New York City Independent Budget Office Fiscal Brief

May 2015

Looking Back at the Brad H. Settlement:

Has the City Met Its Obligations to Provide Mental Health & Discharge Services in the Jails?

Summary

The number of inmates in the city's jails coping with mental health issues has been growing in recent years. But questions involving the availability of services for these inmates are not new. More than a decade ago the city reached a legal settlement with plaintiffs in a case that became known as Brad H. The city agreed to provide inmates confined in its jails for at least 24 hours and who receive treatment for mental illness during their time there with a plan for accessing ongoing services upon release.

Despite the court settlement, concerns have persisted about the adequacy of mental health services for inmates in the jails as well as plans for aiding them after their release. In response to the recent turmoil in the jails, the de Blasio Administration has adopted new initiatives for addressing mental health services and other needs in the jails, including the "action plan" recommendations announced in December.

As these new efforts get underway, it is worth looking at how well the Departments of Correction and Health and Mental Hygiene met the obligations of the Brad H. settlement. IBO has compared spending and service provision in fiscal year 2009 (the earliest year the health department could provide data and 2012 (the latest year most data was available when IBO made its request). Among our findings:

- As of 2012, health department spending on correctional mental health services had not kept pace with the increasing number of inmates with mental health diagnoses. With the de Blasio Administration's new initiatives, though, the city will spend more on correctional health this year than was previously spent.
- From 2009 through 2012, health department spending on mental health services in the city's jails remained flat, at about $35 million a year. Over that same period, the number of inmates with mental health diagnoses increased by nearly 10 percent, to more than 20,200 admissions in 2012 and comprised a larger share of the inmate population.
- In terms of the absolute number of services provided to inmates eligible under the Brad H. settlement, the health department delivered more services in 2013 than in 2009, including an increase of over 56 percent in the number of discharge plans completed, to 8,492 in 2013.
- But more than half of the 10 different types of discharge services were reaching a smaller share of eligible inmates in 2013 than in 2009, including referrals made, appointments scheduled for post-release care, and Medicaid and public assistance applications submitted.
- It is not possible to assess the effectiveness of the discharge services because neither the correction department nor health department tracks inmates with mental health issues post-release.

The report also compares data on the demographics, length of stay, and reasons for arrest for the inmates covered by the Brad H. settlement with the general inmate population.

IBO

New York City
Independent Budget Office
Ronnie Lowenstein, Director

110 William St., 14th floor
New York, NY 10038
Tel. (212) 442-0632

Fax (212) 442-0350
iboenews@ibo.nyc.ny.us
www.ibo.nyc.ny.us

New York City's jail system houses a larger and larger number of individuals with mental health issues every year. Caring for these inmates—many of whom require specialized services, some mandated as a result of litigation—is a growing and expensive challenge to the city's Departments of Correction (DOC) and Health and Mental Hygiene (DOHMH). In June 2014, Mayor de Blasio announced a new task force charged with addressing the issue of mental illness and substance abuse within the criminal justice system and their action plan was released in December. This was far from the first attempt to address the problem of how the city provides mental health services amidst one of the largest correctional facilities in the country.

As the result of a class-action lawsuit filed in the 1990s (*Brad H., et al. v. The City of New York, et al.*), the city has been required to provide discharge planning services to inmates with mental health diagnoses since 2003. The goal was to connect inmates with mental health care in the community prior to their release with the hope that this could help end the cycle of reoffending and reincarceration for many of those with untreated or poorly managed mental illnesses.

In order to assess the array of mental health services offered to city inmates and their associated costs, along with any improvement in outcomes associated with the Brad H.-mandated services, IBO requested data from both the Department of Correction, which runs the city's jail system, and the Department of Health and Mental Hygiene, which is responsible for the provision of all mental health services in the jails. Both departments provided data covering fiscal years 2009 and 2012, and in some cases 2013 (all years are fiscal years unless otherwise noted). We chose 2012 because it was the most recent year for which a full year of data was available at the time the request was made, and 2009 because it was the earliest year for which DOHMH was able to provide data. Thus, our analysis is confined to the period prior to the de Blasio Administration.

In the analysis that follows, we will first review the history of the city's and state's efforts since the Brad H. decision to provide services to mentally ill individuals within the criminal justice system, in order to provide context for more recent proposals. Next, we will use the data provided by DOC and DOHMH to examine the characteristics of the population with mental health diagnoses in city jails. Finally, we will detail the services and costs for this population and how they have changed over time. Most of the cost data presented in this fiscal brief concerns DOHMH spending rather than DOC spending. This is because of limited availability of relevant information from the corrections department. Where possible we have attempted to calculate DOC costs related to this population.

Background

New York City is home to one of the largest jail systems in the United States; second only to the Los Angeles jail system.[1] The New York City Department of Correction provides for the care of individuals accused of crimes as well as those convicted and sentenced to one year or less of jail time. Besides the holding facilities located in the criminal, supreme, and family court houses across the city, there are 15 different inmate facilities throughout New York: 10 are located on Rikers Island. The remaining five include the borough facilities in Manhattan, the Bronx (a five-story barge) and Brooklyn, as well as hospital wards at the Health and Hospitals Corporation's (HHC) Elmhurst and Bellevue facilities.[2]

The jail population has been on a steady decline since 2003, while the number of inmates with a mental health diagnosis has increased during the same period. In 2009, the daily population of city jails averaged 13,362 and of these 27 percent (3,607 inmates) had some kind of mental health diagnosis; in 2012, the average daily population of the jails had declined to 12,287, while the share of this population with a mental health diagnosis had increased to slightly more than a third (4,177 inmates).

