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THE COUNCIL OF THE CITY OF NEW YORK

Briefing Paper and Committee Report of the Human Services and Justice Divisions

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COMMITTEE ON CRIMINAL JUSTICE
Hon. Keith Powers, *Chair*

COMMITTEE ON JUSTICE SYSTEM
Hon. Rory Lancman, *Chair*

COMMITTEE ON MENTAL HEALTH, DISABILITIES AND ADDICTION
Hon. Diana Ayala, *Chair*

June 17, 2019

Oversight: Preventing Recidivism for Individuals with Mental Illness

Int. No. 903: By Council Member Richards

Title: Local Law to amend the administrative code of the city of New York, in relation to funds remaining in inmate accounts when inmates are released

Administrative Code: Adds Section 9-154

Int. No. 1590: By Council Member Chin

Title: A Local Law to amend the administrative code of the city of New York, in relation to requiring the department of health and mental hygiene or its designee to report information to the attorney of record for individuals in the custody of the department of corrections who are diagnosed with serious mental illness

Administrative Code: Amends Section 17-1801 and adds Section 17-1805

I. Introduction

On June 17, 2019, the Committees on Criminal Justice, chaired by Council Member Keith Powers, Justice System, chaired by Council Member Rory Lancman, and Mental Health, Disabilities, and Addiction, chaired by Council Member Diana Ayala, will hold an oversight hearing to evaluate efforts to prevent recidivism for individuals with serious mental illness**.** The Committees will also hear two bills pending in the Criminal Justice Committee, Int. No. 903, A Local Law to amend the administrative code of the city of New York, in relation to funds remaining in inmate accounts when inmates are released, and Introduction No. 1590, A Local Law to amend the administrative code of the city of New York, in relation to requiring the department of health and mental hygiene or its designee to report information to the attorney of record for individuals in the custody of the department of corrections who are diagnosed with serious mental illness. Among those expected to testify are representatives from the New York City's Department of Health and Mental Hygiene ("DOHMH"), the Department of Correction ("DOC"), Correctional Health Services ("CHS"), the Mayor's Office of Criminal Justice ("MOCJ") advocates, and other interested parties.

II. Background: History of Mental Healthcare in New York City and the Rise of Correctional Facilities as Treatment Locations for Individuals with Mental Illness

The transformation of mental healthcare in New York City has evolved in tandem with the broader evolution of behavioral healthcare policy models in the United States. From the founding of Bellevue Hospital with its first public "pavilion for the insane" in 1879 and the first alcoholic ward in 1892, New York City has served as "a major incubator" for innovative public behavioral healthcare delivery.[1]

[1] "Bellevue Hospital Celebrates 275th Anniversary," New York City Health and Hospitals (2011), available at https://www.nychealthandhospitals.org/pressrelease/bellevue-hospital-celebrates-275th-anniversary/.

With the advent of the 1890 State Care Act, New York State placed all responsibility for the care and treatment of those suffering from mental disorders into the hands of state government.[2] The New York State Department of Mental Hygiene (DMH) was created in 1926, and by 1949, New York State psychiatric institutions included twenty-seven facilities with the state's inpatient census among the largest in the nation.[3] In 1949 the New York State Mental Health Commission (SMHC) was charged with the creation of a master plan for all state mental health programs. In the face of escalating costs, the New York State Community Mental Health Act (CMHSA) was passed in hopes of increasing access to less expensive care in community-based settings.[4] In addition to the fiscal concerns of providing care in an institutional setting, global mental health conferences in the early 1950's began to argue that "involuntary commitment and institutional regimentation, no matter how gentle, robbed patients of decision-making abilities and other skills needed to function in society."[5]

According to the New York Times, "as tranquilizers became the panacea for the mentally ill, state programs were buying them by the carload and sending drugged patients back into the community [and] psychiatrists never tried to stop this."[6] As a result, "the discharge of mental patients from in-patient facilities accelerated in the late 1960's and 1970's as health policy experts and public officials carried out a public mandate to "abolish the abominable conditions" of what were referred to as "insane asylums."[7] Whereas, "drugs got people back into the community," there was often a lack of planning that forgot to include "a place to live and someone to relate to

[2] "Mental Health in New York State 1945-1998: An Historical Overview," New York State Department of Education Archives, Publication Number 70, p.2 (1998), available at http://www.archives.nysed.gov/common/archives/files/res_topics_health_mh_hist.pdf.
[3] *Id*. at 7.
[4] *Id*, at 8.
[5] *Id*, at 9.
[6] "How Release of Mental Patients Began," *The New York Times*, October 30, 1984, available at https://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html.
[7] *Id*.

... the result was like proposing a plan to build a new airplane and ending up only with a wing and a tail."[8] Congress and state governments did not create a complete community mental health program that, in addition to the centers, allowed for adequate staffing and long-term financial supports for behavioral healthcare services.[9]

As deinstitutionalization efforts continued into the 1990's and 2000's—increasingly driven by managed healthcare systems—poor planning and flawed execution often marred the process of providing a safe, healthy and successful patient transition back into society.[10] Under the "Transformation Plan" for New York State's Office of Mental Health (OMH), Governor Andrew Cuomo sought to reduce the average daily census and total number of beds in New York State psychiatric centers by relying more on community out-patient mental health services in hopes of providing better care at lower costs.[11]

Key findings of the Transformation Plan: [12]

- Non-forensic state psychiatric centers in New York City lost about 15% of their total adult bed capacity during 2014–18, while the average daily census declined by about 12%.
- During 2015–17, the number of seriously mentally ill homeless New Yorkers increased by about 2,200, or 22%. In response, City government opened six new dedicated mental health shelters between Fiscal Year (FY) 2014 and FY 2018.

[8] *Id*.
[9] *Id*.
[10] "Systems Under Strain: Deinstitutionalization in New York State and City," *Manhattan Institute Report*, November 28, 2018, available at https://www.manhattan-institute.org/deinstitutionalization-mental-illness-new-york-state-city.
[11] "Statewide Comprehensive Plan, 2016-2020," New York State's Office of Mental Health (OMH), p. 50, available at https://www.omh.ny.gov/omhweb/planning/docs/507-plan.pdf.
[12] *Id*.

