.

DR. NICOLE ADAMS: We're going to have to get back to you with some details on this work. I'll do it right away.

CHAIRPERSON JOHNSON: Okay. So when will Rikers Island the Department of Correction be fully PREA compliant. [pause]

DR. NICOLE ADAMS: The process itself of becoming compliant--compliant is several years.

CHAIRPERSON JOHNSON: So several years from now, or several years from when?

[background comments, pause]

DR. NICOLE ADAMS: So we've already begun this process. The first three facilities scheduled to come into compliance are Rose, MDC and INDC.

CHAIRPERSON JOHNSON: When will that--

DR. NICOLE ADAMS: [interposing] Our audit process begins for that next year.

CHAIRPERSON JOHNSON: Say that again.

DR. NICOLE ADAMS: The audit process trying to see kind of where we are in the process of becoming compliant begins next year.

CHAIRPERSON JOHNSON: Who conducts the audit?

DR. ELIZABETH FORD: [off mic] The Federal Bureau.

CHAIRPERSON JOHNSON: The Federal Bureau.

DR. ELIZABETH FORD: Yes.

CHAIRPERSON JOHNSON: So that's three of the jails that you expect will get their audit next year.

DR. NICOLE ADAMS: Yes.

CHAIRPERSON JOHNSON: Out of how many jails.

DR. NICOLE ADAMS: 12.

CHAIRPERSON JOHNSON: So 3 out of 12.

DR. NICOLE ADAMS: Yes.

CHAIRPERSON JOHNSON: So when all 12 be in compliance?

DR. NICOLE ADAMS: We're--we're starting the process. I mean it's--it's--its important for us to be in compliance everywhere. So it's starting for everyone. It just the specific facilities that are expecting to be audited, those three are the first to come up.

CHAIRPERSON JOHNSON: Okay, I am really grateful that the Mayor and Commissioner Ponte had--inherited a God Damn mess when they came into office, horrible. I don't know if you saw the ABC News Report this past week, but it's really upsetting what's been occurring on Rikers far too long. Now the Council has tried, has been trying to undertake

Criminal Justice reform issue to hopefully not have people end up on Rikers. But over the last two budget cycles under the leadership of Chair Crowley and her advocacy, along with the Mayor and Commissioner Ponte, and I'm sure some of the staff that's here today have received an enormous amount of City tax levy. Hundreds of millions of dollars, and you are telling me that you have received all of that money and we're still not fully PREA compliant. We don't know when we're going to be PREA compliant. We'll have three jails next year. We don't when we're going to have 12 jails. Why are we spending all this money if we can't even protect people and ensure that we are compliant with things? People are--need to get their lives back. If they're being raped and sexually abused in our jail system, under our care, it's unacceptable, and I don't feel a sense of like urgency or sickness over this.

DR. NICOLE ADAMS: So I think not the--we PREA compliance itself is a process, but that doesn't mean we're not doing anything to address those individuals that are making these allegations of rape or violence or abuse. We do have immediate response that we support people immediately. The PREA

compliance piece of it has specific regulatory parts that we need to follow, but it's not that people are ignoring individuals that are--

CHAIRPERSON JOHNSON: [interposing] How many people in DOC is work--are working PREA?

DR. NICOLE ADAMS: We all are. Everybody is working on it. Like it's a--it's team effort.

CHAIRPERSON JOHNSON: [interposing] How many were in charge of it?

DR. NICOLE ADAMS: Commissioner-- Commissioner Brand. That is specifically designated. It's her specific project to work on, and she has an entire of compliance officers and individuals that are working to make sure the project is successful.

CHAIRPERSON JOHNSON: Okay, I'd like some answers to all those questions that I laid out.

DR. NICOLE ADAMS: Okay.

CHAIRPERSON JOHNSON: SO, the PACE Units earlier you said that you believe the next PACE Unit is going to come online in the next two weeks. Is that correct?

HOMER VENTERS: In the coming weeks. It's a construction issue, and I don't know the--

CHAIRPERSON JOHNSON: [interposing] But Homer, we've been hearing the coming weeks for a very long time.

HOMER VENTERS: Okay, let's ask DOC its construction issue.

CHAIRPERSON JOHNSON: So what--what is-what is--I'll ask Dr. Adams since she--

CHAIRPERSON JOHNSON: [interposing] I don't want to hear the coming weeks. I want like a date. We're going to open--be open by this date and then we can come back and say why weren't you opening by this date? What's the date that the next PACE unit will be open?

DR. NICOLE ADAMS: I don't have a date to give you at this time.

CHAIRPERSON JOHNSON: What do you think the date is going to be?

DR. NICOLE ADAMS: I--I can't speculate.

CHAIRPERSON JOHNSON: Well, what's--what's the hold up?

DR. NICOLE ADAMS: The hold up is by June 1st we're making sure to end punitive segregation for our adolescents, and all of our resources and focus is ensuring that that's going to happen. So we're

focusing on opening our secure unit. So it's the construction around making sure that happens that is causing the delay currently.

CHAIRPERSON JOHNSON: So you just asked for a variance at the Board of Corrections to extend the amount of time?

DR. NICOLE ADAMS: Yes.

CHAIRPERSON JOHNSON: Extend the amount of time on what? To extend the amount of time of-- of--of not having everyone taken out of solitary, right?

DR. NICOLE ADAMS: Right.

CHAIRPERSON JOHNSON: So--

DR. NICOLE ADAMS: [interposing] So, to-- to clarify, we're working towards having it open June 1st. That is our goal. That is what is before us. Every single day that's the focus, but in the case that doesn't happen, we want to make sure the variance is in place.

CHAIRPERSON JOHNSON: This is like really embarrassing. I mean I completely support and I applaud the Mayor and I applaud his leadership on these issues, because I think he has done a great job at making some significant policy changes, and

prioritizing Rikers when it was neglected for a long time. So I give the Mayor credit, but what I'm hearing today from the folks that have to implement the Mayor's vision is--it does not give me much confidence. I mean you--the--all these questions you don't have answers to. Okay, so if we're behind, and you can't give me a date on when PACE is going to open, when do we expect, how do we expect to stay on target for two PACE units for fiscal year to open? Is that realistic?

DR. NICOLE ADAMS: We think so.

CHAIRPERSON JOHNSON: How?