A large and growing number of inmates with mental health diagnoses in correctional facilities is not unique to New York City, but rather is a problem throughout much of the country. Comprehensive national data on this problem are scarce; nor is there even a standardized definition or measure of mental illness in the correctional context. One often-cited 2006 study by the federal Bureau of Justice Statistics found that more than half of all prison and jail inmates incarcerated in the United States had some type of mental health problem, with the largest percentage found in local jails.[3] Three jails—Chicago's Cook County Jail, the Los Angeles County Jail, and New York City's Rikers Island—now comprise the three largest mental health institutions in the country.[4]

Brad H. Litigation and Settlement. City and state officials have been grappling with the problem of mentally ill individuals in the criminal justice system for at least the past 15 years. In 1999, the Urban Justice Center, Debevoise & Plimpton LLP, and New York Lawyers for the Public Interest filed a class-action lawsuit on behalf of seven plaintiffs who had all been arrested multiple times and received mental health treatment while incarcerated, but were never given a discharge plan upon release.

The lawsuit challenged New York City's practice of discharging people with psychiatric disabilities from the city jails in the middle of the night with only $1.50 and two subway tokens, and without any medication or referral to services. Failure to provide discharge planning in the jails was determined to be a violation of New York State Mental Hygiene Law 29.15, which mandates "providers of inpatient health services to provide discharge planning."[5]

A settlement with the plaintiffs was reached that took effect in 2003. The city agreed to provide comprehensive discharge planning to all inmates who qualify as a member of the protected class. A class member is defined as an inmate whose period of confinement in city jails lasts 24 hours or longer, and who during confinement receives treatment for a mental illness. However, individuals who see mental health staff only once or twice and are assessed as having no need for further treatment are excluded from the class.

All those covered by the settlement are entitled to have a comprehensive treatment and discharge plan in place for services while in jail and after they are released. Anyone who is on psychiatric medication is entitled to a 7-day supply of medication and a prescription for 21 days regardless of whether they are Medicaid eligible. Inmates who qualify for Medicaid must have Medicaid benefits activated or reinstated upon release in order for the inmate to have a way to pay for the services they will need. Inmates who lack active Medicaid, but are presumed eligible and have a Medicaid application completed within seven days of release, are entitled to obtain a Medication Grant Program (MGP) card, which provides them with financial assistance in order to purchase medication while they wait for their Medicaid to become active. Brad H. class members are also entitled to receive either a referral for mental health treatment and services (if the release date is unknown) or an appointment for the same (if the release date is known). Lastly, inmates who are homeless receive assistance in applying for supportive housing.

Inmates classified as having serious and persistent mental illness (SPMI) receive additional services.[6] SPMI inmates get assistance in applying for public assistance, food stamps, supportive housing, Supplemental Security Insurance, and veterans' benefits if eligible. (Note that non-SPMI inmates may also be eligible for some of these programs, excluding supportive housing, but DOHMH is not required to assist with their applications under the current interpretation of the settlement agreement.) SPMI inmates also receive case management, transportation, and follow-up calls for housing and mental health appointments. If needed they also get referrals to a mental health program shelter.

Who Are Brad H. Inmates?

The Number of Inmates with Mental Health Diagnoses. Using the data provided by DOHMH, there are two different methods for tallying the number of inmates with mental health diagnoses in the city's jail system. The first includes an unduplicated count of all individuals admitted to the jail system in a given year who have had a mental health status in that year or during any previous incarcerations. This metric shows that the number of inmates with mental health diagnoses increased by 9.8 percent from 2009 through 2012, from 18,463 to 20,279 admissions. The second method includes only those inmates with a consistent M-status in their medical record. An M-status indicates a mental health diagnosis and is used either when an inmate is referred for mental health services or if he or she is on a specific psychotropic medication. It can be removed from a patient's medical record if clinical staff later determines that he or she does not need follow up care. Filtering out all patients who later had their M-status removed, the number of inmates with mental health diagnoses in city jails was 15,171 admissions in 2009 and 16,265 in 2012, a 7.2 percent increase.

IBO has opted to use the first, more inclusive method of tallying inmates with mental health diagnoses for our fiscal analysis under the rationale that any inmate referred for mental health services will require some outlay of resources. Based on this broader metric, individuals with mental health diagnoses accounted for 33.6 percent of all unique jail admissions in 2012, up from 27.2 percent in 2009.

However, not all of these individuals require follow up care and/or discharge planning services under the terms of the Brad H. settlement. Therefore, in sections of this report that focus on the provision of these services we will use the narrower definition and look only at those individuals who qualify as Brad H. class members at the time of their release.

Types of Mental Health Diagnoses. The only information on specific mental health diagnoses that was provided to IBO by the Department of Health and Mental Hygiene was the number of inmates with a serious and persistent mental illness in 2009 and 2012. Inmates' SPMI status is determined by mental health staff in the jails based upon New York State Office of Mental Health guidelines. The guidelines state that in order to receive a SPMI designation, an individual must be at least 18 years of age and meet the criteria for a Diagnostic and Statistical Manual of Mental

Disorders, fourth edition (DSM-IV) psychiatric diagnosis.[7] In addition, he or she must also meet at least one of the following criteria:

- Enrollment in Supplemental Security Insurance or Social Security Disability Insurance due to mental illness
- Extended impairment in functioning due to mental Illness, or
- Reliance on psychiatric treatment, rehabilitation, and supports.

