Testimony before the
New York City Council

## Committee on Justice Systems
## Committee on Criminal justice
## Committee on Mental Health, Disabilities and Addiction

### Testimony of

**Becky Scott, Bureau Chief of Facility Operations**
**Joseph Antonelli, Acting Associate Commissioner of Budget Management and Planning**

## City Council Oversight Hearing-
## Preventing Recidivism for Individuals with Mental Illness

Good Afternoon Speaker Johnson and Chairpersons Powers, Lancman, and Ayala and members of the Committee on Justice Systems and the Committee on Mental Health, Disabilities and Addiction. I am Becky Scott, the Bureau Chief of Facility Operations with the Department of Correction (DOC). I am joined by my colleague, Joseph Antonelli, Acting Associate Commissioner of Budget Management and Planning.

Before reading my testimony, I would like to acknowledge two recent deaths that occurred in our facilities. The first was of a young transgender woman, Layleen Polanco, and the second was of an older man who passed away in the ICU of Bellevue Hospital while under doctor's care. I would like to extend my condolences to both of their families and loved ones, as well as to the LGBTQI

community, during this difficult time. We take these matters extremely seriously and the Department is committed to providing updates to the Council and the public with additional details as they emerge. I appreciate the Council's understanding that there is not much that can be said with specificity about either case at this time.

I further want to acknowledge that the Department understands that the lack of information in the death of Layleen Polanco is painful and frustrating for her family and friends. Layleen's family deserves answers and we are working with partners in the Bronx DA's office and at the Department of Investigation to provide her family with accurate information as quickly as possible. While this matter is still under investigation, we have not found evidence of violence or foul play contributed to her tragic death.

Safety is this Department's number one priority, which includes safely housing individuals according to their gender identity. We are proud to be known as a national leader in transgender housing practices and remain committed to working with advocates, and this Council, to continue to provide safe and appropriate care for transgender individuals in our custody. As the investigation continues, we remain committed to treating Layleen Polanco's memory, and family, with respect. Once again, we will share more information about this incident as we receive it.

On behalf of Commissioner Brann, I thank you for including the Department of Correction in today's important discussion on serious mental illness and recidivism. The Department recognizes that preventing future recidivism begins by providing mental health support and services to individuals while they are in our care. We are proud to partner with Health and Hospitals' Correctional Health Services to provide health and mental health services across our facilities. In addition to health care services, the Department also partners with a number of program providers to afford access to programming that enhances behavioral coping skills, supports anger management, addresses substance use, and encourages productive and prosocial behavior. It is the department's goal to address the needs of the whole person while in our custody, which includes providing varying levels of mental health support depending on the need.

For individuals in need of enhanced support, the Department also runs several specialized housing units for individuals with more acute mental health concerns as well as those with serious mental illness.

Mental Health Units

Although all individuals have access to mental health providers, certain individuals may require structured support and more frequent observation. For that population, the individual runs Mental Observation units (MOs). MO units operate under the guidance of a multi-disciplinary team of unit-based mental health providers who conduct daily rounds, provide group programing and individual psychotherapy and also oversee medication treatment. MO units are not punitive and afford the same out-of-cell time as General Population units.

For individuals with serious mental illness who require intensive support but who do not require hospitalization, the Department works in conjunction with CHS to operate the Program for Accelerating Clinical Effectiveness, known as PACE. PACE focuses on enhancing coping skills, improving communication abilities, and promoting insight and competency in managing one's mental illness and emotions and behavior. CHS advises the Department on what individuals are suited for PACE placement based on their clinical need.

The Department recognizes that individuals with serious mental illness do not belong in a 23-hour lock-in setting. Since 2016, the Department has eliminated punitive segregation for individuals with serious mental illness and has since housed individuals with guilty adjudications for serious infractions in restrictive units with therapeutic support. Following an adjudication, CHS performs a thorough evaluation to the individual to determine his or her fitness for punitive segregation. If CHS deems the individual is not fit for PSEG, they may be subsequently assigned to units known as CAPS or RHU.

The Clinical Alternative to Punitive Segregation (CAPS) is a housing unit that provides intensive mental health treatments for individuals with serious mental illness who have been adjudicated for a serious infraction but do not need to be hospitalized. Like PACE, CAPS units are staffed by both DOC and CHS personnel

who support residents by helping them enhance their coping skills, improve their communication skills, and develop insight and competency in managing their mental illness as well as their emotions and behavior.

Restrictive Housing units (RHU) provide mental health treatment and programming for incarcerated individuals who have been adjudicated and found guilty of a violent grade 1 infraction, but who do not have serious mental illness. This incentive based housing operates in 3 levels, gradually providing individuals with more time out of cell based on their participation in mental health programming and by displaying positive behavior. Due to the comparatively small population of individuals in RHU at our female facility, the RHU in the female facility operates at Level 3, affording all individuals with up to 7 hours lock-out. Individuals in RHU are afforded 3 hours mental health programming from CHS every week day, including group therapy and art therapy.

Safe and inclusive housing options are part of an evolving conversation about how best to meet a wide spectrum of needs. There is no one size fits all approach, the department has worked tirelessly with CHS to ensure that we provide a responsive plan of action for incarcerated individuals with significant mental health needs.

In addition to providing appropriate therapeutic housing, the Department also recognizes maintaining a robust workforce of well-trained trained staff is critically important to supporting those entrusted to our care.

Providing Mental Health Training for Staff

In 2014, the department began Mental Health First Aid (MHFA) training in its Academy curriculum. The training is conducted over an eight hour day and builds mental health literacy by training staff to identify, understand, and respond to signs of mental illness. By February 2019, the department trained over 7,200 staff members. In August 2016, the department began offering the training to its incarcerated population and through February 2019 has successfully trained over 800 individuals while in custody.

The Department began Crisis Intervention Training (CIT) at AMKC in July 2015, and has since expanded the trainings to five jails. The forty-hour training aims to develop a first-responder understanding of mental illness and intervention skills in

order to achieve safe resolutions to mental health crises. To date, approximately 725 uniform staff have completed the training alongside 206 NYC Health & Hospitals staff who provide health services in DOC facilities. DOC plans to expand CIT trainings to RNDC this year.

Commissary Account Overview

In regards to the legislation being discussed at today's hearing, the Department supports the spirit of Intro 903 and is eager to work with Council, and potentially other agencies or community groups, to improve formerly incarcerated New Yorkers' access to their commissary funds following their discharge from custody. Although we have some concerns about the operational feasibility of all the requirements of Intro 903, we agree this is an important area for reform. We look forward to working with the Council in the coming weeks to better connect formerly incarcerated individuals with nearly $3.7M in unclaimed commissary funds held by the Department.

Thank you again for inviting us to discuss these important matters, and we welcome any questions you have at this time.

NYC
HEALTH+
HOSPITALS

Testimony

of

Elizabeth Ford, MD, Chief of Service, Psychiatry
New York City Health + Hospitals/Correctional Health Services

before the

New York City Council
Committee on Criminal Justice
Committee on the Justice System
Committee on Mental Health, Disabilities, and Addiction

on

# Oversight: Preventing Recidivism for Individuals with Mental Illness
# Int. 1590: Reporting Information to Attorney of Record for Individuals in New York City Department of Correction Custody Diagnosed with Serious Mental Illness

June 17, 2019
City Hall – Committee Room
New York City

Good afternoon, Chairpersons Powers, Lancman, and Ayala, and members of the Committee on Criminal Justice, Committee on the Justice System, and Committee on Mental Health, Disabilities, and Addiction. I am Dr. Elizabeth Ford, Chief of Service, Psychiatry for Correctional Health Services, or "CHS," at NYC Health + Hospitals. I am joined by Dr. Patsy Yang, Senior Vice President for CHS, and Dr. Ross MacDonald, our Chief Medical Officer, in addition to our colleagues at the NYC Department of Correction (DOC).

As the Council is aware, there were two tragic and heartbreaking deaths in the jails this past week. Death in jail, particularly for two individuals who were incarcerated on minor charges, should offend our sense of decency and humanity. Our deep condolences go out to the families, loved ones, and friends of these two individuals.

