NYC HEALTH + HOSPITALS

NEW YORK CITY COUNCIL

OVERSIGHT: EVALUATING RECENT CHANGES IN HEALTHCARE IN CITY CORRECTIONAL FACILITIES

COMMITTEE ON FIRE AND CRIMINAL JUSTICE SERVICES,

COMMITTEE ON HEALTH &

COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITY, ALCOHOLISM, SUBSTANCE ABUSE AND DISABILITY SERVICES

PATRICIA YANG, DrPH, SENIOR VICE PRESIDENT

NYC HEALTH + HOSPITALS

MAY 26, 2016

Introduction

Good morning Chairpersons Cohen, Crowley, and Johnson, and members of the Health, Mental Health, and Fire & Criminal Justice Committees. I am Dr. Patsy Yang, Senior Vice President for Correctional Health Services at NYC Health + Hospitals. I am joined by Dr. Homer Venters, Chief Medical Officer of Correctional Health Services, and other senior members of our team. Thank you for the opportunity to review recent changes to Correctional Health Services, or CHS.

Transition

In the five months between the time Health + Hospitals assumed responsibility for CHS on August 9th, 2015 and the December 31st, 2015 expiration of the Corizon contract, we successfully created a new division of Correctional Health Services - a $235 million program with 1,500 employees and 24/7 operations in twelve jails citywide.

During this transition period, there were no lapses in coverage and no disruptions in patient care. To achieve this, we worked closely with representatives from the Mayor's Office and City agencies to clarify governance structures, resolve legal liabilities, and ensure budget neutrality to Health + Hospitals. Furthermore, we reviewed the personnel and credential/licensing files of, and conducted background checks for each of more than 1,200 Corizon employees.

Simultaneously, we negotiated with each of our four union partners – Doctors Council, NYSNA, 1199 and DC37 – for the smooth transfer of nearly 300 city staff by August 9th; and for the employment by January 1st of over 1,000 Corizon staff to whom we offered jobs beyond December. At the time of both transitions, all union staff whom we selected to retain were covered by collective bargaining, with salaries, leave balances, pensions and health benefits preserved.

Improvements to CHS in FY16

<u>Workforce and Infrastructure</u>

Despite the complex challenges presented by the transfer to Health + Hospitals and disengagement from Corizon, we didn't want to miss the opportunity to begin building a framework for our new service. An immediate and fundamental change has been to unify all management – from senior executive to jail site leadership – into one team within Health + Hospitals, replacing the previous model of an oversight agency and an entirely separate vendor. This set new expectations and replaced a culture of inherent distrust, with a new culture that emphasizes we are all in this together.

Moving away from a for-profit vendor to a public healthcare system has also enabled us to recruit and retain more mission-driven professionals. To that end, we've brought in psychiatrists, psychologists and social workers who have devoted their professional lives to working in the field of correctional health at institutions such as Sing Sing, Bridgeport Community Correctional Center, Lincoln Hills Juvenile Justice facility, and Bellevue Hospital.

We have integrated our mental health and discharge planning staffs into one professional psychiatric social work service. This service is led by a newly hired licensed clinical social worker with a psychotherapy background. These changes have already resulted in positive outcomes, from the quality of our discharge readiness services and connection with community agencies to our ability to recruit high quality staff. In addition, we've ensured that we now have deputy medical and nursing directors responsible for specific jails, and site medical directors performing some patient care.

We have also created and filled key leadership positions. Heading up our new department of substance abuse services will be an Addiction Medicine physician who has worked in an academic affiliate caring for homeless patients and who will help us optimize the clinical efficacy of our extensive substance use treatment programs and keep the care we provide on the cutting edge. We created a new position for Clinical Quality Improvement to singularly push us to constantly improve the quality of care we provide. We've overhauled our Quality Assurance and Quality Improvement structure and processes and are integrating into the robust quality assurance structure of Health + Hospitals.

We've recruited a Director of Clinical Education who will train the medical staff and promote a culture of continuing education; and a medical expert in geriatric and palliative care who will manage the care of elderly patients. We have a designated nursery coordinator who meets with every pregnant woman at the Rose M. Singer Center, pre-screens all pregnant women for eligibility for nursery placement, and reinforces the importance of prenatal care and breastfeeding. We have increased our educational efforts, establishing medical and mental health grand rounds that offer continuing education credits across multiple disciplines, and we are working to expand educational collaborations for trainees with academic partners.

The opportunity to create a unified approach in one of the nation's largest correctional health services has also attracted professionals with expertise in the administration and operations of correctional health - areas previously managed by Corizon. On the administrative side, we built our own in-house system of employee review and tracking to ensure that anyone working in CHS has the requisite credentials, licenses and background clearances. We created a new department of Policy and Planning comprised of epidemiologists, data analysts and patient relations experts who coordinate incident and complaint investigations; responses to external inquiries ranging from patient to federal court requests; and data collection, analysis and reporting. Policy and Planning also guides the implementation of key initiatives involving external partners including our pre-arraignment screening in the Manhattan Detention Center, our collaboration with Health Homes throughout the city, and our efforts to ensure Medicaid coverage for CHS patients.

Our Operations department, led by a recently recruited professional with significant administrative and nursing experience in correctional settings, is rolling out new standards and systems for every aspect of the operation that supports the provision of clinical care.

Everything from staff and patient scheduling, to inventory management is being overhauled to increase accountability and productivity.

Our Operations team has spearheaded critically important improvements to staff safety in the jails. Earlier this year, we conducted the first-ever safety survey of every clinical space in the jail system to create a baseline for necessary improvements. We are working with DOC and the health unions to determine how we can operationalize improvements to safety. With the assistance of the City's Office of Labor Relations, we have convened a pioneering workplace safety committee that includes DOC, COBA and the four health unions and focuses on creating a safer work environment for all staff in the jails. Additionally, Operations has designated a CHS Safety Officer and has set up a CHS Safety Report line in the clinic areas so that staff concerns can be directly communicated for follow-up.

Safety in the jails cannot be discussed without acknowledging our essential partner, the Department of Correction. At an executive level, we coordinate on strategic directions and critical matters and meet weekly to jointly plan and problem solve. With the direct support of Commissioner Ponte, DOC and CHS staffs at our most challenging jails (AMKC, GRVC, GMDC and RMSC) meet daily to discuss the most pressing issues surrounding safety and patient production. Weekly meetings of custody and health jail leadership are also held to review and plan for the management the most challenging patients system-wide.

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

Continuity and Access

As with our workforce and infrastructure, we also began making improvements in service delivery even while we were managing the transition.

We worked with Health + Hospitals health plan, MetroPlus, to establish a presence at the Visit Center on Rikers Island. Each Friday since last December, people leaving jail or visiting someone at Rikers Island can stop at the MetroPlus desk for assistance in getting health insurance. In the seventeen weeks since we began this collaboration, 77 of our patients or their families got health insurance coverage, with 96 percent of these individuals choosing to enroll in MetroPlus.

Last month we launched a telehealth pilot program – the first-ever in the Health + Hospitals system. In collaboration with the Infectious Disease service at Bellevue Hospital Center, CHS now offers audio-video consultation to patients at jail locations. Telehealth sites have been

established and tested in three jails; and physicians at the Bellevue telehealth sites have the ability to view the CHS electronic health record to facilitate clinical consultation.

Also last month, we launched Safe Landing, a new re-entry group for sentenced individuals with mental health needs. The groups provide an opportunity to discuss challenges people may face as they reenter the community, such as stress related to reuniting with family or friends. Led by our Psychiatric Social Work Service, Safe Landing helps patients learn how to identify triggers and develop coping mechanisms so they have the best chance at bringing out a positive change for themselves when they leave jail.

I am excited to announce the June 1st opening of our new Correctional Health Services Assistance Center. Located in part of our facility across the street from the Rikers Island Bridge, the Center is a "one-stop" location to help people leaving jail and their families get connected to services in the community. The Center will be staffed by representatives from CHS' Reentry & Continuity Services, MetroPlus, Gotham Health, and NYC Health + Hospitals' Health Home. Over time, we expect to expand beyond these four anchor programs to include key City and private agencies to improve the transition of our patients into the community.

Being part of the nation's largest public health care system offers many opportunities to improve continuity of and access to care. For example, we've been working with Gotham Health on a number of fronts including connecting patients to Gotham providers when they are released. We've strengthened our relationship with the Health + Hospitals' Health Home by exchanging information about known patients and dedicating resources to facilitate care coordination for eligible Medicaid patients who are dealing with multiple health issues. Most recently, the team at Bellevue Hospital Center is granting us direct access to its clinic scheduling system so that we can streamline the process for getting our patients appointments for world-class specialty care.

FY2017 and Beyond

All the important structural and systems improvements I've described were accomplished with existing resources. In the coming fiscal year, we will continue to examine existing processes and pilot new strategies particularly around patient production and staff productivity. We will keep pushing ourselves to try different ways to address long-standing problems.

Additionally, we have another transition ahead of us, namely the disengagement from Damian Family Health Center, the contracted service provider at the Vernon C. Bain Center in the Bronx. The process will be similar to that which we undertook with Corizon although on a smaller scale. It is our intention to ensure a smooth transition by the expiration of the Damian contract on October 1st, that results in no disruption in patient care.

We are very excited that FY17 brings opportunities to make more significant changes in the way we provide care. We were gratified to see that Mayor de Blasio's Executive Budget includes a commitment to change the way we care for incarcerated persons. This five-year commitment will help us achieve our two main goals: to increase the quality of and access to care we provide

our patients while reducing challenges to and demands on security; and increase continuity of care during and following incarceration.

PACE expansion

The Program for Accelerating Clinical Effectiveness (or PACE) units are housing units for inmates with serious mental health issues. They have resulted in increased adherence to medical regimens, reduced injuries to patients and fewer uses of force. As with the first four PACE units, these newly funded treatment units will be designed to bring high level behavioral health services to specific cohorts of patients. PACE units operate at a cost of approximately $2 million, and the cost of the new units will be equal to or less than each of the current units, based on the blend of services in these settings. We are scheduled to open two PACE units each fiscal year through 2020.

