



Testimony
of

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New York City Department of Health and Mental Hygiene

before the

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

regarding

**Oversight: Examination of Violence and the Provision of Mental Health and Medical
Services in New York City Jails**

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New York City

Good afternoon Chairpersons Crowley, Cohen, Johnson and members of the committees. I am Dr. Mary Bassett, Commissioner of the New York City Department of Health and Mental Hygiene. I am joined by Dr. Amanda Parsons, Deputy Commissioner of the Department's Division of Health Care Access and Improvement, and Dr. Homer Venters, the Department's Assistant Commissioner for Correctional Health Services. Thank you for the opportunity to testify today on the topic of violence and the provision of mental health and medical services in New York City jails. This is an important and complicated issue for the Department and our City, and I thank you for focusing on it.

My testimony today will provide an overview of the role of the Health Department in New York City jails and some of the challenges that we face in providing health services to inmates. Commissioner Ponte and I have already met several times and I have had the opportunity to visit the Rikers Island complex. So today I will discuss some of the activities on which Commissioner Ponte and I, with our respective agencies, are currently collaborating on to address these challenges, as well as new initiatives aimed at reducing the violence that has no place in any healthcare setting.

Background

The Department is charged under the City Charter with providing health and mental health services in the City's correctional facilities. The City has 12 jail facilities, each with at least one health clinic. As Commissioner Ponte discussed, there are approximately 11,000 individuals in these jails daily, and most stay for only a short period of time. Over ninety percent of inmates are male, nearly all are African American or Latino, and many come from the poorest neighborhoods in the City. Educational attainment is low and unemployment is high. These inmates enter the jail system with a high burden of disease; rates of HIV, hepatitis C, asthma, hypertension and substance use are all significantly higher than they are among the general population.

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-related discharge planning services. High quality correctional health services are critical for patient 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 63,000 health care visits in jail facilities, most of which occur at Rikers. 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. It includes a comprehensive health assessment, sexually transmitted disease screening and initial mental health assessment. These help guide further treatment, discharge planning and entitlement applications.

Approximately 46 percent of inmates report that they are active substance users, although we believe the actual prevalence of substance use to be much higher. New arrivals are more likely to admit to substance use if their treatment records include medications like methadone, otherwise substance use may go unreported. The Department actively seeks to identify and assist individuals with a history of substance use in order to provide them with care while they are detained so they may return to their communities linked with appropriate assistance.

The New York City correctional health system is the only large correctional system to provide methadone treatment. Since 1987, we have provided methadone detoxification and methadone maintenance services to approximately 17,000 patients annually. Upon discharge, these inmates are referred to community-based methadone programs. Further expansion of addiction services would encourage more patients to report their substance use and enter treatment while in jail and after their return to the community.

In addition, since 2008, the Department has offered *A Road Not Taken*, a substance use treatment program which focuses on inmates who are potentially eligible for drug treatment as an alternative to continued incarceration. The program provides case management to connect patients to treatment in the community, liaises with drug courts, and coordinates care for eligible patients. Since 2008, over 6,300 individuals have been enrolled and treated in this program.

The Department is also a national leader in the adoption and use of prevention-oriented electronic health records in our jail facilities, allowing our health care workers to better coordinate care for their patients. These patient electronic health records can be shared with community providers via the Healthix Regional Health Information Organization.

Provision of Services

Although oversight of health services and discharge planning in City jails is the Department's responsibility, direct medical, mental health and dental care services are performed by vendor personnel from the health services providers Corizon Health Inc. ("Corizon") and Damian Family Care Centers ("Damian"). Hospital-level services are provided by the New York City Health and Hospitals Corporation. Corizon, the largest private for-profit correctional health services provider in the United States, manages the day-to-day medical and mental health services operation at Rikers and two other jail facilities. Damian Family Care Centers is a New York State-licensed Article 28 Diagnostic and Treatment Center and a non-profit Federally Qualified Health Center with a long history of providing high quality healthcare to the City's underserved. They provide services at the Vernon C. Baines Correctional Center.

The Department closely monitors these vendors through multiple lines of supervision. These include the credentialing of physicians and physician assistants, formulating all policies for medical, nursing, mental health and substance use care services, and ensuring compliance with those policies through a rigorous quality assurance process based on reporting of 40 performance measures. Through many weekly meetings between the Department and the vendors, we ensure that key issues are proactively identified and addressed early.

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 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. Because they are less likely to exit the system, they are overrepresented in the inmate population. While we do not know exactly why this occurs, it is an issue we are working to better understand, and I look forward to discussing it with Commissioner Ponte and other members of the Mayor's Behavioral Health and Criminal Justice System Task Force in the coming months.