I began my psychiatric career at Bellevue Hospital almost 20 years ago and witnessed firsthand the deeply harmful effects of jail incarceration on individuals with mental illness. The trauma experienced and the layers of stigma accumulated – mental illness, substance use, incarceration, poverty, race, gender identity – did not disappear when the patient was released from custody. The struggle to survive and to be noticed and to be cared for continued outside of the bars. Community mental health providers, housing agencies, and employers were largely disinterested in providing services and support to those being released from jail.

Since that time, and most particularly since the transition from a for-profit, private vendor to NYC Health + Hospitals on January 1, 2016, the mental health care in the jails has undergone a radical and significant transformation. Guided by the principles of a strong commitment to the mission of providing a community level of care in the jail setting, creating an innovative and patient-centered clinical approach that includes the development of a therapeutic relationship with a consistent treatment team, building a robust network of clinical supervision and staff support, and reducing the impact of incarceration on the mental health of not only those with mental illness, but all incarcerated individuals, the mental health service has been able to flexibly approach the diverse clinical and re-entry needs of our patients and develop what has become a national model of care.

Mental Health Service

All new admissions to the jail receive a comprehensive medical exam, from which they can be referred immediately to the mental health service. DOC, family, advocates, and other health care providers can also refer patients at any time during their incarceration. Every patient referred is seen no later than 72 hours after the referral, and typically within several weeks, a comprehensive treatment and discharge plan has been created. Given the unexpected nature of many of the releases in jail, we try to do as much as we can in the early part of an individual's incarceration.

Approximately 43 percent of the jail population has been under the care of the mental health service at some point during their incarceration. Roughly one-third of the mental health service, 16 percent of the jail population, and approximately 1,100 people at any time, have been diagnosed with a serious mental illness (SMI), defined in our system as schizophrenia, bipolar or depressive disorders, and post-traumatic stress disorder.

There are four broad levels of mental health care available to patients. First, we have the equivalent of an outpatient clinic in each jail, where patients in general population receive individual counseling and medication treatment.

For those patients with serious mental illness, intellectual disability, or who are more vulnerable in the general population, we have 18 mental observation (MO) units, more than 540 beds, spread across the 10 jails and Horizon juvenile center. Each mental observation unit, the approximate equivalent of a residential treatment setting in the community, has a dedicated treatment team that includes a psychologist, a social worker, a psychiatric provider, a creative art therapist, and a court liaison. Patients have access to group therapy, individual counseling and medication management, and unit-based community-building activities.

Court liaisons are a relatively new staff position that we created several years ago in response to the clear struggles that patients with serious mental illness have navigating the complicated, frustrating, and slow criminal justice system. Court liaisons function as the connection between the mental health treatment teams and patients in the NYC jail system and defense agencies, treatment courts, and alternative to incarceration programs across the City. These liaisons communicate with defense attorneys and treatment courts with patient consent and can help expedite medical records requests to facilitate opportunities for diversion from jail.

If a patient has serious mental illness, is at high risk of clinical decompensation in the jail, and requires a higher level of care than the treatment offered on the MO units, we have six Program for Accelerating Clinical Effectiveness (PACE) units, each designed to be as therapeutic as possible given the environmental restrictions of jail. The PACE units are comprised of more than 150 beds. Staffing ratios, for both CHS and DOC, are higher than on MO units and there is a full complement of health staff embedded on each unit for 16 hours per day, allowing near constant access to care and therapeutic interventions throughout the day. Each PACE unit has a specific treatment population, with units for patients returning from State or acute hospitalizations, patients with intellectual/developmental disabilities, and women and men who are City-sentenced. We also have the equivalent of the PACE model of care for individuals with SMI who have been charged with an infraction for which the DOC has determined that punitive segregation is indicated, known as the Clinical Alternative to Punitive Segregation (CAPS). There is one CAPS unit comprised of 18 beds, with an additional 10 beds for patients at Rose M. Singer Center. Since the end of punitive segregation for individuals with SMI, for which we applaud the DOC, we have been providing intensive treatment, rather than lock-in, for these individuals.

The PACE units have demonstrated a 50 percent increase in medication adherence, a 25 percent decrease in both self-injury and injuries sustained as a result of fights, and an 85 percent reduction in 30-day re-hospitalization rates as compared to MO treatment prior to the implementation of PACE.

Finally, we are fortunate and almost unique in the nation to have access to dedicated inpatient psychiatric beds in two H+H facilities – Bellevue Hospital has two units for men who need acute care, and Elmhurst hospital has a unit for women. Patients on these units receive the same kind of psychiatric and medical care as they would receive on the civilian inpatient psychiatric units.

Admission to and discharge from MO units and PACE units, and referrals for psychiatric hospitalization, are all initiated by the mental health service. If a patient requires this level of care, CHS notifies DOC to transfer the patient into the appropriate housing area. CHS and DOC also collaborate in operating what we believe to be the nation's first jointly-led Crisis Intervention Teams (CITs) in a jail. Crisis Intervention Teams respond to MO/PACE and CAPS units when a patient requires additional support to avoid violence or self-injury. Verbal de-escalation, active listening, and teamwork are hallmarks of the CIT response.

Re-entry Planning and Discharge Services

All patients on the mental health service, regardless of the level of care, receive comprehensive re-entry and discharge planning services. Patients who have less severe mental illness receive assistance with Medicaid applications, receive referrals or appointments to community mental health and substance use treatment, and receive medication – both actual medication and a month's prescription – upon discharge. Patients with serious mental illness receive those same services as well as assistance obtaining public assistance, supportive housing, and intensive case management services, such as Assertive Community Treatment (ACT) and Assisted Outpatient Treatment. All individuals with serious mental illness are also offered transitional case management services, through a vendor contracted by CHS, for at least six months upon release from custody. In recognition of the importance of re-entry social work services in the clinical care of our patients, the transition to H+H also involved joining the social work and mental health services – formerly separate – under one clinical service. This has allowed much greater collaboration between the clinicians who are diagnosing and treating and the social work staff who are creating a discharge plan.

In addition, we initiated and have maintained a citywide work group related to the care of individuals with intellectual/developmental disabilities in the criminal justice system and, as a result, have been able to better identify and treat this population in custody, and work more closely with the NYS Office for People With Developmental Disabilities to establish appropriate discharge plans. We have created the equivalent of an ACT team to provide care coordination services for those individuals returning to the jail after being hospitalized with the NYS Office of Mental Health for restoration of competence. This "mobile team" is dedicated to maintaining the clinical stability of these patients so that their cases can be more quickly disposed and they can get out of jail faster.

Conclusion

The ability to provide such a comprehensive level of integrated mental health care has led to some significant improvements. The average suicide rate from 2011-2013 was 18.5 per 100,000. While this is well below the latest national average of 45 per 100,000, the average suicide rate in NYC jails from 2016-2018 was 10.8 per 100,000, almost half the previous rate. We have had one suicide in the past three years, unheard of in the history of the jail system. Self-harm rates have dropped significantly. The MO units no longer have the highest use of force rates. DOC officers are actively expressing interest in learning about mental health issues and are requesting steady posts on mental health units,

including PACE. Since January of 2016, we have hired more than 90 psychiatrists, psychologists, and social workers.

While we do not think that the jail environment is ever the most therapeutic option for the treatment of mental illness, we continue each day to strive to minimize the impact of incarceration, respect the humanity and struggle of our patients, and advocate for greater community involvement in the collective mission to reduce the chance that those not only with mental illness, but all of those with less privilege and more stigma, will end up in jail.

THE
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**TESTIMONY**

**The New York City Council**

Committee on Mental Health, Disabilities, and Addiction
Committee on Criminal Justice
Committee on the Justice System

Public Hearing on

Oversight: Preventing Recidivism for Individuals with Mental Illness.

Proposed Legislation: Int. No. 0903 – In relation to funds remaining in inmate accounts when inmates are released.

Proposed Legislation: Int. No. 1590 – In relation to requiring the department of health and mental hygiene or its designee to report information to the attorney of record for individuals in the custody of the department of correction who are diagnosed with serious mental illness.

June 17, 2019
New York, New York

Prepared by:

Stefen R. Short, Staff Attorney
Prisoners' Rights Project
The Legal Aid Society
199 Water Street
New York, New York 10038
(212) 577-3530

## INTRODUCTION

Thank you for the opportunity to testify about recidivism and the needs of people with mental illness incarcerated in the State of New York, and in New York City specifically. We submit this testimony on behalf of The Legal Aid Society Prisoners' Rights Project and thank Chair Diana Ayala, Chair Keith Powers, Chair Rory I. Lancman, the Committee on Mental Health, Disabilities, and Addiction, the Committee on Criminal Justice, the Committee on the Justice System, the other sponsors of Intro No. 0093 and Intro No. 1590, and the members of this Council who are interested in this critical issue, for inviting our thoughts on the subject.