EPASU Expansion

Our Enhanced Pre-Arraignment Screening Unit (EPASU) opened last May and currently operates Monday through Friday from 6am to 2pm in Manhattan Central Booking. In eleven months of operation, almost 7,300 individuals were screened for acute medical and behavioral health needs. Approximately 28% of these were referred to a nurse practitioner for more in-depth assessment and 3% (or 59) of those 2,020 individuals, were sent to the hospital for emergency treatment. Notably, 338 individuals with acute medical needs were treated by our staff on-site, avoiding the need to transport patients to the hospital and conserving hospital, EMS and NYPD resources. Increased funding will allow us to cover all three shifts and weekends at Manhattan Central Booking.

Hepatitis C Treatment Expansion

Thanks to the Executive Budget, for the first time we will have dedicated resources to ensure we are able to treat patients with hepatitis C who are in most need. The prevalence rate for hepatitis C in NYC jails is estimated to be 12 percent, and this funding will allow us to treat more patients who have tested positive for the disease or who are continuing treatment initiated in the community.

Mini-Clinic Expansion

We will also be able to significantly increase the number of mini-clinics we currently operate close to or within housing areas. These satellite clinics bring our services closer to where the patients are, thereby increasing access to needed services particularly in the larger jails. These units also reduce the challenges of patient movement and waiting.

Telehealth Expansion

Telehealth funding in the Executive Budget will allow us to greatly expand our pilot to sites, services and uses of technology to increase access to care and reduce the need for resource-intense and disruptive patient transportation. Our hope is to expand to other services within Bellevue as well as to other Health + Hospitals locations. While telehealth may not be appropriate for every patient, service or encounter, it can offer greater access to urgent,

specialty and routine care among the jail clinics as well as between the jails and hospitals, and even within single facilities where patient movement may be a challenge.

Conclusion

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

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

Although this concludes my formal testimony, we were asked to provide feedback on some proposed legislation. My colleagues from other affected agencies and I would be happy to give additional feedback on the bills on today's agenda. First, I will briefly comment on the three bills that directly pertain to work that CHS currently performs.

- <u>INT 1064 (Crowley)</u>
  This bill would require DOC to report on providers delivering inmate programming, which is defined to include education, training, or counseling regarding drug dependencies. The substance abuse treatment services that CHS currently offers are among the most extensive offered by correctional health systems in the nation.

- <u>INT 1013 (Johnson)</u>
  This bill would require DOC and DHS to place inmates who have been identified as having multiple arrests and have lived in a shelter into appropriate treatment, health and mental health programs immediately after discharge. As part of its discharge planning activities, CHS already works with DHS regarding placement of undomiciled persons being released from jail.

- INT 1183 (Cohen)
  This bill would require NYPD staff to observe and report on symptoms of mental illness and require DOHMH to conduct pre-arraignment mental health screening. As noted earlier, we currently run and will be expanding a pre-arraignment screening program at the Manhattan Detention Center that enables us to screen patients for medical and behavioral health needs. For patients who don't go through our pre-arraignment screening program, we have a comprehensive clinical evaluation on admission which allows us to screen, diagnose and often initiate treatment for a variety of medical and mental health issues.

We're happy to further discuss how the services we provide could help address the concerns raised in these bills.

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New York City Council
Committee on Fire and Criminal Justice Services Jointly with
Committee on Health and
Committee on Mental Health, Developmental Disability, Alcoholism,
Substance Abuse and Disability Services

Oversight Hearing – Evaluating Recent Changes in Healthcare in City Correctional Facilities

Thursday, May 26, 2016
Council Chambers, City Hall
New York, NY

Testimony of
Urban Justice Center / Mental Health Project
40 Rector Street, 9th floor
New York, NY 10006

Prepared by Jennifer J. Parish
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Thank you for convening this hearing on changes in healthcare in the New York City jails and for inviting us to testify today. The changes that have occurred since we testified before you at the March 3, 2015 oversight hearing are quite encouraging and have the potential to result in significant improvements in the healthcare provided to people incarcerated in the City jails.

Fundamentally jails are not conducive to good health. Conditions of confinement exacerbate health problems. So, to the greatest extent possible, individuals accused of committing crimes should not be detained pre-trial, and low-level crimes should not be punished with incarceration. We commend the Council on its efforts to reduce the number of people subjected to the criminal court system and urge you to continue to enact reforms targeted at reducing the jail population.

But the City is responsible for providing for the health and safety of the people in its custody. Health and safety are intertwined. Whenever the Department of Correction (DOC) develops a policy to address safety concerns, it must consider the possible health implications of that policy and address any potential repercussions. Health should not be

an afterthought – but it has been. For example, DOC increased its reliance on escorted movement to address safety concerns, but it did not plan for an increase in escort officers to ensure that incarcerated individuals could receive prompt medical attention. NYC Health + Hospitals (H+H) will not be able to improve healthcare on its own. It will require DOC's full cooperation and support.

We appreciate that the City Council recognizes the importance of providing appropriate healthcare in jail and has drafted legislation to support it.

Replacing For-Profit Provider with NYC Health + Hospitals Correctional Health Services

For almost thirteen years, the Urban Justice Center has monitored the City's compliance with the settlement agreement in *Brad H. v. City of New York*, which requires the City to provide discharge planning services to people who receive mental health treatment in the City jails. The City's failure to comply with its obligations to provide appropriate discharge planning services can be attributed in significant part to the bifurcation of mental health treatment (provided by its previous contractor) and discharge planning services (provided by Department of Health and Mental Hygiene (DOHMH) staff). With H+H taking responsibility for providing all care, the potential for the City to come into compliance with the settlement agreement is greatly enhanced. But it will not happen without DOC taking action as well.

One of the fundamental requirements of the settlement is the provision of medication and prescriptions to class members released from jail. During the last reporting period, only 81.4% of the class members entitled to medications and prescriptions at discharge received them.[1] The City reported that 43% of the noncompliance was the result of class members not being escorted to meet with discharge planning or nursing staff upon discharge.[2] Clearly DOC plays a critical role in providing discharge planning services.

Our monitoring work includes meeting individually with as many as 40 *Brad H.* class members each week. During these encounters individuals frequently report difficulty accessing mental health and other health care. They complain of a lack of continuity in treatment of chronic conditions, such as HIV/AIDS, psychiatric disorders, and Hepatitis C. They report having their medication regimens changed without jail health staff consulting their community treatment providers. Our clients also report repeatedly signing up for sick call but not being seen for days or even weeks; others recount waiting for hours in the clinic. Some clients report being treated for injuries promptly but then experiencing pain later on and being unable to access follow-up care.

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[1] Thirty-fourth Regular Report of the Compliance Monitors, February 8, 2016, pp. 86-87, available at https://mhp.urbanjustice.org/mhp-bradH.v.cityofnewyork.

[22] *Id.* at 88.

Clients request our assistance in advocating for them to be seen by a specialist. One person with an infected tooth was told that he would have an emergency extraction within two days, but a week later, he still had not been seen. We also receive complaints about clients missing medications; some are due to facility lockdowns, others' prescriptions expire and they have difficulty being seen to have the prescription renewed.

We are encouraged that H+H is focused on developing ways to improve the provision of care so that clients are seen promptly and on addressing access to specialty care. We hope that Telehealth will prove successful. As H+H and DOC create mini-clinics, we encourage them to ensure that clients can be seen in an appropriate treatment setting that allows for confidentiality.

We are encouraged by many of the City's initiatives, including pre-arraignment screening in Manhattan, additional PACE units, and Crisis Intervention Teams (CIT). Our clients report positively on their experiences in PACE units. I was impressed by the CIT training I observed at West Facility. If implemented as designed, CIT has the potential to make the jails safer and improve outcomes for people in emotional distress.

Comments on Proposed Legislation

Prop. Int. No. 852-A - In relation to mandating that correction officers escort inmates to medical visits in a timely fashion.

We support amending the Administrative Code to include requirements regarding prompt access to medical care. The Council is focused on critical elements – access to sick call, specialty and follow-up appointments, emergency, staffing. Most of the provisions in this bill are consistent with Board of Correction Minimum Standards on Health Care. The additional requirement that medical personnel assess every individual within two hours of arrival at medical facilities is a welcome enhancement.

We urge the Council to include reporting requirements in this bill. Notably the Minimum Standards on Health Care require that records be maintained daily of the names and number of incarcerated people requesting sick call, the names and numbers of inmates arriving in the clinic, and the names and number of individuals seen by health care personnel.[3] Given that the records are required to be kept and maintained for three years, the agencies should be able to report on the percentage of people who were given access to treatment within 24 hours of their request. We recommend that reporting be disaggregated by jail and that it be made available to the public consistent with the reporting required by Local Law 58 (NYC Administrative Code 17-199) enacted in 2015.

[3] Board of Correction Minimum Standards on Health Care 3-02(c)(5).

Int. No. 1013 - In relation to discharge planning for inmates in city correctional facilities, and to repeal section 3 of local law number 54 for the year 2004.

We support requiring DOC and DHS to make efforts to secure services for people who are incarcerated and have no place to live. Glaringly absent from the enumerated services – and most clearly necessary – is housing. The legislation should also make clear that these services are provided to the individuals on a voluntary basis.

Int. No. 1014 - In relation to requiring the office of criminal justice to post on the office's website an annual report regarding discharge planning for mentally ill inmates and recidivism.

The *Brad H.* settlement agreement in requires that a Comprehensive Treatment and Discharge Plan (CTDP) be completed for class members within seven days of the initial mental health assessment for those housed in mental observation units and within 15 days for those housed in general population. The City is not in compliance with this obligation. The most recent report by the court-appointed monitors indicates that only 85.9% of eligible class members received a timely CTDP. But what is more significant when considering this specific bill is that class members are not provided with a CTDP but are instead provided with a Comprehensive Treatment Plan (CTP) within the time frame described above and then seven business days later provided with a Discharge Plan. Given the rate at which individuals are released from the jails, many who have a CTP completed do not remain in jail long enough to have a Discharge Plan completed. Reporting on the differences in recidivism rates between those who received a CTP and those who did not is unlikely to provide useful information about the effectiveness of a Discharge Plan. It will simply differentiate between those who receive mental health treatment and those who do not – not on who actually received discharge planning services.