DR. NICOLE ADAMS: I think that all of us want these things happen to happen in a way that's timely, in a way that we can be accountable, and I--I really do appreciate the conversation. I don't take it personal at all. What I do feel like is that you are entitled to those answers, and you do need that timeline. It's just many times when we come to these meetings, and we say the things that we would like to see happen, other things end coming into play that cause delays, and that's not a good answer. That is a real answer, and when we talk about kind of trying to identify those priorities so that we can move

forward with these initiatives. You know, we want to end punitive segregation. It has to end. We see all the research about it.

CHAIRPERSON JOHNSON: Right it sounds like we can't like chew gum and walk at the same time. Like how--why can't--

DR. NICOLE ADAMS: [interposing] It's not that easy.

CHAIRPERSON JOHNSON: No, but why can't we do multiple things at the same time if the Mayor has put an enormous amount of money into this, and entrusted the leadership at DOC to implement his plan? We should be able to do multiple things.

DR. NICOLE ADAMS: And I--okay.

CHAIRPERSON JOHNSON: On the PACE Units, currently DOC is under headcount, correct?

DR. NICOLE ADAMS: Yes.

CHAIRPERSON JOHNSON: Okay, so how do we expect to adequately staff these two additional PACE units per fiscal year if we're under headcount? What's the plan on that?

DR. NICOLE ADAMS: Now, you're talking about from the correction officer standpoint of the mental health--

CHAIRPERSON JOHNSON: [interposing] Both.

DR. NICOLE ADAMS: --standpoint?

HOMER VENTERS: From the health standpoint, we have not had a hard time staffing up. We've been able to recruit staff pretty quickly I think.

CHAIRPERSON JOHNSON: Okay and then on Corrections?

DR. NICOLE ADAMS: We have three--we're recruiting strongly. We actually just graduated a class of approximately 700. We're expecting a new class to come in, and we're continuing our recruiting efforts to make sure we have officers in place.

CHAIRPERSON JOHNSON: Okay, I don't know if this was asked before, but there was a jail health report that was sent to the Council earlier this month. I don't know who can answer this question but do you think that report was adequate that was sent to us to be in compliance with local law? Because it didn't have much information, and the information that was provided to the Board of Correction was actually a lot more robust than the information that was provided to the Council, and we passed a law. So why--what is the Board of Correction getting more

information that the City Council when we're the oversight body?

ROSS MACDONALD: So the indicators that were sent to you are directly related to the bucket's intake, follow-up care, patient safety, available hospitalizations that were in the bill. Indicators are responsive to that, and they were developed I guess as par of an apparatus that's new to the Correctional Services. So in the past, the report that you had received was a contract document essentially from Corizon. These indicators that you have received are static and ossified in the contract. They were non-changeable until we negotiated another contract, and essentially with that process, we have come together with Corizon. They will--we would talk about the indicators that they didn't meet, and they would be fine. And that was part of a--a process and a methodology that didn't work. It was reactive essentially to what was--was going wrong. So as part of Health and Hospitals we have a new Senior Director of Quality Assurance. We also have direct responsibility to governance of Health and Hospitals the Quality Assurance Committee. These indicators that you

received are the same indicators that for the most part that we send to them to review, and these are the experts essentially for healthcare for Health and Hospitals that they use to review our care that we're delivering them in the jails.

CHAIRPERSON JOHNSON: So for example, do you track completeness and timing of intake?

HOMER VENTERS: Yes.

CHAIRPERSON JOHNSON: Do you track wait times for scheduling appointments?

HOMER VENTERS: Yes, but it's different across types of encounter.

CHAIRPERSON JOHNSON: Do you track care for specific commissions?

HOMER VENTERS: Yes.

CHAIRPERSON JOHNSON: Okay. So these are all things that Corizon tracked as well. Why don't we have this data?

HOMER VENTERS: So we put together a report that was responsive to the law. We can certainly talk about how this report looks going forward.

CHAIRPERSON JOHNSON: But the Board of Corrections got more information than we did. This

is what the Board of Corrections got. It's a lot of information. The Council got like nothing. Not much. They got a lot more than we did. It's--it's--it's like it's unacceptable. I'm going to turn it back over to Chair Crowley.

CHAIRPERSON CROWLEY: Thank you, Chair Johnson. Earlier DOC was reporting the number of correction officers or how many correction officers are you in headcount.

DR. NICOLE ADAMS: 1,200.

CHAIRPERSON CROWLEY: 1,200.

DR. NICOLE ADAMS: Yes.

CHAIRPERSON CROWLEY: So how many are staffing Elmhurst Hospital and how many are staffing Bellevue Hospital [pause]

DR. NICOLE ADAMS: Approximately 170.

CHAIRPERSON CROWLEY: For both hospitals?

DR. NICOLE ADAMS: Yes.

CHAIRPERSON CROWLEY: Because I visited Elmhurst Hospital recently and there were a lot of correction officers there, and there were hardly any patients. So do you have correction officers going directly to the hospital and not knowing how many inmates are going to be there?

DR. NICOLE ADAMS: I think that at times yes, the population can be trendy.

CHAIRPERSON CROWLEY: I mean it's a yes or no question.

DR. NICOLE ADAMS: Yes.

CHAIRPERSON CROWLEY: My numbers are showing that in Elmhurst Hospital you have 72 correction officers working for five inmates. That seems like a very large ratio. So say 72 work. They're stationed to work there regardless of how many inmates there are.

DR. NICOLE ADAMS: Kind of.

CHAIRPERSON CROWLEY: Well, doesn't that seem wasteful?

DR. NICOLE ADAMS: It could be. I think it depends on the needs that we were trying to meet at the time.

CHAIRPERSON CROWLEY: But that's not even the Mental Health Unit. Your Mental Health Unit, which probably would requite a good--the ratio that you would need more officers is at Bellevue. I'm--you know, if the department is at 1,200 officers below headcount, you have to look at where you're wasting, and--and to me it would seem very wasteful.

First, I saw it first hand how many officers were there and how few inmates/patients there were. But regardless I need to know. Regardless--e you sending regardless of how many even if there's not one inmate there you are going to have 72 correction officers working out of that hospital?

DR. NICOLE ADAMS: We have to be prepared for the maximum potential inmates that could essentially be there any time, but I think your point is duly noted, and it's something we can absolutely look and have a further discussion about. The Commissioner is very committed to kind of looking at what are ways that we can streamline where we're being staffed so that we can make sure we have appropriate support in places that need more officers. So, duly noted. I've been there myself as well. I--I--I noticed exactly what you saw, a few inmates and lots of officers.

CHAIRPERSON CROWLEY: Right, and the department is 1,200 officers below headcount?