Many of you are familiar with the crisis we are here today to discuss – the criminalization and over-incarceration of people with mental illness. New York is at the epicenter of these nationwide crises. This is in part because New York City was the wellspring of the two social phenomena that birthed this crisis -- the "deinstitutionalization" and "law and order" movements. During the 1960s and 1970s, New York led "deinstitutionalization," which shuttered several large psychiatric institutions in the state.[1] But both New York State and City failed to devote the necessary resources to create a community-based care model sufficient to serve the needs of those who would otherwise be institutionalized.[2] Without the necessary care, many of the individuals who stood to benefit from the end of the "institutional" model wound up poor and homeless.[3]

At the same time, New York initiated the rapid criminalization of these same populations. The Rockefeller Drug Laws and other draconian interventions exponentially increased the percentage of people with mental illness incarcerated in our state prisons and city jails.[4] Between 1991 and 2002, the percentage of individuals receiving active mental health treatment in New York prisons increased by 73%, and has only grown since.[5] Over that same period, the overall prison population increased by 14.6%.[6] The increase in those incarcerated with mental health needs was *five times greater* than the increase in the overall prison population.[7] These

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[1] Editorial, *Suffering in the Streets*, N.Y. TIMES (Sept. 16, 1984), http://www.nytimes.com/1984/09/16/opinion/suffering-streets-deinstitutionalization22-letter-mouthful-that-once-referred.html [https://perma.cc/6W65-WFJ4].

[2] *See* Hitesh C. Sheth, *Deinstitutionalization or Disowning Responsibility*, 13 INT'L J. PSYCHOSOCIAL REHABILITATION 11, 11–21 (2009) (discussing the growth of prisons and jails as de-facto mental health institutions due to a governmental failure to devote adequate resources to deinstitutionalization).

[3] *Id.*

[4] Jeremy W. Peters, *Albany Reaches Deal to Repeal '70s Drug Laws*, N.Y. TIMES (Mar. 25, 2009), http://www.nytimes.com/2009/03/26/nyregion/ 26rockefeller.html [https://nyti.ms/2lpaxoR]. *See* Press Release, N.Y. Civil Liberties Union, NYCLU Announces Findings About Statewide Impact of Rockefeller Drug Laws (Mar. 11, 2009), https://www.nyclu.org/en/press-releases/nyclu-announces-findings-about-statewideimpact-rockefeller-drug-laws [https://perma.cc/E7ZE-VZEZ] (finding that "[m]any of the thousands of New Yorkers in prison under these laws suffer from substance abuse problems; many others struggle with issues related to homelessness, mental illness or unemployment").

[5] HUMAN RIGHTS WATCH, ILL EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 19 (2003), https://www.hrw.org/reports/2003/usa1003/usa1003.pdf [https://perma.cc/Q26F-CQHJ].

[6] *Id.*

[7] *Id.*

trends mirrored the trends nationwide: the population of people with mental illness entering prisons swelled and community-based mental health services contracted.[8]

The Legal Aid Society's Prisoners' Rights Project ("PRP") has worked to address these issues for four decades, as they impact individuals behind the walls *and* all of us in our communities. Since its inception, PRP has successfully challenged the state's failure to provide treatment to incarcerated people with mental illness, a disproportionate number of whom were slated to return to one of New York City's five boroughs. In *Disability Advocates, Inc. v. New York State Office of Mental Health*, 02 Civ. 4002 (GEL) (S.D.N.Y.), PRP along with co-counsel from Disability Advocates, Inc., Prisoners Legal Services of New York State, and Davis, Polk, & Wardwell, LLP, challenged the state's practice of subjecting incarcerated people with serious mental illness to prolonged stays in solitary confinement. That case resulted in a landmark settlement whose substance largely has been codified into state law. The case resulted in the expansion of mental health programs for people in state prison with serious mental illness, including in prison units that serve people scheduled for release in the near future. But despite the expansion of mental health programs in state prisons, individuals did not receive adequate discharge planning to create a mental health care plan upon release. In *Messiah S. v. Alexander*, 07-cv-1327 (MGC) (S.D.N.Y.) PRP along with co-counsel from The Urban Justice Center and Cravath, Swaine & Moore LLP, challenged the state's failure to adequately plan for the discharge of people with serious mental illness.

Today, one of the most pressing problems undermining successful reentry of people with serious mental health needs who are released from state prison is the lack of housing and community-based mental health services and supports.

This issue is at the heart of *M.G. v. Cuomo*, 19-cv-639 (S.D.N.Y.) a lawsuit PRP recently filed with co-counsel from Disability Rights New York and Paul, Weiss, Rifkind, Wharton & Garrison LLP. The Plaintiffs in *M.G.* are homeless people with serious mental illness who are being held in state prison past their release dates because they require community-based mental health housing upon release, but none is available. Some members of the *M.G.* putative class are slated to return to one of the five boroughs of New York City. Our investigation leading to *M.G.* has shown us that even the most promising supportive housing initiatives can be derailed by inadequate resources. We applaud the Council for its continued passage of legislation to improve the reentry prospects for people with mental health needs and to increase accountability and transparency in New York City's carceral agencies, and we encourage the Council to exercise its oversight responsibility to ensure New York City's community-based mental health housing programs are sufficient to meet the City's need for such housing.

**The Importance of Community-Based Mental Health Housing**

It is impossible to discuss recidivism without discussing housing. And for people with mental illness, the consequences of a lack of housing are even more dire. Studies show that supportive housing greatly increases the chances that people with mental illness will successfully

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[8] *See, e.g.*, Robert D. Morgan et al., *Treating Offenders with Mental Illness: A Research Synthesis*, 36 LAW & HUM. BEHAV. 37, 37 (2012) (over one quarter of incarcerated individuals are diagnosed with a mental illness).

reenter society from incarceration.[9] Mental health housing provides not only a stable home, but services that facilitate people's access to care and crisis intervention. These programs reduce recidivism and reconviction among homeless individuals with mental illness because they provide people with individualized services responsive to their needs.[10] Investment in community-based mental health housing also results in other positive outcomes, such as a reduction in the utilization of emergency health services and emergency shelters.[11]

New York City has recognized some of these benefits, and as a result, has developed new community-based mental health housing units within the last several years.[12] Many of those units have been earmarked for people leaving forensic settings, including prisons and jails. When Mayor DeBlasio proposed the development of additional supportive housing in the City for people with mental illness, the task force convened to implement his proposal identified a core group of people who should be targeted -- people with mental illness who were recidivating at rapid rates due to a lack of housing.[13] Similarly, the New York City Department of Health and Mental Hygiene, after studying this issue, found that "the most frequently returning jail cohort should be specifically targeted for supportive housing and . . . the criminal justice system should have the tools to divert this cohort to housing rather than send them to jail for minor charges."[14] In 2016, and largely in response to these findings, Mayor DeBlasio announced the development of 15,000 more units to support this very population, stating "it means thousands of people . . . away from the revolving door of the criminal justice system and emergency rooms."[15]

Unfortunately, these measures did not solve the problem giving rise to *M.G.* -- delayed releases from state prison due to the lack of community-based mental health housing statewide, and in New York City in particular. The New York State Office of Mental Health and the New York State Department of Corrections and Community Supervision share joint responsibility for the discharge of people with serious mental illness from prison, including planning for, assessing, and approving housing in the community to which these people may be released. Annually, 2,050 people with serious mental illness are discharged from New York State prisons to the community.[16] A large percentage of those individuals are discharged to New York City.

In the discharge planning process, OMH counselors are required to meet with people with serious mental illness who are within six months of their scheduled release date. If the counselor determines that the person will be, or risks being, homeless upon release, OMH must prepare a "Single Point of Access" application for that person to secure the community-based mental health housing and services they need in the county to which they will return. OMH's

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[9] *See generally* Julian M. Somers, Stefanie N. Rezansoff, Akm Moniruzzaman, Anita Palepu, and Michelle Patterson, *Housing First Reduces Re-Offending Among Formerly Homeless Adults with Mental Disorders: Results of Randomized Controlled Trial, available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3762899/

[10] *Id.*

[11] *Id.*

[12] Press Release, *At Visit to Supportive Housing, Major De Blasio Announces Task Force to Help Deliver 15,000 New Units* (Jan. 12, 2016), *available at* https://www1.nyc.gov/office-of-the-mayor/news/043-16/at-visit-supportive-housing-mayor-de-blasio-task-force-help-deliver-15-000-new.