Another important factor to consider is that a Discharge Plan includes various services. The City is noncompliant in providing the critical components that enable continuity of care – medication at release, Medicaid, appointments for follow-up care, etc. I have attached to my testimony the compliance findings from the Monitors' Thirty-Fourth Report, issued on February 8, 2016. Knowing that a Discharge Plan was created without knowing the services that were in place does not seem particularly useful in considering recidivism. Knowing the number of people who were released from jail with active Medicaid and those without and comparing recidivism data seems more useful – or comparing individuals who have an appointment scheduled compared to those who do not.

We urge the Council to pressure the City to make remedying discharge planning barriers a priority. The Council has been instrumental in our efforts to advocate for discharge planning to be provided. We believe that with the leadership of H+H, there is an opportunity to realize the goals of the *Brad H.* settlement, and we remain eager to work

with the City to ensure that individuals with mental health issues are released from jail with the services they need. We will continue to monitor discharge planning services until we have a system that operates effectively.

Int. No. 1064 - In relation to requiring the department of correction to evaluate the effectiveness of programs it utilizes.

We support the increased availability of programming in the jails. Evaluating the effectiveness of these programs is worthwhile. This legislation, however, does not require reporting that will enable the Council to determine program effectiveness.

While program goals may have differ to some degree, all should have the goal of reducing violence in the jails. Reporting on violence in housing areas where programs operate and in housing areas where they do not seems useful.

Int. No. 1144 - In relation to requiring the use of trauma-informed care in city correctional facilities.

We wholeheartedly support training staff on the use of trauma-informed care and requiring DOC to establish guidelines and to monitor its use. To ensure that such training actually results in meaningful culture change, we urge the Council to require DOC to report on its adoption of guidelines for the use of trauma-informed care and the rollout of the training initiative.

Res. No. 461 - Resolution calling on the federal government to continue Medicaid coverage for individuals while they are incarcerated in correctional facilities, including New York City jails.

We agree that continuing Medicaid coverage for those incarcerated in the City jails would avoid any lapse in coverage. Currently state law allows for Medicaid benefits to be suspended during incarceration and reinstated upon release. The data exchanges between the DOC and State Department of Health which are necessary to carry out the suspension and reinstatement process are not seamless and individuals who had Medicaid coverage upon incarceration leave without it.

T2015-3243 - In relation to requiring arrestee mental health screenings and the exchange of health information of inmates in the custody of the department of correction.

We support the police department sharing information about an arrestee's symptoms and medical treatment while in NYPD custody for the purpose of assisting in the person's treatment while incarcerated. We also recognize the value of obtaining information from previous treatment providers to ensure continuity of care during incarceration. This

legislation, however, includes provisions, such as linking the information to the person's New York State identification number, which would enable DOHMH to create a database of information about a person's mental health issues. The legislation does not require DOHMH to obtain the individual's consent, and it does not have any provision for DOHMH to expunge the information at any point. We question the need for DOHMH to be the repository for such information without any safeguards.

The legitimate goals of sharing information can be accomplished by fully expanding H+H's role in pre-arraignment screening to all five boroughs and by requiring NYPD to report information's about an arrestee's symptoms or treatment to H+H at the point of the pre-arraignment screening. The legislation could mandate that H+H request pertinent medical records and maintain them as a treatment provider without the involvement of DOHMH.

This legislation focuses on mental health screenings, but as H+H's pre-arraignment pilot has shown, there are a number of chronic health conditions, in addition to mental illness, that can be identified during the screening and more quickly treated once the person is incarcerated. The focus on collecting and exchanging mental health information seems unnecessarily narrow and contributes to our concerns about creating a registry of arrestees' mental health treatment information.

Conclusion

We must all consider the impact that the language we use has on the policies we promote. Referring to people with mental health issues as "the mentally ill" or describing them as "mentally ill inmates" perpetuates stigma and discrimination. Using person-first language recognizes that person's identity separate from diagnosis or disability. The language we use actually affects attitudes about stigmatized populations. A study published in the January 2016 issue of *The Journal of Counseling and Development* demonstrated that people were less tolerant toward people who were referred to as "the mentally ill" than to those referred to as "people with mental illness."

Thank you for this opportunity to comment. We commend the Council for having this hearing and for playing an active role in the oversight of the City jails.

I. Introduction

This constitutes the Thirty-Fourth Regular Report of the Monitors covering Defendants' compliance with the Stipulation of Settlement for the Reporting Period May-August, 2015.

Compliance

The main findings of compliance during the current Reporting Period are summarized in Table 1.

Table 1: Compliance findings, Report 34

Item			*Finding*	*Section*
Initiation of Prescreen at SPAN		4.1.2	Compliant	IV.C
Completion of Prescreen		4.2	Compliant	IV.C
Submission of MA Application at SPAN		5.2.2	Compliant	IV.C
Provision of MGP Card on Release Date		5.3.1	Compliant	IV.C
Provision of MGP Card at SPAN		5.3.2	Compliant	IV.C
Provision of Medications by SPAN-day of Release		7.1.2	Compliant	IV.C
Provision of Medications by SPAN-after day of release		7.1.3	Compliant	IV.C
Provision of Appointments by SPAN		8.2	Compliant	IV.C
Provision of Referrals		8.3	Compliant	IV.C
Provision of Transportation		11.1	Compliant	IV.C
Provision of Transportation by SPAN		11.2	Compliant	IV.C
Offer of assistance re: Housing		12.0.3	Compliant	IV.C
Follow up contacts re: Appointments by LINK		12.1	Compliant	IV.C
Direct Placement in Program Shelters			Compliant	IV.H
Time of Release			Compliant	IV.I
Timeliness of Initial Assessment		1.1	Noncompliant	IV.C
Timeliness of CTDP		3.1	Noncompliant	IV.C
Initiation of Medicaid Prescreen		4.1	Noncompliant	IV.C
Submission of MA Application		5.1	Noncompliant	IV.C
Medicaid Reactivation		6.1.1	Noncompliant	IV.E
Temporary Medicaid		6.1.1	Noncompliant	III.C
Provision of Medications and Prescriptions upon Release		7.1.1	Noncompliant	IV.C
Provision of Appointments		8.1	Noncompliant	IV.C
Submission of PA Application		9.2	Noncompliant	IV.C
Submission of HRA 2010e Application		10.1	Noncompliant	IV.C
Follow up contacts re: Appointments		12.0.1	Noncompliant	IV.C
Follow up contacts re: Referrals		12.0.12	Noncompliant	IV.C
Follow up contacts re: Housing		12.0.2	Noncompliant	IV.C
Follow up contacts re: Referrals by LINK		12.2	Noncompliant	IV.C
Follow up contacts re: Housing by LINK		12.3	Noncompliant	IV.C
Offer of assistance re: Housing by LINK		12.4	Noncompliant	IV.C
Appropriateness	Appointment/referral	3.2	Noncompliant	IV.D
	SPMI assessment	2.4	Noncompliant	IV.D
	Supportive housing	3.2	Noncompliant	IV.D
	Case management	3.2	Noncompliant	IV.D

FOR THE RECORD

REMARKS OF JAMIN R. SEWELL
COUNSEL & MANAGING DIRECTOR FOR POLICY AND ADVOCACY
THE COALITION OF BEHAVIORAL HEALTH AGENCIES

OVERSIGHT - EVALUATING RECENT CHANGES IN HEALTHCARE IN CITY CORRECTIONAL FACILITIES
May 26, 2016

Good Morning, Chairs Cohen, Crowley and Johnson and the members of the NYC Council Commitees on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services, Fire and Criminal Justice and Health. I am Jamin Sewell, Counsel & Managing Director for Policy and Advocacy of The Coalition of Behavioral Health Agencies ("The Coalition").

The Coalition is the umbrella advocacy organization of New York's behavioral health community, representing nearly 140 non-profit community-based behavioral health and substance abuse agencies that serve more than 350,000 clients/consumers throughout NYC and surrounding counties. Our member agencies are on the ground, front-line safety net providers. The vast majority of the individuals served are on Medicaid. We treat some of the most needy clients, including those with dual diagnoses of mental health and substance abuse problems. Our providers serve the homeless and the formerly incarcerated, as well as victims of trauma and abuse. They serve people of all ages and every racial, cultural and ethnic background. The agencies we represent are in every Council District and neighborhood in the city.

We represent community-based agencis for whom providing services to the justice-involved population is their primary mission such as CASES, The Fortune Society and The Osborne Association; as well as other providers who serve numerous individuals with forensic backgrounds as part of their overall services to people with behavioral health issues, such as Center for Urban Community Services (CUCS), Project Renewal and Good Shepherd Services.

Thank you for the opportunity to submit testimony in this oversight hearing, "Evaluating Recent Changes in Healthcare in City Correctional Facilities."

The Coalition strongly supported the transition of NYC prison physical and behavioral services from Corizon Health, a for-profit company that operated correctional health services to the NYC Department of Health and Mental Hygiene (DOHMH). The numerous problems with Corizon reported in the media made it clear that the City

needed to change its provider of these services. The transition began in July 2015 when the de Blasio administration announced it would take over the program in order to provide better services to inmates. In August, NYC Health + Hospitals acquired control of the program, with a $237 million annual budget, 1,700 employees and around-the-clock operations in twelve jails citywide, and successfully brought on essential Corizon and DOHMH staff prior to Corizon's contract expiring on December 31.

NYC Correctional Health Services (CHS) has already begun to leverage NYC Health + Hospitals' large network of services and programs to improve patient care. Since December, MetroPlus, NYC Health + Hospitals' health plan, has set up enrollment counselors at the Rikers Visitor Center to help patients and their families enroll for health insurance. CHS is also working with the NYC Health + Hospitals Federally Qualified Health Center organization, Gotham Health, to help inmates and their families connect to community-based health centers and primary care outside the jail system.

The connection to community-based physical and behavioral health providers is the crucial link in the process to drive down recidivism, help individuals recover and be productive members of communities. The Coalition's members stand ready to work with Correctional Health Services to make the connection to care upon discharge from incarceration.

Although the transition to physical and behavioral healthcare delivery in NYC jails is in its infancy, we are cautiously optimistic that the quality of care will significantly improve.

With regard to the specific bills considered by the Committees at today's hearing, we are generally supportive of the entire package.