DR. NICOLE ADAMS: Yes.

CHAIRPERSON CROWLEY: How many PACE units or specialty units are there altogether? You know, I know they've very different. They have different

names, CAPs, anyone of them. How many different units do you have H&H working with.

HOMER VENTERS: We have about 30. For the Mental Health Service, we have about 30 mental observation units.

CHAIRPERSON CROWLEY: And this is where inmates stay for 24 hours of the day?

HOMER VENTERS: Those are housing areas--

CHAIRPERSON CROWLEY: [interposing] Housing areas.

HOMER VENTERS: --that are actualized. Yes. We also have other areas like the Infirmary--

CHAIRPERSON CROWLEY: [interposing] Of the 30, how many inmates are served in the 30? How many inmates are under the constant watch of H&H?

HOMER VENTERS: In those mental observation areas, there are probably about 800 patients, 800. Dr. Ford has a better--

DR. ELIZABETH FORD: 864.

CHAIRPERSON CROWLEY: Oh, good and is there a--or how--how many are on a waiting list to get into one of those units.

DR. ELIZABETH FORD: So in terms of the--the Mental Observation Units, we actually have 29,

and there's--there's one CAPS unit. There are three funded PACE units, and then again there's the fourth PACE unit that's coming on. There--we have at any time identified the numbers of patients who can benefit from a pace level of care, particularly those who are coming back or headed to the State hospitals who have been found not fit to stand trial or have been restored to fitness.

CHAIRPERSON CROWLEY: Of these units are you including Alternative of Punitive Segregation?

DR. ELIZABETH FORD: So CAPS is the alternative to Punitive Segregation Unit.

CHAIRPERSON CROWLEY: And that's the only unit?

DR. ELIZABETH FORD: That's an MO unit specifically for that population.

CHAIRPERSON CROWLEY: Right, right but that is the only unit that H&H sees--oversees that is for those that would have ordinarily been sent to Punitive Segregation, but they have mental observation.

DR. ELIZABETH FORD: That is the only mental observation unit, yes, in that category.

CHAIRPERSON CROWLEY: And is there a way to administrate (sic) that unit?

DR. ELIZABETH FORD: Not at this time.

CHAIRPERSON CROWLEY: How many inmates are in CAPS?

DR. ELIZABETH FORD: That's a good question. I have to get back to you about that.

CHAIRPERSON CROWLEY: All right, because I heard differently. I heard that there was a long waiting list.

DR. ELIZABETH FORD: At this point we have 18 beds on that unit.

CHAIRPERSON CROWLEY: And how many--how many inmates are in Punitive Segregation in the total population?

DR. ELIZABETH FORD: I'll have to defer to the Department of Correction on that.

[pause]

DR. NICOLE ADAMS: There are 164 individuals in punitive segregation at this time.

CHAIRPERSON CROWLEY: There are 164 inmates out of the entire population?

DR. ELIZABETH FORD: Yes, ma'am.

CHAIRPERSON CROWLEY: And there are 18 that would have other--ordinarily gone into a punitive segregation area, but they had mental health needs so they are in CAPS?

DR. ELIZABETH FORD: Yes.

CHAIRPERSON CROWLEY: Yes, and there's no waiting list for CAPS?

DR. NICOLE ADAMS: Dr. Ford is going to clarify.

DR. ELIZABETH FORD: Sorry. So I'll try--I'll try to clarify the process. So yeah when--when an individual receives an infraction, and is--is on the mental health service, they're assessed by our team to try to better understand whether they need to be in the CAPS unit or not, which is specifically for individuals with serious mental illness. We also provide treatment in the RHU, which is another alternative setting for individuals with mental illness.

CHAIRPERSON CROWLEY: Right, I'm just trying to get at whether you have people who are the waiting for CAPS because the violence is out of control at Rikers, and we hear back from people who are working there that there are a number of people

who are waiting to go into a specialty unit, but have to stay with the general population because there's no space for them and those are the folks, the inmates who have been infracted, and that they're likely to continue to infract, and a lot of those infractions are flight acts of violence and affects overall safety. So, I'm trying to get at how many individuals are waiting to go into CAPS to understand whether you're building enough of these mental observation alternative spaces to keep the overall population safe.

DR. ELIZABETH FORD: Understood. So just a point of clarification from our perspective, we do have individuals waiting to get into these higher level units. Largely those are not individuals who have infractions. So they're people who we think need treatment to avoid violence, and to avoid mental health decompensation, if that helps to answer your question.

CHAIRPERSON CROWLEY: Yeah, I would like to get the exact numbers. I--I do believe we passed a bill to get the number that the Department of Correction is supposed to be reporting to us, and I

haven't seen those numbers. And so, you have them because we--we should have them. Do you have them.

DR. NICOLE ADAMS: I just need a second. You're specifically talking about violence numbers, and--and the number. Yes, I actually have them, and I'm happy to share it with you as well. Would you like me to report on those like we--we talk about--

CHAIRPERSON CROWLEY: [coughs] Basically, how many inmates would--have infracted, and should be put into the CAPS unit, but cannot go to the CAPS unit because they're on a waiting list. I just want to know what the waiting list looks like

DR. NICOLE ADAMS: Okay, we don't have a waiting list. We do not have a waiting list. The numbers that I was talking about that I had to share with you specifically talk about the different types of violence, and what those numbers have been since January.

CHAIRPERSON CROWLEY: I'd like a copy of it.

DR. NICOLE ADAMS: Certainly.

CHAIRPERSON CROWLEY: Yeah.

DR. NICOLE ADAMS: Can I, Council Member, when we were talking about the--the officers that are

working at the hospitals, just for a point of clarification, their only task is not just to service those, or support those inmates that are in there. They're actually also doing escorts for specialty clinics. They're also serving as relief for other officers as they come back from their hospital run, and they also can be sent back to their individual facilities as need dictates. It's all--but you may see a large number in the moment specifically there. They have multiple other responsibilities determined by kind of what is the need that the captains communicate at the time.

CHAIRPERSON CROWLEY: I want to make sure that there are--that you don't have a situation where you have correction officers standing around the hospital without any inmates to look after, and the need for 1,200 more on Rikers Island or your various facilities. There are obviously--there is a number of officers based what I have observed that are not doing anything at the hospital because there's nobody there to take care of or to--to have in their own custody.

DR. NICOLE ADAMS: Duly noted.