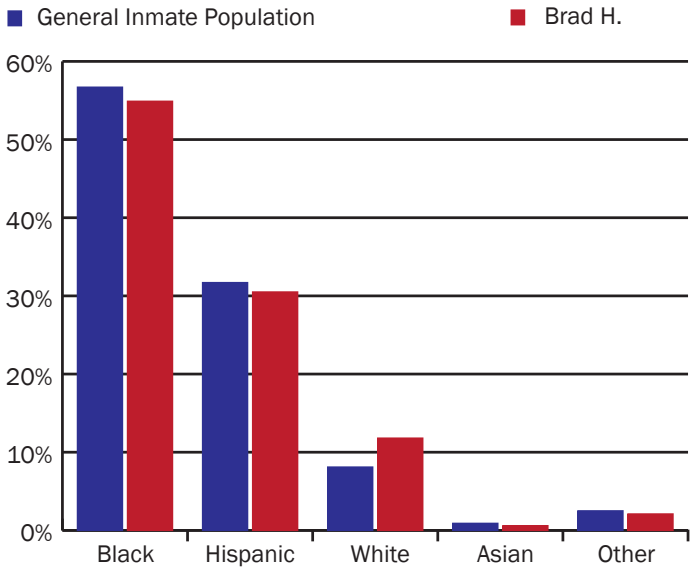
There has been a decline in the number of SPMI inmates over time, as well as in the share of Brad H. inmates classified as SPMI. Using the narrower definition of Brad H. class members described above, there were 4,331 seriously mentally ill individuals admitted to the jails—28.5 percent of all Brad H. inmates—in 2009 versus 3,808 (23.4 percent of Brad H. inmates) in 2012. Despite the decline in the number of SPMI inmates, the share of all inmates with serious and persistent mental illness was nearly identical in both years—6.4 percent and 6.3 percent, respectively.

Inmate Demographics. In 2012, DOC had 84,754 admissions with an average daily population of 12,287. IBO compared the demographics of inmates who are not class members (the general population) to those of inmates who are Brad H. class members and found that the share of women who are Brad H. class members was 16 percent, nearly double the share of women in the jails' general population (9 percent). Another major difference was in the racial composition of the two groups: 12 percent of Brad H. class members were white, compared with 8 percent of the general population of inmates.

Length of Stay. Inmates who are Brad H. class members tend to spend more time in jail than the general inmate population, which excludes Brad H. inmates. For inmates admitted in 2012, Brad H. class members were incarcerated 115.2 days on average compared with an average of 38.4 days for the general population; the difference in length of stay averaged nearly 77 days. Moreover, the length of stay for Brad H. class members increased from 2009, while length of stay for the general inmate population remained roughly constant throughout the period.

A Bureau of Justice Statistics report found that inmates with mental illness tend to experience more disciplinary problems and require more medical interventions because they either harm themselves or have some kind of substance abuse disorder.[8] These factors may explain why

Race/Ethnicity of Inmates Who Are Brad H. Class Members Compared with General Population of Inmates
Inmates admitted in 2012

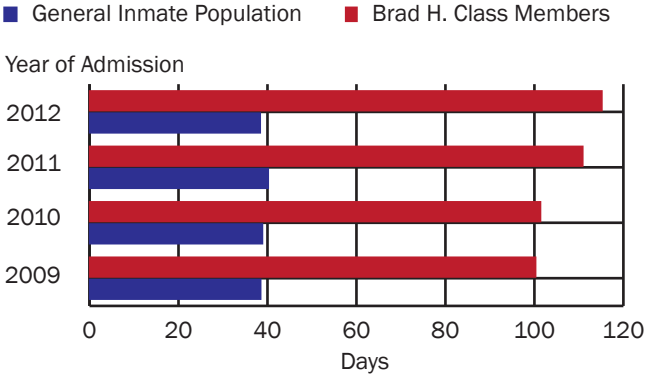


SOURCE: Department of Correction
NOTE: General Inmate population excludes Brad H. class members.
New York City Independent Budget Office

Brad H. class members average longer lengths of stay. Difficulty posting bail also contributes to the length of stay of the Brad H. population, according to a 2012 report by The Council of State Governments on New York City's criminal court and correction systems.[9]

Types of Charges. IBO looked at data on types of charges for both the general population of inmates and the Brad H. population at admission in 2012. Inmates who are Brad H. class members were somewhat more likely than the general population to be charged with more serious felony crimes such as robbery and drug felony sale. The general population

Brad H. Class Members Stay in City Jails More Than Twice as Long as General Inmate Population



SOURCE: Department of Correction
NOTE: General inmate population excludes Brad H. class members.
New York City Independent Budget Office

Most Serious Charges at Admission for 2012		
Felonies	**Brad H.**	**General Inmate Population**
Robbery	10%	6%
Drug Felony Sale	8%	5%
Other Felonies	5%	5%
Assault	5%	4%
Burglary	5%	3%
Drug Felony Possession	4%	5%
Grand Larceny	3%	2%
Murder/Attempted Murder/ Manslaughter	3%	1%
Weapons	2%	3%
Rape/Attempted Rape	1%	1%
Misdemeanors	**Brad H.**	**General Inmate Population**
Other Misdemeanor	11%	15%
Misdemeanor Larceny	8%	7%
Drug Misdemeanor	7%	12%
Misdemeanor Assault	5%	6%
Other Sexual Offenses	1%	1%
Loiter/Prostitution	1%	1%
Misdemeanor Weapons	1%	1%

SOURCE: Department of Correction
NOTE: General inmate population excludes Brad H. class members. Columns do not add up to 100 percent as some miscellaneous charges have been left out of the table.

New York City Independent Budget Office

was somewhat more likely to be charged with misdemeanor crimes such as drug misdemeanor, misdemeanor assault, and other misdemeanors. It is likely that the differences in the severity of charges contribute to longer lengths of stay for the Brad H. population. However, DOC only provided us with aggregate level data which did not allow us to match length of stay and charge for specific individuals.