- Spending on such shelters, which numbered 28 as of the end of FY 2018, has grown every year since FY 2014 and currently stands at about $150 million. There are more beds in mental health shelters in New York City than the combined total of adult beds in state psychiatric centers and psychiatric beds in NYC Health + Hospitals facilities.
- The number of "emotionally disturbed person" calls responded to by the New York City Police Department (NYPD) has risen every year since 2014. The number of seriously mentally ill inmates in New York City jails is now higher than in 2014.
- Both state- and citywide, more psychiatric-care beds are located in general hospitals than in the traditional network of state psychiatric centers. But due to the financial pressures that many general hospitals face, they are unlikely to expand their systems of inpatient psychiatric care, and some have already reduced capacity.

According to its Statewide Comprehensive Plan,[13] OMH continues to strive for *deinstitutionalization*, which aims to provide community-based services to individuals in need of mental health treatment in clinically-supported community environments, in lieu of traditional in-patient hospital settings.[14] While the move to community-based care has been lauded by OMH as "broadening the public health safety net by providing high-quality cost-effective community based services [which] avoid costly in-patient stays,"[15] advocates argue this approach has resulted in the "criminalization of mental illness"[16] citing statistical data confirming the state of New York "incarcerates more individuals with severe mental illness that it hospitalizes."[17]

[13] Statewide Comprehensive Plan: 2016-2020, Office of Mental Health, p. 50, 2015, available at https://www.omh.ny.gov/omhweb/planning/docs/507-plan.pdf.
[14] *Id.*
[15] *Id.* p. 49.
[16] "State Specific Data: New York," Treatment Advocacy Center, 2017, available at https://www.treatmentadvocacycenter.org/browse-by-state/new-york.
[17] *Id.*

The intersection of those with serious mental illness and our criminal justice system remains a significant issue. According to the Mayor's Office of Criminal Justice (MOCJ), approximately 11% of the current NYC jail population has been diagnosed with a serious mental illness, and almost one third of the population has some kind of psychiatric diagnosis.[18] According to a report by the Cornell University Department of Psychiatry,[19] "at Rikers Island, the average daily population dropped 12% from 2005 to 2012, but the prevalence of mental illness rose 32%." As a result, advocates sought restoration of psychiatric beds in public hospitals and supported the introduction of first responder crisis intervention trainings in hopes of helping to better identify individuals with serious mental illness and thereby preemptively and proactively divert them away from jails and toward appropriate mental health treatment.[20]

In an effort to reform the city's correctional health system, in June of 2015, the administration announced that the City had returned management of its correctional health services from the private non-profit organization Corizon, Inc., to the public Health + Hospitals Corporation (H+H), which operates Correctional Health Services (CHS) in city jails.[21] Advocates hailed this as a "critical first step away from profiteering that callously put lives and well-being at risk"[22] and one that was "especially appropriate…with respect to mental health care, since the City [was] attempting to improve mental health treatment in jails, including implementing multi-disciplinary crisis intervention teams" in order to better provide more effective treatment.[23]

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[18] Mayor's Office of Criminal Justice, "Smaller, Safer, Fairer: A Roadmap to Closing Rikers Island," *available at* https://rikers.cityofnewyork.us/

[19] "Fact Sheet: Incarceration and Mental Health," Wolff, M., PhD, MPH, Cornell University Department of Psychiatry, 2017, available at http://psych-history.weill.cornell.edu/his_res/imi.html#_ftn4.

[20] *Id*. at 4.

[21] "Office of the Mayor: Health and Hospitals Corporation to Run City Correctional Health Service City of New York," NYC Mayor's Website, 2015, available at https://www1.nyc.gov/office-of-the-mayor/news/383-15/health-hospitals-corporation-run-city-correctional-health-service.

[22] *Id*.

[23] *Id*.

In 2016, CHS worked closely with the Board of Correction (BOC) to begin producing monthly reports in hopes of "identifying the strengths of the system as well as major barriers to care."[24] Recently, CHS conducted outreach, asking select prospective contractors to study the design and cost of creating locked therapeutic housing units, in close proximity to existing H+H facilities, which would serve to provide treatment to incarcerated individuals with "mental-health issues, drug-related problems and complex medical needs."[25] According to CHS,[26] these new Outposted Therapeutic Housing Units (OTxHU) would serve "patients whose clinical conditions are not so acute as to warrant inpatient medical or psychiatric admission, but who would otherwise benefit from close and frequent access to specialty and subspecialty care available in H+H facilities."[27]

Today, as the population of Rikers Island continues to decrease, the percentage of the population with serious mental illness continues to rise and MOCJ has reported approximately 10 percent of the entire jail population has been diagnosed with a serious mental illness.[28] Referencing the continued rise in mental health diagnoses among incarcerated individuals at city jails, DOC acting warden John Gallagher recently argued to the Board of Correction (BOC), that in the absence of a commitment to build additional psychiatric hospitals and outpatient facilities, "this is the Band-Aid we've come up with."[29]

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[24] "Reports: Correctional Health Authority Reports," New York City Board of Correction, 2016), available at https://www1.nyc.gov/site/boc/reports/correctional-health-authority-reports.page.

[25] "City Seeks to Move Mentally Ill Inmates to Hospitals," Blau, R. and Goldensohn, R., *Intelligencer*, March 21, 2019, available at http://nymag.com/intelligencer/2019/03/nyc-seeks-to-move-mentally-ill-inmates-to-hospitals.html.

[26] Health + Hospitals – Correctional Health Services (2019). OTxHU EIS and Conceptual Design Scope of Services, March 8, 2019. Available at https://www.documentcloud.org/documents/5775803-CHSplan.html

[27] City Seeks to Move Mentally Ill Inmates to Hospitals," Blau, R. and Goldensohn, R., *Intelligencer*, March 21, 2019, available at http://nymag.com/intelligencer/2019/03/nyc-seeks-to-move-mentally-ill-inmates-to-hospitals.html.

