CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON CRIMINAL JUSTICE, COMMITTEE ON JUSTICE SYSTEM, COMMITTEE ON MENTAL HEALTH, DISABILITIES AND ADDICTIONS

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June 17, 2019
Start: 1:16 p.m.
Recess: 4:03 p.m.

HELD AT: Committee Room – City Hall

B E F O R E: KEITH POWERS
Chairperson

RORY I. LANDMAN
Chairperson

DIANA AYALA
Chairperson

COUNCIL MEMBERS: Alicka Ampry-Samuel
Robert F. Holden
Mark Levine
Donovan J. Richards
Carlina Rivera
Andrew Cohen
Laurie A. Cumbo
Farah N. Louis
Alan N. Maisel
Deborah L. Rose
Ritchie J. Torres
Fernando Cabrera
James G. Van Bramer

A P P E A R A N C E S (CONTINUED)

Becky Scott, Bureau Chief, Facility Operation, Department of Correction

Joseph Antonelli, Acting Associate Commissioner of Budget Management and Planning, NYC Department of Correction

Dr. Elizabeth Ford, Chief of Service for Psychiatry, Correctional Health Services New York City Health and Hospitals

Dr. Patsy Yang, Senior Vice President for Correctional Health Services, CHS, New York City Health and Hospitals

Dr. Ross MacDonald, Chief Medical Officer New York City Health and Hospitals

Elizabeth Glazer Director, Mayor's Office of Criminal Justice, MOCJ

Myla Harrison, Assistant Commissioner, New York City Bureau of Mental Health

Geoffrey Golia, Associated Executive Director, the Getting Out and Staying Out GOSO

Mary Beth Anderson, Director, Urban Justice Center

Jennifer Parish, Director of Criminal Justice Advocacy, Urban Justice Center

Kelly Grace Price, Close Rosie's

Dr. Victoria Phillips

Kathrine Bajuk, New York County Defender Services

Stephen Shore, Legal Aid Society

Darlene Jackson, Woman's Community Justice Project

Julia Solomon, Senior Criminal Defense Social Worker on Policy, Bronx Defenders

Tracy Gardner, Vice President of Policy and Advocacy, Legal Action Center

Darlene Jackson, Project Coordinator, Women's Community Justice Project

Stefen Short, Prisoners' Rights Project, Legal Aid Society

Katherine Bajuk, Public Defender and the Mental Health Attorney Specialist, New York County Defender Services

[sound check] [pause] [gavel]

CHAIRPERSON POWERS: Good afternoon. I'm City Council Member Keith Powers, Chair of the Criminal Justice Committee joined here today Council Member Rory Lancman, the Chair of the Committee on the Justice System, and Council Member Diana Ayala, Chair of the Committee on Mental Health, Disabilities and Addiction for tonight's—today's oversight hearing on preventing recidivism for individuals with mental illness. New York City has failed to fully address the mass incarceration of people with mental illness in our Criminal Justice System for decades. Until 2003, most mentally ill people were released in jail in the middle of—in the middle of the night with only one--$50 in cash a two-fare Metro Cards, no medication, no referral to services, no assistance obtaining Medicaid or public benefits and no referral to shelter The case *Brad H. v. City of New York* sought to challenge these conditions and the subsequent settlement now requires the city to provide better discharge planning. Nevertheless, the recent report from Brad H. compliance monitors in February 2019 shows that while the city has made important efforts, we can do more to ensure that

incarcerated people with mental illness have access to essential services both in and out of the jail. Even with the strong efforts by the Department of Correction such as the successful creation of CAPS Units in 2013 and PACE Units in 2015 to provide specialized housing to people with mental illnesses, these individuals still face hurdles accessing basic care. People with mental illness continue to miss nearly one-fifth of scheduled mental health appointments because of failure to produce them to Correctional Health Services, other practices like the placement of people with mental illnesses in restrictive housing units as a form of punishment may not meet standards of appropriate and rehabilitative care that the city seeks to provide. Despite Brad H. requirements barriers remain to secure and supportive housing as part of discharge planning when people with mental illnesses are released. I believe our goals here are threefold. First, we must commit ourselves to prevent people with mental illnesses from entering the Criminal Justice System in the first place especially when that incarceration takes the place of receiving much needed and critical treatment. Second, we have to ensure that those who

go through the system receive the appropriate level of care and treatment in custody, and third, we must ensure that people with mental illness receive adequate reentry planning, which emphasizes continuity and care upon their release. At today's hearing we look forward to hearing from all the agencies that are here today about how they plan to help us reach those goals diverting more into individuals from incarceration ensuring better continuity of care and reentry, and resuit—and reducing people from ever coming back. I also want to hear how addressing the prevalence of mental health conditions in jails will factor into the city's new borough based—borough based jail plan. We'll also be hearing today two pieces of legislation. The first is Get Well and Get—Get Well and Get Out Act introduced by Council Member Chin, which requires Correctional Health Services to report information to defense attorneys for purses—for persons in custody diagnosed with serious mental illness so they can better argue and advocate on behalf of their clients. Second, pertaining to general discharge policies we'll hear Intro 903, a bill by Council Member Donovan Richards, which would

require the Department of Corrections to return any remaining funds in an incarcerated—incarcerated person's commissary account to that person within 60 days following their release from custody. This will help incarcerated individuals including those with mental illness successfully return home. With that being said, I want to thank you agency for being here today. I want to thank my committee staff, my staff for helping to put together this hearing today, and I want to recognize all the Council Members who are here in attendance, Council Member Cabrera, Council Member Holden, Council Member Rivera, Council Member Ampry-Samuel, Council Member Richards whose bill is on the agenda today, and our Chair Ayala, Chair Rory Lancman, and Council Member Jimmy Van Bramer. Now, we'll hear from Chair Ayala who is the Chair of the Mental Health Committee

CHAIRPERSON LANCMAN:

CHAIRPERSON AYALA: Thank you. Good afternoon everyone. I'm Council Member Diana Ayala, Chair of the Committee on Mental Health, Disabilities and Addiction. I would like to thank Chair Keith Powers and Rory Lancman for holding this hearing with me today. Today, we are here to talk about the

intersection of mental illness and our Criminal Justice System. This issue is deeply personal to me as I have seen first hand through members of my own family just how significantly our Criminal Justice System overlaps with mental illness. Overall, in the last two decades we have seen a drop in the number of incarcerated individuals in New York City. The daily population at Rikers Island dropped 12% between 2005 and 2012. This is a good thing. What is alarming, though, is that in that same time period the prevalence of mental illness at Rikers Island rose by 32%. Today, approximately 10% of the entire jail population at Rikers has been diagnosed with a serious mental illness. As the institutionalization of mental illness continues across the United States, our prisons and jails are becoming our largest providers of mental healthcare. Today's hearing focuses on recidivism for individuals with mental illness, and mental health challenges. According to reports from the Department of Corrections, the overall recidivism rate amongst those released hovered just above 20% in 2015, 2016 and 2017, but for individuals with mental illness that number was 48% in 2015, 47% in 2016 and 2017. This means that

nearly half of the individuals with mental health challenges that are released from jails are going to right back. We need to do better. We need to ensure that individuals are receiving the services that they need while they are incarcerated, but more importantly, we need to more—we need more safeguards in place to ensure that individuals with mental illness do not end up unnecessarily incarcerated in the first place. I am happy to see our police force utilize T and a Co-Response Teams that include mental illness professionals, and I'm happy that discussions around the use of diversion centers as well are on the way, but we need to allocate more resources to mental healthcare for vulnerable populations so that individuals that need help and support do not end up in jail. We also need to ensure that once individuals are released into communities that they have the support and resources once they're out there. We need to ensure follow-up and proper system of checking in on individuals who might need a little bit of extra help particularly as we move closer to closing Rikers Island and into a smaller borough-based jail system. I want to feel confident that we are doing our best to care for our families, friends

and neighbors who may be in need of mental healthcare. I want to thank the Administration for coming today to have this soft (sic) conversation with us. I would also like to acknowledge my fellow committee members who have joined us. Thank you for all being here today. I look forward to a productive conversation. [pause]

CHAIRPERSON LANCMAN: Good afternoon. I'm Council Member Rory Lancman, Chair of the Committee on the Justice System. Thank you to Council Members Keith Powers and Diana Ayala for leading this hearing on reentry services, and preventing recidi--recidivism for those in our Justice System with a serious mental illness. It is a maxim among many in the Criminal Justice community that planning for reentry should begin as soon as someone is incarcerated. For no one is that more true than those with mental illness. After release a diagnosis or need for continued mental health treatment can present an additional barrier to obtaining or sustaining housing, employment, medical care or services for concurrent substance use disorder, but we must also not miss the forest for the trees. Many of those struggling with reentry

into our communities after incarceration should never have found themselves in the Criminal Justice System to begin with. Instead of merely addressing the aftermath of our widespread criminalization of mental illness, we must confront it head-on. As we track the rising number of emotionally disturbed person calls to the police and the increasing percentage of those in our jail system with mental illnesses, even as the overall population declines, we can see that many of our city's efforts to decarcerate are failing to reach this key population. We can no longer rely on untrained police, court personnel and correction officers who are ill-equipped to address the needs of those with serious mental illness. Instead, we must seek to develop and imple—implement more pre-entry non-carceral alternatives to prosecution, detention and incarceration in consort with our community-based providers, our public hospital system, public defenders and district attorneys. I'm encouraged—encouraged that today we will hear from so many actively involved in this work, and I look forward to hearing their ideas and their suggestions for how we can accomplish this goal. Thank you.

CHAIRPERSON POWERS: Thank you. Wit that being said, we'll ask you all just to raise your hand and we'll swear you, and then we'll—we'll look forward to your testimony.

LEGAL COUNSEL: If from left to right you can all say your names please.

PATTY YANG: Patty Yang.

ELIZABETH FORD: Elizabeth Ford.

BECKY SCOTT: Becky Scott.

JOSEPH ANTONELLI: Joseph Antonelli.

LEGAL COUNSEL: Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this committee, and to respond honestly to Council Member questions?

SPEAKERS: [interposing] We do. (sic)

CHAIRPERSON POWERS: Great. Thank you. You can give your testimony.

BECKY SCOTT: Good afternoon Chairpersons Powers, Lancman, Ayala and members of the Committee on Justice System and Committee on Mental Health, Disabilities and Addiction. I am Becky the Bureau Chief of Facility Operations with the Department of Correction. 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 a—of a young transgender woman Layleen Polanco, and the second was of an older many who passed away in the ICU of Bellevue Hospital while under a 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, and during this difficult time. We take these matters extremely seriously within the department, and we are committed to providing updates to the Council and the public with additional details as they emerge. I appreciate the Council's understanding there is—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 our 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 of foul play contributed to her tragic death. Safety is the 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—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 for 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—in addition to healthcare services the department also partners with

a number of program providers to afford access to programming and enhance behavior coping skills, support anger management, address substance abuse, and encourages productive and pro-social 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 healthcare, 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 illnesses. The Mental Health Unit. 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—the individual-run observation unit, MO Unit, operate under the guidance of a multi-disciplinary team of unit based mental health providers who conduct daily rounds, provide group programming and individual psychotherapy and also oversee medical treatment—medication treatment. Excuse me. MO units are not punitive and afford the same out-of-cell time as the General Population Unit. For individuals whose serious mental illness requires

intensive support, but who do not require hospitalization, the department works in conjunction with CHS to operate programs 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 and the department—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 lockdown setting. Since 2016, the department has eliminated period of segregation for individuals with serious mental illness and have since housed individuals with guilty adjudications for serious infracts 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 for PSEG, they may subsequently assign units known as--individuals to units known CAPS or RHU. The clinical alternative to Punitive Seg, CAPS is a housing unit that provides intensive

mental health treatment for individuals with serious mental illnesses 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 provide insight and competency in managing mental illness as well as the emotions and behavior. Restrictive Housing Units 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 mental illnesses—serious mental illnesses. Disincentive based housing operates in three levels gradually provide 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 in our female facility, the RHU in the female facility operates at a Level 3 affording all individuals with up to 7 hours lockout. Individuals in RHU are afforded 3 hours mental health programming from CHS every day, 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, through providing appropriate therapeutic housing the department has recognized maintaining a robust workforce of well trained staff is critically important to supporting those entrusted to our care. In 2014, the department began Mental Health First Aid training in its Academy curriculum. The training is conducted over an 8-hour day and builds mental health literacy by training staff to identify, understand and respond to signs of mental illness. By several other in 2019, the department trained over 7,200 staff members. In August, 2016, the department began offering the training to incarcerated population. Through February 2019, has trained over 800 individuals while in custody. The department begin Crisis Intervention Training at AMKC in July, 2015, and it has since expanded the training for five facilities. The 40-hour training aims to develop a first responder

understanding of mental illness and intervention skills in order to achieve safe resolutions to mental health crisis. To date, 725 uniformed staff have completed the training along side 206 New York City Health and Hospital staff who provide health services in DOC facilities. DOC plans to expand CIT training to RNDC this year. In regards to the legislation being discussed at today's hearing, the department supports the spirt of Intro 903 and is eager to work with the Council and potentially other agencies or community groups to improve formerly incarcerated New York—New Yorkers access to their commissary funds allowing their discharge from custody. Although we have some concerns about the operational feasibility of all requirements of Intro 903, we agree that this is an important area for reform. We look forward to working with the Council in the coming weeks to better connect with formerly incarcerated individuals with nearly 3.7 million in unclaimed commissary funds. Thank you again for inviting us to discuss these important matters, and we welcome any questions you have at this time.

CHAIRPERSON POWERS: Thank you. Are we hearing testimony from H&H, you know, Correctional health Services, too?

DR. ELIZABETH FORD: Good afternoon, Chairpersons Powers, Lancman and Ayala and member of the Committee on Criminal Justice System, the Committee on Justice System and the Committee on Mental Health, Disabilities and Addiction. I am Dr. Elizabeth Ford, Chief of Service for Psychiatry for Correctional Health Services or CHS at New York City's Health and Hospitals. I'm joined by Dr. Patsy Yang the Senior Vice President for CHS and Dr. Ross MacDonald, our Chief Medical Officer in addition to Bureau Chief Scott and our colleagues at the New York City Department of Correction. As the Council is aware, there were recently two tragic and heartbreaking deaths in the jails. 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 first hand 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 boroughs. 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 New York City Health and Hospitals on January 1, 2016, the mental healthcare 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 and innovative and patient center 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

individuals who are incarcerated. Where mental health service has been able to flexibly—flexibly approach the divers clinical and reentry needs of our patients and to develop what has become a national model of care. 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, patients and other healthcare 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 from jail, we try to do as much as we can in the early part of an individual's incarceration. Approximately 43% of the jail population has been under the car of the Mental Health Service at some point during their incarceration. Roughly one-third of the Mental Health Service or 16% of the jail population and approximately 1,100 people at any time have been diagnosed with a serious mental illness, which is 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 than the general population we have 18 Mental Observation Units more than 540 beds spread across the 10 jails and the Horizon Juvenile Center. Each Mental Observation Unit, which is 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 relatively new staff positions 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 New York City 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 a 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 PACE Units, as Bureau Chief Scott described 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. Each PACE Unit has a specific treatment population with units for patients returning from state or acute hospitalizations, patients with intellectual or developmental disabilities and women and men who are

city sentenced. We also have the equivalent of a PACE model of care for individuals with serious mental illness who have been charged with an infraction for which the DOC has determined that punitive segregation is indicated. This is know as the CAPS Unit, which you heard about earlier as well. There is one CAPS Unit comprised of 18 bed for the men and an additional 10 beds for the patients at Rose M. Singer. Since the end of punitive segregation for individuals with serious mental illness for which we greatly applaud the DOC, we've been providing intensive treatment rather than lock in for those individuals. The PACE Units have demonstrated a 50% increase in medication adherence, a 25% decrease in both self-injury and injuries sustained as a result of fights, and an 85% 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 in-patient psychiatric beds in two Health and Hospitals 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 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—operating what we believe to be the nation's first jointly led crisis intervention teams 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 team work are hallmarks of the CIT response. All patients of the Mental Health Service regardless of the level of care, receive comprehensive reentry 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 or ACT, and Assisted Outpatient Treatment or AOT. All individuals with serious mental illness are also offered transitional case management services through a vendor contract—contracted by CHS for at least six months upon release from custody. In recognition of the importance of reentry social work services and the clinical care of our patients, the transition to Health and Hospitals 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 have initiated and maintained a citywide work group related to the care of individuals with intellectual and 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 much more closely with the New York State 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 New York State Office of Mental Health for restoration of competence. This mobile team is dedicated to maintaining the clinical stability of these patients, and so that their cases can be more quickly disposed and they can get out of jail faster. The ability to provide such a comprehensive level of integrated mental healthcare has led to some significant improvements. The average suicide rate from 2011 to 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 New York City jails from 2016 to 2018 dropped to 10.8 per 100,000, almost half of 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 study 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 wind up in jail. Thank you.

