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Reports Indicate City's Progress is Slow on Mental Health Planning for Inmates

By **Roshan Abraham** | January 12, 2017

William Sostre takes medication for depression, as well as paranoia and claustrophobia, symptoms that he says began in solitary confinement. He currently lives in supportive housing and attests to its benefits. *Adam Shrier*

Some inmates enter New York City's correctional facilities with prior mental illness made more severe by incarceration. Others have more subtle mental-health issues exacerbated by release, jarred by the change in environment and lack of institutional support.

This was the experience of Jonathan Stenger, a former inmate and Director of Communications at the Osborne Association.

"Prison is a sensory deprivation experience. Some senses are over-stimulated, but for the most part it is extremely controlled," Stenger says.

"I was incarcerated for 15 months, and I come from a very supportive family, and yet the experience of coming home, the experience of being back in the city for months after that relatively short time, was difficult," he says.

Those who seek mental-health connections often have trouble navigating the system and making appointments on their own.

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A class-action lawsuit, *Brad H. et. al v. City of New York, et. al* , lead to a settlement intended to remedy this. The settlement required the city to provide specific mental health discharge planning for prisoners covered in the *Brad H.* class—those jailed in New York City correctional facilities with persistent mental-health issues. The settlement required discharge planning to include filing Medicaid applications upon release or unsuspending it for those who had it when they entered jail. The court also mandated that discharge planners provide seven days of psychotropic medication for those who need it upon release, as well as a prescription for 21 days of medication, referrals to appropriate mental-health services, and that they check in with recently released prisoners within three days.

But the city has never met the requirements of the settlement in the 13 years since it was made, according to the plaintiff's representatives as well as the independent monitors the court appointed in the landmark 2003 settlement, which has generated constant litigation.

Court-appointed monitors were optimistic that the early 2016 transfer of the city's correctional health services from the

Department of Health and Mental Hygiene to NYC Health and Hospitals Corporation, as well as the end of a private contract with Corizon, would eliminate bureaucratic hurdles keeping the city from meeting its obligations. But this improvement has yet to manifest, and by some metrics, the city is performing more poorly since the transition.

The 36th monitor's report, published October 6, covers the period of January to April 2016, the first such report released since the de Blasio administration shifted mental-health discharge planning from the Department of Health and Hygiene to NYC Health and Hospitals last January

The report portrays a system that has met some benchmarks but has largely fallen short in crucial requirements like distribution of psychotropic medication, follow-ups with prisoners, and referrals for supportive housing, all important for keeping ex-prisoners with mental-health and substance-abuse problems from falling into a dark place.

Worse, the report says that correctional staff used flawed metrics to report data for years, over-representing the success of their discharge planning by failing to account for changes in housing need and mental health over the course of incarceration.

A right to discharge planning

The 2000 suit was filed under the name of a plaintiff named *Brad H*. by the Urban Justice Center, Debevoise & Plimpton LLP, and New York Lawyers for the Public Interest. It asserted that inmates were entitled to mental-health discharge planning under New York State Mental Hygiene Law 29.15. The settlement required that the city, prior to releasing prisoners, assess each inmate's mental health and provide appropriate connections with outside mental health providers, along with appropriate medication and prescriptions. The length of the settlement was initially five years, with the stipulation that the plaintiffs could extend it over two year periods if the city did not meet its benchmarks.

The suit was revisited in 2009 when lawyers for the plaintiff said that the city was still failing to meet obligations and in fact had decreased services. The city tried to appeal, claiming the settlement's five-year time limit had expired, but the Court of Appeals extended the settlement for another two years, after a lengthy arbitration that ended in 2014. In September 2016, the court extended that settlement by six months so that the plaintiff's lawyers could help the city come into compliance. It's now set to expire on March 20, 2017.

Back in 2014, in preparation for the de Blasio administration's revamp of the city's correctional health system, the Independent Budget Office (IBO) analyzed data provided by the Department of Health and Mental Hygiene as part of the *Brad H*. settlement. It found that while the city had expanded discharge planning significantly between 2009 and 2012, "health department spending on correctional mental health services had not kept pace with the increasing number of inmates with mental-health diagnoses."

