NYC HEALTH + HOSPITALS

Testimony

of

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before the

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

on

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

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City Hall – Committee Room
New York City

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

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

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

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

Mental Health Service

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

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

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

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

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

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

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

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

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

Re-entry Planning and Discharge Services

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

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

Conclusion

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

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

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