[13] Justice Served: Fair Treatment for the Formerly Incarcerated, April 26, 2016, *available at* https://www.csh.org/wp-content/uploads/2016/04/NYC_SHTaskForce_JusticeRecommendations_4.26.16.pdf

[14] *Id.*

[15] Press release, *supra* note 12.

[16] Central New York Psychiatric Center Annual Pre-Release Services Report, 2015.

preparation of a Single Point of Access application for housing reflects its assessment that a person is eligible for community-based mental health housing.[17]

Unfortunately, the supply of community-based housing is far outstripped by need, in New York City and across the state. Through *M.G.*, we found several individuals who were held in New York State prison past their release dates due to a lack of supportive housing in the five boroughs. These individuals each waited months past their maximum expiration date before they were discharged. One person was sentenced to less than six months in state prison, yet spent nearly six months in prison beyond his release date while waiting for housing

Given the clear consensus among researchers that community-based mental health housing is the most effective tool to reduce recidivism of people with mental illness, the City Council must exercise its oversight authority to ensure that the City adequately develops such housing. There are concrete steps that this Council can take. For example, the Council should direct City agencies to make public the number of individuals on the waiting list for community-based mental health housing and other supports in New York City. It should also expand access to Forensic Assertive Community Treatment (FACT), a support that is critical to this population. FACT is a multidisciplinary team approach to providing comprehensive and flexible treatment, support, and rehabilitation services to people with serious mental illness and has been shown to be effective for people with criminal justice histories. While New York City has more FACT teams than elsewhere in the state (six currently), we need more. For example, the waiting list for FACT in December 2018 was over 130 individuals. The City should also probe these issues with representatives of many of the City agencies who will undoubtedly testify during this hearing. The Council should probe the reasons for such long waiting lists for housing and supports, and the method by which City agencies determine who will receive community-based mental health housing and related services.

It takes concerted and committed cooperation between the City and state to develop the community-based mental health housing system necessary to support all eligible individuals. Councilmembers should engage with other stakeholders to encourage adequate funding for such programs. They should also impress upon state authorities that when an individual from New York City reaches their prison release date, state authorities have an obligation to release them. If the state authorities have failed to develop housing sufficient to make that a reality, it is their responsibility to do so. The current approach--to hold people in prison past their release dates due to the failure to develop sufficient supports--is unlawful and unworkable. So long as the state prison population is disproportionately drawn from the five boroughs of New York City, the practice that we challenge in *M.G.* will disproportionately impact New York City residents. We call on this Council to join our effort to remedy this problem.

Thank you for allowing us to testify today about this critically important issue. We look forward to working with you collaboratively to ensure that people with mental health needs are properly housed and supported upon their release from jails and prisons.

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[17] Central New York Psychiatric Center Corrections-Based Operations Manual, Policy 8.13: Housing Referrals - SMI (06/28/16).

**Proposed Legislation: Int. No. 0903 – Funds in accounts of incarcerated people:** We support Int. No. 0903-1918. The bill is a modest measure to cut through the often insurmountable bureaucracy individuals face in seeking to recover the funds they trusted to the Department of Correction while incarcerated in the City jails. It is a matter of basic fairness and consumer protection, providing them with information about how much of their personal money the City is holding upon their release, and taking simple measures to return it to them. Incarceration overwhelmingly targets poor families and individuals; these harms should not be exacerbated by making it more difficult for them to access the funds they do have upon release.

**Proposed Legislation: Int. No. 1590 – Provision of mental health information to defense counsel:** We appreciate this bill's aim to streamline provision of important information to defense counsel about the well-being of their clients with serious mental illnesses. In particular, section b(6)'s requirement that counsel be informed of the individual's housing unit, and the services being provided therein, would be beneficial. The individuals' informed consent to disclosure is essential, and we hope the bill's consent provisions are bolstered to protect the clients and their health information by requiring appropriate releases, and to ensure they understand their ability to withdraw consent at any time.

LEGAL ACTION CENTER

P2PH
FROM PUNISHMENT TO PUBLIC HEALTH

**To:** Donna Frescatore, New York State Medicaid Director and Greg Allen, Director of the Division of Program Development and Management, NYS Office of Health Insurance Programs

**From:** Legal Action Center (LAC) and From Punishment to Public Health (P2PH)

**Subject:** Comments to the draft New York State Criminal Justice Medicaid Redesign 1115 Waiver Amendment

**Date:** April 1, 2019

Thank for you opportunity to provide feedback on the current draft of the New York State Medicaid Redesign 1115 Waiver Amendment focused on improving care provided to criminal justice-involved populations. We commend Governor Cuomo for advancing this initiative in his 2020 Justice Agenda and recognizing that access to medical and pharmaceutical care along with health care coordination services will greatly increase outcomes and help curb the opioid and substance use epidemic throughout our State. New York State's decision to re-submit its waiver application demonstrates its continued far-sighted policymaking and national leadership in addressing one of the most pressing social justice issues of our time: ensuring that people leaving incarceration with opioid and other substance use disorders, mental health and other health problems are appropriately assessed and provided needed care. Legal Action Center (LAC) and the From Punishment to Public Health (P2PH) initiative based at John Jay College of Criminal Justice are pleased to submit these joint comments in order to further focus the waiver amendment on resolving the most significant barriers to providing robust discharge planning and care continuity for individuals leaving jails and prisons and returning to the community.

LAC and P2PH maintain strong working relationships with key stakeholders operating at the intersections of criminal justice and public health, and we regularly convene colleagues through the NYC Health & Justice Working Group. This working group includes managed care, Health Home, care management and direct service providers striving to engage and serve criminal justice-involved individuals. We frequently welcome presentations from local and state government stakeholders committed to improving policy and practice surrounding justice-involved individuals with chronic behavioral and physical health issues.

P2PH was also invited to facilitate the Health Home-Jail Liaison meetings between the downstate Health Homes receiving pilot funding from DOH to enhance collaborations with Correctional Health Services (CHS), the main provider of health services to New York City's jail populations. Key learnings from this project have shaped the conversation around jail-to-community care continuity and the feasibility of relying on Health Homes and care

management agencies to deliver services to clients in the hours and days following discharge from jail.

**Lessons learned from 2017-18 Health Home Pilots**

As noted above, P2PH was invited to facilitate the Health Home-Jail Liaison meetings between the downstate Health Homes receiving pilot funding from DOH to enhance collaborations with Correctional Health Services (CHS), the main provider of health services to New York City's jail populations. As detailed in a forthcoming report from P2PH to DOH and other key stakeholders, Health Homes began matching their client rolls with CHS' medical intake census in early 2018, and quickly set up work plans with CHS' various discharge planning units to identify common clients, obtain consent to communicate medical information and begin collaborative discharge planning and reentry supports. Several positive outcomes from the pilot included increased knowledge and awareness among Health Homes and CMAs about when their clients were entering and leaving jail and resulting increased lengths of stay within Health Homes because clients were not "lost to service." CHS also invited the Health Home leads to present at discharge planning unit staff meetings to build stronger ties with line staff and highlight the advantages of connecting clients with Health Home services.

The pilot project also laid bare the challenges of relying on Health Homes and care management agencies to deliver services to clients in the hours and days following discharge from jail. Only a portion of Health Home members identified in the census match were "active" members, meaning most clients did not have an assigned care manager at the time of their jail admission. Fewer still were willing to provide consent for CHS' jail-based staff to communicate with Health Home liaisons with whom they were not familiar. Towards the end of 2018, Health Homes also reported that recent changes in "Outreach" billing protocols reduced the ability of CMAs to mobilize in response to a discharge alert provided by CHS and passed on through the lead Health Homes. Key statistics collected by partners on the project showed that:

- Over 3,400 Health Home clients entered Rikers Jails between March and September of 2018; fewer than 1,300 were "active" members at the time of the match
- Over 2,000 discharge alerts were sent to Health Homes between June and September of 2018, but just over 200 of those alerts were actionable and referred to assigned CMAs (the remaining alerts were for "inactive" members without assigned CMAs)
- Health Home clients had extremely short jail stays. Almost two-thirds of the clients matched on the census never reached CHS discharge planners, meaning they spent less than 72 hours in jail

The comments and recommendations below on the waiver application are based on the findings from the Health Home Pilots, direct experiences of LAC and P2PH staff, our working

group members and other colleagues who are striving to improve care for one of the most vulnerable populations in our community.