[28] Mayor's Office of Criminal Justice, "Smaller, Safer, Fairer: A Roadmap to Closing Rikers Island," *available at* https://rikers.cityofnewyork.us/

[29] Health + Hospitals – Correctional Health Services (2019). OTxHU EIS and Conceptual Design Scope of Services, March 8, 2019. Available at https://www.documentcloud.org/documents/5775803-CHSplan.html

While the City, State, and Federal government all continue to allocate resources and capital to mental healthcare for justice-involved individuals throughout the Country, there is still a long way to go in understanding and treating mental health issues within the criminal justice system. The Committee is interested in learning how the city can lead in this area by focusing on mental health treatment and discharge planning within correctional facilities, along with services available for individuals with mental illness outside correctional settings.

III. Services Within NYC Correctional Facilities For Individuals With Mental Illness

All individuals who enter custody are required to receive a medical intake within 24 hours of admission and to be seen by a mental health professional within three days if given a referral by Department professionals, the patient, 311, legal advocates, or community providers.[30] After receiving a mental health evaluation, such individuals may be assigned to specialized housing units or to the general population with access to outpatient clinics. The Department currently operates 24 designated housing units for those with mental illness. These include Mental Health ("MO") Units, Clinical Alternative to Punitive Segregation ("CAPS") Units, and Program for Accelerating Clinical Effectiveness ("PACE") units, in addition to psychiatric wards at Bellevue and Elmhurst Hospitals.[31]

The Department offers 17 MO Units comprised of 540 beds. Each patient in a MO Unit is assigned a multidisciplinary treatment team comprised of a social worker, art therapist, substance use counselor, court liaison, mental health counselor, and psychologist.[32] Crisis Intervention Teams (CITs) also play a significant role in MOs, and include a mental health specialist along with

[30] NYC Health +Hospitals, *Mental Health and Treatment for Individuals with Serious Mental Illness in the NYC Jails,* March 12, 2019, *available at* https://www1.nyc.gov/assets/boc/downloads/pdf/Meetings/2019/March/H+H_Mental-Health-Presentation-March-12-2019.pdf
[31] *Id.*
[32] *Id.*

DOC staff to intervene in order to diffuse conflict within the unit. The approach has been described as a significant improvement from previous mental health approaches, which failed to account for inter-disciplinary communications and continuity of care.[33]

The CAPS unit is designed for male patients with a serious mental illness (SMI)[34] who have violated jail rules and otherwise would have been punished with punitive segregation.[35] The unit provides intensive therapeutic schedules including morning meetings, frequent programming, in-house treatment, and one-on-one appointments with mental health staff.[36] There are six PACE units, which are designed for sentenced SMI patients and SMI pre-trial patients who have not infracted but have particular behavioral health needs.[37] The CAPS and PACE models are functionally equivalent; they are both designed to encourage continued treatment success by helping with medication management, frequent programming, and behavioral management. Current PACE units include one for those returning from Bellevue Hospital, an "Acute Care Unit" for those with a particularly high risk of decompensation, a unit for those with intellectual and developmental disabilities, a unit for those returning from state hospitals after an examination of fitness to stand trial, a unit for women, and a reentry unit for those who have been sentenced.[38]

For those who experience non-serious mental illness and have infracted, the department has developed Restricted Housing Units (RHUs).[39] These units are intended to provide "integrated

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[33] *Id.*
[34] Serious Mental Illness is defined by the New York State Office of Mental Health as individuals who meet criteria established by the commissioner of mental health, "which shall include persons who are in psychiatric crisis, or persons who have a designated diagnosis of mental illness under the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and whose severity and duration of mental illness results in substantial and functional disability." N.Y. Section (§§) 1.03
[35] *Supra*, note 30.
[36] Department of Correction, CAPS and PACE Backgrounder, *available at* https://www1.nyc.gov/site/doc/media/caps.page
[37] *Supra*, note 30.
[38] *Id.*
[39] Department of Correction, Clinical Alternatives to Incarceration/Restricted Housing Unit (CAPS/RHU), available at https://www1.nyc.gov/site/doc/media/caps-rhu.page

behavioral management programming for mentally ill inmates in a punitive segregation setting," where incarcerated individuals can "move up a system of 'levels'" to receive additional out-of-cell time or "reintegative activities," including "games, discussion sessions and TV/movie viewing opportunities."[40] The department claims that individuals in RHU are allowed up to 7 hours of out-of-cell time for the purposes of participating in scheduled programming;[41] however during programming, such individuals are restrained.[42]

The CAPS and PACE units have proven effective in reducing self-harm rates and in improving adherence to treatment regimens.[43] Medication adherence, for example, has increased by between 83% and 90.5% in various PACE units for males and has increased by 77.7% for females between 2016 and 2018.[44]However, there is little data on the impact of RHUs on individuals who have serious mental illness, and how much out-of-cell time such individuals are afforded. Issues also remain in providing mental health care to those individuals who are housed in the general population. In the most recent Access to Care report published by Correctional Health Services, about 34% of patients were not seen for mental health appointments in April of 2019. Of those individuals, approximately half (17%) were not seen for mental health appointments because they were not produced by the DOC, while others were not seen due to court appearances (5%), verified refusals (5%), rescheduling by CHS (6%), and leaving without being seen (1%).[45]

[40] *Id.*
[41] *Supra,* note 36
[42] Conversation with Board of Correction, June 12, 2019.
[43] *Supra,* Note 30.
[44] *Id.*
[45]Correctional Health Services Access to Care Monthly Report, April 2019, *available at* https://www1.nyc.gov/assets/boc/downloads/pdf/chs_access_report_apr2019.pdf

IV. Discharge Planning and Brad H.

In 1999, the Urban Justice Center, Debevoise & Plimpton LLP, and New York Lawyers for Public Interest brought a class-action lawsuit on behalf of several incarcerated individuals with mental illness against New York City challenging its practice of discharging individuals with a mental illness from jail without a plan for reentry.[46] The court found that the city's failure to provide discharge planning in correctional facilities violated state law, which requires discharge planning for individuals with mental illness who receive state-funded inpatient or outpatient mental health treatment.[47]