Services for Inmates with Mental Health Diagnoses

Almost all direct mental health care services New York City jail inmates receive are delivered by outside providers under contract with DOHMH, with most of the services provided by a single vendor. In contrast, many of the discharge planning services are provided by city employees. From 2009 through 2012, the number of mental health care staff supplied by Corizon Health—by far the largest contractor—rose by 7.5 percent and the number of DOHMH discharge planning staff declined by 9.9 percent. During this same period, the number of inmates admitted to the jails and who ultimately received mental health diagnoses rose by 9.8 percent and the number of Brad H. class members rose by 7.2 percent

Direct Mental Health Care. DOHMH is responsible for the oversight and provision of all medical and mental health care to inmates of New York City jails, along with policymaking in this area. Delivery of most of the medical and mental health services provided to inmates is contracted out to third-party vendors. All of the direct mental health care that inmates receive in the jails, along with their medical care, is provided by Damian Family Care Services and Corizon Health. Damian, a nonprofit health care provider, provides medical and mental health services in just one facility, the Vernon C. Bain Center, the Bronx-based jail barge. Damian's $38.9 million contract with DOHMH went into effect in September 2013 and covers three years' worth of services. Prior to that date, all direct health care services on the barge were provided by Health and Hospitals Corporation staff. Corizon's current contract with DOHMH, which covers both medical and mental health care in the remaining jails, is for $126.7 million over three years and expires in December.

Substantial questions have been raised about the care provided by Corizon, a for-profit company, both in New York and around the country. Minnesota's prisons dropped Corizon in 2013 after 15 years as the health care provider, as did prisons in Maine after 9 years. A number of upstate New York counties have also ended their relationship with Corizon due to concerns about the quality of care, inmate deaths, and overbilling.

In 2012, Corizon employed 178.7 full time equivalent (FTE) staff in mental health positions in New York City jails, a 7.5 percent increase over the number of mental health staff employed by Prison Health Services in 2009 (Corizon was formed in 2011 when Prison Health Services merged with another company). The most common job title in both years was mental health clinician, a position that requires both a state license and a master's degree in social work, psychology, or a related field. Among other duties, a mental health clinician is responsible for conducting patient evaluations, assessments, and crisis interventions, as well as providing individualized follow-up care and leading group therapy sessions, all while the patient is incarcerated. There was a small increase in the number of mental health clinicians over the 2009-2012 period (84.3 FTEs in 2009 and 88.4 FTEs in 2012).

Much of the increase in Corizon's mental health staffing, however, resulted from an increase in psychiatric coverage. The total number of its psychiatric staff in the jails went from 33.7 FTEs in 2009 to 45.0 FTEs in 2012, an increase of 11.3 FTEs, or 90.6 percent of the overall staffing increase. Specifically, most of the increase was attributable

to Corizon adding psychiatric nurses (in permanent and temporary positions) and psychiatric physician assistants, an increase of 17.4 FTEs from 2009 through 2012. In contrast, the number of permanent and temporary psychiatrists and senior psychiatrists, higher level positions that require a medical degree, state license, and board certification, decreased by 6.1 FTEs. (The number of psychiatrists fell by 8.3 FTEs, while the number of senior psychiatrists rose by 1.2 FTEs.)

The remainder of the direct mental health care received by inmates is provided by the city's Health and Hospitals Corporation. HHC supplies all psychotropic medication used in the jails and also maintains two off-site prison wards where inmates with psychiatric emergencies are sent. The larger unit, at Bellevue Hospital, has about 65 beds for male psychiatric patients, and the smaller unit, at Elmhurst Hospital, has space for up to 15 female psychiatric patients. Prior to September 2013, HHC also provided health care staffing inside the Bronx jail barge. Excluding money transferred from DOHMH's budget, HHC spent $52.6 million on correctional health in 2012, $29.1 million of which came from inpatient Medicaid reimbursements and $23.5 million from city subsidy. Available budget documents do not break out how much of this was for psychiatric versus other medical care.

Discharge Planning and Case Management Services. Under the terms of the Brad H. settlement, class members are entitled to comprehensive discharge planning services both inside and outside the jails. Although the number of Brad H. class members rose by 7.2 percent from 2009 through 2012, the number of DOHMH discharge planning staff inside the jails declined.

Inside the jails, planning services are provided by DOHMH discharge planning staff, whose numbers dropped from 81.0 FTEs in 2009 to 73.0 FTEs in 2012 (a 9.9 percent decline). Most of the decrease was among managers and support staff, while the combined number of caseworkers and social workers fell by just 1, from 49.0 to 48.0 FTEs. Caseworkers and social workers interact directly with the inmates and provide much of the front line discharge planning services they receive. Specifically, their responsibilities include collaborating with mental health staff in the development of a discharge plan and assisting inmates with obtaining referrals and appointments with community-based providers, supportive housing, Social Security Administration benefits, and public benefits such as Medicaid, public assistance, and food stamps.

DOHMH also directly employs a relatively small number of other correctional mental health staff, in titles such as administrative psychologist, program administrative associate, and attending physician psychiatrist. These personnel perform a variety of tasks, including executive leadership, program development, oversight of Corizon staff, program evaluation and data analysis, coordination with community providers, and administrative support. As of 2012, one of these positions was also devoted to assisting Corizon staff with direct patient care. The number of these staff whose responsibilities are unrelated to discharge planning also declined from 12.0 FTEs in 2009 to 9.0 FTEs in 2012. Thus the overall decrease in DOHMH's correctional mental health headcount was 11.0 FTEs, or 11.8 percent.