CHAIRPERSON CROWLEY: And I just want to make sure that the department is not being wasteful there because I've--I've seen--I've seen the waste of the officers there and I want to make sure that they are in the facilities where they're needed.

DR. NICOLE ADAMS: Duly noted. Thank you.

CHAIRPERSON JOHNSON: Sure. Council Member Crowley may have just asked this [coughs] but I want to understand for the units that are replace solitary units, the new restricted housing units, what is the Health and Hospitals role in those units.

HOMER VENTERS: Sure. So just to make sure I understand, you're talking for the young adult--

CHAIRPERSON JOHNSON: Yes.

HOMER VENTERS: --they have the units, they're variously called secure units for the most restrictive and then there are second chance and true units. So those settings are not mental health settings. They're not mental observation settings. We don't count them as--as clinical settings, and the distinction is that we're not the ones deciding that people need to go there and not go in there for, you

know, a clinical treatment need. However, we are partnering with the Department of Correction to make sure that we have access to the patients that we can deliver all the health service, mental health services that are needed for those patients. Importantly, any patient that has a medical of behavioral health need that would be better served by being in a different setting or more clinical setting, we are--we have full agreement that we can identify those patients, and have them transferred whether it's to the infirmary or mental observation area, any clinical setting. So they're not health units. However, we will be there providing care, and we will have the capacity everyday to identify people who need to go somewhere else.

CHAIRPERSON JOHNSON: So the most recent report from the Federal Monitor in Brad H. settlement found that DOC is out of compliance with numerous criteria. When does the Department of Correction expect to be fully compliant with Brad H.? [pause]

DR. NICOLE ADAMS: I don't have specific information about that report, but I know that we meet all the time to talk about ways that we must be in compliance immediately. I don't think waiting--

waiting is not something that we want to do. We work towards compliance daily.

CHAIRPERSON JOHNSON: Are you--are--you know the report I'm talking about, the Federal Monitor--

DR. NICOLE ADAMS: [interposing] Yes.

CHAIRPERSON JOHNSON: --made a report.

DR. NICOLE ADAMS: Yes.

CHAIRPERSON JOHNSON: So what--what are the criteria that the department's not compliant on?

DR. NICOLE ADAMS: I'm not familiar with the specific requirement--the specific areas, I don't have that report.

CHAIRPERSON JOHNSON: [interposing] Is there anyone here that is? Yeah.

DR. NICOLE ADAMS: No, not at this--I don't know.

CHAIRPERSON JOHNSON: No? There's no one here to--

DR. NICOLE ADAMS: Not at this time.

HOMER VENTERS: I apologize the Federal Report that I--there's a Federal Report that relates to Nunez. I mean that's the federal process, then there's--then there's the Brad H. Process where we

have a quarterly report that comes out about discharge planning

CHAIRPERSON JOHNSON: I'm not talking about Nunez. That was settled three months. I'm talking about the original Brad H. settlement that requires federal monitoring. The most recent Federal Monitor report has said that DOC is out of compliance multiple--in multiple ways, and I want to understand when not DOH--DOC--when DOC is going to be compliant?

DR. NICOLE ADAMS: I can speak to that at another time.

CHAIRPERSON JOHNSON: Because we have no sense?

DR. NICOLE ADAMS: Not right now. Sorry.

CHAIRPERSON JOHNSON: Okay. I want to go back to the--the report that was provided to the Board of Corrections. So can we expect in the future that--that we're going to be given the same information as the Board of Corrections since this is public, and we can go look it up ourselves. Instead, it might be easier if you just send it to us instead of sending less data.

HOMER VENTERS: Yes, we can do that.

CHAIRPERSON JOHNSON: Great, and then lastly, I want to ask about [coughs]--so the department is required to identify inmates who repeatedly enter Corrections' custody and who are part of the shelter system. So homeless people they, you know, break the law in some way. They end up on Rikers Island. What does the department do with that information when they receive it? Do they talk to DHS? Do they reach out to a social service provider to try to ensure that this person doesn't become frequent flyer and continue to enter the system? What gets done?

DR. NICOLE ADAMS: So you're talking about the discharge planning for the non--or non-mentally ill--

CHAIRPERSON JOHNSON: [interposing] Homeless people.

DR. NICOLE ADAMS: Homeless people.

CHAIRPERSON JOHNSON: Yeah.

DR. NICOLE ADAMS: We actually have partnerships with the Fortune Society, Osborne and they actually come in and--so we--we reach out to those partners, and we talk about what options are available. They actually have spaces in our

facilities to provide ongoing care and services as appropriate. It's made available to every inmate, and the inmates that have been identified as seriously mental ill and mentally ill, discharge planning services happen with H&H.

CHAIRPERSON JOHNSON: So is this information made part of their discharge plan, these individuals' discharge plans?

DR. NICOLE ADAMS: We--

CHAIRPERSON JOHNSON: There may not be a--if you're saying they're going to work, or you're going to connect them to Fortune, and Osborne, is that included in their discharge plan?

DR. NICOLE ADAMS: Yes, meaning--yes, that ongoing conversation happens. They come in with the inmates, and they have options. Actually spent some time at Fortune talking about ways that we can enhance those services for inmates.

[background comments]

CHAIRPERSON JOHNSON: So my bill, Introduction 1013 would require DOC and DHS to place inmates who have been identified as having multiple arrests and having lived in shelter into appropriate treatment. Are you saying that you do that already?

DR. NICOLE ADAMS: It's--it's happening already. Yes, it does exist to some extent. We'd be happy to have more discussion about the ways that we can make that--make sure that all the concerns that you have presented in your bill are being addressed, but that service does exist already in some way.

CHAIRPERSON JOHNSON: So, does--does the department have a contract with any of these organizations to actually provide a housing plan for such individuals who are homeless, they're going to be discharged? you know they're going to end up back on the streets. They--there isn't supportive housing for them to be immediately put into. Is there a contractor or is it just a--a volunteer relationship with these non-profit providers that are already doing this type of work? [pause]

DR. NICOLE ADAMS: I'm not--I'm not exact--I'm not exactly sure, but I can get back to you because I meet with them regularly, but as far as is there an actual contract or is it just an understanding, I need to get clarification on that point.

CHAIRPERSON JOHNSON: That would be helpful and the same--

DR. NICOLE ADAMS: [interposing] Okay, great.

CHAIRPERSON JOHNSON: --and the same for drug treatment and mental health treatment if necessary.

DR. NICOLE ADAMS: I'll find out and get back to you.