**Program Design**

The continued focus on Health Homes and their Care Management Agencies to provide continuity of care to criminal justice populations unnecessarily ties the success of this waiver amendment to a business model that has yet to be proven sustainable in the long-run. All Medicaid-funded health service providers with an interest in serving criminal justice populations should be eligible to bill for in-reach services with clients and consultations with jail-based health clinicians and discharge planners.

Likewise, the proposed delay in serving jail populations pending the creation of new data exchange processes between county jails, State criminal justice agencies and DOH unnecessarily restricts the waiver from reaching the much larger and often more vulnerable jail populations. Clients cycling in and out of jails, hospitals and homeless shelters, particularly those with Opioid Use Disorders (OUD), represent the most significant opportunity for this waiver to improve health outcomes and reduce costs across the board. To ensure this waiver amendment has the best chance of reaching these vulnerable populations, LAC and P2PH recommend the following adjustments to the current draft:

- Allow all community-based health service providers (public and private) to bill Medicaid for in-reach activities that facilitate robust continuity of care between incarceration and community settings. This should include initial client consultations and care coordination services, a broad range of medications for SUD, SMI, HIV/AIDs and HepC, as well as moment-of-release services such as peer engagement activities, transportation support, housing and legal assistance and food support services such as food bank for medical conditions and meal delivery services.
- Include jail-based clients during the first 15 days of their stay. This will capture the vast majority of jail-based clients who typically spend less than two weeks in jail before returning to the community. As noted below, during the Health Home-jail liaison pilot in NYC, two-thirds of the Health Home clients identified between March and September 2018 spent less than 72 hours in jail. This opportunity to bill for services should stimulate community-based providers to collaborate with county jails and encourage the best practice of including discharge planning as part of jails' medical intake sessions.
- Separate discussions of medications for SMI and SUD, since existing policy frameworks make SMI medications much more accessible than those for SUD. Additionally, long-acting/depot medications may not be appropriate for everyone with SUD, and it is critical to ensure continuity of the indicated form of MAT as part of the services available under this waiver by making all FDA approved drugs in all formulations available.
- Highlight the importance of Peer Engagement Specialists and peer-led activities as billable services in the hours and days following discharge from incarceration. This growing field of health promotion practitioners with lived experience is a crucial

element to the success of care continuity for justice-involved populations faced with complex health and behavioral health challenges.

**Eligibility**

As noted above, the waiver amendment should focus on the most vulnerable populations passing through the criminal justice system, including opioid users and homeless individuals. Many of these clients are eligible for Health Homes but far fewer are actually enrolled in a Health Home with an assigned care manager. This was a key learning from the downstate Health Home pilot – less than one-third of clients identified were actively engaged in Health Home services at the time of their arrest, meaning they had no real relationship upon which to build a collaborative discharge plan. To ensure this waiver amendment has the best chance of reaching the most medically vulnerable populations, LAC and P2PH recommend the following adjustments to the current draft:

- Include as priority populations those at high risk for overdose upon release (including Rikers' KEEP clients) and those likely to be discharged to homeless shelters, *regardless of Health Home eligibility*,. These clients, along with those with SMI diagnosis and other Health Home eligible, are the most likely to require emergency medical services or suffer a health-related fatality in the days and weeks following discharge from incarceration. The current waiver amendment draft estimates less than 25% of the eligible population qualifying through an SUD chronic condition, but jail-based providers estimate that over 75% of their clients were misusing substances prior to their arrest.
- Include jail-based clients during the first 15 days of their stay. As noted above, most clients who enter jail spend less than two weeks there, and those with high medical needs have been shown to spend only a few days, on average. The waiver amendment offers perhaps the best chance to overcome the multitude of care continuity disruptions caused by arrest and short-term detention.
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**Enrollment**

- Focus on enrolling clients into Medicaid Managed Care plans prior to release. This is especially critical for individuals who may need residential SUD treatment upon reentry, which is not covered by Fee for Service (FFS) Medicaid.
- Allow for the presumption of Medicaid eligibility to accelerate the delivery of core services prior to release. Clients who lack insurance at the time of their arrest and incarceration are highly likely to be eligible for Medicaid based on their income or lack thereof.
- Obtain consent for CHS to speak with Health Homes in coordinating discharge plans, because Health Homes don't list H&H on their standard forms.

**COMMITTEE ON CRIMINAL JUSTICE**
Hon. Keith Powers, *Chair*
**COMMITTEE ON JUSTICE SYSTEM**
Hon. Rory Lancman, *Chair*
**COMMITTEE ON MENTAL HEALTH, DISABILITIES AND ADDICTION**
Hon. Diana Ayala, *Chair*

Oversight - Preventing Recidivism for Individuals with Mental Illness
Testimony**: Getting Out and Staying Out**
June 17, 2019

Thank you for the opportunity to speak today.

Founded in 2003, Getting Out and Staying Out (GOSO) is a comprehensive reentry program, serving 16- to 24-year-old young men who have been involved in the criminal justice system. We work with participants from all five boroughs; many we meet during the four days a week we provide services in the jails on Rikers Island, others join our community program–located in East Harlem–through referrals from probation and parole officers, judges and District Attorneys, defense attorneys, alternative-to-incarcerations programs, other participants, and City Councilmembers. Additionally, we correspond with hundreds of participants currently incarcerated in upstate and Federal prisons.

At GOSO, we start with the three E's–employment, education, and emotional well-being. Our program is tailored to address those core concerns, while also providing individual attention to each participant's individual needs and goals. All GOSO participants work with a licensed social work–LMSWs and LCSWs–who are equipped to provide psychotherapy as well reentry planning. Every week, we run a comprehensive job readiness curriculum that all participants must pass in order to move forward in our program. If and when they do pass, they are eligible for a number of different programs designed to help them achieve personal and professional success.

As a staff of mental health professionals, we seek to address the biopsychosocial issues that our participants experience. Even before their first interaction with the justice system, our participants faced poverty, racism, trauma, and a number of broken systems. Often, these issues are exacerbated by the trauma of incarceration. Successful reentry cannot happen without a robust emphasis on mental health and emotional well-being. Through individual and group therapy, trauma-informed interventions, psychoeducation, and referrals to more intensive psychiatric services, the staff of GOSO seeks to destigmatize mental health treatment and encourage our participants to prioritize their emotional well-being.

We cannot emphasize enough how important it is for our city to invest in robust mental health treatment for incarcerated and formerly-incarcerated people both now and in the future, as we move toward a community jail model. We estimate that 50% of our participants have some kind of mental health diagnosis. Additionally, all of our participants can benefit from the empathy and support of a licensed and trained mental health practitioner. At GOSO, we work with young people who are incarcerated to provide a "warm handoff" into our community, which provides continuity and security. For all of those who are incarcerated, but especially for those who have mental health issues, it is essential to have strong reentry planning and advocates that can assist with treatment and reintegration. We support **Intro 1590, the Get Well and Get Out Act, which** will require the Department of Correction to communicate essential information about patients with SMI to their attorneys.

We also strongly support **Intro 903,** which will provide a way for recently incarcerated New Yorkers to receive money left over in their "inmate accounts". The criminal justice system is one of the drivers of income inequality in our city and elsewhere; this is one policy that can help to address that issue.

nycds
Fighting for your rights, one person at a time

**Stanislao A. Germán,** Executive Director
**Carolyn P. Wilson,** Director

Testimony of

Katherine L. Bajuk

Mental Health Attorney Specialist

New York County Defender Services

Before the

Committees on Criminal Justice, Justice System and Mental Health, Disabilities and Addiction

Oversight Hearing: Preventing Recidivism for Individuals with Mental Illness
and
Int. 903-2018 & 1590-2019

June 17, 2019

My name is Katherine Bajuk. I have been a public defender in New York City since 1994, and the Mental Health Attorney Specialist at New York County Defender Services (NYCDS) since 2015. NYCDS is a public defender office that represents approximately 20,000 clients in Manhattan's criminal and Supreme Courts annually. As the Mental Health Attorney Specialist at NYCDS, I participate in our client's forensic exams; represent clients involved in Manhattan Mental Health Court; assist other attorneys in my office with cases involving mental health issues; and participate in Behavioral Health meetings with the Mayor's Office of Criminal Justice and other policy work groups both locally and nationally.