- **Int. 0852A-2015 (Crowley)** – Mandates that correction officers escort inmates to medical visits in a timely fashion.
    - Clinical evidence shows that the sooner an individual has a psychotic break, the better and sooner the possibilities for recovery ensue. We support this proposal.
- **Int. 1013-2015 (Johnson)** – Requires the Department of Correction ("DOC") and Department of Homeless Services ("DHS") to make every effort to provide appropriate services and programs to inmates immediately upon their release from the custody of the DOC, if such inmates had been identified by the departments as having been housed in shelters provided by DHS prior to their incarceration.
    - Strong discharge planning services are crucial for reducing recidivism and coordination between the agencies will help assist in bringing people to care. We strongly support this proposal.
- **Int. 1014-2015 (Johnson)** – Requires the office of criminal justice to post on the office's website an annual report regarding discharge planning for mentally ill inmates and recidivism.

- Collecting this data regarding discharge planning for individuals with behavioral health issues and recidivism could lead to robust evidence-based practices that lead to recovery. We strongly support this proposal.

- **Int. 1064-2016 (Crowley)** – Requires the DOC to evaluate the effectiveness of the programs that are offered to inmates regarding education, training, counseling, addressing drug dependencies, or other related issues. The DOC would be required to submit a yearly report summarizing this evaluation to the Mayor and Council.
  - Similar to Int. 1014, The Coalition believes that the date yielded from these yearly reports could be useful in creating evidence-based practices that will encourage recovery. We support this proposal.
- **Int. 1144-2016 (Cumbo)** – Requires the Department of Correction to train staff on the use of trauma-informed care, and to use trauma-informed care consistently with federal guidance.
  - There is a universal assumption of trauma for individuals with behavioral health conditions who are incarcerated. Additionally, most people in custody have experienced or are currently experiencing significant traumatic stressors. Individuals who have experienced repeated, chronic, or multiple traumas, like many, if not most, people who have been incarcerated, are more likely to exhibit pronounced symptoms and consequences, including substance abuse, mental illness, and health problems. Subsequently, trauma can significantly affect how an individual engages in major life areas, including interpersonal relationships, as well as treatment. Trauma informed protocols improve correctional setting relationships between inmates and custodians, provide evidence-based and best practice information for behavioral health service providers and administrators who want to work more effectively with people who have been exposed to acute and chronic traumas and/or are at risk of developing traumatic stress reactions. A trauma-informed correctional system will help to support improved interactions between correctional officers and inmates. The Coalition strongly supports this legislation.
- **Int. 1183-2016 (Cohen)** – Requires arrestee mental health screenings and the exchange of health information of inmates in the custody of the department of correction.
  - While in principle, this proposal could potentially lead to diversion of individuals with behavioral health issues from jail to treatment, we do have some concerns related to the privacy rights implicated by this data sharing. If our privacy concerns are built into this legislation, The Coalition could support it.
- **Res. 0461-2014 (Crowley)** – Continue Medicaid coverage for individuals while they are incarcerated in correctional facilities, including NYC jails.
  - This is an excellent proposal and along with enrolling individual in Medicaid who are not covered before they are released, this would

dramatically improve outcomes by removing barriers to care. Continuity of care is critical to maintaining an individual's health and wellbeing and would support efforts to reduce recidivism.

Mental Health Services for Court-Involved Youth Initiative
Finally, I would be remiss if I did not mention the Mental Health Services for Court-Involved Youth Initiative, which the Council has generously funded since FY '15.

The Coalition strongly supports the restoration of the Council Member Rose sponsored initiative of $1.9 million, which has expanded the capacity of community-based providers to meet the mental health needs of youth involved with the criminal justice and foster care systems and their families. The funding has been allocated to 15 service providers—Acacia, Astor Services for Children & Families, Catholic Charities Neighborhood Services, Center for Alternative Sentencing and Employment Services (CASES), The Children's Aid Society, The Fortune Society, Good Shepherd Services, Jewish Child Care Association of New York, New Alternatives for Children, The Osborne Association, Safe Horizon, SCO Family of Services, Staten Island Mental Health Society—and to The Coalition which has developed a training series tailored to the needs of behavioral providers who work with court-involved youth.

The initiative is in its second year, it has already touched the lives of more than 700 hundred young people and their families. The Coalition will provide specific numbers of youth screened, assessed and treated, as we near the end of the fiscal year. We believe that if the initiated is restored, we will begin to see even more impact in the coming fiscal year and hope you will continue this valuable project.

CONCLUSION
On behalf of our over 140 members in the metro region, we appreciates the Council's constructive proposals and the City's efforts to improve physical and behavioral health services for individual who are incarcerated. We would be very pleased to work with you on implementation strategies.

Again, thank you again for the allowing me to testify before you today.

THE COALITION OF BEHAVIORAL HEALTH AGENCIES, INC.

FOR THE RECORD

Mental Health Services for Court-Involved Youth FY '16
Anecdotes from the Field

Catholic Charities Brooklyn and Queens

The Catholic Charities of Brooklyn and Queens (CCBQ) Court Involved Youth (CIY) Program has screened more than 90 individuals this year and accepts referrals from more than half a dozen referral sources including the Far Rockaway Youth Court, a peer lead adjudication process for juvenile offenders that opened in the fall of 2015. The CCBQ Far Rockaway Behavioral Health Clinic is located just two blocks from the Youth Court, so when the court made a referral, our Program Specialist met with a young woman, age 15 and in trouble for fighting and truancy at school, at the clinic. The young woman scored positive for symptoms of depression on the CIY's standardized depression screen, the PHQ-A, and symptoms of trauma on the CIY's standardized trauma screen the UCLA PTSD-2.

After the screening, I discussed with the mother that counseling would be the best way to deal with the kinds of problems her daughter was presenting. The mother was very cooperative in terms of arranging an in-take appointment for her daughter at the Clinic, but as the discussion continued, she became noticeably upset. I asked if everything was OK and she began to cry. She said that her daughter's problems made her think about her own problems. I informed her that the Court Involved Youth program is also available to family members, and she agreed to complete the same mental health screens with me. In addition to responses that indicated, she may be suffering from depression the mother revealed that she had been a victim of both physical and sexual abuse beginning at the age of eight. Even though it had occurred thirty years earlier, she told me that this was the first time she had really spoken about it.

I brought both mother and daughter to the clinic's front desk where they each began the in-take process to receive counseling.

When our program followed up a month later, the mother informed me that both she and her daughter were doing much better, and that both of them were still attending counseling.

THE COALITION OF BEHAVIORAL HEALTH AGENCIES, INC.

THE CHILD CENTER OF NY

G.B. is a 19-year old male referred from Queens Adolescent Probation. The young man was on probation for robbery and was using marijuana daily and drinking alcohol regularly, with toxicology levels that were very high. G.B. dropped out of school in the 10th grade and was unemployed. He also had a strained relationship with his biological parents.

Since being in treatment beginning in 2016, G.B has stopped using all illicit substances, he has obtained his GED and he is working full time in a restaurant in Manhattan.

His relationship with his family has vastly improved as well. He has not been re-arrested and attends individual and group therapy twice a week. His attendance is close to perfect and he is due to successfully complete treatment within the next month.

JCCA JEWISH CHILD CARE ASSOCIATION *Every Child Deserves to Grow Up Hopeful*

1) J.C., a 16 year-old African-American male, began attending the Second Chances program at JCCA after being arrested in the Fall of 2014. J.C. had two charges against him and after being arrested, he spent a month in a non-secure detention facility. J.C. reported that this was a scary time for him. After the month in detention, J.C. was placed on probation for two years. It was through his probation officer that J.C. came to the Second Chances program. At first, J.C. had no interest in participating in the program. J.C. was not attending school and was often getting into fights with both peers and family members. J.C. would get angry quickly and had difficulty managing his anger. However, after working with the social worker for a few weeks, J.C. began to open up and discuss the issues he was experiencing. J.C. learned numerous tools to control his anger instead of dealing with issues through fighting. Then a few months into his participation with Second Chances, J.C. was arrested again. Luckily, this time he did not have to be placed in detention. In discussions with the social worker, J.C. began to take responsibility for his actions and learn from his mistakes. He became determined to make changes. J.C. began working at a part-time job as well as participating in another program where he was able to learn job skills. He was also able to transfer to a different school that better suited his needs. After five months in the Second Chances program, J.C. was attending school and reported better relationships with his family members.

2) When E.C., a 17-year-old African-American female, first enrolled in the Second Chances program, she was depressed and overly stressed with everything she had to do. She had a difficult relationship with her mother and struggled to find ways to repair that relationship. Furthermore, E.C. did not have a strong relationship with her father

leading to E.C. feeling as though she had no support system. She experienced a lot of anxiety and even suffered from panic attacks. E.C. also struggles with a medical condition, putting further stress on her and her family. Oftentimes when people feel depressed or anxious, they avoid people or things that used to give them joy because they are fearful or believe those things will only make themselves feel worse. In addition, sometimes they may find camaraderie with other people who influence them to participate in illegal activities, such as stealing, misusing substances, or getting into fights. What people may not understand is that doing these things actually makes depression and anxiety worse.

E.C., however, was able to notice she was slipping and decided to speak with her school guidance counselor who then connected E.C. to the Second Chances program. Through her work with the social worker, E.C. was able to express her feelings regarding her experiences and discuss the difficulty she has had in connecting with her mother as well as the challenging relationship she has with her father. With the help of the social worker, E.C. was able to come up with ways to try to repair the relationship between her and her mother and is taking steps to build a stronger connection. The social worker provided psycho-education regarding stress and the importance of taking care of herself, especially due to E.C.'s health concerns. E.C. now has numerous tools she can use when needed to help her better deal with her stress and anxiety. E.C. also began to participate in the Second Chances Leadership group, Aim High, where she was able to connect with peers and form new friendships. E.C. is very motivated to improve herself and is determined to go to college and become a veterinarian.

SCO
Family of Services

This fiscal year, we had a young woman who was referred to our Family Assessment Program (FAP), overseen by NYC Administration for Children's Services. The FAP program's purpose is to provide preventive services to youth at risk of becoming Persons in Need of Supervision. Because of the screening tools, which were used for her and her adoptive father, work has centered on communication skill building.