CHAIRPERSON POWERS: Thank you. That— anyone? I got some. Thank you for that testimony. I also just want to before we jump into questions, acknowledge we've been joined by Council Member Rose, Council Member Dromm, Council Member Levine, Council Member Maisel and Council Member Chin as well, and I'm going to start with a couple of questions. I—I also just wanted to briefly acknowledge and congratulate the person sitting next to me. We just got engaged, and not to put her on the spot, but I want to congratulate her as well. I-and before I jump into questions on this particular topic, and I know there's a lot sensitive information related to the case, but can you just give us status on the

investigation around the Polanco death, and it was in two deaths, but I think that one has garnered a lot of attention, and a lot of information you can't share because investigation is ongoing, but maybe just a timeline and where the stat was—what the status or the investigation is right now?

BECKY SCOTT: As we've stated Council Member the—the timeline is part of the ongoing investigation. So those facts I'm not able to provide at this time, and I do understand, and I'd like to repeat how frustrating that is, but if you would like information on the process of notifying the family members, I can share that with you. The department makes every effort to identify the next of kin to provide some notification. Historically, the Chaplin contract—contacts the next of kin and if they can be reached the department notifies attorney of record.

CHAIRPERSON POWERS: I think we were just—I—I as I understand it, kin has been notified. I think we were—actually the question was who's in charge of the investigation? I think maybe has it the Bronx DA take over the investigation?

BECKY SCOTT: [interposing] The Bronx DA, yes.

CHAIRPERSON POWERS: And is there an expected timeline when there might be conclusion to the investigation or some outcome to that?

BECKY SCOTT: Not at this time.

CHAIRPERSON POWERS: At time. Has DOC handed this investigation over? So, it is—are you--?

BECKY SCOTT: The Department of Investigation, the Medical Examiner's Office and the Bronx DA.

CHAIRPERSON POWERS: Okay. I threw out those questions but we'll come back to that. I—I saw testimony here on—on Council Member Richard's legislation around the commissary. I didn't see any commentary around the other bill, Council Member Chin has the Get Well—Get Well, Get State—Get—the Get Well Again bill I was hoping we could share with us your thoughts from the Administration or Correction Health Service and DOC on that piece of legislation as well since it's a, you know, it's a big piece of today's hearing.

DR. PATSY YANG: Sure. Once again, thank you. [coughs] We support very much so the sharing of appropriate information with the defense counsel to help get people out of jail or find alternative to

incarceration. We do that now. Dr. Ford mentioned the Court Liaison Program that we have. Within that program, which is a very active contact with—with the defense in courts, but anywhere in the service when a defense attorney obtains informed consent from his or her client for release of clinical information that can support diversion, we actually—we offer that.

CHAIRPERSON POWERS: And-and so, can you just walk us through the process today if a defense attorney has a client they want to get access to their information to help them in terms of their defense and representation? Can you tell us what that process is today?

DR. ELIZABETH FORD: Sure, absolutely. So, it—it—we can—we have contact with attorneys initiated many times by the patients themselves. So, they will be in touch with our clinical staff and then later the court liaisons, and they provide written consent for us to contact the defense attorney to discuss relevant health related information that may be used for the defense's strategies particularly with respect to Alternatives to Incarceration Programs. So, the—so in that case the patient approaches us. We field tens—at least

tens of referrals each day from the defense counsel requesting discussion with us about patients' clinical needs, and the court liaisons will communicate to the defense attorney request consent from the patient and then if consent is obtained them we'll communicate. The time from receiving consent to discussion with the attorney is on the order of a day or two. It happens fairly quickly.

CHAIRPERSON POWERS: And are you required—are you sort of—does the defense attorney then have to go and request information from you or do you proactively share with them, or how does the information sharing work once consent has been given?

DR. ELIZABETH FORD: So, once the consent is signed, the attorneys typically have specific questions, and we will share with them appropriate information that answers those questions.

CHAIRPERSON POWERS: Are there—even with the consent, are there restrictions on what information you can share or can't share even—I know that it was hit by another law in place, but after consent is given, is there—are there any restrictions in terms of what you can share?

DR. ELIZABETH FORD: Yeah, so, it depends on the kind of consent that is given. There are patients who will consent to provide every piece of information and there are others who will limit it specifically to certain areas. We do try to stick very closely to information that we think is relevant to the questions being asked. So, we will not be releasing an entire medical record if that doesn't relate to the question.

CHAIRPERSON POWERS: Got it. So, is—is it fair to say the Administration supports the legislation?

DR. ELIZABETH FORD: I think it's fair to say that we're in active discussions with the Council about this, and would be happy to continue those after this meeting.

CHAIRPERSON POWERS: Okay, I trust Council Member Chin and staff to follow up with you on your particular conversation. I see we're also joined by Council Member Any Cohen. There's one seat for you over there I think. You know, I just want to—taking a large step back and your testimony reflects, and I think there's even particular statements in here about, you know, concerns or

acknowledgement that this may not even be the right venue for providing services especially to those with a serious mental illness, and that a jail setting while you have an ability to provide concentrating services in one place, may be the wrong place, and I think I heard some either direct or—[coughs] or at least some acknowledgement of that in both testimonies, and, you know, we're-we're obviously opening up where we're—we're-we're having a discussion of looking at new facilities. There's I think an acknowledgement in this body as well that folks who amongst many members that have a serious mental illness probably shouldn't be in a jail setting. Can you tell us what the—what steps the—the Administration is taking, the agencies here? Maybe this includes MOCJ as well, to address that particular issue, which is potentially not, you know, not—what programs we're looking at, what is—what are plans or proposals that we're—that are being considered to get out of the process of sending people who are diagnosed as—with a serious mental illness to a city jail and potentially putting them in a place where they can get better services, and maybe more continuity of services. Can you share with

us any plans that the Administration has today round addressing both—I mean what I think both agencies said, which was this is probably not the right place to be providing services for those who have at least some serious mental illnesses? And then we did welcome MOCJ up here as well. [pause]

DR. ELIZABETH FORD: I mean for-for Correctional Health Services the—since—since the transition over to Health and Hospitals, we certainly, you know, maximize and optimize the—and leverage the—the community-based resources of the nation's largest healthcare system. We also link up and refer and establish and strengthen referral patterns to other than Health and Hospitals' facilities. Trying to improve care within the hospital, within—within the jails and strengthen those linkages for care in the community after release have been our focus. You know, people are not incarcerated for clinical reasons, and so our attempt to is and our work is really to try and get resources in the community strong enough and—and built up enough for the capacity to stabilize people and keep them from--from coming back.

CHAIRPERSON POWERS: Appreciate it and maybe and I think we have to—we have to swear you in as well. Just—just somebody from MOCJ. This witness, but I think the question is really what are we doing in the community today to prevent anybody from entering the Criminal Justice System with a serious mental illness and then what approach—and then once somebody has been arrested what are we doing? What is the strategy around not putting them into a city jail? Like it just seems to be a consensus to me that there isn't—that may not—that's a wrong place, and—and I just want to—I want to say that with an acknowledgement. You know, reading the statistics I think it's 43% of the jail population has been under the care of Mental Health Services at some point during their incarceration. One-third have been diagnosed with a serious mental illness, Schizophrenia, Bi-Polar, Depressive Disorder, Post-Traumatic Stress Disorder. Is it—no is saying it's not a challenge. Correctional Health Services is a huge challenge, and some of the stats around the suicide and things have been better than the national average in terms of addressing those, and what we've taken—we've been to the city—when we've been Rikers

Island we discussed those as we visited CAPS and PACE. But it just strikes me that maybe the Administration and the agencies here should be focusing on some—not just the treatment of people when you're in their care, but getting them out of care, and addressing that population a different way. So, I think that's what the question—my question is really focused on that and we can—we can-I think you want to answer the question. We just swear him in.

LEGAL COUNSEL: If you could state your name, please.

ELIZABETH GLAZER: [off mic] Elizabeth Glazer. (sic)

LEGAL COUNSEL: Do you—do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this committee, and to respond honestly to Council Member questions?

ELIZABETH GLAZER: Yes.

CHAIRPERSON POWERS: Thank you.

ELIZABETH GLAZER: Sure. So, I can—I can—I can speak to that broadly. At-at MOCJ, the Mayor's Office of Criminal Justice, we are working with different agencies across the Administration to reduce the number of people with behavioral health

disorders who end up in the Criminal Justice System, and specifically who end up in jails. We are improving the Criminal Justice response for people in crisis making sure that our diversion programs have a focus on mental health and substance use work with CHS to ensure standard models of therapeutic settings in jails, and supporting reentry and diversion through attention to social determinants of health like employment and housing. I can talk in more detail about any of those initiatives or programs if you—

CHAIRPERSON POWERS: [interposing] I mean I guess the question is if somebody gets arrested and they're diagnosed with a serious mental illness, should they be sent to a city jail or should they—or there should be—there's some other places with-with services that-that can--can address them, and had—so--

ELIZABETH GLAZER: Sure.

CHAIRPERSON POWERS: --has the de Blasio Administration, this is where in your text--

ELIZABETH GLAZER: Uh-hm.

CHAIRPERSON POWERS: --what has been to address that particular population to when, you know,

upon an arrest, and we should—we're going to ask a lot of questions about diversion and continuity post—post-release, but to look at that population differently and this is the context of the conversation around opening new facilities in the boroughs, and this should be a—I mean this should be and others who work in the facilities have raised questions about whether it should be, you know, dedicated facilities to them, not just units but buildings, but, you know, it strikes me that we all agree there's not a-this is a—this population probably doesn't belong in jail in the first place. It's a long venue. So,

ELIZABETH GLAZER: Sure. So, we're ensuring that our Diversion Programs like Supervised Release, Pre-Trial Diversion are alternatives to incarceration and our reentry programs all have the supports available to be able serve people with the behavior health disorders and with serious mental health, medical and substance use issues, and supervised release, which was ruled out citywide in March 2016. There was expanded funding dedicated to the program in July 2017 that was specifically aimed at reducing the number of people with behavioral

health needs in city jails, and so that—that investment included more funding for clinical social workers who have smaller caseloads and for additional peer specialists. So, we're ensuring on the pre-trial diversion side that there's a lot of capacity. We want to make sure our strategy is again focused on paying attention to the social determinants of health to ensure that people stay out of jail, and that means increasing different kinds of supports, and making sure that providers have access to—to supports to be able to create individualized plans for people not on creating new mandates for people. I think the—the shared goal of reducing the number of people with behavioral health disorders in—in these systems requires that we focus on those kinds of voluntary supports and individualized plans and not on creating new mandates that people have to follow or additional mandates just because you have a behavioral health disorder.

CHAIRPERSON POWERS: Yeah, and I'll ask one more question, and then move on, but do you have any statistics during this Administration in terms of reduction of people with serious mental illness in

the city jails in terms of success at efforts to reduce the population?

ELIZABETH GLAZER: So, Correctional Health Services might be able to speak more to the population of people with serious mental illness, but in terms of folks who are Brad H. who have an indication of a mental health need, since the—the Mayor took office, the average daily population has been reduced by 20% and the number of admissions of people with a Brad H. indicator has declined by 36%.

CHAIRPERSON POWERS: That is okay. Thank you.

ELIZABETH GLAZER: Oh, I just and individuals with an M designation or Brad H. designation have-were readmitted to DOC custody at a—a lower rate that—than those without it. So, I think that also shows that a lot of our reentry planning and discharge planning is critical. (sic)

CHAIRPERSON POWERS: Is there a—in—in the context from the conversation, the new borough-based facilities is there—how does the DOC and MOCJ plan to ensure that people are serious enough—folks not—end up with a serious mental health incidents are housed? Is there any strategy or discussion around changes in

housing or policy in terms of the new borough-based facility?

ELIZABETH GLAZER: So, those facilities though they're not specifically designed yet, we are ensuring that they have more program space, more clinic space, more space for services. I think there will also be a lot more access for different kinds of service providers especially local service providers to be able to—to access the facilities and—and get to people, and we'll also make sure that coordination of care is—is improved because the facilities will be in the community, but we at—at MOCJ and in the Administration aren't waiting for the new built—jails to be built to try and improve all of the ATI and reentry services and make sure that there's more of a focus.

CHAIRPERSON POWERS: Just to follow up on this, how does putting them in the community and ensure continuity of care?

ELIZABETH GLAZER: Well, I think people being closer to the—like there will be more service providers who are local who are potentially able to access the facilities so we can make sure to have a referral or a handout to people as they leave, and

there will be, I think, increased access to those facilities from a lot of different providers.

CHAIRPERSON POWERS: Okay.

ELIZABETH GLAZER: Especially in reach and—and discharge planning as well as services for them.

CHAIRPERSON POWERS: And there have been some—I think there's been some discussion about housing or expanding H&H involvement—the—the—we talked about Elmhurst and Bellevue currently have beds. One question—two questions. One is do you believe today you have enough beds at those two hospitals, and then can you talk to us about the plans to expand to other H&H facilities and the status of that—that proposed expansion.

DR. PATSY YANG: Yeah. We believe that we have enough inpatient—acute inpatient beds for medical and psychiatry at Elmhurst and Bellevue. That's not where the gap is. One thing you know in a borough jails what is being planned is—is—are many more therapeutic housing units like PACE like CAPS or like some of the medical dorms or substance use dorms cohorts that we have currently in the jail, which we would increase, but the physical plants are behind

jails, and that's--that's pretty prohibitive. So—so we will have more therapeutic units in the borough-based jails. The gaps really that we're looking at are the ones between people who can be supported well enough in a jail and people whose clinical needs are such-so acute that they merit inpatient admissions in a hospital, and so, CHS has retained the services at the architectural firm to do a feasibility study both in terms of fit tests and cost estimates to see whether the kinds of therapeutic units that we have in the jails and are planning more of in the borough-based jails can actually be located in some of the Health and Hospital facilities where people who need regular and frequent access to specialty services at a—at a hospital or a specialty service can offer, they'll have greater access.