Thank you for inviting NYCDS to testify about the two bills on today's calendar.

According to Correctional Health Services, approximately 1,100 incarcerated people – 16 percent of the entire jail population – have been diagnosed with a serious mental illness.[1] A February 2018 news report documented that city jails actually house more clients with mental illness than

[1] Reuven Blau & Rosa Goldensohn, *City seeks to move mentally ill inmates to hospitals*, NEW YORK MAGAZINE, March 21, 2019, available at http://nymag.com/intelligencer/2019/03/nyc-seeks-to-move-mentally-ill-inmates-to-hospitals.html.

all city hospitals combined.[2] Our clients with mental health issues cycle through the system repeatedly, stay in jail longer than other clients, and face a greater risk of victimization and re-traumatization while incarcerated.[3]

Both bills on today's calendar could be of great benefit to our clients.

1) The "Get Well and Get Out Act," Int. 1590-2019 - A Local Law to amend the administrative code of the city of New York, in relation to requiring the department of health and mental hygiene or its designee to report information to the attorney of record for individuals in the custody of the department of corrections who are diagnosed with serious mental illness

NYCDS supports Councilmember Chin's bill to provide information about a client's mental health status to the defense attorney, since this legislation will help clients with mental health issues receive the appropriate treatment or assist in getting them released to community-based programs.

But we ask that the Council consider some concerns we have about this bill.

The first is to ensure that any consent given by client with mental health issues to share information is truly "voluntary." For some of our clients, there is a question as to whether the person is mentally competent to proceed to trial, pursuant to New York Criminal Procedure Law 730. Clients whose competency is at issue should not be asked by the Department of Corrections (DOC) to give their voluntary consent until this issue of fitness has been resolved. Thanks to many changes that have been made, this should not be longer than a few weeks. If DOC were to speak with these clients, and they are ultimately found not competent to proceed, the voluntariness of their consent could later be challenged. Additionally, prosecutors challenging such a finding could argue that since the client executed a legal document, they are indeed competent – when they are actually not. So rather than risking more harm than help, we ask that if DOC knows that a person has a pending competency issue, they wait to go forward with the voluntary consent request until a determination is made that the client is indeed competent to proceed to trial.

The second concern is making sure that whomever is tasked with gathering the information pursuant to this statute be a social worker or someone with a clinical background as opposed to a corrections officer. This could both reduce the likelihood of further traumatizing a client with mental health issues and ensure more accurate reporting on a client's psychiatric condition.

We also ask that you ensure that our client's confidential information, including mental health and medical records, not be shared with other parties, including the District Attorney's Office, by making explicit in this legislation that these reports are not something that a prosecutor can access without the defense attorney's consent. Defense attorneys currently receive Pre-Arraignment Screening Unit letters reporting a client's substance abuse or mental health issues at criminal court

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[2] Mary Murphy, *Rikers and city jails have more mental patients than all hospitals in NYC: doctor*, PIX11, Feb. 24, 2018, available at https://pix11.com/2018/02/24/rikers-and-city-jails-have-more-mental-patients-than-all-hospitals-in-nys-doctor-says/.

[3] *See, e.g.,* National Alliance on Mental Illness, "Jailing People with Mental Illness," available at https://www.nami.org/Learn-More/Public-Policy/Jailing-People-with-Mental-Illness.

arraignment, and only defense counsel receives it or is aware that it even exists. A similar process for this kind of information would be ideal.

Finally, in the event the information is later used by a bail fund, let's make sure there is a discharge plan for the client before being bailed out. No one wants a client remaining in jail, but we want to avoid what has happened in the past where a client with serious mental illness dies by suicide after being bailed out without having a discharge plan in in place. To avoid this, the Council should continue to fund supportive housing and services for people with mental illness so they can access these services immediately and automatically upon release.

2) Int. 903-2018 - A Local Law to amend the administrative code of the city of New York, in relation to funds remaining in inmate accounts when inmates are released

NYCDS also supports Int. 903-2018, which would benefit all incarcerated clients, not just those with mental illness. The bill requires the Department of Correction to provide incarcerated people with written notification of the amount of funds remaining in their account and instruction on how to request refund of such funds. The bill also requires that the department return such funds to the person within 60 days of their release and requires annual reporting on the aggregate amount of funds remaining in accounts for all formerly incarcerated people who are no longer in the custody of the department.

Int. 903 is long overdue, and we urge you to pass it this year. Our clients and their families should have swift, easy access to their own money as soon as they are released from custody. We ask that the Council inquire into this issue of inmate fund accounts further and determine what the DOC's current practice is and what steps, if any, the Council can take to ensure a fairer and more transparent process.

Lastly, I would like to briefly discuss some steps the City can take to prevent recidivism and criminal justice involvement for people with mental illness.

We cannot allow our jails to serve as warehouses for those who have mental illness. We cannot continue to punish people for being ill by imprisoning them, and then expect them to get better in an environment that exacerbates their mental health issues and often serves to re-traumatize them.

The City can and must do more to help people with mental illness quickly transfer out of our jails and into programs and housing that can better support their needs and facilitate their re-entry into the community.

We need more community-based supportive housing for people with mental illness.

We need multiple levels of care and treatment.

We need more free and affordable treatment options in the communities where our clients live. There currently are not even enough beds for all who need them,[4] which is often why clients with mental illness are brought to jail instead.

Just this morning I had to return to Mental Health Court because a client who was released to a program just last Friday - after waiting many months for a residential program that could serve a client whose primary language was Spanish - had to be returned to jail because he did not have a co-occurring substance abuse issue and unbeknownst to us, this program only serves people with both substance abuse and mental health issues.

We need more education in the community that the solution to dealing with a friend or family member with mental health issues is not to call the police but rather seek help in a medical facility. We also need more high-quality service providers, which means paying people who work in the mental health field a living wage and providing them with the support they need to remain in the field for the long-term. While the City has increased funding for mental health services over the past few years, these problems remain.

We understand that all of this requires a massive infrastructure investment from the City - and so we urge you all to make those commitments in next year's budget

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Thank you again for your time and consideration here.

If you have any questions about my testimony, please contact me, Katherine Bajuk at kbajuk@nycds.org. For further questions about NYCDS' positions on public policy, contact Andrea Nieves, NYCDS Senior Policy Attorney, at anieves@nycds.org.

[4] *See, e.g.,* Jarrett Murphy, *Housing for NYC's Most Vulnerable Under Scrutiny for 'Screening'*, CITY LIMITS, July 5, 2018, available at https://citylimits.org/2018/07/05/debate-about-whether-nyc-housing-for-the-most-vulnerable-rebuffs-some-who-need-help/.

**New York City Council**
**Joint Hearing: Committee on the Justice System and**
**Committee on Mental Health, Disabilities, and Addiction**

**Re: Oversight- Preventing Recidivism for Individuals with Mental Illness and Int 0903 - In relation to funds remaining in inmate accounts when inmates are released**
**June 17, 2019**
**Written Testimony of The Bronx Defenders**
**By Julia Solomons, LMSW, Senior Criminal Defense Social Worker- Policy**

Chairs Lancman and Ayala, my name is Julia Solomons and I am the Senior Criminal Defense Social Worker focused on policy work at The Bronx Defenders. The Bronx Defenders ("BxD") has provided innovative, holistic, and client-centered criminal defense, family defense, immigration representation, civil legal services, social work support, and other advocacy to indigent people in the Bronx for more than 20 years. Our staff of close to 400 represents nearly 28,000 people every year and reaches thousands more through community outreach. The primary goal of our model is to address the underlying issues that drive people into the various legal systems and to mitigate the devastating impact of that involvement, such as deportation, eviction, the loss of employment and public benefits, or family separation and dissolution. Our team-based structure is designed to provide people seamless access to multiple advocates and services to meet their legal and related needs.