The health department also provides discharge planning and case management services to Brad H. inmates outside of the jails, but these tasks are outsourced rather than performed by DOHMH staff. The first of the two out-of-jail programs is called the Service Planning Assistance Network, or SPAN, and it provides discharge planning for inmates released directly from court or with short jail stays. Any class member can also receive services from SPAN within 30 days of his/her release from jail. The services include assistance obtaining medication along with assistance applying for Medicaid, or any of the other discharge planning services inmates should receive in the jails but may not have sufficient time to access prior to release. Provision of SPAN services is contracted out to the Bowery Residents' Committee, which provides drop-in centers for inmates near the courts in every borough except Staten Island.

The second program is called Link and it provides short-term, intensive case management services to SPMI inmates who are leaving jail. This program is contracted out to four different vendors, each operating in a different part of the city.

Housing and Staffing for Inmates with Mental Health Diagnoses

Inmates with mental health diagnoses may be housed in any jail within DOC's system, both on and off Rikers Island. Ten of these jails provide mental health services to inmates using on-site Corizon employees.[10] However, the extent of Corizon's mental health staffing varies by jail, as does the number of inmates needing mental health services. Each jail is divided into different units that are used to house different types of inmates, including those with a mental health diagnosis and those being punished for breaking rules.

Staffing and Population by Jail. Inmates with mental health diagnoses may receive care from HHC staff in the prison wards at Bellevue and Elmhurst hospitals, or in 2012, in the Bronx jail barge. There are 10 additional jails on and off Rikers Island in which inmates may receive mental health services provided by Corizon staff. IBO received data on the average number of all inmates—the general population and Brad H.—housed in each jail in 2012 from the Board of Correction, along with the specific number of inmates with mental health diagnoses housed in each jail as of June 30, 2012 from DOHMH. Additionally, we were able to obtain 2012 Corizon staffing data by jail, although it is important to note that these numbers indicate total staff assigned to these facilities, not the number on duty at any one time. These data show that both mental health staffing and inmate counts vary considerably by jail.

The Anna M. Kross Center had the largest inmate population, housing 2,286 total inmates on an average day in 2012 and 981 inmates with a mental health diagnosis at the end of 2012. It also had the greatest concentration of mental health staff (54.9 FTEs). Five other jails in the system housed between 1,000 and 1,500 total inmates, 300 to 525 of whom had mental health diagnoses, and had 14 to 22 Corizon mental health FTEs assigned to them.

Mental Health Staffing and Inmate Counts In 2012

	Corizon Mental Health Staff (FTEs)	Average Annual Daily Inmate Population	Inmates With M Status (6/30/12)
Anna M. Kross Center	54.9	2,286	981
George Motchan Detention Center	14.8	1,460	521
Otis Bantum Correcitonal Center	22.4	1,443	416
Eric M. Taylor Center	12.3	1,401	356
Robert N. Davoren Complex	13.7	1,259	309
George R. Vierno Center	18.5	1,105	467
Rose M. Singer Center	24.5	821	498
Manhattan Detention Complex	6.1	745	167
Brooklyn Detention Complex	4.5	487	148
North Infirmary Command	6.7	124	70

SOURCES: Board of Correction; Department of Health & Mental Hygiene
NOTES: Only those facilities with permanent on-site Corizon staff are included (other facilities may have Health and Hospitals Corporation or Damien staff). Corizon staffing numbers indicate total staff assigned to these facilities, not the total number on duty at any one time.
New York City Independent Budget Office

There are four jails averaging fewer than 1,000 inmates, the two borough jails in Brooklyn and Manhattan and two on Rikers Island: the Rose M. Singer Center and the North Infirmary Command. The Brooklyn and Manhattan Detention Complexes housed 148 and 167 inmates with mental health diagnoses, respectively, as of June 30, 2012. Neither of these jails contains a Mental Observation unit (discussed on page 8), so inmates with significant mental health needs were typically housed elsewhere. However, both had a handful of mental health staff (4.5 FTEs in Brooklyn and 6.1 FTEs in Manhattan) on-site to assist inmates. The Rose M. Singer Center likewise houses less than 1,000 inmates on a given day, but a considerably higher number of these have mental health diagnoses—just under 500 at the end of 2012. This is because it only houses female inmates and as noted earlier, a higher share of female as opposed to male inmates have a mental health diagnosis. Accordingly, the Singer Center also has more Corizon staff (24.5 FTEs) than any jail but the Kross Center. Lastly, more than half of the inmates at the North Infirmary Command, which houses only those inmates requiring infirmary care or extreme protective custody, have mental health issues. As of June 30, 2012, the North Infirmary Command housed 70 Brad H. inmates who were served by 6.7 Corizon mental health FTEs.

Housing Units Within the Jails. Each jail is divided into different units that are used to house different types of inmates; in general, each unit houses fewer than 50 inmates. DOC places inmates who have committed jail infractions into punitive segregation units, more generally known as solitary confinement: single-occupancy cells for 23 hours per day, with 1 hour of recreation and access to daily showers in the unit. There are two types of punitive segregation units, one for the general inmate population and one for inmates with a mental health diagnosis. Since the fall of 2013, most inmates with a SPMI classification were no longer placed in punitive units and more recently it was also stopped for 16- and 17-year olds.

The first Mental Health Assessment Units for Infracted Inmates were opened in 1998 as a way to provide mental health services to inmates who have violated jail rules and would normally not receive these services while in punitive segregation. Amid mounting concerns about the use of punitive segregation for inmates with a mental health diagnosis, particularly those identified as having serious and persistent mental illness, the Department of Correction and the Department of Health and Mental Hygiene made a joint decision to close these units as of December 2013, in part to shift more of the focus from punishment to treatment.