HOMER VENTERS: We have--we do have specific contracts with partners in the community so that when we have--there's multiple processes and so one is that if we identify people as having concerns, as--as part of their health discharge planning, the mental health discharge planning or for people with chronic medical problems for HIV or substance use disorder, we will make referrals to DHS for instance for some patients. There are other patients, however, that aren't going the DHS route. They're going actually to some sort of other housing arrangement. We also have partners--we have community partnerships. There are contracts call Lincoln Spam (sic) that has to do with accessing social services for people that are--that they're on their way out of the jail. And I don't know if Patrick wants to mention that, but basically we have

multiple contracts with--with Pilot, the--the non-profit world. We also have close collaboration with DHS.

CHAIRPERSON JOHNSON: Okay. So how many people are in the Restrictive Housing Unit, the solitary light setting for mental health patients?

HOMER VENTERS: Dr. Ford would know. I would guess it would be around 25 or 30. 30.

CHAIRPERSON JOHNSON: And how much time out of cell are these individuals getting per day?

DR. ELIZABETH FORD: So speaking specifically about the one unit, the Restrictive Housing Unit.

CHAIRPERSON JOHNSON: RHU, yes.

DR. ELIZABETH FORD: RHU, yeah. So they are on progressive hours out of cell per--per week, and we've actually reduced the time it takes to earn that given the changes in--in SAG (sic) time, and so based on the patient's behavior they earn progressive hours. It could be--

CHAIRPERSON JOHNSON: [interposing] What's the most number hours you can earn?

DR. ELIZABETH FORD: I believe it's five, but I'll have to--

CHAIRPERSON JOHNSON: [interposing] Five per day?

DR. ELIZABETH FORD: Yeah, not including groups. So you get an hour out for groups, and for individual sessions, but I'll have to double check on those.

CHAIRPERSON JOHNSON: [interposing] And those are each an hour? Group's an hour.

DR. ELIZABETH FORD: Yeah, group is roughly an hour and--

CHAIRPERSON JOHNSON: And individual?

DR. ELIZABETH FORD: Individual varies, but it's about half an hour to 45 minutes.

CHAIRPERSON JOHNSON: Okay, so five hours plus potential two hours, seven hours. So otherwise people in RHU are in their cell for 17 hours a day alone?

DR. ELIZABETH FORD: So again, I'll confirm the--the high level of hours, but as a reminder the RHU is considered a punitive segregation house, and so mental health does not control as many of the times--many of out the out-of-cell time.

CHAIRPERSON JOHNSON: And you said there are 30 people currently in RHU?

DR. ELIZABETH FORD: We'll have to figure out exactly the number, but I think roughly that, yeah.

CHAIRPERSON JOHNSON: And out of those 30 people, have they been in RHU for longer than 15 days?

DR. ELIZABETH FORD: I'm sure some of them have, but I don't know the exact number.

CHAIRPERSON JOHNSON: Homer, do you think that's bad from a medical standpoint?

HOMER VENTERS: I think that the obligation we have to our patients is to get them into settings that are restrictive, and that that--

CHAIRPERSON JOHNSON: [interposing] So then why do we have RHU?

HOMER VENTERS: We have gone from five RHUs to one and this process of reducing the footprint of solitary confinement and the number of patients, and the length of time they're exposed to this is--we've made a lot of progress, but we haven't finished the job.

CHAIRPERSON JOHNSON: Okay. So I'm not going to ask any more questions. I--I just want to say that as tough and difficult as I've been with you

all in this hearing, I know that you have an enormously difficult job, and that you're working in an incredibly stressful, intense sometimes dangerous situation and setting. That is not an workplace to be in, and the providers, the psychiatrists and the medical staff and even the correction officers who are there for the right reasons and who are not breaking the law, and are treating people with respect they're there for the right reasons as well, and they deserve our credit and respect. I want to praise the Mayor and thank the Mayor for actually from the start of his Administration, where this wasn't really talked about during the campaign or even in the first 90 days of his administration, for really grabbing this really difficult head-on. Putting an enormous amount of money, getting rid of Corizon where people were dying, bringing in Health and Hospitals Corporation. Getting Health and Hospitals Corporation a huge amount of money to actually do this type of work, and putting good people like Dr. Homer Venters in charge of trying to make some changes, and Patsy, who has-- You have done such a good job at making this transition, and I know how difficult it's been. So I am not here to--

to try to besmirch you or to say that you are not doing your job. But there are so many unanswered questions. I mean the number of unanswered questions is like embarrassing to day. It's like did you not expect to come to a hearing after all this has happened mostly from the DOC side, and be able to answer questions on things that we've asked during multiple budget hearings that have been rolled out with the Board of Corrections that have been talked about in the press that advocates have testified about, that law enforcement have been involved in, that the U.S. Attorney has looked at, where there have been Federal Monitors and settlements, and not have not a--not have answers? It's like embarrassing. So I want to thank you because I know that this is really difficult work, and I know that there have been enormous changes in the right direction, and we still have a lot, a lot, a lot more work to do. But I think that in the one facility that has seen the changes fully implemented, it's been really good results. There results have been good when the plan has been executed. We need to execute the plan in all the facilities. We need to treat our inmates, many of whom are mentally ill,

with dignity and respect and rehabilitate them and get their lives back, and send them back out into the world as productive New Yorkers who are going to be treated with the care that they need so that they don't end back on Rikers, so that they don't become Kalief Browder. So that they actually can get back and reintegrate into society. I know that many of you who are involved in this work share that goal, which is why you're doing it. And so, I look forward to working together with you to actually see it executed and done. But showing up to a Council hearing with--with--not with answers I expect that [coughs] Chair Crowley and Chair Cohen and myself and our staff and committee staff are going to send you pretty quickly, probably the beginning of next week dozens of questions that were not answered here today. And I would hope that we could get an answer not in two weeks or three weeks or a month or two months, which is what typically happens. But that given the level of seriousness surrounding this, given the amount of money that the City has put into this that we will get questions in a timely manner. Which I think a timely manner for these questions is like a week, a week to come up with answers. So,

thank you for testifying. Thank you for your hard work. Patsy, Homer, DOC, I look forward to working together, and I want us to all to do right by the people who have ended up at Rikers and are trying to get their lives back. And I look forward to a day, one day when we are not torturing New Yorkers that end up on Rikers. Thank you.

CHAIRPERSON CROWLEY: Thank you, Co-Chair Johnson. Just because no one here from DOC or H&H knew the answer to the question I had earlier about how many people are waiting to go into a segregated area, the DOC has reported to the Council that over 700 people were on a waiting list in March, and that--that's only two months ago. So I don't believe that you've taken care of the 700 people.