The lawsuit, known as *Brad H. et. al. v City of New York, et. al.*, resulted in a settlement in 2003 in which the city agreed to provide comprehensive treatment and a discharge plan to people in custody who qualify as a member of the class action.[48] Under the settlement, a *Brad H* individual is any person in custody who is confined for at least 24 hours and receives treatment for mental illness during their confinement.[49] However, individuals who are assessed as having no need for additional treatment after seeing a mental health staff once or twice are not *Brad H* eligible.[50] The settlement provides two monitors assigned to oversee the city's compliance with the requirements in the settlement and with establishing performance measures to effectuate the terms of the settlement.[51] The primary goal of the settlement is to ensure *Brad H* individuals can smoothly

[46] New York City Independent Budget Office, Looking Back at the Brad H. Settlement: Has the City Met it Obligations to Provide Mental Health & Discharge Services in the Jails? (May 2015), Fiscal Brief, available at https://ibo.nyc.ny.us/iboreports/looking-back-at-bradh-settlement-has-city-met-obligations-provide-mental-health-dischsrge-services-in-jails-51115.pdf

[47] Doug Jones, Discharge Planning for Mentally Ill Inmates in New York City Jails: A Critical Evaluation of the Settlement Agreement of Brad H. v City of New York, 27 Pace L. Rev. 305 (2007), available at https://digitalcommons.pace.edu/cgi/viewcontent.cgi?article=1124&context=plr

[48] Roshan Abraham, Reports Indicate City's Progress is Slow on Mental Health Planning for Inmates (Jan. 2017), City Limits, available at https://citylimits.org/2017/01/12/reports-indicate-citys-progress-is-slow-on-mental-health-planning-for-inmates/

[49] Supra note 46

[50] *Id.*

[51] Supra note 47

transition from receiving mental health treatment in correctional settings to receiving mental health treatment in the community. However, these individuals can refuse discharge planning and other services at any time.[52]

In February 2019, the compliance monitors released their fortieth report, which shows that the city has made progress in meeting some requirements of the settlement while continuing to fall short on others (see **Appendix I**). The settlement requires the city to assist *Brad H* individuals who are eligible for Medicaid with activating or reinstating Medicaid benefits upon release to ensure that they can pay for services.[53] This measure requires DOC to prescreen individuals for Medicaid upon admission and to complete and submit a Medicaid application to HRA so these individuals can have Medicaid activated or reinstated upon discharge.[54] According to the report, the city has not provided any data on Medicaid prescreening, making it difficult for the monitors to assess compliance with this provision.[55] However, the report found that the city remains compliant with completing and submitting Medicaid applications within five business days of prescreening.[56] In fact, the city's performance on this measure increased over the last three reporting periods from 93.8% timely completion rate to 97.0%.[57] However, the monitors expressed concerns that the information DOC provides to HRA to (re)activate Medicaid benefits is often incomplete and have recommended that the city "develop systems for ongoing monitoring of completeness of datasets, especially the released class members set sent from DOC to HRA."[58]

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[52] *Id.*
[53] Supra note 46
[54] Henry Dlugacz and Erik Roskes, *Brad H., et al. v City of New York, et al*., Fortieth Regular Report of the Compliance Monitors (Feb 2019), pgs. 82-88, available at https://mhp.urbanjustice.org/sites/default/files/BRAD%20H%20Report%2040%20Final%202019_02_28.pdf
[55] *Id*., p. 83
[56] *Id*., p. 84
[57] *Id.*
[58] *Id*., p. 87

The settlement also requires the city to provide *Brad H* persons with access to the city-funded Medication Grant Program (MGP), which provides these individuals with financial assistance to purchase medication while their Medicaid benefits are pending.[59] The report shows that the city has made significant improvement in this area from the last reporting period. The monitors observed a jump in the city's performance from 84.8% last reporting period to 91% this reporting period, which is above the performance target required by the settlement.[60]

Additionally, under the settlement, the city is obligated to provide *Brad H* individuals a 7-day supply of psychiatric medication and a prescription for 21 days upon release regardless of their eligibility for Medicaid.[61] This provision ensures that such individuals are able to access medication and services upon discharge. While the city appears to have remained compliant with this measure over the last three reporting periods, the report points out discrepancies between stated policy and practice regarding this provision. According to the report, the monitors observed in one instance a *Brad H* recipient signed for receipt of medication but did not actually receive the medication upon release from DOC staff.[62] The report recommended that DOC and CHS develop joint policy for providing medication to *Brad H* individuals upon release that "is uniformly followed across facilities [and] ensures that compliance data…properly report[s] on class members' taking possession of medication at the point of release."[63]

Similarly, under the settlement, the city is responsible for providing *Brad H* individuals with discharge planning and case management services outside of jail. Specifically, class members who are released directly from court are entitled to the same services provided to those who are

[59] Supra note 46
[60] Supra note 54
[61] Supra note 46
[62] Supra note 54, p. 89
[63] *Id*., p. 90

released from jail.[64] The city provides these individuals with discharge planning services through the Service Planning and Assistance Network (SPAN)—now the Assistance Network Services (ANS).[65] "Provision of SPAN services is contracted out to Bowery Residents' Committee, which provides drop-in centers for inmates near the courts in every borough except Staten Island."[66] The city also provides "short-term intensive case management services to [people with serious mental illness] who are leaving jail" through LINK, a program that was contracted out to several vendors across the city, which has since been replaced with Community Re-Entry Assistance Network (CRAN).[67] The report found that these programs are compliant with provisions to follow-up with *Brad H* individuals about appointments, referrals, and housing, surpassing performance targets provided in the settlement.[68]