## I. Introduction

I first want to thank you both, along with the rest of the committee members, for taking the time to listen to this testimony today. I also want to thank you and the rest of the City Council for dedicating time and energy to think creatively about how to best serve New Yorkers struggling with mental health concerns and, as a result, often cycling through the criminal legal system and city jails. We are excited about the possibility of expanding services for this population and taking a closer look at how to improve the services we currently have. Our recommendations include:

- Increasing access to free trauma-informed treatment options;
- Breaking down significant barriers to successful treatment; and
- Improving and expanding supportive housing programs.

We believe that increasing the city's capacity in these respects would greatly improve our ability to support our clients with mental health issues in their attempt to gain stability and work towards recovery.

## II. Trauma-Informed and Trauma-Responsive Treatment Providers and Therapies

### A. Defining SMI

As an initial matter, when we address the issue of mental illness in our communities and within the population of people currently incarcerated in our city jails, we are not just talking about those labeled as "severely mentally ill," or "SMI," by Correctional Health Services (CHS). Mental illness covers a much broader array of conditions. Notably, the National Institute of Mental Health (NIMH), defines SMI as "a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities."[1] Correctional Health, however, uses a narrower definition, further limiting the universe of people considered SMI to severely mentally ill individuals whom CHS is mandated by court order to help with discharge planning upon release (otherwise referred to as "Brad H"[2]). In order to qualify for these services, an individual must present with acute symptoms such as those of psychosis, suicidality, or a diagnosis that would have previously been labeled an Axis 1 diagnosis under the DSM IV. These diagnoses are most commonly: bipolar disorder, schizophrenia, and schizoaffective disorder. While people in custody labeled with those diagnoses or set of symptoms do make up a large percentage of the jail population, there are many people whose mental health disorders interfere with or limit "one or more major life activities" but may not meet CHS' exacting criteria. These people have often experienced complex trauma, and unfortunately, it is very rare that their struggle is correctly defined and appropriately addressed. As a result, many people who would benefit from this type of support during incarceration and upon release do not receive it.

### B. Trauma Is Overlooked and Misunderstood

People with a history of trauma—and its attendant effects on their mental health—often fall through the cracks. In our work as Criminal Defense Social Workers at BxD, it is very rare that we work with a client who does not have a significant trauma history. While the research is limited and numbers underreported even within existing research, we know that rates of childhood and adult trauma among the justice-involved population is very high. One study found that over 56% of incarcerated men reported childhood physical abuse and one in six reported experiencing sexual or physical abuse before age 18.[3] Additionally, trauma looks different for

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[1] Retrieved from https://www.nimh.nih.gov/health/statistics/mental-illness.shtml.

[2] For additional information on Brad H, et al. vs. the City of New York, et al. (2000), see https://mhp.urbanjustice.org/sites/default/files/The_settlement.pdf.

[3] Wolff N., Shi J., Siegel J. Patterns of victimization among male and female inmates: Evidence of an enduring legacy. Violence Vict. 2009;24:469–484.

everyone — in fact, it is defined by how a person experiences a given event.[4] It can range from a female client who was sexually abused throughout her childhood by a caregiver, to a young adult male who grew up in public housing surrounded by violence and saw his first dead body at six years old. These types of traumatic experiences change people's brain function in the same way that brain chemistry is affected by a mood or psychotic disorder, but the symptoms are not as easily identified, or at least identified correctly. For this reason, many of our clients either receive no treatment or they receive inappropriate diagnoses and treatment for their mental health conditions.

We believe that funding more trauma-informed and trauma-responsive mental health providers, both in our city jails and in the community, would dramatically reduce recidivism. Trauma-informed providers have an understanding of how trauma affects the brain and what behaviors manifest as a result, and are trained to respond appropriately to those exhibiting trauma responses when triggered. As of now, despite the high prevalence of trauma histories among incarcerated individuals, there are very few accessible, trauma-informed providers within New York City. The few that do exist, like the Crime Victims Treatment Center, often have extremely long wait times to be connected with a therapist, and even longer times to be connected to a psychiatrist and receive regular access to medication. This means that many people who could benefit immensely from this type of targeted mental health intervention often live for years with unaddressed complex trauma. It means they end up cycling through our hospital and jail systems without regular access to providers, being misdiagnosed and treated ineffectively. It means that often our only option for getting our clients connected with treatment providers in a timely manner is to connect them with anyone who has an available appointment, or any residential program with an available bed.

The majority of accessible providers are not trauma-informed or trauma-responsive, despite often labeling themselves as such, and this lack of understanding often ends up causing harm to our clients. For example, we had a client recently who was participating in substance abuse treatment and during the group sessions she read her bible to help her stay present in her body and in the group. It is common for people with a history of trauma to dissociate during difficult or triggering conversations, and for this client reading her bible served as a tool to prevent that. The program clinicians, however, did not have a trauma-informed approach and wanted to discharge her from the program for being non-compliant. Beyond the limited availability of trauma-informed clinicians, most treatment options in the city are not at all accessible to those who do not qualify for insurance. As a result, our clients struggle to find any therapeutic support, let alone a trauma-responsive provider. We call on the City to fund free trauma-informed and trauma-responsive mental health services, ideally those that provide wraparound services but at a bare minimum easy and expedited access to psychiatric as well as therapeutic interventions and continued support.

**III. Break Down Barriers to Successful Treatment**

[4] Substance Abuse and Mental Health Services Administration (SAMSHA), 2019. Retrieved from https://www.integration.samhsa.gov/clinical-practice/trauma

Homelessness is an acute challenge for a large percentage of New Yorkers struggling with mental illness. For many of our homeless clients in the Bronx who seek a treatment resolution for their criminal case, we see that they are typically only approved to be monitored by court-sanctioned alternatives to incarceration like Mental Health TASC if they are placed in a residential setting. Not only does that limit the pool to people with some type of co-occurring substance use disorder (as those are the only residential treatment settings that currently exist in New York City), it also all but eliminates that possibility for anyone that does not fit the traditional mold of residential treatment.

Existing residential treatment programs are extremely limited in who they are able to serve successfully. Many of these programs are not at all trauma-informed and they do not offer trauma-focused therapies. They are therefore often ineffective for people with significant trauma histories that affect their engagement with treatment. Additionally, we see the restrictions of "not mentally ill enough" range also to "too mentally ill," and result in an extremely small pool of people with mental health issues who actually qualify for residential treatment. If a client has any even semi-recently disclosed suicide attempts or suicidal ideation, for example, no program will take a risk on them. The same standard applies to anyone with active hallucinations or delusions — it is extremely difficult to find a residential program that is able to "meet their needs" as we are often told by program providers.

Beyond the limiting qualifications of who needs treatment enough but not too much, there are a host of other barriers that bar large groups of our clients from accessing effective treatment, especially residential treatment. The same barriers often apply to outpatient treatment as well. Among these barriers are gender identity, language access, and sex offender status, to name only a few:

- With regard to gender identity, we see our transgender clients being rejected for residential programs for the sole reason that they don't outwardly present as the gender with which they identify. The rates at which transgender clients experience trauma are astronomical, yet they have one of the most challenging experiences of attemping to access gender-affirming treatment options.

- With regard to language and cultural sensitivity, despite the diversity of our population in New York City, mental health providers in both outpatient and residential treatment programs are very rarely able to accommodate clients who speak a language beyond English and Spanish. For example, we have had situations in which everyone involved in a case (the client and his defense team, the judge, and the prosecutor) is in agreement that a non-English speaking client presents with an acute need for mental health treatment but for whom no one is able to find appropriate services that can accommodate specific language needs.

- Perhaps the most stigmatized subset of justice-involved individuals with mental health needs are those on the sex offender registry. The only long-term residential treatment program in the city that accepts those on the sex offender registry is not staffed as a "mentally ill and chemically addicted (MICA)" program, meaning it is unable to

accomodate those substance users with even the most mild of mental health needs. It is our experience and belief that there are no long-term residential programs in New York City that can currently accommodate someone with mental health needs on the sex offender registry. This means that if someone ends up on the registry for committing an offense that may have correlated with unmet mental health needs, the likelihood of that person ending up incarcerated again for a similar offense is high. Barring them from receiving what may be a critical intervention does not effectively keep the public safe nor does it prevent them from cycling back through our city jails.