As a Multi-Systemic Therapy (MST) program[1], SCO works predominantly with the parents around skill building. However, because of the information obtained though the JJMS screening tools, we discovered she had depression and expressed hopelessness in her current life situation. Additionally, it was determined after screening that she also suffers from anhedonia (would like to remain by herself, can derive no pleasure any of the simple things in life).

[1] MST is provided for 4 months in the home and is the only service (except when a psychiatrist must evaluate). After MST ends, the youth and family can be referred for community-based services.

THE COALITION OF BEHAVIORAL HEALTH AGENCIES, INC.

Because of the information we received from the screens, a treatment plan was set up utilizing MST, we were able to assist the young woman to get a psychiatric appointment, and when she completes MST, she is going to be involved with a community-based mental health program.

Over the last few weeks, her mood has improved to the point that she is becoming more interactive in sessions with the therapist and is increasing her communication with her father.

Were it not for the screening tools, it might have taken many weeks to determine her need for ongoing therapy and we believe very strongly that the screenings changed this youth's life for the better.

MENTAL HEALTH SOCIETY STATEN ISLAND 1885

Victor is an 18 year-old male referred to Staten Island Mental Health Society by Legal Aid Society after being arrested and charged with robbery. At intake, he reported an extensive history of trauma (including two near death experiences) and marijuana smoking. Following screening and evaluation, Victor was admitted for treatment and received weekly individual therapy where he focused on his traumatic experiences and the cognitive distortions and behaviors that lead to his arrest. While in treatment, Victor's grades improved and he successfully completed his Regents exams in preparation for high school graduation.

SIMHS provided regular updates to the court on behalf of Victor. As he met his treatment milestones, SIMHS provided Victor with positive reinforcement in the form of program incentives. The court took his compliance with treatment into consideration, and his case was dismissed. This spring, Victor was favorably discharged after satisfactorily achieving his treatment goals. Although legally an adult, Victor authorized his therapist to communicate with his parent on his progress at home. His mother expressed extreme satisfaction with the program, indicating that there was a positive change in her child. At discharge, mother and Victor thanked therapist and agency for services provided.

BROOKLYN DEFENDER SERVICES

TESTIMONY OF:

Riley Doyle Evans – Jail Services Coordinator
BROOKLYN DEFENDER SERVICES

Presented Before

The New York City Council Committees on Fire and Criminal Justice Services, Health, and Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

In relation to correctional healthcare

May 26, 2016

My name is Riley Doyle Evans and I am the Jail Services Coordinator for Brooklyn Defender Services. BDS provides legal services to tens of thousands of people in Brooklyn each year in criminal, family and civil court proceedings. As part of our comprehensive mission, BDS provides dedicated supportive services and advocacy to our clients incarcerated in city jails. BDS deeply appreciates the Council's ongoing efforts to examine and take on issues of our criminal justice system. I especially want to recognize the work of Council Members on the Health and Fire and Criminal Justice Services Committees to improve conditions for people in our city jails. Thank you for the opportunity to share our perspective.

In New York City today, like elsewhere in the country, our jail system has become the city's largest mental health service provider. In fact, it is one of the largest mental health providers in the nation. We agree that adequate, humane medical and mental healthcare delivery in our jail system is of paramount importance. However, we emphasize that high-needs individuals who pass through our jail system cannot get adequate care in a correctional setting. These individuals should be diverted from the criminal justice system long before being sent to Rikers Island.

BDS attorneys spend their days and nights in arraignments vociferously opposing bail requests from prosecutors who send clients living with serious illness to jail for crimes of survival like jumping a turnstile or stealing toothpaste, or behaviors that likely result from mental illness. These individuals should never have been arrested, but even after the trauma of arrest, they could be diverted at arraignments, and certainly should not be incarcerated pre-trial on bail. There is no indication that public safety is served by incarcerating these individuals during the pendency of their case. Moreover, these cases are indicative of serious shortcomings in public health, housing and other service provision systems in the city. Pre-trial incarceration only compounds this issue. When people are unnecessarily incarcerated, the interruption in medical care, mental health treatment, housing and other essential services they endure have devastating consequences and pose a serious drain on scarce resources in the community.

Although BDS expends significant resources advocating for our clients' access to medical and mental healthcare while incarcerated, we acknowledge that jail is an inherently pathogenic institution – people who are sick will be made sicker, and those who enter healthy may leave bearing the scars of trauma, neglect, abuse, and mental illness, which they will carry for life.

Intro. No. 852-A

BDS supports this legislation to bolster access to care for people in city jails, and offers recommendations for amendments. Sick call represents the most important avenue through which people request medical, dental and mental health treatment in the jails and must be improved. Presently, sick call involves people signing up on a piece of paper in their housing unit, or informing a correction officer that they wish to sign up. Correctional staff are responsible for bringing the individuals who have signed up to the clinic to be seen for treatment. This system has many shortcomings, principally that Corrections Officers are the gatekeepers to medical care and medical staff are never provided the complete list of people who have requested care. Worse, many of our clients have been denied the opportunity even to sign up for sick call. Under the present system, denying access to medical treatment is one of the tools used by corrections officers to punish people in the jails. Even if someone is able to sign up for sick call, corrections staff can refuse to escort that person to the clinic and medical staff will never know about that person's condition.

BDS supports Intro. 852-A, and encourages the Council to amend the language to go further in facilitating access to care in the following ways:

- **Mandate H+H to facilitate sick call.** As the provider of healthcare services, Health and Hospitals should have sole responsibility for sick call. It is imperative that healthcare staff know who is requesting medical treatment from the beginning in order to help avoid lapses in treatment with tragic consequences. H+H management of the process will allow more efficient scheduling based on medical need and avoid unnecessarily long wait times. While DOC staff must be accountable for escorting people to the clinic, removing DOC staff from the actual sick call process will end the practice of denying care as a means of punishment. We note that if adjustments are made to sick call procedures, it is crucial that any triage that occurs outside of a clinic is conducted in a confidential setting.

- **Specialty Care Timelines:** We support the provision that specialty care be delivered in a timely fashion. We urge the Council to be even more specific in its delineation of timely treatment to reflect the orders of the treating provider – for example *"...shall be notified of, escorted and transported to such care within the timeframe ordered by a medical provider."* Specialty care may be routine, urgent or emergent, and in each instance, different definitions of "timely" apply; what is crucial is that the treatment is completed within the timeframes ordered by the provider, as presently reflected in the Board of Correction Healthcare Minimum Standards. In general, Council legislation that allows DOC or HHC complete discretion might not have its intended effect, as the agency will remain legally unaccountable.

- **Escorts:** Presently, many jails operate on an "escort only" basis, which provides that any time a person leaves the housing unit for any reason, they must be escorted by a correction officer. Reasons may include family or legal visits, law library visits, educational or other programming, and medical care, among other services. This places a significant strain on escort officers who may also be inappropriately assigned to additional duties. We support the Council's effort to ensure that escorts are available for medical visits. We believe it may be beneficial to utilize staff more efficiently and create specific teams of officers assigned as "medical escorts" who are supervised by an independent captain. Such a change would ensure escorts are available to facilitate prompt access to medical care and return from the clinic after treatment, and avoid conflicting responsibilities.

- **Staffing:** We support the Council's effort to ensure adequate medical staff are present in city jails. We recommend an amendment to the language of this bill to clarify that staffing levels among medical staff should be determined and guaranteed by Health and Hospitals and not the Department of Correction. The bill as written suggests that DOC would make this determination, which would alter current practice in a detrimental way.

Intro No. 1013

BDS supports the Council's effort to increase the availability of discharge planning services. We believe discharge planning should be made available to all people in the jail system. As mentioned above, we believe many people in our jails should be offered services *before* their arrest, arraignment, and as an alternative to incarceration. Services offered should be voluntary and not mandated as a condition of release or housing. Additionally, Health and Hospitals already plays an important role in discharge planning for many individuals in the jail system and their expertise should guide discharge planning for all people with medical and mental health conditions who pass through our jail system. Furthermore, we would welcome enhanced discharge services for individuals released from court, particularly those people with serious medical and mental health needs.

Intro No. 1014

Brooklyn Defender Services supports the Council's effort to document the shortcomings of our current approach to responding to mental illness through recidivism data. It is important to acknowledge, however, that regardless of the quality discharge planning, all available evidence demonstrates that incarceration itself increases the likelihood that people will be arrested in the future. As noted above, incarceration is also likely to trigger or exacerbate mental illness. Jails are

fundamentally inappropriate places to deliver mental health treatment, and the compounding traumas that people experience as a result of incarceration cannot be undone through discharge planning. The primary driver of reform must be made to divert people with mental illness away from the criminal justice system before they are even arrested.

Intro No. 1144

Brooklyn Defender Services supports the requirement that all staff working in city jails receive training in trauma-informed care. We believe the Council should specify a minimum number of hours of training for all staff to ensure that this training is meaningful and effective. Furthermore, we believe the Council should require reporting regarding the implementation and utilization of training, rather than leaving it to the Department to ensure compliance.

T2015-3243

Brooklyn Defender Services supports the efforts of the council to improve practices to document medical and mental health conditions of people who are arrested. We believe continuity of care for this population is essential. However, we believe certain elements of the introduction as drafted may not be effective. Alternatively, we support the expansion of Health and Hospitals' role in pre-arraignment screening to all shifts in all boroughs. In Manhattan, H+H medical practitioners in pre-arraignment screening are able to document injuries, evaluate mental health symptoms, facilitate hospitalizations if necessary, and help ensure continuity of care for individuals with serious needs who enter the jail system. Additionally, because the providers are medical professionals with access to an Electronic Medical Record, the documentation and treatment they provide will be confidential. Some concerns about the proposal are listed below:

- **Documenting Arrest Injuries:** The proposed language suggests that NYPD officers will be responsible for documenting injuries suffered during arrest. While well intended, this provision seems unrealistic, and may ultimately serve as a tool for NYPD to claim that injuries inflicted during arrest were pre-existing. If a person is injured during arrest, they should receive treatment at a hospital from a medical professional who will document the injuries in a confidential medical record. In most cases, the treating hospital will be part of the Health and Hospitals system, thereby facilitating a relatively straightforward transfer of records to H+H Correctional Health Services (CHS).