CHAIRPERSON POWERS: And when do we find out something? You hired a firm to take a look at that and when—when are we expecting the results of that to come back?

DR. PATSY YANG: We're hoping in the next few weeks.

CHAIRPERSON POWERS: Few weeks and when does—how many hospitals are you looking at in terms of expansion?

DR. PATSY YANG: We're still waiting for—for the final findings of the—the firm, but there were six facilities in total that had available space.

CHAIRPERSON POWERS: Where you think you could—where you could recreate some of the therapeutic units in those hospitals rather than putting them into a jail facility?

DR. PATSY YANG: And they would have access to the specialty services, and ideally the integration within the four walls of the hospital. Access would be less, DOC escort needs would be less. We did hopefully get service providers to-to come to our units.

CHAIRPERSON POWERS: And is there any difference that you'd expect in terms of service to someone who is in one of the hospitals versus in one of the new borough-based facilities in terms of access to care or programming or anything like that?

DR. ELIZABETH FORD: There would be therapeutic units, but they would have the benefit of

being collocated in the same place that the subspecialty and specialties are.

CHAIRPERSON POWERS: Okay.

DR. ELIZABETH FORD: Within the units themselves now.

CHAIRPERSON POWERS: I just want to do a few more questions and I'm hand—I'll hand it over to the other chairs. You had I think in—at your Board of Correction presentation in March, CHS indicated opening six additional case units by 2020. Can you tell us if—if you're on pace for that or what's the latest on the additional six PACE units? [pause]

DR. ELIZABETH FORD: We do have six PACE units open and we're actively working with DOC to meet the goal of an additional six by the end of 2020.

CHAIRPERSON POWERS: And are you in contract to do that?

DR. ELIZABETH FORD: I think I'll defer to DOC for that.

BECKY SCOTT: Yes, we are. I don't have a timeline in front of me, but yes we are.

CHAIRPERSON POWERS: And where—and where did—where-what facilities are they going to?

BECKY SCOTT: AMKC. Currently AMKC and I believe GRVC.

CHAIRPERSON POWERS: And in terms of the Mental Health Observation Units, can you tell us about programming in that? We had a hearing on programming last year where we discussed what I felt was the agency was still far from the mandate to provide five hours of programming. I think the number was 2-1/2 or 3 in terms of what somebody is getting today. Can you talk to—tell us about the programming and what—how many hours of programming folks in the Mental Health Observation Units are getting and what types of programming?

BECKY SCOTT: I'm sorry. General population in MO Units?

FEMALE SPEAKER: [off mic] Uh-hm.

BECKY SCOTT: Okay. So, I'll—we have program?

DR. ELIZABETH FORD: I'm sorry. So, on the Mental Health Observation Unit, HS runs the Treatment Programming. So, therapeutic groups and individual sessions and DOC manages the programming that I think you're referring to. We are making good progress at Rose M. Singer on the MOs there in terms

of meeting that requirement, and then I'll refer to DOC for an update on the remaining MOs.

BECKY SCOTT: Let's see. [pause] I'm sorry. I don't have an update right now.

CHAIRPERSON POWERS: Do you have any information on how many hours on average programming are being provided in the Mental Health Observation Units? I'll take that answer as no.

BECKY SCOTT: I don't have the schedule in front of me. Sorry, I'll get that you.

CHAIRPERSON POWERS: Okay, if you could get back to us with that. On—are there—is—is—are there people in the Mental Observation Units that would qualify for PACE units, and as you're adding six—if you're adding six more additional PACE units in the next two—year, or in a year I guess, does that mean that there are people in the Mental Observation Units that would qualify for PACE but there aren't enough beds for them?

BECKY SCOTT: The short answer is yes. Yes, so we-we have in designing the needs for them, and the number of the PACE units we factored in our estimates about the numbers of patients who meet criteria for PACE care and we need that level of

care. So, yes we currently see patients in MO Units who we would like to be in the future PACE units.

CHAIRPERSON POWERS: Okay, and do you know today how many people—how many individuals would fit that category?

BECKY SCOTT: I don't—I don't know. I mean I don't know specifically, but I would estimate roughly a quarter of the patients on MO Units would benefit from PACE care.

CHAIRPERSON POWERS: And so they're supposed to be in a PACE unit. We don't have enough for them. So, they're not getting attended—arguably aren't getting the—the same level of services that you—they would receive if they were in the PACE Unit? Is that correct?

DR. ELIZABETH FORD: So, I—coincident with the implementation of PACE Units has also been a pretty dramatic cultural shift in the jail about the care of people with serious mental illness, which has led to pretty robust improvement on the MO Units themselves. So--

CHAIRPERSON POWERS: [interposing] So, so what do you—what the kind of services and treatment do you receive in PACE that you don't—you would not

receive if you're in the Mental Health Observation Unit?

DR. ELIZABETH FORD: Sure. So the—the primary difference is that the staff on the PACE units are embedded on those units. So their offices are on the units. This is not the case for the Mental Observation Units where the staff come on and they do their daily work, and then will leave the unit to do their documentation. Both units have—while the PACE units have steady officers, the MO Units are close to having all steady officers. So, that's fairly consistent. The PACE Units have dedicated nursing staff 12 hours a day, seven days a week, which means that medication administration can be managed in much different way than on the Mental Observation Units When—where the meds are brought to the unit, the patient sort of does a pill call and then the patients take their medications or not. And then we also have three groups per day on the PACE Units, and we have one to two groups per day on the MO Unit, therapeutic groups.

CHAIRPERSON POWERS: So, what's stops you today from just converting one of the Mental Observation Units into a PACE Unit?

DR. ELIZABETH FORD: Largely the primary issues are environmental. So, a—a big part of each PACE Unit is an environmental design that is therapeutic so that means light. We think about color, we think about space, and—and including office space and the—the jails many of the MO Units need some kind of construction in order to get to that.

CHAIRPERSON POWERS: And what's to stop you from staffing them the same way as PACE today?

DR. ELIZABETH FORD: We have—well, again space limitations. So, if we don't have space for example a nursing station in the unit, it's hard to staff with a nurse if we don't have office space for those staff on the units. We invent them there.

CHAIRPERSON POWERS: Yeah, I understand. I just, you know, it's we're right here acknowledging that there is a group of people who are not getting the service that we believe they qualify for, which is more nursing services, more attention and better adherence to medication, and things that we feel, I would think we all agree on it. I see you nodding, are--would be—would be very important to them and I'm—I'm happy. When we—when we open up six more

units, would there still be a population that is Mental Observation Units that would qualify for PACE?

BECKY SCOTT: The goal is that, and once we open all 12 there will not be a patient in Mental Observation Units who requires a PACE level.

CHAIRPERSON POWERS: So, everybody will who belongs there?

DR. ELIZABETH FORD: We'll have enough beds. We'll have enough beds for those who need them.

CHAIRPERSON POWERS: Okay. I just—I'm going to ask one or two more questions, but restrictive housing units, correct me, those are for people who—who have infracted and have a mental health diagnosis? Is that correct?

BECKY SCOTT: Yes.

CHAIRPERSON POWERS: Thank you. Are individuals in your—those units given seven hours of out of cell time?

BECKY SCOTT: That's a tiered approach. So, there's three different levels. So, based on your level, it will determine your out of cell time.

CHAIRPERSON POWERS: And how does one—Level 3 is the most—is the least restrictive or most restrictive?

BECKY SCOTT: Restrictive.

CHAIRPERSON POWERS: Least restrictive, and so how do you end up in Tier 3 versus Tier 1?

BECKY SCOTT: So, orientation is two weeks based on clinical and programming, participation, and your overall behavior. It's a minimum of two weeks, and then Level 3 is also two weeks, the same participation and then discharge.

CHAIRPERSON POWERS: And so, you're---if you're in Level 3 you qualify for 7 hours of out of cell time?

BECKY SCOTT: Yes.

CHAIRPERSON POWERS: And if you're Level 1 how much do you receive?

BECKY SCOTT: Two—I want to say three.

CHAIRPERSON POWERS: Three, three.

BECKY SCOTT: It's—it's--

CHAIRPERSON POWERS: And-and when they're out of cell are they getting programming as well.

BECKY SCOTT: Yes

CHAIRPERSON POWERS: They're receiving and are they restrained when they're receiving programming?

BECKY SCOTT: I'm sorry. One second. I'm sorry, can you repeat that?

CHAIRPERSON POWERS: I said are they—are-are individuals restrained while they're receiving programming?

BECKY SCOTT: Orientation, yes and Level 1.

CHAIRPERSON POWERS: Level 1 and their orientations. Everybody during orientation in Level 1 who are those who have, in fact, I'm assuming are the most serious level.

BECKY SCOTT: [pause]

FEMALE SPEAKER: Thank you.

CHAIRPERSON POWERS: I'm waiting for an answer on this.

BECKY SCOTT: Okay. Once an inmate has been held in RHU completeness that requires orientation and is not on suicide watch, the inmate is eligible to participate in a three-level incentive program and may be entitled to Level 1 incentives. RHU staff shall award Level 1 inmates with one hour

locked out incentive time per day. A Level 1 during any group activities or locked out incentive period uniformed staff shall apply mechanical restraints, handcuffs to one wrist and secure them to an affixed handcuffing bar/ring. Uniformed staff shall also apply restraints to the inmate and secure the inmate's belt to an affixed bar/ring on the bench or table. The department requires that an inmate remain at Level 1 for a minimum of two weeks at which point as determined by his assigned treatment team the inmate shall be eligible to advance to Level 2.

CHAIRPERSON POWERS: Okay, thank you. I am going to come back to questions, but I want to give my colleague an opportunity and Chair Ayala as well. We're going to just first go to Council Member Chin whose legislation is being heard today. I think she had a brief statement. Okay, thank you.

COUNCIL MEMBER CHIN: Thank you, Chair Powers and Ayala. As the Administration moves forward on this—on its plan to close Rikers Island, New Yorkers have begun a critical conversation about how we can lead service-based criminal justice. Reform focus on reentry and rehabilitation. Throughout these conversations we must lose sight on

a huge pat of the detainee population in special need of our attention, those struggling with mental illness. We need to leverage this moment to identify comprehensive solutions to their struggle instead of temporary Band-Aids. I believe the Intro 1590, our Get Well, Get Out Act will help our city take that step forward and begin the process of breaking a cycle that too often criminalize mental illness from the start. This will give incarcerated individuals diagnosed with serious mental illnesses and are not yet sentenced, a fighting chance for relief to assess life saving services and care. By giving defense lawyers a progress report on individuals response to care prescribed by the Correction Health Services, this bill will put these lawyers in a better position to properly advocate for the terms of their relief. I am proud to join Speaker Johnson and Council Member Levin and Powers on this bill and look forward to hearing feedback from the criminal justice advocates, professional in the legal sector and most importantly New Yorkers with experience in the Justice system to make this bill even stronger. I know the Chair asked the question earlier and you were saying that you are still in conversation on this bill, and right you are

not in support yet. So, I wanted to—maybe you can just highlight some of your concern about the legislation, or something that has already been-that you've been working on? [pause]

DR. ELIZABETH FORD: Good afternoon. Thank you. I'm happy to talk about a few of those and the perhaps we could defer others, but an important concern that we have that we stated a little bit earlier was that the difference in an individual's presentation including sometimes even the sentence of mental illness in a jail setting and how that does not match with the way an individual will behave or their sentence will present in the community. So, we have concerns about making decisions about an appropriate level of community support based on what kind of support the individuals requires in the jail. An example of that might be medication adherence. So, medications, we do not force medications in the jail, and we have found with the implementation of PACE Units actually that we don't look—we don't need that in order to encourage adherence, but jails remain an authoritative controlling environment, which is different than the community, and a patient's adherence in the jail is

likely going to be different in the community. So, again, we want to be careful about conflating those two environments. In terms of care settings.

COUNCIL MEMBER CHIN: But we're talking about real—we're talking detainees, the people that have not been sentenced, Right,

DR. ELIZABETH FORD: Yes, correct. Yes.

COUNCIL MEMBER CHIN: And so, is there a way to sort of help with their situation because (1) you know, they got—right now it's—the only option is Rikers Island, and even with I think from your earlier testimony, it doesn't seem like you even have enough accommodations for these detainees, and while they're waiting to go to court, right, they're not sentenced. I mean it's not like they are already sentenced and they have been sent to jail for a while, then you have to have program in there, but right now, they're—they're waiting to be sentenced and if their lawyer have the critical information about their mental health condition, then there might be a way for them to get help in the community while they're waiting on trial.

BECKY SCOTT: Absolutely agreed and 85% of the jail is waiting trial absolutely. So, I—I-I

respect—I respect and understand that we are not generally talking about the sentenced population here. The—and we do share as described in our Court Liaison Program, with consent the information that attorneys may need in order to facilitate alternative and diversion programs out of the jail. I agree with the prior statements of Chairman Powers that preventing an individuals' detention is probably going to be the most successful, but we do share information, and I absolutely agree that expediting an individual, any individual's time in jail—out of jail rather is—is critically important.

COUNCIL MEMBER CHIN: One last point is I know that we are looking at—I think you—you mentioned earlier about other HHC facilities. I think that's something that my colleague who are going to be getting the borough-based jail, the four of us [bell] are going to love it. Ayala, myself and also Council Member Koslowitz, and we've been having this discussion about how do we lessen the detainee population in the borough and for detainees with special needs if there are possibility of really looking a HHC's facility that can provide the therapeutic treatment for them, and that would help

us bring down the borough-based population, and that's something that we're looking forward to—to see. Thank you. Thank you, Chair.

CHAIRPERSON AYALA: Thank you. Council Member Richards.

COUNCIL MEMBER RICHARDS: Thank you. I'm going to forego my testimony, but I want to thank the Chairs for holding this important hearing. So, I want to speak on Intro-- What is it? 903, my bill on commissary funds. Can you just speak to how much unclaimed commissary funds are currently in the city's possession?

JOSEPH ANTONELLI: Sure. There's approximately $3.7 million.

COUNCIL MEMBER RICHARDS: Okay, $3.7 and that's from last year?

JOSEPH ANTONELLI: No, 3.7, that goes back to 2012.

COUNCIL MEMBER RICHARDS: So, 2012, and where is that money currently located?

JOSEPH ANTONELLI: That money is currently located with the Department of Correction. It's all accounted for in our IFCOM System, Inmate Financial Commissioner System.

COUNCIL MEMBER RICHARDS: So, it's sitting in Corrections right now?

JOSEPH ANTONELLI: Yes, we have possession of it, yeah.

COUNCIL MEMBER RICHARDS: And how long do the funds sit until the DOC appropriates them for any other uses? Do you use Commissary funds?

JOSEPH ANTONELLI: It's not used for anything else. Right now it's just sitting there indefinitely.

COUNCIL MEMBER RICHARDS: [interposing] So, literally $3.7 million is just sitting there?

JOSEPH ANTONELLI: Yes.

COUNCIL MEMBER RICHARDS: Can you just speak to any efforts you've made to return those funds to detainees?