DR. ELIZABETH FORD: So, I--I believe your question to us was how many people are waiting to get into CAPS, and that's a different program.

CHAIRPERSON CROWLEY: Well, actually it was how many people with a mental health need that have infracted, and have been disruptive to the general population, causing violence or a need to be segregated, and brought into an area where they have healthcare professionals working with them, how many

of those? That was what I was asking about, and we understand that that number is over 700, greater than 700. [background comments] And I just want to make sure you're

DR. ELIZABETH FORD: [interposing] So--so--

CHAIRPERSON CROWLEY: --that--that the Department of Correction is aware of this because there needs to be a plan put in place to make sure that there is no waiting list.

DR. ELIZABETH FORD: So, Councilwoman Crowley, just to be clear from our perspective. There are--there is not waiting list for individuals who--with a serious mental illness. So that's not all of the mental health group, but with a serious mental illness who have also been charged with an infraction who are waiting for a CAPS bed. In part that's because we've done a much better job helping the individuals with serious mental illness avoid committing infractions. However, at this time, we don't have a waiting list for CAPS. There does appear to be a waiting list for other segregation house, but not CAPS.

CHAIRPERSON CROWLEY: For people who have mental health needs?

DR. ELIZABETH FORD: For individuals who may have mental health issues. Yes.

CHAIRPERSON CROWLEY: Right.

DR. ELIZABETH FORD: But in CAPS.

CHAIRPERSON CROWLEY: [interposing] And what does the Department and Health and Hospitals plan to do to address that waiting list?

HOMER VENTERS: So to the extent--first of all, I jus want to correct the misconstruing of the relationship between mental health and violence. Mental health does not equate violence. Violence does not equate a mental health problem. Secondly, many people are identified as not appropriate to go into solitary confinement. We're not going to change that determination. Those people often are in mental health units. That's exactly where they should be.

CHAIRPERSON CROWLEY: I'm not asking for the individuals going into Punitive Segregation.

HOMER VENTERS: The list you wrote is a reference to--is--

CHAIRPERSON CROWLEY: [interposing] But the list has to do with the 700 plus being in general

population. Haven't infracted. Many of those infractions have to do with incidents of violence, and they're not removed from the general population or put in an area where they could have the clinical staff meet their health needs, or put in a space where they--they don't have anxiety or get into situations where they continue to infract.

HOMER VENTERS: That's not my understanding of the list. So we'll have to confer later.

CHAIRPERSON CROWLEY: [off mic] You don't have that?

HOMER VENTERS: I'm saying that's not my understanding. My understanding is many of the people on that list, in fact, have been identified as needing mental observation areas, but they're still on that list as waiting to be punished. It's our view, however, that if we identify people who have a mental health concern that should supersede the need to punish them with solitary confinement.

CHAIRPERSON CROWLEY: Why do you have this list if the department has no plan to address the people on the list?

HOMER VENTERS: I'm not sure what list you're referring to. So I think that we need to find out what data you've received and that--

CHAIRPERSON CROWLEY: [interposing] It's a list of people who have infracted who are under mental observation and considered to have mental health needs, and they're infracted--they've infracted in the general population. There's a significant level of violence happening on Rikers Island, and I'm not saying that somebody with a mental health diagnosis is more likely than someone who is not. I'm just saying that there is a large number of individuals who are inmates, who have infracted who continue to stay in the population, and they're not getting the services they need, and they're endangering the other inmates in the population.

HOMER VENTERS: So it sounds like we may have different data. So we'd like to sit down with you, and hear about what list it is you're talking about. [pause]

CHAIRPERSON CROWLEY: Okay, so we'll have to continue that dialogue, but that's something I'm very concerned about as well as the waste of

correction officers at these hospitals or health facilities when there aren't inmates there to be in their custody. So, I look forward to working together, and I--I do appreciate the Department of Health and Hospitals taking over the delivery of healthcare on the island, and I do think that it's moving in the right direction. So, I thank you for being here today, and for your commitment to providing this service, and I look forward to working together more so. There's no further questions or need for the Administration. If somebody from Health and Hospitals and somebody from DOC could stay while member of the public are testify, I'd appreciate that. Thank you. So first up from the public we have testifying today is Lillie Carino Higgins, a representative of 1199 SEIU. [pause]

[background comments]

CHAIRPERSON CROWLEY: Okay. For the record, we have--

MALE SPEAKER: Legal Aid.

CHAIRPERSON CROWLEY: --we have Legal Aid that submitted testimony as well as the Coalition for Behavioral Health Agencies, Incorporated. [pause] Good afternoon.

Hello, good afternoon.

SERGEANT-AT-ARMS: [off mic] Keep it down, please. We have someone to testify so we hear her. (sic)

LILLIE CARINO HIGGINS: My name is Lillie Carino Higgins. I'm here today to testify on behalf of 1199 members who provide healthcare services in correctional facilities. Thank you for this opportunity to testify on these pending bills, and on Resolution 461, all of which we fully support. A year ago, we testified that existing problems inside correctional institutions were serious, and that unless addressed any contractor identified to replace Corizon Health would face similar obstacles. We were not mistaken. The lack of interagency collaboration, cooperation and coordination continue to impact healthcare services provided to inmates as well as the safety of the staff. We recognize that DOC is responsible for security and the day-to-day operations and that at all times persons physically located inside the prison whether they are inmates, visitors or staff are in the custody and care of DOC. DOC will be more effective if they engage the staff in discussions about safety, and particularly when it

comes to serving the large proportion of mentally ill inmates housed in their facilities. This becomes extremely important. 1199 and the other healthcare unions, namely, NYSNA and Doctors Council have long advocated for cross-training with uniformed and civilian staff. A team approach will go a long way toward minimizing assaults against staff. Working together, DOC and healthcare providers will be better equipped to find solutions. HIPAA laws we know prohibit officers from being present during medical exams and procedures, but steps can be taken to decrease the number of incidents of assault. For example minimizing waiting times for appointments. Escorting inmates by correction officers in a more organized and timely manner. Posting correction officers inside the clinics, utilizing cuff bars for violent and aggressive inmates, and on-body panic buttons are all preventive measures that we have proposed and we feel the city needs to seriously consider. Escorting medical staff while doing their rounds and delivering medication to housing units would increase safety as well. Flagging and/or coding medical charts to identify violent inmates. The severity of mental illness that these inmates

might be afflicted with. The chronic medical conditions that would also go a long way. Like we have patients who may not be mentally ill, but have cardiac conditions or diabetes or something else. Like their files should flagged, and we believe that this will go a long way toward a more unified service delivery system, particularly in crisis episodes such as lockdowns and other occurrences that prevent inmates from visiting the clinics or keeping their appointments. Violence against healthcare workers will persist at Rikers and the other facilities until the necessary steps are taken to improve safety and communications amongst all of the workers in each of their facilities. Thank you again for this opportunity to testify.