- **Documenting Mental Health Symptoms:** The bill as written suggests that NYPD officers will speculate about the mental health symptoms exhibited during an arrest or in custody. It is inappropriate for a lay-person such as a police officer to speculate about a person's condition and expect that information to inform care delivered going forward. If a person is exhibiting symptoms of mental illness, they should be offered voluntary treatment by a mental health professional in a clinical setting who will document the symptoms and, if appropriate, provide a diagnosis and treatment plan in a confidential health record. Again, this record may be procured by CHS through H+H or a HIPPA release from the patient.

- **Transmission of Health Information:** The bill suggests that health information about people in custody should be transmitted to the Department of Health and Mental Health. The bill should be amended to reflect changes in the healthcare services provider in DOC facilities. Health and Hospitals Correctional Health Services now delivers care in NYC jails, not DOHMH. Furthermore, the bill suggests that NYPD will transmit healthcare information about people in custody. This raises concerns about confidentiality of medical information. NYPD should not be the custodian of confidential health information; diagnoses and treatment should be delivered by medical professionals who then generate confidential records which can be procured through H+H medical records or HIPPA release by the patient.

Resolution No. 461

Brooklyn Defender Services supports the resolution calling for the Federal Government to continue Medicaid coverage for individuals while incarcerated in New York City jails. In addition to the obvious financial implications of such a change, continuing Medicaid coverage for people in city jails will facilitate safer release for people returning to the community who may presently experience lapses in coverage. In addition, ongoing Medicaid coverage will obviate a cumbersome and expensive bureaucratic process people currently endure upon release from jail. Finally, Medicaid reimbursement for treatment received in the jails will likely improve quality of care through accountability mechanisms utilized in community hospitals, but presently absent in the jail system.

Thank you for your consideration of my comments. Please do not hesitate to reach out to me with any questions about these or other issues at (718) 254-0700 (ext. 225) or rdevans@bds.org.

Testimony before the Fire and Criminal Justice Committee, the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services, and the Health Committee of the New York City Council

Thursday, May 26, 2016

Good Morning. My name is Lillie Carino Higgins. I am here today on behalf of our 1199 members who provide health care services in correctional facilities. Thank you for this opportunity to testify on the pending bills and Resolution 461, all of which we fully support.

A year ago we testified that existing problems inside correctional institutions were serious, and unless addressed any contractor identified to replace Corizon Health would face similar obstacles. We were not mistaken. The continuing lack of interagency collaboration, cooperation and coordination continue to impact health care services provided to inmates, as well as the safety of the staff.

We recognize that the Department of Corrections (hereafter "DOC") is responsible for security and the day-to-day operations of the facilities. We understand that at all times, persons physically located inside a prison – whether inmates, visitors, or staff – are in the custody and care of DOC. And, we believe that DOC will be more effective if they engage the staff in discussions about safety, particularly when it comes to serving the large proportion of mentally ill inmates housed in their facilities.

1199 and the other health care unions – NYSNA and Doctor's Council, have long advocated for cross-training with uniformed and civilian staff. We believe that a team approach to train all staff to identify and de-escalate potential conflicts will go a long way toward minimizing assaults against staff. Working together, DOC and the health care providers will be better equipped to find solutions.

HIPPA laws prohibit officers from being present during medical exams and procedures, but steps can be taken to decrease number of incidents of assault. Effective measures like minimizing waiting times for inmates by increasing staffing and by escorting inmates to the clinics in a more organized and timely manner would be extremely helpful. Posting corrections officers inside the clinics, utilizing cuff bars for violent and/or aggressive inmates, and on-body panic buttons are preventive measures the City has to seriously consider. Escorting medical staff doing their rounds or delivering medication to housing units would increase safety as well.

Flagging or coding medical charts to identify violent inmates, the severity of any detected mental illness, and chronic medical conditions would also go a long way toward a more unified service delivery system, particularly in crisis episodes, such as lockdowns or other occurrences that prevent inmates from visiting the clinics or keeping their appointments.

Violence against health care workers will persist at Rikers and the other facilities until the necessary steps are taken to improve safety and communications amongst all workers in each facility.

Thank you again for this opportunity to testify on these matters.

New York City Council Committee on Fire and Criminal Justice Services with the Committee on Health and the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

Oversight: Evaluating Recent Changes in Healthcare in City Correctional Facilities

City Hall

May 26, 2016

10:00 A.M.

New York, New York

Prepared By:
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Testimony of the Legal Aid Society

Before The New York City Council
Committee on Fire and Criminal Justice Services with the
Committee on Health, and the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

May 26, 2016

I am Sarah Kerr, a staff attorney at the Prisoners' Rights Project of The Legal Aid Society. The Legal Aid Society and I thank you for the opportunity to provide testimony concerning medical and mental health care in the New York City jails. In addition, we offer support and recommendations concerning the several bills that are being considered by the Committees and by City Council. We submit this testimony on behalf of The Legal Aid Society, and thank Chairs Elizabeth S. Crowley, Corey D. Johnson, and Andrew Cohen, and the Committee on Fire and Criminal Justice Services, the Committee on Health, and the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services. We applaud the Council for continuing to tackle important topics and introducing legislation to improve conditions, and increase accountability and transparency, in the City Jails.

The Legal Aid Society is the nation's oldest and largest provider of legal services to low-income families and individuals. From offices in all five boroughs, the Society annually provides legal assistance to low-income families and individuals in more than 300,000 legal matters involving civil, criminal, and juvenile rights issues. The Legal Aid Society Prisoners' Rights Project (PRP) has addressed problems in the New York City jails for more than 40 years. Through advocacy with the Department of Correction (DOC) and HHC, individual and class action lawsuits, PRP has sought to improve medical and mental health care and to reform the systems for oversight of the use of force and violence in the jails. Each week PRP receives and investigates numerous requests for assistance from individuals incarcerated in the City jails, their families, and their defense lawyers from the Criminal Defense Practice and elsewhere. Years of experience, including daily contact with incarcerated individuals and their families, have given the Legal Aid Society a firsthand view of problems in the New York City jails.

Medical and mental health care are among the most frequent subjects of complaints by and on behalf of individuals housed in our City jails (the others are violence or the threat of it from other detainees or jail staff). PRP is contacted every day by individuals in the jails, their family members or attorneys with complaints about medical care issues such as denied access to sick call, failure to provide ordered care, psychiatric emergencies, and the need for special medical diets. PRP routinely advocates with HHC, the Board of Correction (BOC) and, when (as is frequent) the complaint implicates correctional staff, DOC officials. There are clear patterns in the complaints, which reflect ongoing deficiencies in the jail medical care system.

I. Oversight: Evaluating Recent Changes in Healthcare in City Correctional Facilities

In March 2015, the Prisoners' Rights Project testified to City Council concerning the frequently substandard care provided to the jail population by Corizon Health and other problems with the delivery of medical care in the City jails.[1] Since that time Corizon has been replaced as medical provider by the City's Health and Hospitals Corporation (HHC), which has further contracted with the Physician Affiliate Group of New York (PAGNY) to provide medical and mental health care in the City jails. We believe that the removal of Corizon was warranted and applaud many of the efforts of HHC to improve and enhance treatment and access to services. However, many of the same problems, testified to last year, persist.

The problem providing medical care in our City jails is not solely with the medical provider; it is compounded by the failure of the Department of Correction ("DOC") to carry out its responsibilities to get individuals in their custody to medical care in the clinics (or to get clinicians to their patients in other parts of the jails), in an adequate or consistent fashion. Increased requirements of escorted movement in the jails, combined with a frequent lack of escorts, delay access to sick call and to emergency services; there continue to be long waits in the clinic to obtain treatment; and the reports of delayed treatment that we hear of from our clients continue to include emergencies. For example, in one case medical staff did not respond to an individual who suffered a seizure in a housing area for over an hour. The DOC continues to lock down entire jails based on incidents that occur in one area of a facility. Such lockdowns and other alarms in the jails significantly further restrict and hinder movement delaying medical assessments, treatment and follow-up care. Although the DOC now claims that during lockdowns all movement is stopped *except* for medical movement, in reality much medical movement is stopped; even when patients are allowed to move during a lockdown, their movement may be significantly delayed. Further, complaints from our clients about failure to produce them for specialty care appointments continue unabated, even though both the in-jail medical care and the hospital-based specialty clinics are provided by the same agency, HHC.

Access to care is delayed in some locations in the jails as a result of DOC policy—or lack of it. For example, there is no protocol for sick call in Intake areas of the jails. Yet, individuals end up being held in intake areas for substantial periods of time – sometimes many days, a week, or longer.[2] Various restricted housing areas have stricter requirements for movement that either cause individuals to resist needed treatment (*e.g.*, when they must be subjected to burdensome restraints to walk to the clinic) or cause delays in access due to security protocols. "Rounding" when clinical staff walk through housing areas looking in on individuals housed in restricted housing areas lacks confidentiality and is inadequate to identify all but the most seriously deteriorated individuals. Rounding is done in the Enhanced Supervision Housing and punitive segregation housing areas. It is insufficient and inappropriate to provide needed treatment and access to care. All individuals housed in isolating conditions should be able to speak to clinical staff on a regular basis in a confidential setting. A public, cell-side, drive-by is insufficient and all such restricted areas should

[1] See testimony of John Boston dated March 3, 2015 available at: www.legal-aid.org/media/190797/testimony_3.3.15.pdf.

[2] DOC policy calls for new admissions to be housed within 24 hours, and transferred individuals to be housed within 12 hours, but Legal Aid has received a steady stream of complaints of stays in intake areas (receiving rooms) lasting much longer than these nominal limits.

be required to include a private setting appropriate for clinical encounters so that clinical staff does not miss early symptoms of psychiatric need nor inappropriately discourage individuals from seeking needed treatment.

At public oversight hearings, we have urged that the City Council require that HHC and DOC establish a treatment unit for individuals with physical disabilities that is competently administered, handicapped accessible in accordance with the Americans with Disabilities Act, and under the direction of an orthopedist, with enough staff to provide assistance with activities of daily living and the physical therapy equipment and services necessary to allow patients to recover or regain as much function as possible. HHC and the City have not acted to create such a unit, and complaints from individuals with mobility impairments continue. The failure to carry out prescriptions for physical therapy remains a frequent source of complaint.