JOSEPH ANTONELLI: Sure, we've—we put up posters inside the facilities to inform people on how they can retrieve their funding upon release. One of the things that we have struggled with is specific targeted outreach to he individuals whose money we are holding right now. One of the challenges that we have is accurate contract information for people. So, when they come into custody or they do give us

some level of information, but for various reasons their home address could have changed. You know, someone, you know, maybe got evicted during their incarceration or if they were in a homeless shelter maybe they lost their housing. So, the contact information we have for people upon release is not necessarily accurate, and we want to be really sensitive about sending out information like that where if someone, you know, if someone got possession of a letter that talked about someone's prior incarceration history, that could be really damaging to someone. So, we don't—we don't want to do things like that because we think that would be really insensitive to the person.

COUNCIL MEMBER RICHARDS: But $3.8 million is sitting there. So, we couldn't find—and how many individuals? I'm sorry. If you can just speak to the number of individuals who have not claimed their funds?

JOSEPH ANTONELLI: It's approximately 140,000.

COUNCIL MEMBER RICHARDS: 140 individuals and that's--

JOSEPH ANTONELLI: 140,000.

COUNCIL MEMBER RICHARDS: 140—I was about to say, but you just say. Okay, so 140,000 people you have not—and just speak to any efforts you've made to contact these individuals.

JOSEPH ANTONELLI: We don't make specific-for all the reasons that I listed, we don't make specific outreach to individuals.

COMMISSIONER RICHARDS: But you take their money.

JOSEPH ANTONELLI: Well, we're—we're not doing it. We're just holding it right now. We don't have any use for it. Our—our preference would be to give it back, and we would like to work with the Council and any, you know, community organizations in any way we can to try and return the money because that is our preference is to return it.

COMMISSIONER RICHARDS: How much money was returned last year?

JOSEPH ANTONELLI: I don't have that—that information, and we have the--

COMMISSIONER RICHARDS: [interposing] You don't have a guestimate? No guestimates? Alright. Has any effort been made by DOC to increase awareness? So, you spoke of posters?

JOSEPH ANTONELLI: Yes.

COMMISSIONER RICHARDS: And where are these posters at?

JOSEPH ANTONELLI: They're—they're inside the facilities. That's one of our primary—primary methods of communication to people who are incarcerated.

COMMISSIONER RICHARDS: So, just posters? You don't know. Okay. I don't think that's a good strategy to do. So, are there any other strategies you're looking at outside of hanging posters?

JOSEPH ANTONELLI: I'm sorry, can you repeat yourself?

COMMISSIONER RICHARDS: Are there any other strategies you're utilizing outside of hanging posters? And how big are these posters or where are they placed?

JOSEPH ANTONELLI: They're placed inside the housing areas and facilities.

COMMISSIONER RICHARDS: And if—if you—can you speak if someone has a language barrier, are they are in different languages or can you speak to that?

JOSEPH ANTONELLI: Yes, any—any documentation that we have can be translated into the 11 languages.

COMMISSIONER RICHARDS: I didn't ask you documentation. I asked you so the posters that are hanging are they in several languages?

JOSEPH ANTONELLI: [interposing] But the posters are primarily are in—they're primarily in English right now.

COMMISSIONER RICHARDS: Okay. So, you don't think would that serve as a barrier if you didn't speak English?

JOSEPH ANTONELLI: It absolutely does serve as a barrier. Yes.

COUNCIL MEMBER RICHARDS: Okay. So, we're going on language access?

JOSEPH ANTONELLI: Yes.

COUNCIL MEMBER RICHARDS: Okay, and has there been any changes to the system that would allow detainees or inmates to obtain their funds without returning to a DOC facility?

JOSEPH ANTONELLI: At this time, logistically we can't—we don't have the ability to do that. We only have the ability to issue, you know,

for the first $100 we can give someone cash, and then anything above $100, we issue a check by mail. One improvement that we have made, and this was something that came up in a prior Council hearing, is previously with the bank that we were using if someone wanted to cash their check and didn't have a checking account, they wouldn't necessarily be able to do it. Maybe they would have to take that check to a cash checking place and be subject to a fee. Now, that we have—the city has switched banks to the Bank of America, we have ensured that if someone had—gets a check from us they can go to any Bank of America location with that check regardless of whether or not they have an account and they'll be able to cash that check with no fee.

COUNCIL MEMBER RICHARDS: And the Correction Department has heard of something called debit cards, correct?

JOSEPH ANTONELLI: Yes.

COUNCIL MEMBER RICHARDS: Alright, is there—has there been any thought of putting commissary funds on--

JOSEPH ANTONELLI: [interposing] Absolutely we have thought about this, and the thing

that we want to be sensitive to is typically you'd have a third-party company that would be running that, and they would charge a service fee, and we want to be cognizant of the fact that a lot of the people in our custody don't have a lot of money, and we don't want to pass up any fees to them. So, we want to be cognizant of that, which is why we try to do things that will have no fee.

COUNCIL MEMBER RICHARDS: Well, I get the fee issue, but they're not getting their money anyway. I'm sure, and I'm not saying that that would be correct for a dollar to be taken off, but if you're at zero now, I'm—I'm sure that they-they would appreciate getting their money in the first place. Can you just speak to any barriers or hoops the department—how many hoops does the department expect for detainees to jump through during an incredibly vulnerable time to get money back that is rightfully theirs?

JOSEPH ANTONELLI: I mean I think that these are the same hoops that person has to go through to get their personal property, and these are things that are real problems. I think we're all in agreement with that, and I think that anything we can

do to make it easier, we absolutely will do or we absolutely would do. We just have these logistical challenges that are making it very difficult for us to do that, but if we could hand people their money as they walked out the door, we absolutely would do it. There's no reason for us to hold it.

COUNCIL MEMBER RICHARDS: So, I'm trying to understand why we can't.

JOSEPH ANTONELLI: So--

COUNCIL MEMBER RICHARDS: [interposing] I have not heard--

JOSEPH ANTONELLI: --the—the method of which people are released is problematic for us on—from the standpoint of being able to just hand them things. So, if someone, you know, when someone leaves for court in the morning maybe their case gets dismissed while they're at court, and that would prevent us from being able to hand them a check, give them their personal property, which is still on Rikers Island in their housing facility. It's things like that that make it really difficult to--

COUNCIL MEMBER RICHARDS: [interposing] Those are logistical challenges--

JOSEPH ANTONELLI: Yes.

COUNCIL MEMBER RICHARDS: --it sounds like.

JOSEPH ANTONELLI: Yes, yes, those are logistical challenges, yes.

COUNCIL MEMBER RICHARDS: So, there has to be some way to strategically work out these logistical issues and I—I'm from what I'm hearing it sound like there has not been a real effort to actually do that, and then as you said in your testimony, you know, and I'm not going to hammer you over the head. I think you get the point of why we are introducing this legislation.

JOSEPH ANTONELLI: Right.

COUNCIL MEMBER RICHARDS: You know, these are individuals who are leaving prison, and can use that every dollar that they could possibly get, and then to make matters worse, you know, these are individuals whose families are scraping together every little bit of money they have in most cases to send to them, but yet the DOC is holding onto $3.7 million?

JOSEPH ANTONELLI: $3.7, yes.

COUNCIL MEMBER RICHARDS: So, I don't—I am not seeing a real effort, and you—so you support the bill? I heard this. I see in the--

JOSEPH ANTONELLI: [interposing] We—we support the--

COUNCIL MEMBER RICHARDS: -you support the spirit.

JOSEPH ANTONELLI: --the spirit of it, right because I think, you know, along the lines of religious and legal challenges that I was discussing about our inability to be able to just hand people money. I mean I think that if we had the ability to give someone 72 hours notice, right now if we had 72 hours notice that someone is discharged, we would absolutely operationalize letting them know how much money they have, and all of that, but the challenge that we have is that we don't actually have 72 hours notice. You know, in most instances someone pays their bail, we have a couple of hours to process their paperwork custodially and-and, you know, legally release them, you know, as well as if someone just goes to court, the judge releases them. They're free right from court. So, there are real challenges to us being able to operate--

COUNCIL MEMBER RICHARDS: [interposing] Let me—and I—and I want to get to me thought, and get off of this money--

JOSEPH ANTONELLI: Okay.

COUNCIL MEMBER RICHARDS: --but just who handles all of this? Is there a unit? Who—who handles this? How many people are assigned to this specific unit that's in charge of returning commissary funds?

JOSEPH ANTONELLI: So, there's a central cashier's office on Rikers Island at the Sam Perry building, and then each of the borough facilities have their own separate cashier offices.

COUNCIL MEMBER RICHARDS: How many people work in those specific units?

JOSEPH ANTONELLI: I don't have the number of people that work in those units, but those are 24/7 operations. So, people are available 24 hours a day, 7 days a week.

COUNCIL MEMBER RICHARDS: I don't know what to say. I know you support the spirit, but I'm supporting more than jut the spirit. We want to make sure the commissary funds that are rightfully-if those—if those individuals got caught with their hand

in the cookie jar they would be in jail, and I'm not saying that you're there--

JOSEPH ANTONELLI: [interposing] I mean I do want to clarify--

COUNCIL MEMBER RICHARDS: --but—but—but, you know, you're not rightfully returning property to individuals that could be considered--

JOSEPH ANTONELLI: The Department of Correction rightfully returns the money and property to anyone that we can do so appropriately. We don't hold people's money for the purposes of using it or doing anything improper with it. The money is there for people to-to claim. We want to work with the Council and work with any organizations that are willing to help with outreach efforts, but I do have to make it clear that the Department of Correction is not seizing anybody's money. It is not holding anybody's money for any illegitimate purpose. The money is there and available to be claimed and we will happily disperse the money as soon as we possibly can.

COUNCIL MEMBER RICHARDS: Okay, you are holding—that is considered a seizure. I'm just saying

that you seized a 140,000 different individuals' commissary funds.

JOSEPH ANTONELLI: We--we didn't seize anybody's property. They—they deposited the money into an account, and it's unclaimed funds. We didn't=--we didn't seize anybody's personal property.

COUNCIL MEMBER RICHARDS: Yeah, that's a good--

JOSEPH ANTONELLI: Yeah.

COUNCIL MEMBER RICHARDS: --maybe the state comptroller could help with this. I got a mind to--

JOSEPH ANTONELLI: [interposing] Anybody—anybody that would be willing to help us disburse the money, and we have no reason in holding it.

COUNCIL MEMBER RICHARDS: Is there a website that individuals can go to, to look for where there—to locate where their funds are?

JOSEPH ANTONELLI: It is not. We—we don't want to put people's personal information on a website.

COUNCIL MEMBER RICHARDS: I'm not saying—I'm not saying—what I'm saying is that there are—there has to be a way to create a user name and a

password on your website or something of that nature for individuals to access what's rightfully theirs. So—

CHAIRPERSON AYALA: I think he—so we were making a little joke, but it's not funny. The—the State Comptroller has the unclaimed funds website—

JOSEPH ANTONELLI: Yes.

CHAIRPERSON AYALA: --and you cannot disclose anyone's private information, but you would go in and you would log in your own information, and then it would tell you whether or not you were owed money or there was money that was being held for you at some—in some account, and then you would claim it. Is there anything like that, or some—can something like that be replicated.

COUNCIL MEMBER RICHARDS: You said it much more eloquently than I did.

JOSEPH ANTONELLI: We can certainly work towards that. I mean we would want to make sure that anything we did was done in a secure manner that someone couldn't just look up someone's name and their incarceration information because I think we're really sensitive to that.

COUNCIL MEMBER RICHARDS: And you work with the Department of Probation or no for all probations, either one those?

JOSEPH ANTONELLI: For—in any for funds?

COUNCIL MEMBER RICHARDS: Yeah, right.

JOSEPH ANTONELLI: No, we don't work with them.

COUNCIL MEMBER RICHARDS: Okay, so just specifically. Okay, I want to thank you. I've asked enough questions before their passing stuff. Thank you.

CHAIRPERSON AYALA: Thank you, and this would probably have been the last question, but there is—it comes on the heels of Council Member Donavan Richards' questioning. If you can't keep track of an individual to give them back money that is theirs, how do you keep track of them as they're released from the courthouse, and they require mental health services and I mean it doesn't seem like there would be any time to plan some sort of exit strategy for this individual, which would probably claim the rate of recidivism at Rikers?

DR. ELIZABETH FORD: Good afternoon. Our service is primarily focused on trying to do as much

front—as much upfront information and treatment as possible for patients for exactly the situations that you're describing including unexpected release from rout or bails. We—at the—at the time that the mental health service meets every patient, we give them information about community resources including our Community Reentrance—Reentry Assistance Network, and Assistant Network services that allow patients who are released to—they go to these centers, and they can get the services that they would have gotten from us if they had—if we—if they had been detained in the jail and released with our knowledge. So, they—they do have access to for example medications and the Medicaid services, and referrals for treatment that we would have given them had we been able to plan for that release.

CHAIRPERSON AYALA: Now, I guess as that would probably work for individuals being released immediately after being detained, what happens—is there coordination between the city and the state when an individual is sentenced and sent to state prison?

DR. ELIZABETH FORD: Well, so we communicate with the state when individuals—we

provide health information for OMH or DOCs who manages the medical care when patients are transferred from the jail to the prison custody. We do not have any—I think your question is: Is there then communication once the person is released from prison back into the community?

CHAIRPERSON AYALA: Uh-hm.

DR. ELIZABETH FORD: We don't have any direct communication unless they return to our facility on a parole violation.

CHAIRPERSON AYALA: I know because they—I guess the gist of this hearing today is figure out, you know, how—how do we as a city reduce the number of recidivists at Rikers, right? But if people are not really necessarily receiving the services that they need, or not in a coordinated fashion, then they would account for their continuing to come back in and out of the system, and I speak, you know, I mentioned it in my opening remarks, I have a family member that was incarcerated at the age of 11 through the age of 33. This individual was diagnosed with bipolar disorder at the age of 33 because they had—it was never diagnosed while he was incarcerated. You know, in and out of prison, and yet there was never

any coordination of services between the city, the state, between the state, the family, and so was just released out into the street. You know, if you're suffering from mental illness, you're probably not making the best decisions for yourself because you're probably unable to unless you are on some sort of regimen, medication, seeing a therapist of, you know, counseling, you know, at the least, and that's not necessarily happening. So, I'm trying to kind of figure out like what is the experience of an inmate? Right. I walk into—you receive an inmate at Rikers Island. Does that inmate self-identify as an individual with a mental illness or is that something that is identified through the process of the medical screening.

DR. ELIZABETH FORD: Sure. So, whenever any individuals is admitted into the jail system they receive a comprehensive medical evaluation, and at that point can be referred to the Mental Health Service by the physicians who are doing that exam. They can also at any time be referred to the service. So, the patients can request to be seen. The Department of Correction is our second largest source of referrals. So, they will refer people into the

service that may not have self-identified or had been evident at the beginning of their care. Family members, attorneys, advocates we field referrals from a number of different sources, and so at any point during their time with us they can be referred in. Once an individual is referred to the Mental Health Service, we see them. I talked a little bit in the testimony about the timelines around that, and then as soon as possible and a lot hinges on how quickly we can make a diagnosis, and to speak a little bit to the bill that's being proposed, it's very difficult to be sure about mental health diagnoses in a setting where a part of incarceration includes things like not sleeping very well, having a reduced appetite, being irritable, sleep deprived, all of those things can present as mental illness when, in fact, they're just an impacted incarceration. So, it takes us usually a week or so to come up with what we think is a—our best guess as a diagnosis. I would also add that in the past couple of years we have made concerted efforts to have our staff reach out to community providers and to family members as much as possible in order to help with these diagnostic assessments. The prior healthcare providers

discouraged their staff from communicating with the community, and so we think it's incredibly important that that connection get raised. So we—

CHAIRPERSON AYALA: [interposing] Those are recommendations. They're not requirements, right? There's no requirement to make contact with an individual in the family?

