



Testimony
of

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before the

New York State Assembly Committee on
Correction
with the **Committee on Mental Health**

regarding

Mental Illness in Correctional Settings

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Good afternoon Chairpersons O'Donnell and Gunther, and members of the committees. I am Dr. Homer Venters, Assistant Commissioner of the Bureau of Correctional Health Services at the New York City Department of Health and Mental Hygiene ("the Department"). On behalf of Commissioner Bassett, who regrettably could not be here, thank you for the opportunity to testify today on the topic of mental health in correctional settings. This is an important and complicated issue for our city and state, and I thank you for focusing on it.

Background

The Department is charged under the New York City Charter with providing health and mental health services in the city's correctional facilities. The mission of the Department's Bureau of Correctional Health Services is to provide the best possible medical assessment and treatment during an inmate's detention and appropriate health and mental health-related discharge planning services. Our bureau pursues this mission by focusing on patient safety, population health, and human rights as essential elements of our health system. High quality correctional health services are critical for patients' safety and health while they are in jail, but they are also important in safeguarding the health of communities to which individuals discharged from jail return. Each month, the Department provides over 65,000 health care visits in jail facilities, most of which occur at Rikers Island. These include approximately 5,300 comprehensive intake exams, 40,000 medical and dental visits, 2,300 specialty clinic visits, and 20,000 mental health visits.

All inmates receive a full medical intake examination within their first 24 hours of entering custody. New York City is a national leader in this regard, as it takes most jurisdictions between one and two weeks to complete such initial exams. This intake exam allows us to screen patients and guides referral to a range of services they may need, and includes a comprehensive health assessment, sexually transmitted disease screening, and initial mental health assessment. These help guide further treatment, discharge planning and entitlement applications.

Mental Illness in NYC Jails

Identifying inmates with mental illness and helping them receive appropriate services is a core focus of our work. All arriving inmates receive a behavioral health screen and those determined to need a more in-depth mental health evaluation receive one within 72 hours. Our data show that approximately 25 percent of inmates are assessed to have some form of mental health diagnosis while in jail. A smaller group, 4.5 percent, of the total inmate population is designated as seriously mentally ill, which includes psychotic illnesses, such as schizophrenia. Remaining mental health diagnoses include conditions such as depression, anxiety, or adjustment disorders. It is worth noting that rates of diagnosis for both mental and serious mental illness in the jails are consistent with rates among the United States population overall.¹ However, at any

¹ SAMHSA data:

http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/2K12MHF/NSDUHmhfr2012.htm

given time in the New York City correctional system, the overall burden of mental illness is 38 percent. This larger proportion results from the fact that inmates with mental illness diagnoses have, on average, longer lengths of incarceration.

The majority of patients assessed to have a serious mental illness are housed in Mental Observation Units which are designed to meet these patients' health needs. The Department operates 20 Mental Observation Units, which currently house about 700 patients. These patients are provided services ranging from an outpatient level of care with talk-therapy to an inpatient level of care with coordination between social workers, psychologists, psychiatrists and pharmacists. We are in the midst of implementing major improvements to these units, which I will discuss in greater detail later in my testimony.

The care of patients in a correctional setting has complexities that arise from the joint aims of both maintaining security and promoting health and access to care. Our data show that mental health and violence in the jails are intertwined. Research conducted by the Department reveals that serious mental illness and placement in solitary confinement as punishment are predictive of acts of self-harm, including lethal self-harm. Independent of other factors, placement in solitary confinement as punishment increases the risk of self-harm. This risk is especially high among adolescents, whom we found to be nearly seven times more likely to engage in self-harming behavior. We therefore welcome the reforms recently announced by DOC Commissioner Ponte to end solitary confinement for adolescents in the New York City jail system and expand programming and staff training to productively engage with this population.

Two very different approaches exist for persons with mental illness who receive infractions in the jail system. As Commissioner Ponte discussed, for those with serious mental illness, we have a very successful program called clinical alternatives to punitive segregation unit (CAPS). The three CAPS units – two for male and one for female inmates – offer better opportunities for inmates to engage with clinicians and receive mental health services. Initial experience shows that these approaches improve health outcomes and reduce inmate self-injury and violence. CAPS units consistently experience rates of violence and self-harm that are less than half of the rates of units where these patients had been housed previously. CAPS units report about 40 acts of self-harm per 100 patients, compared to 260 acts of self-harm per 100 patients in the restricted housing units, which combine solitary confinement as punishment with some mental health services. The CAPS units provide patients with intensive, therapeutic schedules that include morning meetings, multiple day and evening programs, and one-on-one encounters with Mental Health Clinicians and Psychiatrists. In addition, all of the health and security staff on these units are part of a team that trained together before the unit was opened and work side by side every day without being pulled for other assignments. Further evaluation of these units is ongoing and we plan to make our final report publically available.

For those with less severe mental illness, there are more traditional programs that attempt to mix solitary confinement and clinical care. These units, called "RHUs," house mentally ill inmates that have broken jail rules and combine punishment in solitary confinement and mental health programming with reduced cell lock-in time for inmates that adhere to program rules. Mental health staff oversee therapeutic programming in the RHUs, which may include group and individual psychotherapy as well as structured integrative activities, including music and art

therapy. However, because of the emphasis on solitary confinement in these units, both security and health staff face enormous challenges in accomplishing their daily objectives. There are six RHUs at Rikers; four for adult male inmates, one for adolescent male inmates and one for female inmates. RHUs are a work-in-progress as we strive to reduce violence in these units. We are currently in discussions with the DOC to determine how we can create a more therapeutic setting, as data show that standard practices in the correctional system, particularly solitary confinement as punishment and reliance on force, can be linked to outcomes that we all seek to prevent, including violence against self and others.

Due to the overwhelming success of the CAPS units, the Department received approximately \$7 million to convert the existing mental observation units to ones with much greater levels of staffing and structure, as seen in the CAPS units. The newly converted PACE units, which Commissioner Ponte already described, will dramatically increase our capacity to deliver therapeutic interventions to patients at risk for further decompensation, self-harm, and hospitalization, thereby reducing negative health outcomes. Since PACE units are based on the CAPS approach, the model includes secure treatment aides that engage patients and facilitate participation in group activities, one-on-one encounters with mental health staff and other treatment efforts. These units will deliver a higher level of staffing and services to patients, with the first of these units focused on patients who are returning from inpatient psychiatric hospitalizations. Subsequent units will have programming and staffing tailored to meet the needs of patients with behavioral problems and also those requiring intensive support with medication management and compliance. We are currently working closely with the DOC to develop and roll out these new units.

Finally, the Department provides discharge planning to eligible inmates with mental illness. These services, which are provided to approximately 20,000 individuals annually, include arranging for post-release medical and mental health care, applying for or reactivating Medicaid, applying for public assistance, providing a supply of and prescription for medications, arranging for transportation, and organizing post-release follow up. To further enhance our discharge planning efforts, the Department is piloting an initiative to connect discharged patients back to their Health Home for case management as well as medical and mental health referral services.

Thank you for the opportunity to testify. My colleagues and I are happy to answer any questions.