Two new types of units were created to replace the assessment units: Clinical Alternatives to Punitive Segregation (CAPS) and Restricted Housing Units (RHUs).

The goal of the CAPS initiative, which began in July 2013, was to curb the use of solitary confinement for SPMI inmates. CAPS units are clinical and not punitive. CAPS units house both inmates with SPMI diagnoses who had previously been placed in punitive segregation and those with no jail infractions who had previously been placed in mental observation units and require a higher level of care. All infractions are set aside for those housed in CAPS (with no punitive segregation penalties imposed) and time in the unit is determined clinically while they remain at Rikers.

By September 2014 there were three CAPS units housing a total of 56 patients. At a budgeted health department cost of $3.8 million in 2014 and $3.4 million in 2015 this works out to roughly $60,600 for each CAPS bed in 2015.

The RHUs were designed to provide punitive housing (23 hour a day lock in) for Brad H. class members who had committed infractions, but who are not identified as SPMI. The RHUs featured a self-paced behavior modification program provided in a group setting by mental health staff from Corizon, through which participants have the opportunity to earn additional out-of-cell time. The RHUs began coming online in 2012 but have not met expectations and DOC is working with DOHMH to develop a new model for these units.

Most jails on Rikers also have Mental Observation (MO) units. These units are used for inmates who have significant mental health needs, such as those requiring closer clinical monitoring or medication administration, suicide watch, or evaluation. Mental Observation units are not considered punitive settings. MO units have mental health staff that work directly with inmates (as well as in the clinics) and also offer daily group therapy. The borough houses of detention and the barge in the Bronx do not have MO units.

Costs for Inmates with Mental Health Diagnoses

Most of the cost of providing mental health services to inmates in city jails is funded through the Department of Health and Mental Hygiene's budget. Including city, state, and federal funds, the health department spent just over $35 million on correctional mental health annually in 2009 and in 2012. In both years, more than half of this spending was for Corizon's mental health staff. Because DOC does not allocate costs between the general inmate population and inmates with a mental health diagnosis, it was not possible to break out the cost of guarding and transporting inmates with mental health diagnoses.[11] Our analysis did show that units housing inmates with mental health diagnoses tend to cost more than other housing units because they require additional correction officers.

Health Department Costs. The cost of providing mental health services to inmates in city jails is funded entirely through the DOHMH and HHC budgets. DOC does not provide any direct mental health services and is only responsible for the transport of inmates with mental health diagnoses to receive services. As discussed earlier, HHC's share of service costs is also comparatively small as their staff only serves inmates in a handful of facilities; in contrast the majority of mental health service costs are borne by the health department. Specifically, DOHMH spent a total of $35.3 million from all sources on correctional mental health in 2012, slightly less than the $35.6 million spent in 2009. In 2009, 55.8 percent of total spending was for Corizon staff and 27.2 percent was for Brad H.-mandated services, including discharge planning staff, the SPAN and Link contracts, and funding for the court-appointed monitors who scrutinize DOHMH's compliance with the Brad H. settlement. By 2012, these shares were 61.1 percent and 27.2 percent, respectively. The remainder of spending in both years was on DOHMH's other mental health staff and the purchase of psychotropic medications for inmates.

The majority of DOHMH's correctional mental health costs are city funded, but the department also receives considerable state and Medicaid funding for its Brad H.-mandated services.[12] In 2009 and 2012, direct city funds accounted for 12.1 percent and 12.4 percent of Brad H.-mandated spending respectively, and for 76.1 percent of overall correctional mental health spending. Specifically, discharge planners are entirely supported by Medicaid funds, and the Link contracts and the court monitors are entirely supported by state funding. The only Brad H.-mandated service that DOHMH directly supports with city funds is the SPAN contract. In comparison, all of Corizon's mental health staff inside the jails are paid for entirely with city funds. The state does provide matching funds for medical services provided by Corizon at 10 percent of total costs, but mental health services are not eligible for this type of funding. In addition, federal law prohibits the use of Medicaid funds for medical or mental health care provided within jails and prisons. In the correctional context, Medicaid funding may only be used for inpatient care received at off-site hospitals and for administrative purposes, for example, the DOHMH discharge planning staff that screen and enroll inmates in Medicaid prior to release.

An Increasing Share of Health Department Spending on Correctional Mental Health Is for Corizon Staff
Dollars in thousands

	2009				2012			
	Direct City	Direct State	Medicaid	All Sources	Direct City	Direct State	Medicaid	All Sources
Corizon Staff	$19,866			$19,866	$21,573			$21,573
Other DOHMH Staff	1,199			1,199	995			995
HHC Psych Medications	4,864			4,864	3,120			3,120
Brad H.-Mandated Services	1,165	5,396	3,104	9,665	1,187	5,036	3,385	9,608
DOHMH Discharge Planning Staff			3,104	3,104			3,385	3,385
Link Contracts		5,155		5,155		4,724		4,724
SPAN Contract	1,165			1,165	1,187			1,187
Court Monitors		241		241		311		311
Total Spending	**$27,094**	**$5,396**	**$3,104**	**$35,594**	**$26,875**	**$5,036**	**$3,385**	**$35,296**

SOURCE: Department of Health & Mental Hygiene
NOTES: Spending on Department of Health & Mental Hygiene staff excludes the cost of fringe benefits. Medicaid is jointly funded by the federal, state, and local governments.
New York City Independent Budget Office