DR. ELIZABETH FORD: There's no requirement, correct. We ask and if the patient consents then we will proceed, and then at the point of diagnosis, we as quickly as possible come up with a—a reentry plan that is individually tailored to the—the person's needs. Your point about being transferred Upstate is I think a very important one. We communicate to the state providers our impression of the diagnosis and treatment plan and what reentry services we think might be he helpful for that individual. It can be complicated because an individual in the jail for two months after two years of observation the prison may have different reentry needs, and so what we—what we recommended may not, in fact, be what the person needs several years later. We do communicate with the—with the state, though upon transfer.

CHAIRPERSON AYALA: Now, I'm sorry if I missed this, but is—is an individual at Rikers Island who may be presenting with some sort of mental illness every spent—spending any time in solitary confinement?

DR. ELIZABETH FORD: Nobody with serious mental illness in the New York City jail system is in punitive—is in punitive segregation.

CHAIRPERSON AYALA: What about a moderate diagnosis?

DR. ELIZABETH FORD: Well, no that's—that's a fair because a serious mental illness is defined differently in different jurisdictions.

CHAIRPERSON AYALA: How do you determine that? What is the difference?

DR. ELIZABETH FORD: So, our—the criteria in the jail system are Schizophrenia, Spectrum disorders, which are largely Schizophrenia, Bipolar Spectrum Disorders and that is in our system largely Bipolar 1 Disorder, depressive disorders, largely major depression, and we're one of the first jails in the country to include Post-Traumatic Stress Disorder as a serious mental illness. We changed the criteria for serious mental illness in 2017 to be more in line

with the needs of our patients, and so-and that also has tracked with the reduction in the jail population. So, when we talk about the rising rates of serious mental illness in the jail, at least some of that is attributable to our better recognition of it since those changes.

CHAIRPERSON AYALA: How many psychiatrists on staff?

DR. ELIZABETH FORD: Hold on. I'm going to do some quick math. We have—I believe we have—I'll get you the exact numbers for sure. I believe we have 14 psychiatrists, 20 psychiatric nurse practitioners, and a handful of psychiatric physician assistants.

CHAIRPERSON AYALA: So, I mean I know from, you know, experience that when you see a psychiatrist you don't usually just see those psychiatrists right? There's usually a therapist, and if they're required maybe weekly or bi-weekly visits with someone else. Is there another, you know, mental health provider that is seeing this individual to monitor the effectiveness of the medication and the treatment?

DR. ELIZABETH FORD: Absolutely. So, in addition to the psychiatric staff who are prescribing the medication, and monitoring effects, we have over 90 licensed mental health counselors who are providing psychotherapy on a weekly or every two week basis. We also have—I'm probably going to get the exact number wrong, but roughly 40 clinical psychologists who are also providing that level of care.

CHAIRPERSON AYALA: And how many houses did you say? I think Chief you mentioned you're using two houses now as where the chronically mentally ill inmates held in two different houses or are they scattered throughout Rikers?

DR. ELIZABETH FORD: Are you—are you referring to the PACE Units?

CHAIRPERSON AYALA: I'm not sure if I'm referring to any units. I think I'm referring to just to the inmate population. They're not housed in a specific unit, right. They're --

DR. ELIZABETH FORD: Correct. Yes, correct.

CHAIRPERSON AYALA: They belong to different—they're in different programs so you

identify them differently, but they're not in the same unit. Has there been any thought to, you know, having one unit that is a little bit more contained, and was better equipped at dealing with individuals with high needs?

DR. ELIZABETH FORD: So we, at this point we have five jails that have Mental Observation Units, and we have four jails that have PACE Units. So the higher level of care. We have found in the multi-jail system of New York City that it is useful and helpful for patients to be able to receive the appropriate level of care in the jail in which they are housed. Transfers between jails can be challenging to say the least and can result in—in time spent in pens and on the bus that may not be helpful. So, we have tried to improve the level of care for mental health patients in all of the jails.

CHAIRPERSON AYALA: I think the concern is if you have a person with mental—a chronic mental illness in the general population that they then become more vulnerable to injury or, you know, their perception could be that they wouldn't engage in—in activities because maybe they felt threatened in so way, and so, for safety issues would it make more

sense to house them in one building as opposed to having them scattered in the general population when maybe, you know, a Corrections officer wouldn't be in necessarily, you know, able to fully identify right, because as you mentioned it's very difficult to ascertain whether that person is suffering from some mental crisis or, you know, just seriously depressed because of the conditions, right, and—and really just reacting to their environment. So, I would imagine that for myself I mean for the untrained eyed it's difficult to make that distinction so, you know, the concern is—it's a real safety concern in keeping them in the general population.

DR. ELIZABETH FORD: I absolutely agree with you, and it's possible that I misinterpreted your—your earlier question so apologies. Anybody who is in general population who we have even a remote concern about in terms of their vulnerability or their mental health status is housed in Mental Observation Units or PACE Units if the level of care is—the level of care needed is much more intensive, or referred to the hospitals that level of care is needed.

CHAIRPERSON AYALA: And there's a unit, such a unit in each house?

DR. ELIZABETH FORD: There is a—there are MO Units in five of the jails, and there are PACE Units in four of the jails.

BECKY SCOTT: So, it is correct that if a patient within GP—in a jail that did not have an MO Unit and was in GP required a MO level of care, then we would transfer them to a jail that had that ability.

CHAIRPERSON AYALA: Okay, I'm in. I've been diagnosed, and receiving medication. I'm a part of the program, and then I'm discharged. What does that look like?

DR. ELIZABETH FORD: So, if you—it depends on what the discharge plan looks like foe that particular individual. If a patient is—has a serious mental illness, and has been diagnosed that—that way, we assist them with supportive housing applications if that's indicated, they're homeless and need—and need housing, we assist them with public assistance and SNAP benefits. We assist them with transportation, and we provide for them what we provide for everybody in the Mental Health Service,

which includes assistance with Medicaid and medications upon release from the jail. We have a—a slightly different pathway for individuals who are released unexpectedly, it's very hard to get appointments in the community if the community provider doesn't know when somebody is going to show up. And so, for the patients who are released unexpectedly, we provide for them referrals in the community with their involvement. So, often times patients will say I got treatment here. I'd like go back or alternatively I got treatment there and actually it wasn't that helpful. I'd like to go to some place closer to home. So, we will refer them to those—to those settings, and we have developed over the years very strong relationships with certain—certain community providers who are pretty flexible taking care of our patients.

CHAIRPERSON AYALA: So, so what in your, you know, expertise would you attribute the high rates of recidivism for the mentally illness at Rikers?

DR. ELIZABETH FORD: So, the—the research about recidivism and mental illness, which largely related to research on risk needs, responsivity. I'm

not sure if that concept is familiar, but it—it's a—it's a type of analysis about recidivism that is the most well respected and robust literature source around recidivism, and they have used large amounts of aggregate data including for people with mental illness, and identified eight central factors that directly relate to the recidivism, and none of them related to mental health treatment. So, these eight factors that consistently are found to place somebody at risk for recidivism do not include mental health treatment. Now, that does not mean that somebody who has mental health needs should not be getting as much treatment and support as they can in the community, but what it means is that issues like poor work performance or reduced family support or hanging out with friends who can—who behave in sort of a criminal way are more important in terms of recidivism than mental illness.

CHAIRPERSON AYALA: Getting an appointment at H&H for a psyche evaluation could take some time. Do you—if you're making a referral for someone who's being released, do you get some sort accommodation to ensure that this person is being seen on a timely basis? What is the—the timeframe

between the—the connection between the—the community-based providers, and is someone assessing that? Like does somebody actually follow up from Rikers that had some sort of relationship with this individual to ensure that they did connect to services, and then they're following up on the treatment, but I mean I know that you would be limited if they decided that they didn't want to continue with that treatment plan after they were released, but I just—I wonder in terms of, you know, aftercare, how far out is—is Corrections or Health and Hospitals connected to that individual?

DR. ELIZABETH FORD: Uh-hm.

CHAIRPERSON AYALA: Is—does that—like is there disruption of services immediately after discharge?

DR. ELIZABETH FORD: Yeah, that's—that's a great question, and differs slightly for people with serious mental illness than those without, but for those who we know, we-we can create appointments for individuals that we know when they're being released, and for those individuals, we have been fairly successful at getting appointments within two weeks for those—for those individuals, and then we at

CHS will call to follow up to see if the patient arrived or not. For individuals with serious mental illness, they are followed by a six-month transitional case management service called CRAN that is contracted through CHS, and so we are communicating with them directly about the patients' follow-up into the community and CRAN's role really is to help manage the patient and get them into the treatment and have that treatment stick for every person with serious mental illness who's released.

CHAIRPERSON AYALA: Okay. I know that Council Member Lancman is probably like that's last to ask to questions. So, I'm going to yield to him for now, and I guess we'll come back around. Are you sure? You sure?

CHAIRPERSON POWERS: [off mic] I think so. [laughter] I just have a few follow-up questions, and then I want to give an opportunity for the public to testify as well. Just the first question, how soon after someone's incarceration do they see a—a new—the discharge plan? When does that happen?

DR. ELIZABETH FORD: For individuals under Mental Health Service? Is that—sorry, is that--

CHAIRPERSON POWERS: Sure.

DR. ELIZABETH FORD: How soon? It can be as soon as 72 hours from admission and then it—the sort of out the back end of that is roughly three week.

CHAIRPERSON POWERS: Three weeks, and what's the difference in how, when that person—what—why is one 72 hours, and one is three weeks?

DR. ELIZABETH FORD: It-it largely relates to the diagnosis of serious mental illness, and whether we know if the person is being released quickly. So, if someone is in on a misdemeanor charge with a court date in the next seven days, we will try to see that person much more quickly because of the risk of being released.

CHAIRPERSON POWERS: And then how soon after they're admitted—is—is it at intake when they receive a—when they're diagnosed, or when they receive at intake do they get designated with a serious mental illness or another or not serious mental illness or health issue?

DR. ELIZABETH FORD: So they will—they will get a medical intake immediately, and then the first mental health intake they'll receive the

information about accessing care in the community if they're release unexpectedly.

CHAIRPERSON POWERS: Got you and I'm sorry if I stepped out if this actually, but upon discharge what is their—I—I guess I understand that they're given a seven-day prescription on any—but what—what are they given in terms of prescription and—and con-con, you know, connectivity to services outside of the jail?

DR. ELIZABETH FORD: Sure. Every person who's a patient of the Mental Health Service receives 7 days of actual medication, and then they receive a month's worth of-of an electronic prescription that's to the pharmacy of their choice that is—that's convenient for them. In addition, they receive referrals for treatment, all kinds of treatment if we do not know their release date. If we know when they're leaving, then we will plan—we will create appointments for them.

CHAIRPERSON POWERS: And they get referred to an H&H Facility for treatment?

DR. ELIZABETH FORD: Absolutely?

CHAIRPERSON POWERS: Anywhere else?

DR. ELIZABETH FORD: We will refer to whatever place in the city is most appropriate for that individual's care. Health and Hospitals provides a lot of that, but we will refer wherever.

CHAIRPERSON POWERS: And we had a hearing on this a few months ago. So, I don't want to rehash everything, but obviously the Mayor has a huge Mental Health Initiative here in the city. So, how does—how does the population that we're talking about interact with Thrive and the Mayor's Health—Mental Health Initiative? I'm sorry it--I don't know if this has been asked already but, you know, it's a—it's—it's a huge focus for the Administration, and we're talking about a population that could and should probably take advantage of it. So, upon exit, what service in Thrive are available to a person upon discharge?

DR. ELIZABETH FORD: For Correctional Health Service—Services, Thrive has provided funding to allow us to do screening, and substance use interventions for people in custody who are—who are young. So, 61 to 21-year-olds an age group that we consider highly vulnerable in an incarceration setting whether they have mental health—mental

illness or not. So, that—Thrive's connection for us is--

CHAIRPERSON POWERS: IDNYC did that exist through Thrive or did it exist after Thrive was put into place?

DR. ELIZABETH FORD: We received the funding for that prior to Thrive.

CHAIRPERSON POWERS: Okay, and so can continue with—so that's the 16 to 21 population? What about if you're over 21, what is available to you?

DR. ELIZABETH FORD: We don't—Thrive does not fund any of our services for individuals over—over 21.

CHAIRPERSON POWERS: If I'm really being discharged, what is available to me?

DR. ELIZABETH FORD: So--[background comments] So on the mental health side 16 to 20—21-year-olds receive the same kinds of discharge services as I was describing prior for adults, and it's very tailored to their individual needs. One important difference related to substance use interventions because that age range we know may be less interested in—in the same kinds of treatment and

intervention as—as individuals who are older and—and have had more experience with the substance use disorder, and so we focus a lot of our energy on the young people in terms of education and—and motivation about substance use, but if they--

CHAIRPERSON POWERS: [interposing] But if I'm—so if I'm being discharged and I have an M designation or if I have a serious mental illness, am I connected to a Thrive program when I exit the city's—whatever jail or facility that I am in? Is there a program that I am connected to that is under the—the banner of Thrive--

DR. ELIZABETH FORD: No.

CHAIRPERSON POWERS: --for mental health services?

DR. ELIZABETH FORD: Not specifically. I mean we may—we're referring to whatever treatment provider is most appropriate if that individual. If that provider is somehow funded or connected to Thrive, we wouldn't know that necessarily.

CHAIRPERSON POWERS: Okay, and just a few more question. The—[background comment]—the—well, we talked a little bit about the Crisis Intervention Teams. Can you tells us the process for how they're

deployed, and how many have been deployed in the last six months? [pause] You talked about—you talked about, We believe that CHS and DOC are collaborating and operating what we believe to be an agent's first jointly led Crisis Intervention Training in a jail. We sponsor mental observation unit, PACE and CAPS units when a patient requires additional support to avoid violence or self-injury. So, I think particularly around the mental observation units and PACE and CAPS can you tell us the process for how they get deployed and then in those particular units how many have been deployed over the last six months?

DR. ELIZABETH FORD: I'm happy to walk you through the process. I don't have those specific numbers about how—how deployed, but we can certainly get that for you. We do track that data. So, CIT in the jails is prompted by an officer or a Mental Health staff assigned to medical staff observing a patient who appears to be escalating. I know that's sort of lingo for someone who looks like they may be becoming agitated. They may have gotten bad news on the phone. Something is going on that we feel strongly a supportive presence would help, and verbal de-escalation would help. So whoever notices it,

contacts the central officer for that unit who then depending on the jail communicates with the control room. The CIT Team is dispatched. CIT Teams consist of two correction officers. Typically also there's a captain and a mental health staff, and they have undergone 40 hours of joint training about how to interact with individuals with mental illness who are in crisis, and they will go and-they will go to the specific unit, talk to the patient, engage with the other staff members, and sometimes it takes five minutes and other times it takes two hours. The—the goal is to avoid any further escalation.