Moreover, the settlement requires the city to provide additional services to *Brad H* individuals with SMI. The city must assist persons who are classified as SMI with applying for public benefits, such as food stamps, Supplemental Security Insurance, supportive housing, and veterans' benefits if eligible.[69] However, the report indicates that the city remains noncompliant with this requirement even though it has made significant progress over the last three reporting periods.[70] While non-SMI persons might be eligible for public benefits, the city is not obligated under the settlement agreement to assist them with obtaining these benefits.[71] However, the city is obligated to provide individuals with SMI with case management, follow-up calls for housing and mental health appointments, and transportation to all discharge planning services.[72] But, even here,

[64] Supra note 47
[65] *Id.*; Supra note 54, p. 104
[66] Supra note 46
[67] Supra note 46 and 54, p.104
[68] Supra note 54, p. 102
[69] Supra note 47
[70] Supra note 54, pp. 95-96
[71] Supra note 46
[72] Supra note 47

the city has fallen short. In regards to follow-up calls for housing and appointments provided by DOC discharge planning staff, the city has been unable to meet performance targets required by the settlement.[73] Moreover, while the city has been compliant with the provision of transportation, the report notes a significant reduction in transportation rates over the last eleven reporting periods.[74]

According to the report, non-production of *Brad H* individuals for appointments remains a significant barrier to compliance. The report shows that "class members missed about 6.81% of scheduled social work appointments and 18.25% of scheduled mental health appointments per month due to DOC non-production."[75] It also notes that these rates are nearly identical to the non-production rates from the previous reporting period,[76] which shows that DOC has a systemic problem with producing *Brad H* persons for mental health and discharge planning appointments. In addition, the report found that the higher non-production rate for mental health appointments than discharge planning appointments is consistent across all DOC facilities except GMDC and MDC, where the non-production rates of missed social work appointments is nearly the same as the non-production rates of mental health appointments.[77] The report cited the lack of DOC escorts as the driver of non-production of *Brad H* individuals for mental health and discharge planning appointments.[78]

While DOC provided the monitors with separate data showing higher production rates, the report noted that the data was inconsistent with CHS production data.[79] This inconsistency speaks to a broader issue: the lack of coordination between CHS and DOC on the production of *Brad H*

[73] Supra note 54, p. 102
[74] Supra note 54, p. 101
[75] *Id*., p. 15
[76] *Id*.
[77] *Id*., p. 76.
[78] *Id*., p. 73.
[79] *Id*., p. 15

persons for mental health and discharge planning services. However, the city rejected suggestion from the monitors to have DOC and CHS "craft a joint policy outlining the steps to produce [people in custody] for mental health and social work services."[80]

Because of the systemic problem with producing *Brad H* individuals for mental health and discharge planning appointments, the city remains noncompliant with the requirement to complete comprehensive treatment plan (CTP) in timely manner.[81] Even though the city made significant progress in completing CTP for *Brad H* persons housed in the Mental Observation unit within the 7-day timeframe, it has not been unable to meet the required performance targets.[82] DOC non-production of *Brad H* persons for discharge planning and mental health appointments significantly and adversely affects these individuals' access to required services[83]and CHS efforts to integrate the mental health and discharge planning components of their treatment teams.[84] The report notes that unless CHS and DOC collaborate to address this underlying systemic problem, the city will be unable to meet the clinical and discharge planning obligations.[85] The report recommended that DOC and CHS "develop a coordinated approach to quantify, track and report production data and to categorize the reasons production may not occur."[86]

V. Mayor's Office of Criminal Justice and Re-entry

In 2017, Mayor de Blasio announced that by the end of that year, every individual in DOC custody will receive re-entry services.[87] The Mayor's Office of Criminal Justice (MOCJ) was tasked with overseeing this initiative. Previously, in 2016, the Council passed Local Law 23 which

[80] Supra note 54, p. 42
[81] *Id.*, 81
[82] *Id.*
[83] *Id.*, p. 77
[84] *Id.*
[85] *Id.*, p. 15
[86] *Id.*
[87] March 29, 2017 Press Release, "Mayor De Blasion Announces Re-Entry Services for Everyone in City Jails By End of this Year." Available at https://www1.nyc.gov/site/doc/media/re-entry-services.page

mandated the administration create a Municipal Division of Transitional Services to, among other things, ensure the availability of effective reentry services to individuals residing in New York city who were released from the custody of DOC and other individuals in need of reentry services that served a period of criminal incarceration or criminal detention. MOCJ has been overseeing this effort and issued a report in October of 2018 as required by the law to detail its progress in developing the office and the Council is seeking and update regarding the establishment of the office and its efforts to date.

MOCJ convened a "Diversion and Re-Entry Council" which brings together multiple organizations to help address re-entry issues. One of the overarching concerns of the Re-Entry Council, mentioned numerous times in MOCJ's report to the Council in accordance with Local Law 23 of 2016, is the rate at which those incarcerated in city jails have a diagnosis of serious mental illness, and that 97% note significant drug or alcohol usage.[88] Another clear message is that anything related to re-entry is inevitably multifaceted, where issues with mental health, housing, employment, or substance use all intersect and potentially amplify one another. Heeding this advice, this section will address MOCJ's proposals across the board, not just narrowly as pertaining to serious mental health issues.

Since February 2018, MOCJ has been convening three subcommittees of the Diversion and Reentry Council. The first is broadly on reentry, working towards best practices for service providers, including client engagement strategies and the ways to ensure continuity of services from inside a jail to the community. The second is the subcommittee on women in the criminal justice system, focusing on programming and initiatives specifically built around women's reentry

[88] Macdonald, Ross, Fatos Kaba, Zachary Rosner, Allison Vise, David Weiss, Mindy Brittner, Molly Skerker, Nathaniel Dickey, and Homer Venters. "The Rikers Island Hot Spotters: Defining the Needs of the Most Frequently Incarcerated." American Journal of Public Health 105, no. 11 (2015): 2262-268.

needs. The third is a taskforce specifically on older adults and their specific needs, as required by Local Law 78 of 2018

Based on their findings in three subcommittees, the Re-Entry Council has identified three priorities: housing, employment and health. 15% of the entire Rikers population, and a staggering 52% of the 800 most frequently incarcerated individuals, report a history of homelessness.[89] To meet their unique needs, MOCJ created Justice Involved Supportive Housing that provides short-term housing to individuals who have had multiple jail admissions over a short timeframe.[90] The program has capacity for 120 participants, of which 35 are engaged in mental health services as of 2018. MOCJ is partnering with DOHMH for a full evaluation of the program.