Similarly we have called for HHC and DOC to provide an appropriate clinical setting in a treatment area for suicide watches. No one who is suffering from suicidality requiring the restrictions on clothing, bedding and amenities that is characteristic of suicide watch, should be housed anywhere in the jails other than a treatment setting, *and* utilization of suicide watch should be time limited. If an individual is unable to regain stability within a few days, that person should be transferred to a psychiatric hospital.

The City and HHC have, and continue to, invest in improved mental health treatment in the jails. Four (4) of the existing twenty (20) mental observation housing areas (general population housing for individuals with mental health needs) are now converted to the Program for Accelerating Clinical Effectiveness (PACE). PACE is designed to provide a higher level of mental health treatment services and the individual units are addressing needs of specified populations. The City budget calls for the addition of 8 additional PACE units in the jails. This is an appropriate effort to identify and provide treatment to individuals with serious mental health needs upon their entry into the City jails. The City is also providing additional mental health training for DOC staff and deploying Crisis Intervention Teams (CIT) inside the jails to respond to and de-escalate incidents. The CIT teams are comprised of both DOC and medical staff. CIT is an evidence-based best practice specifically designed for de-escalation of incidents involving individuals with mental illness. The specialized CIT response that incorporates treatment staff is essential and must be encouraged and maintained in the City jails. Moreover, there should be efforts to link PACE, CIT and other mental health efforts inside the jails with mental health care outside of the jails as well. The ability to divert individuals with mental illness out of the jails and provide them with services through discharge planning should be enhanced through better communication protocols between HHC, DOC, and defense counsel and community providers.

II. The Proposed Legislation

In the following sections, we comment on the items of proposed legislation put forward for consideration at this hearing.

Int. No. 852-A - In relation to mandating that correction officers escort inmates to medical visits in a timely fashion.

Int. No. 852-A would add a new section 9-141 ("Proposed § 9-141") to the New York City Administrative Code. Proposed § 9-141 requires prompt medical attention for individuals housed

in the City jails and codifies into local law some of the Board of Correction Minimum Standards on Health Care ("BOC HC Standard"). We support the adoption of these measures into local law.

Sick call is the gateway to all medical treatment in the jails and it is essential that access to regular medical services, as well as emergency services, be provided in accordance with these standards. Proposed §§ 9-141 b. and c. are consistent with BOC HC Standard § 3-02(c)(1) which requires that "sick-call shall be available at each facility to all inmates at a minimum of five days per week within 24 hours of a request or at the next regularly scheduled sick-call." Proposed § 9-141 d. is consistent with BOC HC Standard § 3-02(f), which requires that specialty care be provided with transport to appointments. Proposed § 9-141 e. is consistent with BOC HC Standard § 3-02(d)(1) which requires prompt medical attention for emergencies and requires a personal encounter "face to face" with medical personnel. Proposed § 9-141 f. is consistent with BOC HC Standard §§ 3-02(b)(7) and (c)(4) requiring sufficient medical and security staff are available to carry out these requirements. Proposed § 9-141 e. adds additional requirements about the timeliness of treatment: it requires that the department ensure that no inmate waits for treatment at a medical facility for longer than 2 hours. We support these additional requirements that will improve the timeliness of treatment services.

Additional measures, if added to this provision, would further ensure the timeliness of medical treatment. Although sick call is available in all housing areas of the City jails, many individuals end up in the intake areas of the jails for overly lengthy periods of time.[3] When an individual is being moved between jails or housing is delayed for other reasons, the fact that the person is held in intake should not interfere with their ability to obtain and access medical care. In addition, DOC lockdowns, when movement in the jails is substantially curtailed, interfere with access to medical care with sometimes-tragic consequence.[4] The legislation should require sick call in all areas of the jails (including intake) and should require that medical escorting shall continue during lockdowns.

Important public reporting on measures created by this legislation is covered by Local Law 440 (New York City Administrative Code § 17-199), enacted last year, which requires that the report on health services in the City jails "shall also be posted on the department's website, with the data in such report posted in a non-proprietary searchable machine-readable format, and shall be maintained on such website for no fewer than ten years." New York City Administrative Code § 17-199 b. Continued public access to information is essential to ensure informed policy discussions as to the means to improve the operations of the City jails.

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[3] See footnote 2 above.

[4] In January, inmate Angel Perez-Rios, 44, killed himself after his pleas for stronger antidepressants were repeatedly ignored. Perez-Rios reportedly missed multiple appointments with medical staff due to the lack of an officer escort tied up with lockdowns. In March, inmate Jairo Polanco Munoz, 24, killed himself during a lockdown that prevented him from receiving a comprehensive psychological assessment. According to the New York *Daily News* report on Mr. Munoz' death, Mr. Munoz was found "cyanotic," "cold to the touch," and "[e]mergency medical staff were unable to open his mouth to intubate him." Article available at: http://www.nydailynews.com/new-york/nyc-crime/rikers-inmate-killed-mental-health-check-article-1.2568785. The described condition of Mr. Munoz suggests that there were no security checks done of the housing area for an extended period of time.

Int. No. 1013 - In relation to discharge planning for inmates in city correctional facilities, and to repeal section 3 of local law number 54 for the year 2004.

Int. No. 1013 repeals section 3 of local law 54 for the year 2004 and amends § 9-127 a. of the administrative code to require the department of correction and the department of homeless services to provide services for individuals they have identified as repeatedly being admitted to the City jails and being housed in City shelters. The amendment to § 9-127 a. expands discharge planning to individuals released from the City jails regardless of whether they were sentenced or had a significant length of stay in the jail. If the amendment is adopted, the department of correction and the department of homeless services will be required to make efforts to place anyone who is repeatedly released from jail to a shelter into "appropriate" programs and services. We approve of this expansion of discharge planning services and increased access to services for individuals housed in the City shelters.

We recommend that housing, the most important element of maintaining stability in the community, be explicitly added to the list of "appropriate programs and services" necessary for these identified individuals. We further recommend that the new section conform to § 9-127 b., which explicitly requires the voluntary, consensual participation by the individual being offered services. The Council should consider additional data that could be collected to improve discharge planning services. The current legislation provides for data about recidivism without relating that back to the specific services that were implemented. More specific information connecting service provision to recidivism rates would help to identify those services that are most successful and should be expanded.

The reports on information collected are required to be provided to Council and the Mayor. As with *all* important data on City services, this information should also be available to the public. We recommend that the Council amend § 9-129 with parallel language to that enacted last year in Local Law 440, which requires that the report on health services in the City jails "shall also be posted on the department's website, with the data in such report posted in a non-proprietary searchable machine-readable format, and shall be maintained on such website for no fewer than ten years." New York City Administrative Code § 17-199 b. Continued public access to information is essential to ensure informed policy discussions.

Int. No. 1014 - In relation to requiring the office of criminal justice to post on the office's website an annual report regarding discharge planning for mentally ill inmates and recidivism.

Int. No. 1014 would add a new section 3-117 ("Proposed § 3-117") to the New York City Administrative Code.[5] Proposed § 3-117 requires an annual report from the office of criminal justice on outcomes of discharge planning completed for individuals with mental illness in regards to recidivism. The Council should consider additional data that could be collected to improve discharge planning services for individuals with mental illness. The current legislation provides for data about recidivism without relating it back to the specific services that were provided. More specific information connecting service provision to the effect upon recidivism rates would help to identify those services that are most successful and should be expanded. For example, disaggregation of information by SPAN office would provide information distinguishing success

[5] Section 3-117 already exists in the City Administrative Code. It requires annual reporting on bail and the criminal justice system and was adopted in October 2015.

rates from different locations within the City. Such information would be useful in identifying the most successful initiatives as well as trends that would be useful for fiscal and management decisions.

The report is required to be posted on the Office of Criminal Justice website. In addition to this public access to the report, the data relied upon should also be publicly available. We recommend that the Council amend Int. No. 1014 with parallel language to that enacted last year in Local Law 440 which requires that the report on health services in the City jails "shall also be posted on the department's website, with the data in such report posted in a non-proprietary searchable machine-readable format, and shall be maintained on such website for no fewer than ten years." New York City Administrative Code § 17-199 b. Continued public access to information is essential to ensure informed policy discussions.

Int. No. 1064 - In relation to requiring the department of correction to evaluate the effectiveness of programs it utilizes.

Int. No. 1064 would add a new section 9-141 ("Proposed § 9-141") to the New York City Administrative Code.[6] Proposed § 9-141 requires the Department of Correction ("DOC") to report annually to the Mayor and the Council on the effectiveness of programs in the City jails. Proposed § 9-141 requires that the DOC evaluate "the effectiveness of any provider of inmate programming" yet the annual report requires only a "summary of each evaluation." The requirements for the summary report include only "(i) the amount of funding received; (ii) the number of inmates served; (iii) a brief description of the services provided; and (iv) successful completion and compliance rates, if applicable." This broad description does not adequately specify reporting that will serve the purpose of monitoring and establishing valuable programming in the City jails. The Council should require reporting that evaluates effectiveness of programming so that DOC develops that programming which is a "best practice" within our jails.[7] This requires collection of more specific information on the hours of programming provided and on outcome measures that will evaluate successful completion based on improved or changed behaviors and use of skills.

The annual report is required to be provided to Council and the Mayor. As with *all* important data on City services, this information should also be available to the public. We recommend that the Council amend Int. No. 1064 with parallel language as was enacted last year in Local Law 440 which requires that the report on health services in the City jails "shall also be posted on the department's website, with the data in such report posted in a non-proprietary searchable machine-readable format, and shall be maintained on such website for no fewer than ten years." New York City Administrative Code § 17-199 b. Continued public access to information is essential to ensure informed policy discussions.

Int. No. 1144 - In relation to requiring the use of trauma-informed care in city correctional facilities.

Int. No. 1144 would add a new section 9-141 ("Proposed § 9-141") to the New York City Administrative Code.[8] Proposed § 9-141 requires the Department of Correction ("DOC") to use

[6] Int. No. 852-A discussed above also uses the same "new" section number – § 9-141.