## IV. Improve and Expand Supportive Housing Systems

We were excited to hear of Speaker Johnson's plan to fund one-hundred additional beds in transitional housing for justice-involved men. This is an important first step, and we hope to offer support in shaping this new system and any additional supportive housing efforts to be as efficient and effective as possible. Homelessness is a huge barrier to stability for New Yorkers struggling with mental illness. Lack of stable, accessible housing in our city is undeniably a contributor to the revolving door of justice involvement for this population. In 2013, one third of the homeless population in New York City was identified as having at least one serious mental illness, 50-70% of which also suffered from a co-occurring substance use disorder.[5] We suspect that this number is underreported and, due to the increasing scarcity of housing, may have increased since this study was conducted.

### A. Supportive Housing Is Difficult to Access

Even within the small universe of available beds, the numbers of people accessing supportive housing and remaining stably housed are even lower than they could be due to barriers that exist within our existing supportive housing system for people with mental health concerns. The centralized application form for supportive housing, for example, commonly known as the 2010e, is required as a first step to obtain permanent housing. Unfortunately, only a limited number of mental health providers in the city have access to this online system. Part of the reason for this is that completing applications is a very lengthy, involved process for which not many social service organizations have capacity. It involves up-to-date psychiatric evaluations and psychosocial assessments that must have been conducted within the past six months, and if that time elapses they must be submitted all over again. Once all the necessary documents are obtained, the packet goes through an approval process and is then submitted to various agencies that provide the housing and interviews are scheduled. The whole process takes several months and requires that the individual be in active contact with the service provider throughout in order to complete the packet, attend the interviews, and ultimately be placed, and given the transient nature and many barriers for this particular population, making it successfully through this process is very difficult without significant assistance.

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[5] Groton, D. (2013). Are housing first programs effective? A research note. *Journal of Sociology and Social Welfare, 40*(1), 51-63.

With regard to re-entry, CHS' discharge planning department is, thankfully, one of the service providers in the city that has access to the 2010e application. Unfortunately, however, the likelihood of accessing the application while incarcerated, even for the limited number of SMI individuals who receive discharge planning support, is slim. The services provided to our clients by discharge planning vary greatly by facility, by individual CHS social worker, and by individual client. In our experience, there are some discharge planners and some instances where the process of submitting a 2010e application for the client begins almost immediately after their initial mental health assessment upon intake, and other instances where despite our fiercest advocacy, clients who are otherwise eligible to be approved for supportive housing languish for months in the city jail system without ever having an application completed. In one case, after following up with my client's assigned discharge planner several times about beginning the 2010e, I was told that though my client was technically assigned the "SMI" designation and thus received discharge planning services, she was in category in which her mental health status was not "severe enough" to qualify for discharge planning assistance with the 2010e. Even though she would likely be approved for the housing assistance should the application be completed, she was not "sick enough" to receive help completing the application.

**B. Once Housed, Residents Do Not Often Receive Adequate Support**

Not only are the barriers to successfully being placed in supportive housing significant, but once housed in one of the buildings run by a supportive housing agency, the conditions for this extremely vulnerable population are often not structured to result in long-term stability. We hear countless reports from our clients in supportive housing that they do not have regular, reliable access to the case management support they are supposed to receive. Additionally, when they are struggling with issues directly related to their housing and safety, such as problems with another resident, they find it very difficult to get any assistance. The case management staff are often overworked and overburdened, and the bureaucracy that clients have to navigate in order to make any necessary changes to their housing is nearly impossible to achieve without extremely persistent advocacy. For example, we have had clients report that when they have a neighbor who is not on their medication and may be actively symptomatic and threatening to harm them, they receive little to no response on the part of the agency managing their housing. Requests to move units are in large part ignored but those that are not take far too long to happen, especially if a situation is acutely dangerous for that client and a threat to their stability. We also see this in situations where clients in recovery from substance use are placed in a housing site that, meaning they might have completed drug treatment and be in recovery but their neighbor is actively using drugs — a direct threat to their sobriety and therefore stability. Unfortunately, it is not uncommon for us to witness how the stigma of being a person who lives with mental health issues affects their ability to successfully advocate for themselves in situations like these. Providers often do not view our clients as credible historians given their own history of active hallucinations or delusions despite being currently stable and clear-headed.

We hope that with the creation of new systems for both transitional and supportive housing can come smoother processes for our justice-involved clients with mental health concerns, as well as more structure and active support in place within these agencies given the vulnerable nature of their residents and the many complications that come along with housing such a high-needs

group of people together in one location. At this critical juncture, we must remember that it is not only quantity of available beds, but also quality of life and of service provision that will bolster stability and reduce recidivism for this population in the long-term.

**V. BxD supports Int 0903**

Before closing, I want to briefly address the proposed legislation, Int 0903, regarding the accounts of people in custody after they've been released. The Bronx Defenders' supports this proposed local law requiring the Department of Corrections to release inmate account funds to the formerly incarcerated person in a timely manner as these funds are often critical to achieving post-release stability and may be the only immediate source of income they have, especially if that person's public benefits were temporarily frozen during their incarceration and there is a slight delay getting them back on. We are encouraged by this legislation and are hopeful to see it go into effect as soon as possible.

**IV. Conclusion**

There are innumerable opportunities to improve and expand our mental health treatment systems that would help reduce recidivism for people struggling with mental illness. The expansion of understanding around what mental illness looks like and who needs and deserves effective treatment and the subsequent funding and creation of more accessible trauma-informed therapeutic interventions is critical for making positive change in this arena. Additionally, breaking down some of the most egregious barriers to accessing treatment for vulnerable or otherwise stigmatized populations would greatly expand the numbers of people able to access treatment, both as an alternative to detention or incarceration and also upon re-entry to society after a period of incarceration. Moreover, careful analysis of the existing supportive housing systems and programs within those systems in the consideration of expanding and improving our clients' access to housing stability is critical. We encourage the City Council to take great care in thinking through these complicated issues, and to regularly consult with and receive feedback from those New Yorkers with lived experience of mental illness and subsequent justice involvement. Finally, we support Int 0903, believing it to be urgent that people returning to the community receive the funds in their immediate accounts as soon as possible.

Thank you again for taking the time to address these important issues today and we look forward to next steps.

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☐ in favor ☐ in opposition

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**Address:** 534 W 37

**I represent:** Close Robbins

**Address:** www.CloseRobbins.com

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**I represent:** G-One-Quantum

**Address:** _____

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0903

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**Name:** Jennifer Parish

**Address:** 40 Rector St. 9th floor

**I represent:** Mental Health Project / Urban justice center

**Address:** _____

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**Name:** Katherine Rajuk

**Address:** _____

**I represent:** New York County Defender Services

**Address:** 100 William St, 20th Fl

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**Name:** Mary Benjamin

**Address:** 20 W. Marshall Pkwy

**I represent:** Urban Justice

**Address:** 40 Rector St

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**Name:** Dr. Patsy Yang, Senior Vice President

**Address:** NYC Health + Hospitals/Correctional Health Services

**I represent:** _____

**Address:** _____

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**Name:** Dr. Elizabeth Ford, Chief of Service, Psychiatry

**Address:** NYC Health + Hospitals/Correctional Health Services

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**Address:** _____

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**Name:** Dr. Ross MacDonald, Chief Medical Officer

**Address:** NYC Health + Hospitals/Correctional Health Services

**I represent:** _____

**Address:** _____

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**Name:** Stefan R. Sholt

**Address:** _____

**I represent:** The Legal Aid Society

**Address:** 199 Water St. New York, NY 10038

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**Name:** Julia Solomons

**Address:** _____

**I represent:** The Bronx Defenders

**Address:** 360 E. 161st St. Bronx, NY

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**Address:** _____

**I represent:** DOC

**Address:** _____

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**Name:** GEOFFREY GOLIA

**Address:** _____

**I represent:** GOSD

**Address:** EAST HARLEM

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**Address:** _____

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**Address:** _____

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**Name:** Minstr. Dr. Victoria Phillips

**Address:** 40 Rector St #9th floor

**I represent:** Jails Action Coalition / Mental Health Project

**Address:** " "

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**Name:** Darlene Jackson

**Address:** _____

**I represent:** Women's Community Justice Project

**Address:** _____

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**Name:** [illegible] Gardner

**Address:** _____

**I represent:** Tenant Action Center

**Address:** 275 Varick St NYC 10014

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