Another residential program is for women's transitional housing, in conjunction with the Women's Community Justice Project and the Fortune Society. That program has a capacity of 55 units, for stays of up to six months – so far 100 women have been admitted.[91] Participants must be open to receiving substance use or mental health treatment if deemed necessary. MOCJ is partnering with Hunter College and the New York Women's Foundation for a full evaluation of this program.

Based on the recommendations of the subcommittees, employment is another priority. In April 2018, MOCJ launched their Jails to Jobs initiative, in conjunction with DOC and John Jay's Prisoner Reentry Institute. Its first step is to bridge programming offered to incarcerated individuals to those recently released, to ensure continuity. Transitional employment is another cornerstone – every individual released after finishing a sentence is offered paid, transitional work

[89] Macdonald, Ross, Fatos Kaba, Zachary Rosner, Allison Vise, David Weiss, Mindy Brittner, Molly Skerker, Nathaniel Dickey, and Homer Venters. "The Rikers Island Hot Spotters: Defining the Needs of the Most Frequently Incarcerated." American Journal of Public Health 105, no. 11 (2015): 2262-268.
[90] Unsurprisingly, an analysis of DOC discharge data found that many individuals with multiple jail admissions also entered shelters numerous times over the same period.
[91] October 31, 2018 MOCJ Report complying with Local Law 23, shared with Committee Staff.

in the hopes that it leads to long-term employment. So far, 636 people have had paid short term employment, and 462 placed into permanent positions.[92] Job certification is another, including up to 500 participants a year receiving educational subsidies to the City University of New York after release.[93] Via John Jay, those subsidies can be used to become certified as a peer navigator, a mentor that is now paired with every individual leaving custody after a sentence. In 2019, MOCJ expects to launch a career mentoring and employment subsidy program specifically catering to women.

The third of the taskforce's priorities centered on health. This year, in conjunction with Brooklyn Justice Initiatives and the Maimonides Medical Center, MOCJ plans to launch Brooklyn Connects, a post-plea alternative to incarceration program for individuals for frequent jail admissions, but who have not been charged with a violent felony. However, since under the new bail laws these individuals would no longer be eligible for pretrial detention, it's unclear whether this program would still serve much of a purpose in its current post-plea structure.

Another MOCJ project in this area is a partnership with Dr. Faye Taxman at The Center for Advancing Correctional Excellence at George Mason University. That project involves a gap analysis of what exists in terms of the services and programming that exist – referred to as the New York City Risk Need Responsivity Gap Analysis Research Project. The project's practice guidelines discuss "healthy relationships" in detail.[94] One of their key takeaways from the literature is that individuals coming back into the community cite family support as the single most important factor in their efforts to build stability and avoid recidivism. Another is that individuals

[92] October 31, 2018 MOCJ Report complying with Local Law 23, shared with Committee Staff.
[93] In that same vein, this summer incarcerated individuals at Rikers will be able to take credit-bearing courses from the Borough of Manhattan Community College.
[94] NYC Criminal Justice, "Practice Guidelines" available at http://criminaljustice.cityofnewyork.us/wp-content/uploads/2018/05/Practice-Guidelines-MOCJ-Final.pdf

that have family involvement in re-entry programming report fewer physical, mental and emotional problems. The research project's report has not yet been released.

VI. Mental Health Services Within the Community

New York City provides a number of mental health services for a range of mental health challenges that may arise across wide-ranging communities. Most notably, Mayor Bill de Blasio and First Lady Chirlene McCray launched "ThriveNYC" in 2015, describing the initiative as a "Mental Health Roadmap for All."[95] The plan identifies 54 initiatives, 31 of which were already in existence prior to the announcement of Thrive.[96] Some of Thrives' programs aim to target individuals that are currently or are at risk to become justice-involved, such as Diversion Centers, Crisis Intervention Teams Training, Crime Victim Assistance Program, Reduce Violence and Address Treatment in the City's Jails, Cognitive Behavioral Therapy Plus, MH and SA for Youth in Rikers, Expansion of Mental Health Services at the Family Justice Centers, Geriatric Mental Health Initiative, Integrated Brief Intervention for Substance Misuse at STD Clinics, and Expand and Enhance Discharge Planning Services. Still, the success of these programs are difficult to assess as ThriveNYC does not have clear metrics or reporting, and there has been some additional criticism of Thrive's focus on "improving mental wellness" but ignoring the "seriously ill."[97]

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[95] "Mayor de Blasio, First Lady McCray Release ThriveNYC: A Mental Health Roadmap for All," Office of the Mayor, November 23, 2015, available at https://www1.nyc.gov/office-of-the-mayor/news/873-15/mayor-de-blasio-first-lady-mccray-release-thrivenyc--mental-health-roadmap-all#/0. ThriveNYC is not an organization or agency, since the First Lady is not permitted to hold a paid position under the City Charter's Conflicts of Interest provisions (NYC Charter, § 2602).

[96] *Id.*

[97] "Why $800 Million Thrive/NYC Is Failing," Mental Illness Policy Org., available at https://mentalillnesspolicy.org/wp-content/uploads/thrivenyc-fails.pdf; *see also*, "NYC's mental-health drive ignores those who need the most help," *NY Post*, May 11, 2017, available at https://nypost.com/2017/05/11/nycs-mental-health-drive-ignores-those-who-need-the-most-help/; *see also* "Failure to Thrive," City-Journal, Spring 2017, available at https://www.city-journal.org/html/failure-thrive-15123.html.