The IBO found the number of discharge plans completed rose sharply between 2009 and 2012, by 56 percent, from 5,426 to 8,492. But the services were reaching a smaller proportion of the population with severe mental illness, likely because the number of people with mental health issues in city jails had increased, despite an overall decrease in city jail population over the same time period.

There was also a decrease in mentally ill prisoners who received referrals for follow-up care in this time period, from 94 percent to 83 percent. Appointments for post-release care dropped from 97.1 percent to 91.6 percent.

Still waiting for de Blasio reforms to take hold

In 2014 Mayor de Blasio released a plan created by his Task Force on Behavioral Health and the Criminal Justice System, intended to address mental health issues in NYC jails. The plan allocated $89 million toward crisis intervention teams, mental-health training for corrections officers, and the hiring of additional mental-health clinicians. The plan also funded drop-in centers intended for the mentally ill and homeless to be taken rather than jail.

Perhaps most importantly, the administration ended contracts with a private health provider, Corizon, after a 15-year relationship, and shifted services from the Department of Health and Hygiene to Health and Hospitals, which had previously only been handling a small percentage of correctional health.

Corizon had been controversial for hiring doctors and mental-health employees with criminal convictions. Independent monitors had noted that private contracting often left city agencies with an extra layer of bureaucracy that made it difficult to communicate training objectives, share data, and allocate resources.

According to Jennifer Parish, a lawyer representing Brad H. and plaintiffs in their continuing litigation, this frayed coordination was have a negative impact on discharge planning.

"Someone might meet with a clinician on a regular basis, but they weren't meeting with the discharge planner," Parish notes. As a result, required updates in patient mental health that could alter care weren't being communicated.

Parish says that consolidating services under NYC Health and Hospitals has been a step in the right direction.

"I think that's the change that has the most potential for going forward and for the city to come into compliance," Parish says. But she and the data from the independent monitors indicate those positive changes haven't happened yet.

Missing meds

The 2003 settlement requires that inmates who are on psychiatric medication while in jail must receive a seven day supply upon discharge, along with a 21 day prescription.

But according to the monitors' reports, in the first four months of 2016, close to 200 prisoners who require medication for ongoing mental-health issues were discharged from city correctional facilities without this medication in hand. This was close to a quarter of those eligible.

According to the report, "[The city] demonstrated ongoing lack of compliance with the foundational requirement that they provide supply of psychotropic medications to eligible class members as they leave jail," putting them at "high risk for a break in their treatment."

The 76.7 percent compliance rate for this requirement is significantly lower than the 90 percent threshold that city correctional facilities need to comply with Brad H.. But it is an uptick from September to December 2015, the last quarter before

the transition to NYC Health and Hospitals, when 123 inmates were discharged without needed prescription pills.

Susanna Eckblad, a forensic social worker who has worked with formerly incarcerated individuals at several city non-profits, recalls incidents as recently as last Spring where inmates were released without medication. Eckblad says that some inmates were discharged from Riker's and set up with long-term drug treatment programs that required them to arrive with their medication in-hand. When they showed up without it, they were turned away at the door.

Some former inmates turned to emergency rooms in order to get medication. But faced with the choice of spending a day in the emergency room or stopping their prescription, many chose the latter. And some who were meant to enter drug treatment relapsed.

"We had set them up to go straight there for a reason," Eckblad says.

A disruption in medication also increases the chances that an ex-inmate stops their medication altogether, as many had no experience taking medication outside of jail, she says.

"It's just bad clinical practice, it's going to make the medication less effective," Eckblad adds.

Falling into gaps

Compounding the difficulty for mentally ill inmates is the fact that many experience a gap in medical coverage upon release from city jails. Inmates typically have their Medicaid suspended when they are incarcerated. The *Brad H.* settlement mandates that when inmates are discharged, correctional staff must apply for new Medicaid cases and work to unsuspend existing cases where appropriate. While the city does not keep data on individual inmates' Medicaid status after a few days, the report notes "periodic reports from class counsel about individual class members who suffered considerable disruption in treatment."