CHAIRPERSON POWERS: And is MOCJ or DOC have information on how many deployments there have been of that intervention team? I said six months, and it could be a different time and, you know, last year?

BECKY SCOTT: No, I don't have the particular data for the last six months or year. I have the data on when the training started at AMKC in 2015, and to date 725 uniformed staff have completed the training alongside 206 New York City Health and Hospital staff who provide health services in DOC

faculties, but I can get back to you with the actual responses.

CHAIRPERSON POWERS: Appreciate it. Thank you. Just going back go a few questions like continuity of care, and—and on discharge, and you talked about the seven-day—you given them the seven-day prescription, you give them a 30-day, you know, they get to go to their local pharmacy or whatever, H&H or—have you—do you have any tracking of adherence beyond the days. I know it's—it's a difficult thing to track, but any specifics or information on adherence to prescriptions and-and then medical treatment once they leave custody of the DOC?

DR. ELIZABETH FORD: We don't have data about adherence to medication upon release to the community.

CHAIRPERSON POWERS: Okay, is that—have you taken any steps to try—are there any steps in place to try to improve adherence if there is a belief that those core questions around adherence beyond being in custody?

DR. ELIZABETH FORD: Well specific—I can certain answer about custody and---

CHAIRPERSON POWERS: Beyond like when they're discharged. Yeah.

DR. ELIZABETH FORD: So, I—I am sure that there are efforts for that, but that would be outside of the scope of my testimony. I—I can certainly speak to the in-jail.

CHAIRPERSON POWERS: Is there—is there anybody up there to talk about any programs or—or steps the Administration has taken to try uphold adherence beyond being in custody?

ELIZABETH GLAZER: I don't know if I can speak specifically to programs that their main goal is to uphold the hearings, but as our—all of our reentry services that MOCJ oversees make individualized plans for individual—for—for people to ensure that they can have access to all the reentry services that folks without a mental health need for instance would have access to, and so for instance our Jails to Jobs Program, which is focused on job training, certification, transitional employment, linkages to permanent employment, key to all of or reentry services is key to the things that that model is providing, supportive services that help people retain employment, which includes a lot of supports

for people mental health needs. So there are comprehensive mental, behavioral, physical health care that's part of that path to community stability. So, our Jails to Jobs partners with organizations that all have serious expertise and capacity for working with people with serious mental illness, and a part of those services would certainly be something like working with those on medication adherence as is necessary for an individual.

CHAIRPERSON POWERS: Are there any city like city funded organizations that we—or contract organizations that do work in the community or with that population rather to ensure that they are getting medical treatment? I know that it's a difficult thing and I recognize it's-it's beyond probably the scope for CHS to be able to do outside of the correctional facility.

ELIZABETH GLAZER: Sure so the Jails to Jobs partners work with organizations like Merit (sp?) and Day Top Village, Housing Works, Outgoing (sic) Fortune, Women's Prison Association that cap that all have that capacity. I don't know in terms of their individual—their individual treatment plans like how many are focused on adherence, but that

would certainly be part of it if appropriate. In terms to our Alternatives to Incarceration Programs again, all of our—our HA (sic) to varying degrees offer mental health support, but there are a few that are specifically targeted to our individuals with serious mental illness and substantial—substantial mental health issues. So, all of those would focus on individualized treatment plans for the people that they serve.

CHAIRPERSON POWERS: And would you be able to track—I don't know if this is a violation of any sort of privacy laws, but would you be able to track I mean potentially with somebody's consent prescriptions being filled? [pause] You would then and you would at least know if somebody is returning to get a prescription filled past the 7 or 30, you know, 14 day-period.

ELIZABETH GLAZER: I can certainly bring back that—that conversation to the folks that run these programs, but in general we aren't asking providers to—we aren't trying to mandate any mental health services. We aren't trying to require reporting on details of mental health treatment plans like that in order to prevent the creation of new

mandates or, you know, oversight of how programs by the Criminal Justice System, but I can—I can look deeper into what kinds of data we are able to provide about their services.

CHAIRPERSON POWERS: Okay, the—this is a question for CHIS I think. Do you do an initial screening for somebody when they come in at intake or right—or is it right beyond—right after intake, is that correct?

DR. ELIZABETH FORD: [off mic] Yes.

CHAIRPERSON POWERS: And you in that examination would determine whether somebody has a serious mental health illness or should be diagnosis—should have some diagnosis like an M designation. Is that—is that correct?

DR. ELIZABETH FORD: [off mic] Yes.

CHAIRPERSON POWERS: And is there—so in—beyond that initial intake how does one if they're not in initial intake and screening designated as having a serious mental illness, but—but later potentially may need services like that. How is—how is somebody then determined beyond-after intake when they're in custody that they will need to be in a, you know, in a PACE Unit or in Mental Observation

Unit? How is that diagnosis made or how—how does CHS make a decision on that?

DR. ELIZABETH FORD: So, we do our very best to be as accurate as we can with the diagnosis and as quickly as we can. Any individual who remains on the Mental Health Service, and the vast majority of individuals referred to us do end up enrolling in treatment. We continue to see them on either a weekly or every two-week basis depending on their—their level of need, and at any time during those assessments if the individual presents symptoms or reports a history that's inconsistent with the diagnosis that we gave them prior, we will do a diagnostic re-evaluation including asking some of the new psychologist that we've hired to—to do complicated diagnostic assessments, and so we're constantly refining the diagnosis throughout the individual's stay. If for whatever reason the person is not on the Mental Health Service over time, we rely on referrals from the Department of Correction and other treatment providers and—and outside agencies to then reassess that patient, but it's sort of a continual diagnostic reassessment throughout their time in jail.

CHAIRPERSON POWERS: Okay. I'm going to end my questions there just to give the public an opportunity to testify. I know we have some of the time here, and okay.

CHAIRPERSON AYALA: I just have a question I forgot to ask about the ACT and FACT Programs. So, we've been hearing the applications have been rejected even--even individuals they didn't have a firm release date. Have you been hearing the same? Do you have any information on that?

DR. ELIZABETH FORD: We have struggled with—we have struggled with solidifying ACT and FACT eligibility without a release date.

LEGAL COUNSEL: Can the Department of Health operate under OI? [background comments/pause]

LEGAL COUNSEL: If you could please state your name.

MYLA HARRISON: Myla Harrison.

LEGAL COUNSEL: Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this committee, and to respond honestly to Council Member questions?

MYLA HARRISON: Yes. Can you just repeat the question so I can make sure I understand?

CHAIRPERSON AYALA: I regards to the—the FACT and ACT Program, we've been hearing that applications have been rejected because the incarcerated individuals they didn't have a firm release date.

MYLA HARRISON: So, as you may recall from others who intensively testified, for someone to quality for an Assertive Community Treatment Team or a Forensic Assertive Community Treatment Team, they need to go through our single point of access, and an application has to be made, a universal referral form that gives enough information about somebody's diagnosis and their need for that level of care. The Single Point of Access, which is run through the Department of Health and Mental Hygiene, is making a determination on the appropriateness for a level of care such as an ACT Team, an Assertive Community Treatment Team or a Forensic Assertive Community Treatment Team or perhaps some other level of care, and in order for the team to be able to engage with somebody, they need to access that person. So the Assertive Community Treatment Team is a group of—it's a provider that has multi-disciplinary staff, and they need to meet with the person and then get them

accepted onto the team. So, in order to meet with them they need to know where they are, and they can access on Rikers. It can be challenging for the staff to get access to Rikers, and so that might delay the team starting to work with them or if we don't know when they're discharged, they don't necessarily get assigned because for the team to see someone, they need to be able to see them essentially in the community. It's a community based treatment program, and so I think similar to what we heard here, sometimes if we know when they're going to be released, that is the easiest way to make the connection. If they end up being released and the team doesn't know it, then they all have to look for them in the community, but they're not rejected because they're incarcerated. That—that doesn't make sense. So, Forensic Assertive Community Treatment Team is meant for people with forensic involvement, and that is their whole goal to—to see people who with criminal justice involvement, answer as mental illness and really make strong connections for them in the community so that they are able to live safely in the community.

CHAIRPERSON AYALA: So, H&H is making a referral for the program prior to release, right? Now you received the application, but if it doesn't have a firm date of—of release, you're rejecting them. Couldn't you put--?

MYLA HARRISON: [interposing] No, they're not rejected.

CHAIRPERSON AYALA: They're not rejected? What are they then?

MYLA HARRISON: No, but if—if we have limited slots on our Assertive Community Treatment Team. So, we can't put somebody in a team if they're going to be not in the community for months. So, it may be waiting until they're able to—we'll know when they're released. So, that each team only has 68 people, patients on them. So, the teams are limited in their ability to treat people, and we want to make sure--the teams are generally full, so we want to make sure that there's a slot for them.

CHAIRPERSON AYALA: [interposing] So, do you have a re-association where you're saying you need more.

MYLA HARRISON: [interposing] and they're not—they're not—they're—I don't think I'm free to—to

say something like that, [laughter] but I mean we've built Forensic—the Forensic Assertive Community Teams are new. They didn't even exist three years ago. So those are new services, and they're being used, and they're being used by people who have had criminal justice involvement.

CHAIRPERSON AYALA: So, you're saying that you're not rejecting them. You're putting them on hold?

MYLA HARRISON: So, if they're appropriate for an Assertive Community Treatment Team, they may be waiting until we know when they might be—when they're released. If they're rejected from an ACT Team, it's because it's not the appropriate service for them.

CHAIRPERSON AYALA: And that's communicated through H&H?

MYLA HARRISON: That is communicated to whoever is making the referral. Yes, it's the referral source that contacts us, and then they are told if somebody is not appropriate for that level of care.

CHAIRPERSON AYALA: Do you offer an alternative?

MYLA HARRISON: So, we might say you need to think about alternatives and make some, you know, if there's some discussion about what might make sense.

CHAIRPERSON AYALA: Can you offer an example of what an alternative program would be?

MYLA HARRISON: So, a Community based program that's not at the highest level of treatment like and Assertive Community Treatment Team so it may be an outpatient service with case management. It may be a PROS program, a Personalized Recovery Oriented Service Program. There's a number of mental health services other than Assertive Community Treatment and Forensics.

CHAIRPERSON AYALA: Now, you think it has 68 patients, 68 individuals per program?

MYLA HARRISON: Per team.

CHAIRPERSON AYALA: Per team and how many teams?

MYLA HARRISON: I don't have my numbers in front of me. In the 60s range right now. I think that's right, but we can get back to you with a firm number. I'm just not remembering off the top of my head.

CHAIRPERSON AYALA: Could you and if you could share how—how you distribute them, well, I guess how—how do you decide how by boroughs how many teams, and how this is—how my make that decision, that would be great.

MYLA HARRISON: Yes.

CHAIRPERSON AYALA: Thank you. [pause]

CHAIRPERSON POWERS: Well, thank you. Are there no more questions. Okay, okay thank you. Thank you for your testimony. We'll follow up with additional questions. Thanks. [pause] Okay, we're going to call up a panel now of five individuals, Mary from Urban Justice; Jennifer Parish from Urban Justice; Geoffrey Golia from GOSO; Kelly Grace Price from Close Rosie's; Greg and then Greg Wallman, and then Greg Wallman. [pause] Thank you. We'll start just in a second, and we're going to—we're going to have testimony on—with the timer, and then we'll have the opportunity to ask questions afterwards. We'll start I guess left to right, and let's wait for the staff to put the timer on. [pause] Yes, if you want to send a testimony in writing, you can also hand it into us so we have a copy of it. [pause] Okay, you can begin. Thanks.

GEOFFREY GOLIA: Thank you for the opportunity—

CHAIRPERSON POWERS: [interposing] When you first start just say your name and who you're with. Yes. Go ahead.

GEOFFREY GOLIA: Geoffrey Golia, Associate Executive Director of the Getting Out and Staying Out GOSO. Do you want to go through?

CHAIRPERSON POWERS: No, just that—just that.

GEOFFREY GOLIA: So, thanks for the opportunity to speak today. Aside from being the Associate Executive Director of GOSO, I'm also a Licensed Clinical Social Worker and Trained Psychotherapist. Founded in 2003 Getting Out and Staying Out is a comprehensive reentry program serving 16 to 24-year-old young men who have been involved in the Criminal Justice System. We will get participants from all five boroughs many we meet during the four or five days we provide services in the jails in Rikers Island. Others join our community program located in East Harlem through referrals from Probation and from officers, judges and district attorneys. A defense attorney as to ATI

program, other participants to City Council members. 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 Wellbeing a program that's tailored to address these core concerns while also providing individual attention to each person with individual needs and goals. All GOSO participants work with a licensed social worker, either and LMSW or LCSW who are equipped to provide psychotherapy as well as reentry planning. We also recently hired a psychiatric nurse as well to provide medication management. The staff of mental health professionals who seek to address the bio-psychosocial issues that our participants experience. Even before their first interaction with the Criminal Justice System our participant face poverty, racism, trauma in a number of broken systems. Often these issues are exacerbated by the trauma of incarceration. Successful reentry cannot happen without robust emphasis on mental health and emotional wellbeing. Through individual and group therapy, trauma informed interventions and psychotherapy, out staff seeks to destigmatize mental

health treatment and encourage our participants to prioritize their emotional—their emotional wellbeing. 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 towards 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 woo are incarcerated over by the warm hand-off 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 advocate that can assist with treatment and reintegration, and I will also add that wait times at mental health clinics are very long for folks coming out, and that's an issued that does need to be addressed. We support Intro 1590 the Get Well and Get Out Act, which will require the Department of Corrections to communicate essential information about patients with serious mental illnesses to their

attorneys. We also strongly support Intro 903, which will provide for a way for recently incarcerated New Yorker 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 issue. Thank you.

CHAIRPERSON POWERS: Thank you. Keeping going.

MARY BETH ANDERSON: Well, okay. Good afternoon. My name is Mary and I'm here today to encourage the City Council to provide assistance and service that I received at the Mental Health Project, Urban Justice Center citywide. The Mental Health Project was vital in stopping me from being evicted from place of residence for over 40 years. I was in the process of being evicted and Housing Court referred me to the Adult Protection Unit, which then referred me to the Legal Aid Society. However, they had reached their quota and they referred me to the Urban Justice. That's the run-around that we get. Okay, Urban Justice assisted me in their—in my time of crisis. My story would be very different had they not helped me. In addition, mental health helped me

to get of public assistance, secure FSD, along with much needed Medicaid so that I am able to safely sustain myself. More importantly, while going through this process where the city agencies would only look down on me, and overhear my situation, the Mental Health Project staff taught me how to advocate for—advocate for myself. Although I have not been formally incarcerated, I have family members that were. I and I attend groups and workshops with the Mental Health Project along with those that are reentering society, they made consolation with mental health concerns. I often see how MHP service are life saving educational tools and information not often received mostly without first being incarcerated. I believe that the mental health services were—if the mental health services were across all five boroughs, people living with mental health needs would be funneled through the criminal justice, hospitals and shelter systems. Give the people education and support their needs, and they can live independently. We have so much to offer.