DOC Staffing and Other Costs. It was not possible for IBO to break out the exact cost of Brad H. inmates from DOC's budget as there are many fixed costs involved. It is clear, however, that housing units with inmates with a mental health diagnosis will cost more than other units because they require additional correction officers. Using the current average correction officer salary, IBO calculated an average annual cost per unit. Punitive units for the general inmate population (excluding Brad H.) have six officers per shift. Accounting for 3 shifts per day and making allowance for leave time, IBO assumes that each unit would require 30 correction officers on staff, with an annual payroll cost of about $2.1 million. Some types of punitive units that house inmates with a mental health diagnosis require 8 officers per shift, or 40 on staff. At that staffing level such units have an annual payroll of $2.8 million. These units have a higher number of officers assigned to them in order to handle the transfer to and from the inmates' cells to therapy sessions, medical appointments, and any other out-of-cell appointments they may have. In contrast, nonpunitive units such as general population and Mental Observation have fewer officers assigned to them. The number of officers assigned to nonpunitive units can range from 2 officers to 5 officers per shift, with annual payrolls of ranging from $700,000 to $1.7 million.

Another expense that is directly related to the provision of services to Brad H. inmates is an annual cost of $2.5 million for 32 correction officers to support mandated discharge planning services. In 2001, when the city was preparing to settle the Brad H. lawsuit, the department created the position of mental health discharge planning officer. Despite the title, these 32 uniformed staffers escort inmates from their housing areas to the clinics and do not actually provide discharge planning services.

Changes in Costs and Provisions of Service Over Time

DOHMH's average per inmate spending on correctional mental health services declined by 9.0 percent in 2012 from the 2009 amount. Most of this overall decrease was driven by areas other than direct service staff. Despite the funding drop, DOHMH made progress in expanding the

More Correction Officers Required for Housing With Inmates With a Mental Health Diagnosis

Type of Housing Unit	Number of Posts per Unit	Number of Officers	Average Annual Cost
Punitive			
Mental Health Assessment Unit for Infracted Inmates	8	40	$2,794,480
Restricted Housing Unit	8	40	$2,794,480
Central Punitive Segregation Unit	6	30	$2,095,860
Nonpunitive			
Mental Observation	3	15	$1,047,930
Clinical Alternatives to Punitive Segregation	5	25	$1,746,550
General Population	2	10	$698,620

SOURCE: Department of Correction
NOTE: Average cost per officer is $69,862 (does not include fringe benefits).
New York City Independent Budget Office

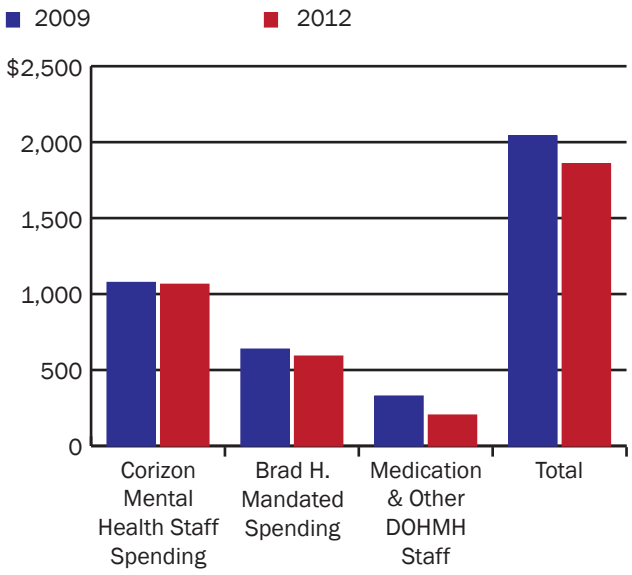
reach of some significant discharge planning services over this time period, most notably the completion of formal discharge plans. However, a number of other discharge planning services that should have been available to class members further along in their incarcerations were reaching fewer inmates in 2013 than in 2009.

Changes in Health Department Costs and Funding. In a comparison of 2012 with 2009, DOHMH's spending on correctional mental health dipped by 0.8 percent, while the total number of inmates with a mental health diagnosis at some point during their incarceration went up by 9.8 percent and the number of Brad H. class members increased by 7.2 percent. Because any inmate referred for mental health services will require some outlay of resources, IBO generally used the broader measure—inmates with a mental health diagnosis—to compare costs. The average per inmate cost was calculated by dividing total DOHMH spending on a given type of correctional mental health service in a year by the total number of unique inmates with a mental health diagnosis admitted during that same year. The one exception is for Brad H.-mandated services, where it was more appropriate to divide spending by the total number of Brad H. class members admitted during that year.

Using this methodology, IBO found that average total per inmate spending on correctional mental health services by the Department of Health and Mental Hygiene declined by 9.0 percent, from $2,041 in 2009 to $1,857 in 2012. Per inmate spending fell slightly for Corizon mental health staffing (from $1,076 to $1,064, a difference of 1.1 percent) and to a somewhat greater extent for Brad H.-mandated services (from $637 to $591, or about 7.2 percent). Together these two spending categories encompass all staff members providing direct services to inmates—the Corizon staff who offer clinical care and the DOHMH staff who provide discharge planning. Most of the overall decrease in per inmate mental health spending (from $328 per inmate to $203, or about 38.1 percent) was driven by areas other than direct service staff, including spending on DOHMH's administrative and support staff and spending on psychotropic medications.

The 7.2 percent decrease in per inmate spending for Brad H.-mandated services is not the full story, however. The number of discharge planning staff declined by a somewhat larger margin, falling 9.9 percent from 81.0 FTEs to 73.0 FTEs. Part of the reason spending has not gone down to the same extent as staffing is that salaries increased. The average salary for all discharge planning staff increased by

Decrease in Per Inmate Mental Health Spending Driven by the Cost of Medication and Support Staff



SOURCE: Department of Health & Mental Hygiene
NOTES: Based on all inmates with a mental health diagnosis. Spending on Department of Health & Mental Hygiene staff excludes the cost of fringe benefits.