CHAIRPERSON JOHNSON: Lillie, I want to thank you, and I just want to give you a message, which hopefully you can give to give to the workers on Rikers Island, and I just want to say thank you. I mean thank you to them for doing this very, very difficult work in a very difficult environment and atmosphere. I'm sure that these very well trained, competent 1199 members could probably get jobs in other places if they wanted to--

LILLIE CARINO HIGGINS: [interposing] Amen.

CHAIRPERSON JOHNSON: --and--and--and make more money, and they are doing this because they are dedicated to doing this type of work, and if you could let them know that the City Council thanks them for their service, and for putting themselves out there like this.

LILLIE CARINO HIGGINS: Thank you, and thanks for your persistence because you have been--both of the Chairs have been consistent in looking out for the corrections--the healthcare services and corrections.

CHAIRPERSON JOHNSON: Thank you, Lillie.

LILLIE CARINO HIGGINS: Thank you.

CHAIRPERSON CROWLEY: And, Lillie, I had conversations with the Department of Correction as well as H&H about how they need to incorporate more and more meetings with the staff. Have you noticed the change since the management has shifted?

LILLIE CARINO HIGGINS: They are having more consistent meetings, but it--there are no results as a result of the meetings. Like they don't act on the problems that are presented.

CHAIRPERSON CROWLEY: Do your members feel just as much in danger as they did under Corizon?

LILLIE CARINO HIGGINS: In the last two weeks, there have been four serious physical assaults against our members.

CHAIRPERSON CROWLEY: Yeah, and those inmates were not escorted when they were--?

LILLIE CARINO HIGGINS: I don't have the details with regard to each.

CHAIRPERSON CROWLEY: It shows the importance of getting this billed passed--

LILLIE CARINO HIGGINS: Uh-huh.

CHAIRPERSON CROWLEY: --as soon as possible.

LILLIE CARINO HIGGINS: Yes.

CHAIRPERSON CROWLEY: I--I thank your members for the work that they do as well, and yourself.

LILLIE CARINO HIGGINS: Thank you. Thank you.

CHAIRPERSON CROWLEY: Thank you. [pause] Riley Doyle Evans, Brooklyn Defender Services. [pause[

RILEY DOYLE EVANS: Good afternoon. I'm Riley Doyle Evans. I'm the Jail Services Coordinator for Brooklyn Defender Services. Thank you for the opportunity to testify, and for the important hearing today. Through our Jail Services Division, BDS provides dedicated supportive services and advocacy to our clients incarcerated in city jails, and we thank you for your efforts to improve conditions for people in the jails [coughs] and to thank you for the opportunity to share our perspective. In New York City today like jails around our country, our jail system has become the large--the city's largest mental health service provider. In fact, it is one of the largest mental health providers in the nation. We agree that adequate humane medical and mental healthcare delivery in our jail system is of paramount importance. However, we emphasize that high-need individuals who pass through our jail system cannot get adequate care in a correctional setting. These individuals should be diverted from the correction--from the Criminal Justice System long before being sent to Rikers Island. BDS attorneys spend--spend their days and nights in arraignments vociferously opposing bail requests from prosecutors

who send clients living [coughs] with serious illness to jail for crimes of survival like jumping turnstile or stealing toothpaste or behaviors that likely result from mental illness. These individuals should never have been arrested, but even after the trauma of arrest they could have been diverted at arraignments and certainly should not be incarcerated pre-trial on bail. There is no indication that public safety is served by incarcerating these individuals during the pendency of the their case. Moreover, these cases are indicative of serious shortcomings in public health, housing and other service provisions that's done in the city. Pre-trail incarceration only compounds these issues. When people are unnecessarily incarcerated the interruption in medical care, mental health treatment, housing and other essential service they endure have devastating consequences and pose a serious drain on scarce resources in the community. Although BDS expends significant resources to advocating for our clients' access to medical and mental healthcare while incarcerated, we acknowledge that jail is an inherently pathogenic institution. People who are sick will be made sicker, and those

who enter healthy may leave bearing the scars of trauma, neglect, abuse and mental illness, which they will carry for life. However, with regard to the specific introductions under consideration today, BDS supports Intro 852-A to bolter--to bolster access to care for people in city jails. Presently, sick call as well as people signing up on a piece of paper in a housing unit or informing a correction officer that they wish to sign up. Correctional staff are responsible for bringing those who signed up to the clinic to be seen for treatment. This system ha s many shortcomings principally that corrections officers are the gatekeepers to medical care, and medical staff are never provided the complete list of people who have requested are. Worse, many of our clients have been denied the opportunity even to sign up for sick call. Under the present system, denying medical--access to medical treatment is one of the tools used by correction officers to punish people in the jails. Even if someone is able to sign up for sick call, corrections staff can refused to escort that person to the clinic, and medical staff will never know about their condition. BDS supports Intro 852-A and encourages the Council to amend the

language to go further in facilitating access to care. Our recommendations are detailed in our written testimony, and include mandating that Health and Hospitals have responsibility and control over the sick call process, but the bill requires specialty care to be delivered within the time frame ordered by the provider, and that the department provide dedicated medical escorts. BDS supports Introduction 1013 and the Council's efforts to increase [coughs] the availability of discharge planning services. We believe discharge planning should be available to all the people in the jail system. As mentioned previously, we believe many people in our jails should be offered services before their arrest arraignment and as an alternative to incarceration. Services offered should be voluntary and not mandated as a condition of release or housing. Additionally, Health and Hospitals already plays an important role in discharge planning for many individuals in the jail system, and their expertise should guide discharge planning for all people with medial and mental health conditions who pass through the system. Furthermore, we would welcome enhanced discharge services for individuals

released from court rather than jail, particularly those people with serious medical and mental health needs. Introduction No. 1014. Also BDS supports this introduction and the Council's efforts to document the shortcomings of our current approach to responding to mental illness through recidivism data. It is important to acknowledge, however, that regardless of the quality of discharge planning all evidence demonstrates that incarceration itself increases the likelihood that people will be arrested in the future. The primary driver of reform must be made to divert people with mental illness away from the Criminal Justice System before they are even arrested.