CHAIRPERSON POWERS: Okay. Thank you for your testimony. We'll go next and also I know that Urban Justice, and I think Victoria Phillips is

scheduled to testify as well, and is on the same testimony. I don't know if you want to come up as well for this testimony. [pause] [background comments] Okay, we'll—we'll get you started. Thanks. [pause]

JENNIFER PARISH: Thank you for the opportunity to testify this afternoon. My name is Jennifer Parish and I'm the Director of Criminal Justice Advocacy at the Urban Justice Center Mental Health Project. You've been provided with our written testimony, which is quite extensive. I hope you'll review it after the hearing, but I want to highlight some of our recommendations. Through the Brad H. Class Action Litigation, Urban Justice Center Mental Health Project represents all people in the city jails who receive mental health treatment. The city has certainly made some progress in complying with its obligations to provide discharge planning services as required by the Brad H. Settlement. However, there are deficits that need to be addressed. For one, there are many people with mental health needs who wind up being released from incarceration before they get the services because the city is not meeting the timelines for doing the

mental health assessment, making the treatment plan, making the discharge plan. If all of that get delayed, the person gets released without ever getting the services they need. Frequently, the reason this happens is because the Department of Correction fails to produce people for their social work and mental health appointments. Another issue that I want to highlight is that some of the referrals that happen to treatment or case management as well as the supportive housing assistant, assistance is not always appropriate for people. Often times, it's not individualized. So someone who needs the highest level of care an ACT team as was discussed here before, may not be connected to one, and instead they're referred to inadequate services. In addition, more needs to be done to obtain information from the community, treatment providers that people were connected with before they came into incarceration, although CHS is doing more to reach out to people, they are not doing that well enough. Beyond discharge planning the city needs to do more to provide people with serious mental health concerns with housing. This is a fundamental issue. A person with serious mental health concerns may come out of

jail with an approved supportive housing application, but that doesn't mean that they will actually be held—housed. [bell] The supportive housing in New York City gives way too much leeway to supportive housing providers to select the individuals who are housed in their program. This results in people with some of the highest needs especially those involved in the criminal legal system not being provided with housing that's specifically designed to serve their needs. What has been effective in our view is Justice Involved Supportive Housing or JISH. To be placed in JISH housing the individual must simply meet the criteria for that housing. There's not interview process. There' no opportunity for the provider to decide who gets their housing and who doesn't. Simply they're place in housing if that's the criteria they need. In addition, the city should be doing all it can to connect people with mental health concerns who are eligible for Social Security benefits whether it's SSI or Disability benefits, to that source of income. Although SSI is inadequate to support an individual in New York City it's substantially more than the cash assistance provided by HRA. There's an evidence-based model called SOAR,

which is described more fully in our testimony that's specifically designed to help people who are homeless apply for SSI. The rates of people who are applying through SOAR are exponentially higher in being approved for those benefits than those who apply without it. However, the organizations that provide the SOAR support applying for SSI, generally do it for the clients that they already have. So clients who are not connected to treatment have very little – very few options in obtaining the service. Mental Health Project is one of the only agencies that provides this service. Finally, when we're thinking about recidivism, we can't just focus on the individual level of services. We have to thank about the policies regarding policing and other law enforcement supervision. We described that in our testimony, but one thing I want to highlight is just the way that parole works for people with mental health concerns. They are more likely to be violated on parole. They don't necessarily commit more crimes than people without mental health concerns, but they are violated and often times that's because they need to be linked to services. Their parole officers are not connected with those services. So, instead they

violate the person. They wind up at Rikers and many of them actually get restored to parole with the supports in place, but they waited in jail for several months for that to happen. Thank you for this opportunity to testify. I'm happy to answer any question you have.

CHAIRPERSON POWERS: Thank you. Were you testifying together or--? Okay. So we'll do—and we'll come back. [pause]

KELLY GRACE PRICE: So, thank you for having this hearing today. It's nice to see everyone. I'm Kelly Grace Price from Close Rosie's and I already submitted testimony via email. I hope you had a chance to glance at it. It's substantially shorter than other testimonies I have turned in in the past. I'm trying to be very sympathetic to your jobs these days, and I'm Councilwoman Ayala and Chin I didn't email it to you, but I'll be happy to email to you. I have five main points that my organization would like to make regarding Intro 903-A. It was about a year and a half ago April 23, 2018 that I sat at this table where I'm still sitting, and I asked you Councilman Powers to introduce a bill that mandated that DOC return our money and our property

to us expediently, and I really appreciate the introduction of that bill. There are some—some asks that I brought up last year that haven't made their way into the bill. The number one and I restate them in our testimony and in the edits that I turned in are—are hopeful edits for your bill. The number one ask is this business with the do not cash checks. This practice is still in operation. This happened to me. I was unable to cash any of those checks whenever I was released from custody from NYPD or from Department of Correction's custody because I unbanked, and that just forced me as a person who was trafficked and pimped back into the arms of the person who pushed me into the Criminal Justice System in the first place. Remember, I wasn't arrested for any prostitution or trafficking related offense, but this is ubiquitous not only with the DOC with—but with NYPD, and that's another one of our asks that that bill and I'm—I'm said that the Council and who's the main sponsor of that bill has already left, but I emailed him my testimony and I reminded him that this do not cash checks business is a ubiquitous practice within the NYPD and the Department of Corrections and it's ridiculous. They can't-they can give us our

money if we—if they have less than a hundred of our money, but they can't give a $101 at the point of exit. I don't buy it. So, I really appreciate specifically your hammering those points today. I'd also speaking of property like to see if you can include notifications about property returned to us. I know when I was released the property office was closed. I testified about this in the past, and I had the warden like see me sitting barefoot outside the Vernon (sic) Visitor Center crying and called the property clerk to come in and distribute my property. I never would have gotten it because you can bet dollars to donuts that I would never have returned to the island to pick up that property, and the last point is we'd like some reporting on what's been happening with that money prior to this year. Let's say the last five years, the last ten years. What's happened to those funds in that police fund? What—what's it called, whatever that fund is called where the money goes when it's not reclaimed? We'd really like to know for the past at least five years what exactly has happened to that money, and also our property that has gone unclaimed. What happens to that property? Is there one charitable organization

that it all gets farmed into? These things are outlined in my bill, and thank you for the extra few seconds and your consideration in allowing me to testify today.

CHAIRPERSON POWERS: Sure. Thank. I'll ask questions at the end, but I'll just note on that subject the sponsor is not here, but we'll pass the thoughts on ways to improve the bill along to him, and obviously our counsels are here to also take a look at, you know, things on property, and the other thigs you raised as well. So, we'll—and we'll follow up with you on that. Thank you.

DR. VICTORIA PHILLIPS: Thank you so much. Good afternoon. My name is Dr. Victoria Phillips (sic) and I'll calling on the city. I just want to touch on something, but of course, I'm speaking for the Mental Health Project and we submitted testimony, but I want to touch on a few things. Very quickly, when we speak about policing in the communities there is—there is a program that was rolled out of NYPD that a social work is supposed to report with all calls for EDPs and as of yet that has not been expended through the five boroughs. I would encourage City Council to get on the Mayor's

Office and-and definitely expanding that. Right now it's all up in the Upper East Side. That's not even an area within the last three years the last 14 people who were killed by—by NYPD responding to EDP calls, but not one of—not one of those occurred in the Upper East Side. So, please the city needs to be diligent in pushing it forward in the areas that NYPD receives the most calls, and with that being said, the-the calls have doubled averaging about 500 a day for EDP across the city. So that's a very—a big concern for the city. As far as mental health concerns in DOC's facilities, they're still not being brought down to their appointments like they should. Most people that I come into contact with who are in contact with mental health services report on average seeing a therapist about every four weeks. So, I don't know what this—the DOC reported two weeks average. I've never heard of that. As well, I would like to say that I just reported last to day to the Board of Corrections that DOC Justice the booths (sic) got approval from Commissioner Brown as of July 1st to pull all chaplains out of the facilities on Rikers, and to a central location. That's very dangerous because many times people won't-will not

get taken to sick call unless a chaplain has walked down the unit and saw that they were in need. Right now the chaplains are being offered one office out of 23 chaplains to share. DOC hires four different types of chaplains for each facility: Jewish, Muslim, Protestant and Catholic, and they're being offered one office to share for—for therapy. Many people who have mental health concerns do not want to see a mental health provider, but they are comfortable seeing clergy members. This is why I feel it's very important that we address this issue today, and this is happening out of the blue and the clergy has signed petitions and they're doing their own fight, but they are not allowed to speak out in these—in these settings. That's why I'm here today to bring this to your attention. Thank you so much.

CHAIRPERSON POWERS: Thank you. I appreciate that, and I just—and everybody's testimony is just great. I had a question for Jennifer Parish from the Urban Justice Center. You talked about supportive housing, NYCHA and the challenges around housing. Are there things—I—can you talk a little bit about the challenges on health—on NYCHA particularly, but also touch upon supportive housing

and any recommendations to the City Council, steps that the City Council can take to address the issues around housing particular supportive housing and NYCHA.

JENNIFER PARISH: Well, I'll talk about supportive housing first, and then Miss Bee can talk about NYCHA. So, we're supporting housing. The genera process to get supportive housing is that there is an application that's submitted. So, Correctional Health Services is changes with doing that as part of Brad H. but once it's approved and that approval comes to HRA pretty quickly, but then what has to happen next is it has to be sent out to all the supportive housing providers who have vacancies, and then they can decide about interviewing the person. To do that, they have set up, you know, CHS has been proactive in trying to do video conference because it's very difficult to get supportive housing providers to come out to the island to do these interviews, but even with the offer of video teleconferencing, it's not happening nearly enough. So, people who need the housing are not getting interviewed. Even when they are interviewed, and often this takes place in the

community they're not necessarily being selected for that housing. The housing provider gets to make that decision, and so what we are concerned about is that the people who are continuing, who are most at need for housing are not being selected, and what will happen often is then they'll be released from Department of Correction. There won't be any one to follow up on their housing although that is CRAN's role and should be happening, but it often doesn't, and then the person may go into another system for example they may go into the hospital, into the shelter and it all gets turned over to somebody else who maybe starts that process again, and as they go through different systems it gets started, but never actually completed. So we think that what was successful about the JISH Model is that they said, okay, who do we really want to have this housing? They identified the criteria. Then they identified the people, and if you happened to come into the jail and your name was on this list because you'd been incarcerated a number of times, then you were connected with a housing provider, and given housing. We had clients that we saw as part of our Brad H. interviews who couldn't believe that they were

actually finally getting housing, but it was working. The problem is it's a—it's a tiny number of—of housing stock.

CHAIRPERSON POWERS: Do you have a recommendation in terms of how to fix that issue.

JENNIFER PARISH: Well, I think that that kind of housing needs to be expanded and then I think there needs to be more oversight of supportive housing more generally. This is something that, you know, HRA knows everyone who's been approved and cold be keeping tracking of that. Certainly the State Office of Mental Health should be keeping track of it, but there doesn't seem to be that kind of oversight.

CHAIRPERSON POWERS: Okay, and you talk about NYCHA as well?

MARY BETH ANDERSON: Yes, so right now many people cannot stay in a NYCHA apartment when they return upon being incarcerated. The city did pilot the program, the Reentry Pilot Program a few years back, FRPP, but it has not extended five boroughs and there was—there was great restrictions on that as well so people who were a pat of that pilot program, you could not stay with the same room

if they had Section 8 NYCHA. There's a difference, and or if you—your family stayed at a NYCHA development that was tax credit. Also, many people were not even allowed—would not support their family members through to terminations of their lease even for having a person just visit. So, we would like to see the city expand that pilot program into the fiber. Just make—make it a program throughout the five boroughs. No more pilots, and we would like the expansion of it to include people who stay in NYCHA developments underneath Section 8 Housing as well, and ---

CHAIRPERSON POWERS: Can I just ask some follow-up questions or maybe two. What boroughs is the pilot program in right now?

MARY BETH ANDERSON: This—it's—it's—it's throughout several different boroughs. I can give you the exact--

CHAIRPERSON POWERS: Right, yes.

MARY BETH ANDERSON: --that one and that it is, but—

CHAIRPERSON POWERS: And a follow-up question as well, is there any—is there any

restrictions on housing for people who are formerly incarcerated in NYCHA today?

MARY BETH ANDERSON: Yes.

CHAIRPERSON POWERS: And what are they?

MARY BETH ANDERSON: Well, right off the bat, if you have any type of sexual assault case you're excluded. If you were—if you were arrested in a NYCHA development for any type of drug charges, that's an automatic exclusion. There are several others, but I can't--

JENNIFER PARISH: A felony.

CHAIRPERSON POWERS: A felony, okay. Okay. So, we'll follow up with our staff on some of the housing issues because I—it's—it's—it's obviously a huge part of this equation not just for today's hearing but in a broadly and I think the Council in general has I'll say a deep interest in addressing issues around housing, and access to housing. So, I want to give others an opportunity to testify as well, but we'll follow up with you on that issue. Thank you. Do you have a question? [pause] Alright our next panel and I think our last panel is Kathrine Bajuk from New York County Defender Services; Stephen Shore at Legal Aid Society; Darlene Jackson, Woman's

Community Justice Project; and Julia Solomon from Bronx Defenders. [pause] Alright. Thank you. We'll start—we'll start the same thing from the left to the right, and you can begin. Just say your name before you start and then you can start your testimony, and we're going to have you on the clock. Thanks.

JULIA SOLOMON: My name is Julia Solomon. I'm the Senior Criminal Defense Social Worker focusing on Policy at the Bronx Defenders, and thank you all so much for giving me the opportunity to speak with you today. I first want to thank you and the rest of City Council for taking the 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're excited about the possibility of expanding services for this population and taking a closer look at how to improve the services we currently have. So, just briefly 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. So, as an initial matter, I just want to point out

that when we address the issue of mental illness in our communities and within the population of people currently incarcerated in our city jails, we're not just talking about those labels as seriously mentally ill by Correctional Health Services. Mental illness covers a much broader array of conditions notably the National Institute of Mental Health 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. So, Correctional Health using this narrow definition further limiting the universe of people considered SMI to, and people in order to receive discharge planning services. In order to qualify for those services, the individuals typically have to present with pretty acute symptoms such as psychosis or suicidality, and—and the diagnosis are most commonly, as we heard earlier by Bipolar Disorder and Schizophrenia. While people in custody labeled with these diagnoses or setoff symptoms do make up a large percentage of the jail population, there are many people with mental health disorders interfere with or limit one or more major like activities, but don't meet this exact same criteria.

These people have often experienced complex trauma, and unfortunately it's 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, don't receive it. People with a history of trauma and its effects on their mental health are often fall through the cracks within the world of mental healthcare generally. At BSA, as social workers at BSD it's very rare that we work with a client who does not have a significant trauma history. There research is limited, and the numbers are under-reported, but we know that rates of childhood and adult trauma among the justice involved population is extremely high. One study found that over 56% of incarcerated men reported childhood physical abuse and one in six reported experiencing or physical abuse before age 18. SO, it's important to remember that trauma looks different for everyone. It's actually defined by how a person experiences an event or saw (sic) events. 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 the age of six. 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 easily identified or at least identified correctly, and for this reason many of our clients either receive no treatment or they receive inappropriate diagnoses and treatment for their mental health conditions. So, generally we believe that funding more trauma informed and trauma responsive mental health providers both in the city jails and in our community would dramatically reduce recidivism. These providers have an understand of how trauma affects the brain, and what behaviors manifest as a result, and are trained to respond appropriately to those exhibiting trauma responses once triggered. Right now—

CHAIRPERSON POWERS: [interposing] You need—I need you to wrap.