There are a number of nonprofit organizations and community-based organizations that also work with justice-involved individuals and communities to break the cycle of imprisonment, and to reintegrate individuals with mental health challenges.[98]

VII. Issues and Concerns

While New York City has allocated additional resources to improve the conditions of individuals with mental illness who are justice-involved, more must be done, particularly as we continue to move toward a model of decarceration and deinstitutionalization. The increasing number of individuals with mental illness in city jails indicates a need to improve treatment and housing both inside and out of correctional facilities for those with mental illnesses. Existing supportive housing programs and certain treatment-based units are a step in the right direction, but the need for expansion is evident. Non-production to medical appointments and placement of those with mental illness in RHUs raise questions and concerns about the quality of mental healthcare within facilities, while non-compliance with certain stipulations of *Brad H.* evince the need for the Department to take greater steps to improve the nature of its discharge planning.

VIII. Legislation

Introduction No. 903

Section 1 of Introduction No. 903 requires the Department to notify within the 72-hour period prior to the release of an inmate from the custody of the department, the amount of funds remaining in each incarcerated person's account and written instructions describing how the inmate may request refund of such funds. It also requires the Department to return funds remaining in accounts within 60 days following release.

[98] *See, e.g.*, Center for Court Innovation, Exponents, National Alliance on Mental Illness, etc.

Section 2 requires the department, to the extent practicable, return to each former incarcerated person who was released from the custody of the department prior to the effective date of the local law any funds remaining in such former individual's account. Section 3 mandates the law is effective 90 days after it becomes law.

Introduction No. 1590

Section 1 of Introduction No. 1590 amends section 17-1801 of the administrative code of the city of New York to change the word "inmate" to "incarcerated individual." Section 2 adds a new section 17-1805 entitled the "Get Well and Get Out Act." The act would require correctional health services to seek consent from defense attorneys in order to communicate pertinent information about patients with SMI to their attorneys. The local law takes effect 90 days after becoming law.

Appendix I

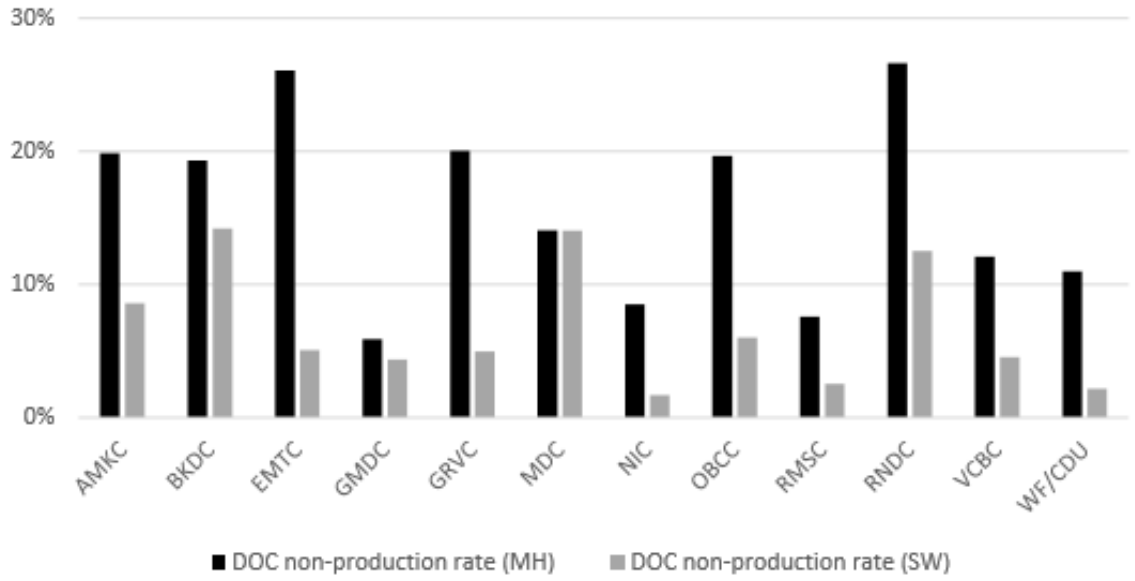
Performance Data, Report 40**

	Measure	Defendants' Performance		Threshold
1.1	Initial Assessment: seen within 72 hours of referral (**Mental Health**)	1658/1824	90.9%	95%
3.1	Timeliness of CTP (**Mental Health**)	1563/1797	87.0%	95%
3.3	Timeliness of DCP (**SW**)	1365/1542[16]	88.5%	95%
4.1.1	Timely completion of Medicaid prescreening **(SW)**	No data	No data	95%
4.1.2	Timely completion of Medicaid prescreening (**ANS)**	No data	No data	95%
5.1	Completion and submission of MA applications within 5BD of prescreen (**SW**)	230/237	97.0%	90%
5.2.2	Completion and submission of Medicaid applications within 5 BD of prescreening **(ANS)**	1/1	100%	95%
5.3.1	Provision of MGP card on release date (**SW**)	495/544	91.0%	90%
5.3.2	Provision of MGP card on first ANS visit (**ANS)**	68/68	100%	90%
6.1	Timely Activation of Medicaid Benefits (**HRA**)	68/68	100%	95%
6.2	Timely Unsuspension of Medicaid Benefits (**HRA)**	502/517	97.1%	95%
7.1.1	Provision of medications (7d) and prescriptions (21d) to CMs who require them at the time of release from jail (**SW)**	852/887	96.1%	90%
7.1.2	Provision of medications to CMs released at court who appear the same day at ANS (CHS pharmacy procedure) **(ANS)**[17]	24/24	100%	90%
7.1.3	Referrals for medications for CMs released at court who appear on days 2-30 at ANS (referral to community provider procedure) (**ANS)**	30/30	100%	90%
8.1	Provision of appointments to CMs with known release dates **(SW)**	371/381	97.4%	95%
8.2	Provision of appointments to CMs who appear at ANS (**ANS)**	68/68	100%	95%
8.3	Referrals for continued MH care for CMs without known release dates (**SW**)	514/581	88.5%	95%
9.1	Provision of Emergency Benefits (**HRA**)	No data	No data	100%[18]
9.2	Timely Completion/submission of PA applications **(SW)**	114/129	88.4%	95%
9.3	Processing and Pending of PA Applications on day of receipt (**HRA**)	No data	No data	95%
10.1	Submission of HRA 2010e applications (**SW**)	183/193	94.8%	95%
10.2	Forwarding of Supportive Housing Approvals **(SW)**	157/186[19]	84.4%	95%
11.1	Provision of transportation from jail to residence or shelter **(SW)**	42/42	100%	95%
11.2	Provision of transportation from ANS to residence or shelter (**ANS)**	32/32	100%	95%
12.0.1	Follow up contacts: SMI appointments **(SW)**	127/142	89.4%	95%
12.0.12	Follow up contacts: SMI referrals **(SW)**	165/185	89.2%	90%
12.0.2	Attempted follow up contacts: appropriateness of housing **(SW)**	399/415	96.1%	99%
12.0.3	Assistance offered re: improving housing situation per follow up contacts **(SW)**	0/0	n/a	95%
12.1	Follow up contacts: MH appointments (**CTCM)**	85/85	100%	95%
12.2	Follow up contacts: MH referrals (**CTCM)**	195/195	100%	90%
12.3	Attempted follow up contacts: appropriateness of housing **(CTCM)**	160/160	100%	99%
12.4	Assistance offered re: improving housing situation per follow up contacts **(CTCM)**	74/74	100%	95%