The city has historically failed to report data on inmate Medicaid status, although the most recent reporting period shows improvement. It is the first time the city has reported the status of Medicaid cases administered through the Human Resource Administration. Of these cases, 25 percent were suspended at the beginning of incarceration, and from this group 7.2 percent took more than three days to be unsuspended after discharge.

While there are still no metrics to judge whether this meets the requirements of the settlement, the report notes optimistically that "The parties and the monitors now have a reasonable and growing sense of what processes need to occur for most eligible class members to have functioning Medicaid."

A gap in Medicaid coverage could be particularly troubling for an inmate with substance abuse or opiod addictions who might need to connect with treatment immediately upon exiting jail, according to Erin-Burns Maine and Kristin Miller of the Corporation for Supportive Housing, a national nonprofit with offices in NY.

Maine says that inmates are more likely to overdose within 72 hours of being free, "so being able to have somebody exit with active Medicaid directly into treatment is really a lifesaver in that population."

New York state is petitioning for a Medicaid waiver that could help close these gaps. An amendment to the state's 1115 waiver, which is used to carve out Medicaid funding for experimental programs with cost-cutting advantages, would activate Medicaid cases for incarcerated people 30 days prior to release from prison. This means that rather than having to wait for their case to be unsuspended, prisoners would have Medicaid upon release.

"That's huge," according to Kristin Miller, CSH's director. "Having Medicaid the minute they leave is so critical to connecting them to care."

In a 2014 report, the Mayor's Task Force on Behavioral Health in the Justice System found that on any given day in city jails, 38 percent of detainees have a mental illness, 7 percent have a serious mental illness, and a staggering 85 percent or more have substance-use disorders. Those in the justice system are seven times more likely than the general population to experience mental illness and substance-abuse disorders, according to the Corporation for Supportive Housing.

"When you think about that and you think about a lapse in their health coverage, the second they're released it's almost like they're being set up to fail," Miller says. "So that Medicaid waiver if granted could be a really important piece of that transition out."

Housing as a health resource

Many who work with prisoners reentering society agree that one factor—perhaps the biggest—in achieving consistent mental health (and avoiding substance abuse) for ex-offenders is having stable housing.

"For those people experiencing mental illness, who do not have a place to live, housing is what we know is a social determinant of health," Miller says.

Ann-Marie Louison is Director of the Center for Alternative Sentencing and Employment Services, or CASES, an organization that tries to improve behavioral health among the formerly incarcerated. Over the years she's observed that a lack of mental-health providers is not as large of a detriment to those with mental illness as the lack of housing. If someone has a stable home, Louison says, they're more able to access things they need around mental-health treatment. A stable home makes it more likely that someone will consistently attend their mental-health appointments and provides a clearer path to access medication and begin to look for work.

But the city is failing to live up to the legal requirements of Brad H. for supportive housing referrals as well, according to monitor's reports and lawyers for the plaintiff. Referrals have increased since the transition to Health and Hospitals, not yet meeting court-mandated benchmarks.

Supportive housing is permanent, affordable housing with built-in support, intended for people with chronic issues like homelessness, mental illness addiction, or disability.

The 2003 settlement mandates referrals for supportive housing if an inmate is suffering from a "serious and persistent mental illness" (a category that the Department of Health has revised to SMI, serious mental illness). The court mandated benchmark is 95 percent. But according to the most recent monitor report, city jails are only providing supportive housing referrals for 88 percent of those eligible under the class action—and that statistic

underestimates the problem, according to the report, because of faulty metrics from jail staff.

"When a person's situation changes, the way they collect the data doesn't reflect that change," explains Parish.

A prisoner might not be in need of supportive housing when they enter jail. But over the course of an incarceration lasting several months, they may lose an apartment or not be welcome back home upon release. Additionally, the stress of jail has been shown to be an impediment to mental health, explains Parish, and if they're not seriously mentally ill when enter jail, but can be qualified as SMI when they leave, they should be protected under *Brad H.*

William Sostre, 63, currently lives in supportive housing and attests to its benefits as well as the psychological impact of jail stays. He has experienced both jail and prisons since the age of 16 and has been in solitary confinement "many times." Sostre is currently medicated for depression, as well as paranoia and claustrophobia, symptoms that he says began in solitary.