JULIA SOLOMON: Sorry.

CHAIRPERSON POWERS: Just go into final statement.

JULIA SOLOMON: Final statement. Okay, I was not close so I need to skip ahead. So trauma-

informed services breaking down barriers to successful treatment to some of the most major barriers that we see—most that we see with residential treatment programs are with regard to gender identity, our transgender clients are not commonly accepted in standard residential programs, language, and cultural sensitivity and then, of course, the stigma of justice involved individuals that are on the sex offender registry that limited extremely their ability to access residential programming. In fact, there are not residential programs currently in the city that can take someone who has a mental health concern that is on the sex offender registry, and then just lastly, I was going to touch on supportive housing access, which I think we spoke about already in detail, but just to reiterate that that application is very lengthy and difficult to access, and actually I have found that at times discharge planning even when a client is assigned a discharge plan in the jail, they have to be—they have to meet a level of severity in the mental illness to qualify to receive that service, and have that application completed for them. I've been told before that my clients are not sick enough

to receive that service. So, that's—that's definitely a problem that we see. So, just in conclusion improving and expanding our mental health treatment systems would reduce recidivism for people struggling with mental illness, and we look forward to being—continuing to be part of this conversation.

CHAIRPERSON POWERS: Thank you.

TRACY GARDNER: Hi. I'm Tracy Gardner from Legal Action Center. We are the country's only public interest law and policy organization fighting for the rights of people in recovery from drug dependence, alcoholism, living with HIV or people with criminal records. So, we've worked at the intersection of criminal justice and health since basically 1973, and we're also part of the ATI Coalition. We're deeply appreciative of your support. I'm a little off topic here, but I'm related because I've been listening to all of the testimony about the challenges of connecting care for individuals who are incarcerated with serious mental illness or addiction or other chronic health conditions. New York has been—has the oldest addiction treatment and mental health system in the country, and so we've got a lot of great programs to

connect people and keep them out of Corrections, but we could do so much better, and we've criminalized as all around the country, we've criminalized mental illness and Substance Use Disorder so a disproportionate number of low-income folks, brown— black and brown are inside. We can't close Rikers unless we address the fact that Rikers and other jails are part of the mental health and addiction system. So, a lot of what was talked about by Correctional Health Services and Health and Hospitals or Health-H&H has to do with the lack of funding quite frankly and real structural barriers that keep communication from happening from inside to outside and back. Part of that has to do with the restriction of Medicaid Law called the Inmate Exclusion. It's been in place since Medicaid was developed, and almost every program we have that links people to care is a—a work around the—the inmate exclusion. So, we just wanted to alert the Council to and hopefully get a resolution that New York is going to be the first state to apply for a waiver to that inmate exclusion and be able to use Medicaid dollars inside of correctional facilities particularly jails either 30 days prior to release

for prisons or within a 30-day period. This could completely change many of the discussions we're having if the work can start when people come in, or certainly right before they leave, and Medicaid is really the only funding stream that can address much of what we're talking about here today. So, you know, a lot of people know or a lot of jurisdictions know that New York is going to do this. We're basically stepping on the third rail to do it. The State Health Department is leading this. It was a Governor's initiative, and so, hopefully the Council can weigh in given the work that the Council has done around these issue to encourage New York to follow through and do this amendment application, and then when it goes to the federal government to weigh in with support as we will be asking people from all over the country to do. Thanks.

CHAIRPERSON POWERS: I'll just ask a follow-up question, and usually near the end, but I just want to—does the state—is it New York State is going apply to the federal government for a waiver? Is that correct?

TRACY GARDNER: Correct.

CHAIRPERSON POWERS: And how long does that process take?

TRACY GARDNER: It actually varies, but it can take anywhere from six to eight months until approval to be able to use federal match for the waiver request.

CHAIRPERSON POWERS: And doe we have any—raised notification about what the feds might say?

TRACY GARDNER: The motion—the reason the state tried to do this in 2016 and then when the election happened pulled the—the request back. The mortality of folks who leave Corrections around opioid I think is the compelling limit here and that there is talk of looking or supporting innovative strategies to address that high mortality. So, this would fit perfectly, and I would also say New York is like many other states. We have separate jail and prison systems, but in states that have a unified system like Rhode Island, they're doing this. They getting people on meds inside for opioid use disorder or mental health medication, and allowing that care to able to be bridged to be outside because Medicaid is inside—well, in this case they're paying grant funds to allow for this connection to care to happen,

and we don't have enough public or private dollars t be—to be able to do this.

CHAIRPERSON POWERS: And I think that's part of our concern is that continuity and the funding around it, but you can follow up with my office or, and contact my office (sic) around that particular resolution with the state level on this as well. Thank you.

TRACY GARDNER: Thank you.

DARLENE JACKSON: So, I actually have a question. So, listening to the—to all the testimony throughout this morning, I hadn't signed up to speak. So, what—what the—I'm sorry. My name is Darlene Jackson. I'm here on behalf of the Women's Community Justice Project, and I wanted to ask with crime being at a historic low, and with the—the amount of folks that are detained have significantly dropped, and you have all of these reforms that that are coming into effect in January, and I didn't see—I saw that there was a release of the Fiscal Budget probably on Friday, and I'm—I could probably bet you $100 that—the DOC Budget probably didn't change. I know the last time I checked the DOC Budget it was at—we would spend—the city was spending at least $80 billion, and

that's BA, the NYPD and the current purchase (sic) combined. So, we don't—so the question I have is how come the budget is not reflecting all the reforms that are going to take place in January, the crime that's gone that's historically low. They're now being called to sue (sic) the city and nation, and—but yet--

CHAIRPERSON POWERS: [interposing] I just—I mean I just want to state this is really an opportunity to testify on this hearing. We had budget hearings to talk about this but, you know, I—I can offer at least a, you know, a cursory explanation on that, which is part of the—a lot of things we're asking for include new funding for programs that are going to, you know, we think assist with those who are need—have needs, with a lot of mental health hear particularly, but we—we do expect there to be a—a decline in the—probably with the overall census a daily and annual, and we think that will be reflected long-term in our—in our budget, but today I think we're not, and I think that's been a modest reduction and once those—those go into effect, we'll see more but this really an opportunity to testify on this topic if you have any comments on that.

DARLENE JACKSON: So, the reason why I bring it up is because at some point we have to reallocated the—the funding from the DOC Budget, and really think—and really think about the borough of the coming of Corrections because as you can see, they are part of the-the environmental havoc on Rikers island, and now with the Mayor's proposal to-to create these proposed sites, we don't want to bring—we don't want to replicate Rikers Island into the communities that have been directly impact—impacted on mass incarceration. So, I'm saying this because the Department of Correction needs to start shifting their role into more mental health union jobs, and I think there needs to be a real conversation with the union about what that should look like, and being that this really probably is happening now, and it's should have some type of framework once it hits city planning about what their—what that should really look like about the Department of Correction, and their role and shifting it so more of mental health union job positions because that no only requires 60 college credits and a major to be a police officer, and so it has become a social, community services, mental health. So

they're not really—they're not really—they're not really trained to—to—there's no trauma-informed care when you're coming into contact with people who are going to come from the justice system, and so I would say that when you think about these four proposed sites to think about having non-profitability come in and be the main operators of—of these facilities. There more focus on mental health and trauma-informed care, and it's the folks who come into contact with these—these facilities that they are—they're actually given the—the care they just—they should be getting.

CHAIRPERSON POWERS: Yeah, thank you.

DARLENE JACKSON: And so, I didn't—I didn't necessarily know that this was forum to—to say this, but I want to say and to the city.

CHAIRPERSON POWERS: [interposing] No, you—we-we hear you. It's a—it's on topic, and it's totally appropriate to raise, and I think we had the conversations with the Administration as the siting process continues, those are the types of feedback we'll bring back to them. So, thank you. Yes.

Good afternoon. My name is Stefen Short. [coughs]. I'm a staff attorney with the Prisoners' Rights Project at the Legal Aid Society, which has

been working for over four decades to address the needs of incarcerated people with mental illness. I want to thank the Committee Chair Members here for the opportunity to testify today, and I'm going to talk about something slightly different. One of the most pressing problems undermining successful reentry for people with serious mental illness who were released from state prison is the lack of housing and community-base mental health services and supports. That is the issue that is at the heart of *M.G. v. Cuomo*, which is a class action lawsuit the Prisoner's Right Project recently filed with co-counsel from Disability Rights New York and Paul Weiss. The plaintiffs in M.G. are homeless people with serious mental health needs 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. This is an issue that is impacting plaintiffs statewide, and some of the members of the M.G. class are slated to return to one of the five boroughs of New York City. It is obviously impossible for us to talk about recidivism without discussing housing, and for people with serious mental health needs, the consequences of lack

of housing are even more dire. Studies show that supportive housing greatly increase the chances of people with serious mental health needs will successfully reenter society from incarceration. Mental health housing provides not only a stable home, but services that facilitate people's access to care and crisis intervention. New York City has recognized some of these benefits, and as a result has developed the new community-based mental health housing units within the last several years, but unfortunately those measures did not solve the problem that gave rise to the N.G. lawsuit, which is delayed releases from state prison due to the lack of community-based mental health housing statewide, and in New York City in particular. The supply of community-based mental health housing is far outstripped by need--as we heard earlier today,--in New York City and across the state. Through M.G. we found several individuals who ware held in New York State prisons past their release dates due to lack of supportive housing in the five boroughs. These individuals each waited [bell] several months past their maximum expiration date before they were discharged. One person who was sentenced to less

than six months ended up serving more than six months additional time past his release date while waiting for housing. So, we're here to say that given the clear consensus among researchers that community-based mental health housing is the most effective tool to reduce recidivism for people with serious mental illness. The City Council should exercise its oversight authority to ensure that the city adequately develops such housing. There are concrete steps that the Council should take. For example, the Council should direct city agencies to make public the long waiting list for community based mental health housing and other supports in New York City. It should also expand access to FACT, which is a program that we heard about earlier today, and a program that is critical to this population. FACT is a multi-disciplinary team approach to the providing comprehensive and flexible treatment, support and rehabilitation services to people with serious mental illness and has shown to be effective for people with criminal justice histories. It takes concerted effort and committed cooperation between the city and the state to develop the Community-based mental health housing system necessary to support all

eligible individuals. Council members should engage with other stakeholders to encourage adequate funding for such programs, and they should also critically impress upon state authorities that when an individual from New York City reaches their prison release date, state authorities have a obligation to release them. If the state authorities have failed to develop appropriate housing sufficient to make that reality, that's not an excuse, and it is their responsibility to do so. The current approach, which is told people in prison past their release dates due to a failure to develop sufficient supports is unlawful and unworkable. So, as the state prison population is disproportionately drawn from New York City that is a problem that will disproportionately impact New York City, and we call on the Council to join our efforts to remedy this issue. Thank you.

CHAIRPERSON POWERS: Thanks--thank you.

KATHERINE BAJUK: Good afternoon. I'm Kathryn Bajuk. I'm a 25-year public defender and the Mental Health Attorney Specialist for New York County Defender Services. My office supports both bills, but comment here only Get Well and Get Out Act sharing the following concerns: First, when a

client's mental competency is in question, we ask that Corrections not seek consent from these clients until they are deemed mentally fit. In this way we can always be sure that any consent is truly voluntary, and we can also avoid a situation where prosecutors challenge a not competent finding by using the fact that the client executed a legal waiver against them. Second, we ask that your bill specify that whomever gathers this information have a clinical background [coughs] to assure accurate reporting of psychiatric issues, and also avoid our clients suffering further trauma. Third, to further protect our clients, we ask that you make explicit that these reports cannot be shared with anyone without their defense attorney's consent. Fourth, in the event this information is used by a bail fund, let's make sure there is a discharge plan in place before the client is bailed out so we can avoid what's happened in the past where a client with serious mental health issues dies by suicide because there was no treatment plan in place upon their release. Beyond this bill, we need the city to prevent and reduce this population's criminal justice involvement. We cannot allow the city jails to

continue to be warehouses for this population. Last year city jails housed more people with serious mental illness than all city hospitals combined. We need more supportive housing, as people have discussed, and more free and affordable treatment options [bell] in our clients' communities. We also need more education of the community so people know that when a friend or family have mental health issues to not call the police but instead seek help from doctors, clinics or hospitals. We need more high quality service providers and pay these people in this field a living wage, and give them support for the long term. Lastly, while the city has increased funding for Mental Health Services, what is really needed is a massive infrastructure investment. So, we ask you all please make those commitments in this year's budget. Thank you.

CHAIRPERSON POWERS: Thank you and on the legislation we'll take those comments back and—and pass them off to the sponsor as well. On the budget we have a number I think of historic investments around criminal justice. I'm not sure we have an investment to the scale you're asking for, but certainly as we engage in, you know, we start looking

ahead, and I think it's worth talking about other infrastructure in—in terms of the correctional system funding and upgrades that we can make as well, and I would be happy to talk with you on that, and contact it as well.

KATHERINE BAJUK: Thank you.

CHAIRPERSON POWERS: Thank you. Thank you, everybody for your testimony. That you everybody and Council Member Ayala for this topic. [background comment] Did you sign up? Okay. Okay, we will thank you for the panel. Thanks. Hi, okay.

JOEL WALLMAN: [off mic]

CHAIRPERSON POWERS: Yeah, I--and I did just to note this, we did call you for a previous panel.

JOEL WALLMAN: Yes.

CHAIRPERSON POWERS: So, you—you can go.

JOEL WALLMAN: Okay, give me one second, my friend. [pause]

CHAIRPERSON POWERS: Are you ready, ready to go?

JOEL WALLMAN: Yeah, yeah. Can you give me one second? [pause]

JOEL WALLMAN: Thank you for giving me, you know, an extra few seconds there. Councilman Powers, General Counsel, Council Ayala, good to see you. Joel Wallman testifying from Juvenile Quantum. It seems that these issues kind of go back to obviously resource allocation. There are different types of funds, but, you know, kind of what I've been echoing for the past few months here parsing through the Green New Deal, value narratives, media and things like that, with the type of solutions that you need when you create these type of fiscal budgetary constrains on different types of programs, and you're trying to reallocate resources and you have budgetary obviously hearings and different types of proposals that are being due, you know, when—when solutions are presented such as solar applications to the wall and then tethering to the contracts out of New York, and you see the dollars and cents behind that where you're putting solar panels on say some 2,000 miles and ten feet on the southern side, you're creating some 242 trillion kilowatt hours of energy. So, when a superior bid is submitted to the FBO and then the DOD gets involved, and there's lots of federal value narratives, Green New Deal to be precise, I'm here to

break those things down. So, I'm just echoing that in the type of scale and capacity that you might be able to then use to relieve the allusion of choice of fiscal budgetary constraints that, you know, my colleagues and other people were testifying to. So, when we bring all these issues together, it's important that these solutions are presented to the public as a viable choice or opportunity so that the advancement of the dialogue continues on, and it's our special type of resolution. [bell] Well, there's my time.

CHAIRPERSON POWERS: Okay, thank you. Thanks. With that, we are concluded with today's hearing and we will be—resume testimony and doing follow-up in the coming weeks. Thank you to Chair Ayala and all our staff as well.

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 29, 2017