The majority of patients assessed to have a serious mental illness are housed in the Mental Observation Units that Commissioner Ponte touched upon earlier, which are designed to meet these patients' health needs. The Department operates 19 Mental Observation Units, which currently house about 645 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 currently in the process of completely reforming mental observation housing areas in the jails, 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. Mental Observation Units are among the most violent settings on Rikers, as was the recently closed MHAUII unit, which housed mentally ill inmates who were placed in solitary confinement as punishment.

Research published by the Department shows that half of adolescents arrive in jail with a history of both being struck on the head and suffering altered consciousness. These factors are associated with traumatic brain injury. Others sustain head injuries while in jail, due to injuries

¹ SAMHSA data:

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

from inmate fights and as a result of reported “use of force” by correctional officers. In approximately 30 percent of violent interactions between correctional officers and inmates there is evidence of a blow to the head. We are in ongoing 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.

As a result of these discussions, in 2013, the Department and the DOC worked to eliminate solitary confinement as punishment for the seriously mentally ill, and opened the Clinical Alternatives to Punitive Segregation, or “CAPS” units. 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.

During a recent visit to Rikers, I met a patient in a CAPS unit who had spent nearly two years in solitary confinement as punishment where he was involved in multiple violent encounters every month. When I saw him in the CAPS unit, he had spent approximately six months without any violent encounters or other problems. We have a total of 32 clinical staff in these units to ensure the provision of programming and mental health services for the seriously mentally ill men and women housed there.

In addition to CAPS, the Health Department and the DOC are working together to design new units for inmates with mental illness. This includes six Restrictive Housing Units across the jails; four for adult male inmates, one for adolescent male inmates and one for female inmates. These units are a work-in-progress as we strive to balance punishment and appropriate treatment.

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.

Addressing Challenges

The success of health care delivery in our City jails depends on the safety of correctional health care workers. It is difficult to overstate how distressing the recent increases in assaults are to the Administration, the Department, and to me personally. Incidents of assaults against health care workers at Rikers spiked in December of 2013 and have continued, on average, to occur at a higher rate in 2014 than in years past. We are working to better understand the factors that have contributed to this rise in violence and our most urgent priority is to work with DOC and Corizon to protect our health care workers.

First, we are improving communication between health care workers and correctional staff. This includes ensuring health care and DOC staffs communicate about high-risk patients

after every tour of duty, allowing staff to target resources and treatment to these patients. Second, health care staff and jail wardens are meeting to address jail-specific safety concerns, resulting in improvements to staff workflows and additional security measures in the clinics. We have also revised our protocols so that high-risk patients receive services in clinic areas instead of their housing units, ensuring a safer setting for staff to administer care. Furthermore, the Department, DOC and Corizon are addressing environmental issues in jail facilities, which involve moving units in areas with unsafe features, such as narrow corridors, to areas that have a more secure layout.

Other efforts to increase safety and security include implementing an aggressive patient alert function in our Electronic Health Record system so that safety precautions are addressed prior to treating high-risk patients. We are also focusing our attention on locations where assaults are most frequent, such as mental health areas and high security settings. Although we do not believe staffing needs to be increased across the board, there are areas where we think additional staffing may improve safety, such as the Mental Observation Units, to better identify patients in crisis and provide them with services in order to prevent a violent encounter.

The Department is also working closely with the DOC to reassess the treatment of mentally ill and seriously mentally ill inmates, especially since a majority of recent assaults on staff and patient deaths have occurred in the Mental Observation Units. As I mentioned earlier, we are working together to redesign the workflows in these units to improve staff safety and patient health. Goals of this redesign include giving staff more say in how these units are run, enhancing support to our social workers, and instilling routine, patient-centered communication between health and security staff that covers basic elements of each patient's status. The Mental Observation Unit redesign process is expected to take several months and we look forward to sharing more information about these changes in the future.

Finally, I want to reiterate what Commissioner Ponte said earlier, that he and I communicate regularly, not just on jail safety and inmate health issues, but also on broader reforms to the criminal justice system as we work together on the Mayor's Behavioral Health and Criminal Justice System Task Force. The Task Force, chaired by Deputy Mayor Barrios-Paoli and the City's Director of the Office of Criminal Justice, Elizabeth Glazer, is charged with developing and implementing strategies to ensure the appropriate diversion of mentally ill people away from the criminal justice system. I look forward to future collaboration with Commissioner Ponte and his agency as we move forward, together, to improve the health and safety of staff and inmates in our City's jails.

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