Source: Compliance Monitors 40th Report (May-August 2018)
**the shaded rows in the table identify the measures for which the city is noncompliant

Appendix II

Missed Appointments due to DOC non-production, Report 40



Source: Compliance Monitors 40th Report (reporting period May-August 2018)

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Int. No. 903

By Council Members Richards, Adams, Miller, Holden, Ampry-Samuel, Powers, Rose, Rivera and Rosenthal

A Local Law to amend the administrative code of the city of New York, in relation to funds remaining in inmate accounts when inmates are released

Be it enacted by the Council as follows:

Section 1. Chapter 1 of title 9 of the administrative code of the city of New York is amended by adding a new section 9-154 to read as follows:

§ 9-154 Inmate accounts. a. Definitions. For the purposes of this section, the term "inmate account" means an institutional fund account maintained on behalf of an inmate in the custody of the department or a former inmate who has been released from the custody of the department.

b. Within the 72-hour period prior to the release of an inmate from the custody of the department, the department shall provide to the inmate written notification of the amount of funds remaining in the inmate's account and written instructions describing how the inmate may request refund of such funds.

c. Within 60 days following release of an inmate from the custody from the department, the department shall to the extent practicable return to such former inmate any funds remaining in the former inmate's account.

d. No later than March 31 of each year, the department shall report to the council the aggregate amount of funds remaining in the inmate accounts of all former inmates who are no longer in the custody of the department.

§ 2. Within 120 days following the effective date of this local law, the department of correction shall to the extent practicable return to each former inmate who was released from the

custody of the department of correction prior to the effective date of this local law any funds remaining in such former inmate's account.

§ 3. This local law takes effect 90 days after it becomes law.

NB
LS #5954, 5956 & 6334
4/26/2018

Int. No. 1590

By Council Member Chin, the Speaker (Council Member Johnson), and Council Members Levin, Powers and Rosenthal

A Local Law to amend the administrative code of the city of New York, in relation to requiring the department of health and mental hygiene or its designee to report information to the attorney of record for individuals in the custody of the department of corrections who are diagnosed with serious mental illness

Be it enacted by the Council as follows:

Section 1. Section 17-1801 of the administrative code of the city of New York, as added by local law number 124 for the year 2016, is amended to read as follows:

§ 17-1801 Definitions. For the purposes of this chapter, the following terms shall have the following meanings:

Arrestee. The term "arrestee" has the same meaning as set forth in subdivision a of section 14-163.

Health care provider. The term "health care provider" means any person licensed or certified under federal or New York state law to provide medical services, including but not limited to doctors, nurses and emergency personnel.

Health evaluation. The term "health evaluation" means any evaluation of an ["inmate"] incarcerated individual's health and mental health upon their admission to the custody of the department of correction pursuant to minimum standards of inmate care established by the board of correction.

[Inmate] Incarcerated Individual. The term ["inmate"] incarcerated individual means any person in the custody of the New York city department of correction.

Screened. The term "screened" means evaluated by a health care provider.

§ 2. Chapter 18 of title 17 of the administrative code of the city of New York is amended by adding a new section 17-1805 to read as follows:

17-1805 Short title. This section shall be known as and may be cited as "The Get Well and Get Out Act".

a. Information sharing with attorneys of individuals diagnosed with serious mental illness in the custody of the department of correction. For each incarcerated individual who is not sentenced and who is diagnosed with a serious mental illness, the department or its designee shall seek voluntary consent from such individual to share medical information with the attorney of record of such individual within 48 hours of their diagnosis, and provide such information created or obtained pursuant to sections 17-802 and 17-804 to the attorney of record for any such individual within five calendar days of obtaining consent from the individual.

b. Confidential medical condition reports for individuals diagnosed with serious mental illness. Within 5 days prior to each calendared court appearance for any incarcerated individual who is not sentenced, the department shall provide a confidential medical condition report to the attorney of record for each individual diagnosed with serious mental illness, as permitted by law. Such report shall include the following information for each such individual:

1. Their psychiatric diagnosis.

2. The type of housing area in which the individual is being housed.

3. Their prescribed psychiatric medication.

4. Their record of compliance with such medication, including any factors that may have contributed to their record of compliance.

5. A detailed description of their current condition, including but not limited to any reduction in symptoms and any indication that the individual's condition has improved or diagnosis changed.

6. A description of the supportive measures and mental health treatments employed within their housing unit and the medical factors contributing to their placement in such housing unit.

c. Notwithstanding the requirements of subdivision b, the department shall not be required to issue a new report for a scheduled court appearance within one week of a prior scheduled court appearance.

This local law takes effect 90 days after it becomes law.

D.A.
LS 10876
6.7.19