"I used to wake up sweating," Sostre says, adding that at one point he suffered from violent nightmares, including that he was being attacked by a pack of wild dogs.

Sostre was released from jail in late 2009 and since 2010 has been at Brooklyn Gardens, a 50,000 square foot supportive-housing facility in Fort Greene, operated by Brooklyn Community Housing Services. Brooklyn Gardens focuses on improving residents' life skills through regular meetings and social gatherings.

Sostre credits supportive housing with giving him a stable community-based setting where his well-being and mental health have improved. He's able to receive mail-order prescriptions of Zoloft, which he takes daily to deal with depression and paranoia.

"It's helped me out, calmed me down. It's a place I can get knowledge to do positive stuff," Sostre says of supportive housing.

Sostre was recommended into supportive housing through Frequent User Services Enhancement (FUSE) , a program developed by the Corporation for Supportive Housing which directly targets those who continually cycle through the correctional system.

The monitor's reports show, however, that not all prisoners eligible under Brad H. settlement are receiving crucial supportive housing referrals.

According to the report, "The frequency with which class members eligible for supportive housing were not recognized as eligible and therefore were not offered supportive housing applications," lead jail employees to overreport their success in meeting the benchmarks set by Brad H.

The report gives a quality rating for compliance with supportive housing referrals at 25 percent. Case management is rated at 61 percent, and appointments and referrals at 56 percent.

Not making connections

The report notes a failure to contact previous treatment providers to get information when a prisoner enters the system. Monitors had worked with staff to develop a form to collect inmate information about previous treatment. But during the period correctional health was handled by Corizon, correctional staff did not contact city facilities like Bellevue or Elmhurst, for instance, because inmates couldn't remember contact information and staff made no attempt to find it.

This information would give discharge planners a better understanding of the person's prior history and lead to better decisions on where the person could go for care, according to Parish.

The report even suggests employees misled independent monitors regarding training employees to collect information, citing "the defendants' lack of progress in obtaining collateral information to inform discharge plans, and what, until now, have been misleading representations to the monitors about the direction given to clinical staff concerning whether staff were instructed to attempt to collect collateral information. "

By consolidating mental health discharge services and ending their contract with Corizon, the city has created a more efficient system, the report says. But it warns that "while the removal of barriers may ease the path to compliance, it does not inevitably lead to success in the long run."

The report also notes that the beginning of transition to a new system may be bumpy, but urges the city to expedite integration of treatment and discharge planning.

Federal policy shifts could hurt

Discharge planning and post-release programs like supportive housing face uncertainty from a funding standpoint, tied to choices that will be made by the incoming presidential administration. While federal law already prohibits the use of Medicaid funds for health care within jails and prisons, discharge planning services do rely on a federal funds according to the 2015 IBO report. That means they could be cut. Serious alterations to the Affordable Care Act and cuts to Medicaid—which are likely—could complicate the quality and amount of mental healthcare inmates receive after release.

Miller is optimistic that political support around this issue in New York State is strong. She foresees funding taking a hit under the new federal administration, but believes that if more money is presented in the form of a block grant—federal funds provided to states who do their own cost-cutting and financial reorganization—the flexibility would allow local officials to put the money where it's most needed.

But the precariousness—and the crucial need for federal funding to mitigate mental-health issues still looms. "I think what you're hearing is that Medicaid is a really important resource in our work," Miller says.

Despite bumps in the transition, advocates involved with the Brad H. case are optimistic that newly hired administration at Health and Hospitals have a more comprehensive view of discharge planning and a desire to bring the city into compliance.

"Change in a large bureaucracy is slow," says Mary Beth Anderson, Mental Health Project Director at Urban Justice Center. But she added that among new managers of correctional health hired after the transition, "there's a real movement to help people engage in their recovery."

"We all wish we could make the problems go away today," Anderson says, "But change is slow. The city is going to be able to sometime in the future comply with Brad H."