[7] Developing evidence-based best practices requires the collection of the evidence that demonstrates the effectiveness of the programming.

[8] Int. No. 852-A and Int. No. 1064 discussed above also use the same "new" section number – § 9-141.

trauma-informed care in the City jails. The bill adopts the definition of trauma-informed care as defined by the Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human services and applies the requirement broadly to "all staff."

We approve of introducing trauma-informed care to the City jails. The vast majority of individuals in our jails have experienced trauma in their lives in one or more form and training in working with survivors of trauma will improve interactions between incarcerated individuals and programming and treatment staff, as well as, interactions between incarcerated individuals and security staff. However, the broad initiative that is proposed requires more defined parameters: one size does not fit all for this purpose. For some staff, trauma-informed care will reference medical treatment and clinical interventions. For others, trauma-informed care will reference increased sensitivity to avoid triggering responses from trauma survivors and utilizing de-escalation techniques. Not "all staff" may be capable of the trauma-informed care required for participation in specific interventions such as participation in the CIT team will require.

Council should define the parameters of trauma-informed care that is being required by legislation and set out a time line for training and adoption of guidelines that are in line with the standards developed by SAMHSA.

T2015-3243 - In relation to requiring arrestee mental health screenings and the exchange of health information of inmates in the custody of the department of correction.

T2015-3243 would add a new section 14-155 ("Proposed § 14-155") and a new chapter 18 to Title 17 ("Proposed §§ 17-1801 through 17-1806") of the New York City Administrative Code.[9] Together these new provisions would require the New York City Police Department to create a report when an officer arrests any person who appears to suffer from a mental illness, or when any person they arrest is treated at a hospital. These reports would be required to be promptly sent to the Department of Health and Mental Health ("DOHMH"), and the DOHMH would be required to use these reports in evaluating any such person who is admitted to the custody of the Department of Correction ("DOC"). The bill also requires the DOHMH to screen every person scheduled for arraignment in a criminal court for possible mental health issues, and to utilize a report of such screening in evaluating any such person who is admitted to the custody of the DOC. The bill would also require the DOHMH to request and maintain any pertinent medical records of any inmate admitted to DOC custody.

Proposed § 17-1804 requires that DOHMH request the medical records of any inmate identified in any report provided to them pursuant to Proposed § 14-155 c. Proposed § 17-1806 references reports from the New York City Police Department that are made pursuant to § 14-157. However, § 14-157, which is not yet signed into law, references only quarterly reports by the NYPD concerning the issuance of summons.[10] It does not reference any reports relevant to mental health screenings or the exchange of health information.

We agree that the New York City Police Department should share with HHC information about their observations and concerns about individuals with mental illness who are taken into custody. This sharing of information should include information about medications that are

[9] NYC Administrative Code § 14-155 already exists in the City Administrative Code. It requires social service planning and accountability and was adopted in May 2016.

[10] Proposed Int. No. 639-B.

vouchered by the police when they take a person into custody.[11] We also agree that HHC should obtain relevant medical records to assist them in providing treatment and continuity of care for individuals housed in the City jails.

We agree that the expansion of HHC evaluations pre-arraignment is a positive step. Pre-arraignment mental health evaluations enhance the ability to divert individuals with mental illness from our jails and should enhance the identification and early intervention by clinical staff for those individuals with mental illness who are incarcerated at arraignment. We recommend that the bill include language about maintaining the confidentiality of information obtained at mental health screenings, restricting its use at arraignment, and requiring voluntariness of participation in the screening and access to defense counsel at that time.

III. Conclusion and Recommendations

- Int. No. 852-A – Pass the proposed legislation, but enhance it by adding additional requirements to ensure the timeliness of medical treatment: *e.g.* require sick call in all areas of the jails including intake, and require that medical escorting continue during lockdowns.
- Int. No. 1013 – Pass the proposed legislation, but enhance it as follows:
    (a) Add housing to the list of appropriate programs and services necessary for discharge planning.
    (b) Include language maintaining the voluntary, consensual participation by the individual being offered services.
    (c) Add additional data points that will evaluate the effectiveness of services provided.
    (d) Make the proposed report public, along with the underlying data, in a non-proprietary searchable machine-readable format and require that the report and data remain on the web for no fewer than ten years.
- Int. No. 1014 - Pass the proposed legislation, but enhance it as follows:
    (a) Add additional data points that connect service provision to the effect upon recidivism rates to identify the most successful initiatives: e.g. disaggregate information by SPAN office.
    (b) Make the underlying data relied upon in making the report public in a non-proprietary searchable machine-readable format and require that the report and data remain on the web for no fewer than ten years.
- Int. No. 1064 – Pass the proposed legislation, but enhance it as follows:
    (a) Add additional data points that will evaluate effectiveness of programming initiated in the jails.
    (b) Make the proposed report public, along with the underlying data, in a non-proprietary searchable machine-readable format and require that the report and data remain on the web for no fewer than ten years.

[11] Providing information about vouchered medications should not be limited to mental illness. The police should inform HHC about any medications taken from an arrestee in order to ensure appropriate continuity of care. HHC should have the ability to obtain medication from the police when needed for continuity of care.

- Int. No. 1144 – The proposal to introduce trauma-informed care to the City jails is commendable but requires further definition of its parameters for different categories of staff. Legislation should distinguish between trauma-informed care required for more increased sensitivity to avoid triggering responses from trauma survivors and more intensive training needed for specific interventions and treatment. Council should define the parameters of trauma-informed care that it intends to require by legislation and set out a time line for training and adoption of guidelines that are in line with the standards developed by SAMHSA.
- T2015-3243 – Pass the proposed legislation, but enhance it as follows:
    (a) Require the police to report to HHC any medications recovered from a person taken into custody.
    (b) Add language that will maintain the confidentiality of information obtained at pre-arraignment mental health screenings, assure that participation in the screening is on a voluntary basis, and restrict its use at arraignments and provide for access to defense counsel during the process.
- Orthopedic Unit - Require HHC and DOC to establish a treatment and residential unit in the City jails for individuals with physical disabilities that is handicapped accessible in accordance with the Americans with Disabilities Act and is under the supervision of a suitably qualified specialist. The unit must be sufficiently staffed to provide physical therapy and assistance with daily living, and equipped with the physical therapy equipment and services necessary to allow patients to recover or regain as much function as possible.
- Suicide Watch Unit – Require HHC and DOC to establish a suicide watch unit in the City jails within a mental health treatment area, and conduct all suicide watches there.
- Improve Communication Protocols – Require HHC and DOC to improve communications between their staff and with the community. Improved communication with defense counsel and with community providers will serve to improve discharge planning, successful reentry and provide the necessary continuity of care upon discharge to the community. Improved communication will also result in reduced lengths of stay in City jails.
- Board of Correction – Fund the Board of Correction sufficiently and support its efforts to monitor HHC and DOC compliance with the Board Standards related to medical and mental health care. It is essential that BOC have sufficient field staff to respond to and report on problems in the jails. Urge the BOC to exercise its right to investigate and report on all deaths in the City jails.

We thank the Committees for this public forum to discuss vital areas of concern about the management of our City jails. The City Council should continue to provide public forums so that important issues concerning the criminal justice process and City jails continue to be the subject of informed public discourse. The City Council plays and must continue to play an important role in understanding, monitoring and tracking the conditions of confinement for individuals incarcerated in the City jail system and the efforts taken to provide for successful reentry and reduced recidivism.

We appreciate the opportunity to provide this testimony.

Dated: May 26, 2016
New York, New York

Public

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1013, 1064, 1183 Res. No. _____

☒ in favor ☐ in opposition

Date: 5/26/16

(PLEASE PRINT)

Name: Lillie Carino Higgins

Address: 330 W 42 St., 7 FL, 10036

I represent: 1199 SEIU

Address:

THE COUNCIL
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Public

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☐ in favor ☐ in opposition

Date: 5/26/16

(PLEASE PRINT)

Name: Jennifer Parish

Address:

I represent: Urban Justice Center

Address: 40 Rector St., 9th fl., NY, NY

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. All Res. No. All

☒ in favor ☐ in opposition

Date: 5/26/16

(PLEASE PRINT)

Name: Jamin Sewell

Address: 123 William Street, Stelop, NY, NY

I represent: The Coalition of Behavioral Health Agencies

Address:

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Name: Riley Doyle Evans

Address: _____

I represent: Brooklyn Defender Services

Address: 177 Livingston St, 7th Fl, Brooklyn, NY 11201

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☑ in favor ☐ in opposition

Date: 5/26/16

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Name: ELIZABETH M. WARD

Address: 118 OCEAN SIDE / ROCKAWAY BEACH / N.Y.

I represent: CHS / HHC

Address: _____

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☑ in favor ☐ in opposition

Date: 5/26/16

(PLEASE PRINT)

Name: DR. ELIZABETH FORD

Address: _____

I represent: CHS / H+H

Address: _____

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(PLEASE PRINT)

Name: DR Nicole Adams

Address: 75-20 Astoria Blvd

I represent: Dept. of Correction

Address: 75-20 Astoria Blvd East Elmhurst NY

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Name: Ross McDonald, MD

Address: _____

I represent: NYC Health + Hospitals, Correctional Health

Address: _____

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Date: 5/26/16

(PLEASE PRINT)

Name: Gary Strebel

Address: Assistant Chief

I represent: NYPD

Address: 1 Police Plaza

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Name: John Iuliano

Address:

I represent: NYC Health + Hospitals

Address:

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☐ in favor ☐ in opposition

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(PLEASE PRINT)

Name: Levi Fishman

Address:

I represent: NYC Health + Hospitals, Correctional Health

Address:

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☐ in favor ☐ in opposition

Date: 5/26/16

(PLEASE PRINT)

Name: Dr. Patsy Yang

Address:

I represent: NYC Health + Hospitals, Correctional Health

Address:

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☐ in favor ☐ in opposition

Date: 5/26/16

(PLEASE PRINT)

Name: Dr. Homer Ventners

Address: _____

I represent: NYC Health + Hospitals, Correctional Health

Address: _____

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☐ in favor ☐ in opposition

Date: 5/26/16

(PLEASE PRINT)

Name: Patrick Alberts

Address: _____

I represent: NYC Health + Hospitals, Correctional Health

Address: _____

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