CHAIRPERSON CROWLEY: I--sorry. We have to be out this room by 1 o'clock.

RILEY DOYLE EVANS: Okay.

CHAIRPERSON CROWLEY: Can you summarize the rest of your testimony?

RILEY DOYLE EVANS: Absolutely. It's relatively brief. We support 1144 and advise that the Council may wish to require a certain number of hours of training that relates to trauma-informed care. We support the [coughs] we support 2015, 3243

although we believe that there are some issues with the current language of the bill especially related to NYPD officer speculating around mental health symptoms, and our comments are included in the written testimony. And finally, we support the resolution calling for Medicaid coverage to continue for people in the jails, and we believe that this will have important outcomes both for the individuals as well as for accountability in the system. Thank you.

CHAIRPERSON JOHNSON: Thank you for your testimony. I have a question for you. So what did you think of the testimony by the department today?

RILEY DOYLE EVANS: Which department?

CHAIRPERSON JOHNSON: The--the Department of Corrections.

RILEY DOYLE EVANS: I think it's disappointing in many respects, and it's--it's disappointing that they once again come into a public setting where they should be expecting the important questions that were asked, and again weren't prepared to answer them. Although we were here only a few months and had much the same experience.

CHAIRPERSON JOHNSON: Do you think that there's progress? Have they gotten better in some regards?

RILEY DOYLE EVANS: Certainly there have been improvements. I mean the reality is that there are far few people spending far less time in solitary confinement than there were in the past, but as you noted, anyone who's in such a setting for longer than 15 days is enduring inhumane treatment. And so even one person who's--who's enduring that is--is something this--the city shouldn't condone.

CHAIRPERSON JOHNSON: Okay, thank you very much.

RILEY DOYLE EVANS: Thank you.

CHAIRPERSON CROWLEY: Thank you. Our last up to testify today is Jennifer Parish of the Urban Justice Center. [pause]

CHAIRPERSON CROWLEY: [off mic]

JENNIFER PARISH: Sorry. Good afternoon. My name is Jennifer Parish, and I'm the Director of Criminal Justice Advocacy at the Urban Justice Center's Mental Health Project. Thank you for convening this hearing, and for inviting us to testify. Fundamentally, jails are not conducive to

good health. Conditions of confinements exacerbate health problems. So to the greatest extent possible, individuals accused of committing crimes should not be incarcerated pre-release, and low-level crimes should not be punished with incarceration. We commend the Council on it's effort to reduce the number of people subjected to the criminal court system, and urge you to continue enact reforms that reduce the jail population overall. But the city is responsible for providing health and safety to the people in its custody, and health and safety are intertwined. Where--whenever the Department of Correction develops a policy to address safety concerns, it must consider the possible health implications of that policy, and address any potential repercussions. Health should not be an after thought, but it has been. For example, the Department of Correction, and it's been discussed here and it's part of your bills, it's increased its reliance on escorted movement to address safety concerns. They did not come up with a plan for increasing the number of escorts to en--to ensure that incarcerated individuals could receive prompt medical attention. We think that Health and

Hospitals has potential to improve the healthcare, but it can't do it on its own. It's going to require the full cooperation and support of the Department of Correction. For the--for almost 13 years, the Urban Justice Center has monitored the city's compliance with a settlement agreement in the Brad H. lawsuit, which requires the city to provide discharge planning services to people who receive mental health treatment in the city jails. [bell] Part of the problem with compliance in that has been this division between Corizon and Department of Health and Mental Hygiene. So we are hopeful that this combination of H&H will work, but it won't if the Department of Correction is not on board. From the last Monitor's Report, which you mentioned, they were only providing medication upon release to about 80% of the people who needed it. And when they looked at why that was, 43% of the non-compliance was based on a lack--a lack of escorts. So, you have my written testimony. I just wanted to highlight a couple of things. We definitely support Intro 852-A, and--but reporting will be really important for that bill. You know that H&H has the capacity to report its numbers. It did that very full report the Department

of Correction, I mean for the Board of Correction, but the Department of Correction under the minimum standards is required to report on the number of people who want to be seen for sick call. That's in the standards already. So they should be able to give you those numbers as well. So we hope that you include those requirements in that bill. I am concerned about the bill requiring reporting on recidivism based on discharge plans, and I--I just encourage you to look at that part on my testimony because they actually don't create a discharge plan. When they create a comprehensive treatment and discharge plan, they just create--create a treatment plan. So if you start looking at numbers, it's not really going to tell you anything about what's been successful or not. And the other piece of that is that you should really be looking at what services a person gets comparing people who receive Medicaid at release, had an appointment scheduled. That's going to be more meaningful than whether they actually did a discharge plan or not. It's really about the services. And finally, I have grave concerns about the bill--I think it's T-2015-3243. I don't think it's been assigned a number, the one about the

arrestee mental health screening. That's laid out in my written testimony, but I think it's very concerning that the Department of Health and Mental Hygiene is going to be gathering information about people connecting it to their New York State Identification Number and keeping indefinitely without consent. So I really encourage the bill.

CHAIRPERSON JOHNSON: [interposing] Thank you.

JENNIFER PARISH: You need to consider that.

CHAIRPERSON JOHNSON: Thank you for your--thank you for your testimony. We'll ensure that the staff before you get out before us, make sure the staff looks at your testimony and considers your testimony in making changes potentially to the bills. I just want to say that I'm glad that you came with the chart on how they're not compliant with the Brad H. They didn't have it, but you have it, and it looks like that they're out of compliance in 2, 4, 6, 8, 10, 12, 14, 16, 18, 20 different areas they're out of--they're non-compliant.

JENNIFER PARISH: And actually it's even worse than that because that compliance part at the

top if you look at that, most of those are things that are provided by Span and Link. So they're only compliant in about three or four areas.

CHAIRPERSON JOHNSON: They should have known this. Thank--thank you for your testimony.

CHAIRPERSON CROWLEY: Thank you. I want to thank my Co-Chairs Council Member Johnson and Council Member Cohen. This concludes--and, of course, the staff who worked on preparing this hearing. This concludes the Fire and Criminal Justice, Health and Mental Health Services Committee on May 25th, 2016. [gave] Oh, May 26th [gavel] 2016. [laughter[[gavel]

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date June 15, 2016