New York City Independent Budget Office

4.2 percent, from $48,000 in 2009 to $50,700 in 2012 (the increase for caseworkers was larger, growing by 4.2 percent, from $41,400 to $45,300). According to DOHMH, the salary increases were needed in order to attract more qualified candidates. The health department also spent more on the SPAN contract and court monitors in 2012 than in 2009, though less on Link contracts.

Funding sources for correctional mental health spending shifted somewhat over time. Direct city spending on correctional mental health remained roughly constant from 2009 through 2012, declining by 0.8 percent from $27.1 million to $26.9 million. Direct state spending declined by 6.7 percent, from $5.4 million to $5.0 million. In contrast, Medicaid spending on correctional mental health increased by 9.0 percent, from $3.1 million in 2009 to $3.4 million in 2012. Thus, Medicaid represented a larger share of the funding for correctional mental health in 2012 than in 2009—9.6 percent versus 8.7 percent. Medicaid has displaced state funding rather than city tax-levy dollars, with the city-funded share of correctional mental health spending remaining constant at 76.1 percent in both 2009 and 2012.

Changes in Discharge Planning Over Time. The city does not systematically track inmates with mental health diagnoses once they are released into the community. Therefore, the only data we were able to obtain to assess the impact of mental health services in the jails concern the

discharge planning process. In this case, however, we were able to obtain more recent 2013 data for our analysis.[13]

These data show that, in absolute numbers, the amount of discharge planning services DOHMH provided for Brad H. class members increased for 4 out of 10 services in 2013 compared with 2009. Specifically, the number of comprehensive treatment plans completed, which is the first step in the discharge planning process, increased from 9,787 to 10,117. The number of discharge plans completed, the second step in the process, rose more dramatically from 5,426 in 2009 to 8,492 in 2013. This represents a 56.5 percent increase in the number of discharge plans completed, a far larger change than the 5.9 percent increase in the number of Brad H. patients discharged. There were also small—in absolute terms—increases in the number of Medication Grant Program cards issued and supportive housing applications completed over this time period.

DOHMH's performance on other discharge planning metrics declined in 2013 from 2009 levels. In both absolute numbers and percentages, the largest decreases were in terms of the numbers of Medicaid prescreenings conducted and appointments scheduled. There were 2,327 Medicaid prescreenings conducted in 2013 (918, or 28.3 percent, fewer than in 2009) and 1,057 appointments scheduled (632, or 37.4 percent, fewer than in 2009). The numbers of referrals made, public assistance applications submitted, and Medicaid applications submitted each also fell by more than 13 percent in 2013 compared with 2009. However, evaluating DOHMH's performance solely in terms of these absolute numbers may be misleading for a number of reasons.

Under the terms of the settlement agreement DOHMH is not legally required to provide every service to every Brad H. class member. For example, only SPMI inmates are entitled to help in applying for public assistance and supportive housing. The Brad H. settlement agreement also includes a timeframe during which DOHMH must provide certain discharge planning services, and the agency is not legally required to provide services to inmates who are released from custody before this timeframe is up. For example, DOHMH has from 7 days to 15 days after the mental health intake visit to complete an inmate's comprehensive treatment plan (7 days if the inmate requires mental observation housing, or 15 days if he or she can be housed with the general population). They have an additional seven days after this to complete the class member's discharge plan. If an inmate is released from custody before this period is up, the health department is required only to give him or her access to the SPAN offices. DOHMH is also not required to provide services to Brad H. class members who refuse discharge planning. The data released to IBO did not include information on inmates who were released without discharge plans but who would have been eligible for Brad H. services if the time span allowed for completion of the treatment plan and discharge plan had been shorter.

Provision of Comprehensive Treatment and Discharge Plans Has Gone Up, While the Provision of Most Other Discharge Planning Services Has Declined

			Change	
	2009	2013	Number	Percent
Total Number of Brad H. Patients Discharged (SPMI & non-SPMI)	**14,763**	**15,633**	**870**	**5.9%**
Comprehensive Treatment Plans Completed	9,787	10,117	330	3.4%
Discharge Plans Completed	5,426	8,492	3,066	56.5%
Medicaid Prescreenings Conducted	3,245	2,327	(918)	-28.3%
Walking Medications Provided	2,224	2,213	(11)	-0.5%
Referrals Made	2,081	1,800	(281)	-13.5%
Appointments Scheduled	1,689	1,057	(632)	-37.4%
Medicaid Applications Submitted	576	419	(157)	-27.3%
Medication Grant Program Cards Issued	128	138	10	7.8%
Total Number of SPMI Inmates Discharged	**3,872**	**3,443**	**(429)**	**-11.1%**
Public Assistance Applications Submitted	421	254	(167)	-39.7%
Supportive Housing Applications Completed	129	183	54	41.9%

SOURCE: Department of Health & Mental Hygiene (including data from SPAN and Link)
NOTES: These numbers represent the number of services provided to Brad H. class members by incarceration date. Class members may receive multiple services; which services each person should receive depends on a number of variables including release date, Medicaid eligibility, and whether or not he/she refused services. Walking medications means an inmate was released with a 7-day supply of medication(s) plus a written prescription for another 21-day supply. A public assistance application is for both public assistance and food stamps.

New York City Independent Budget Office

Trends in Share of Eligible Inmates Receiving Various Discharge Services Are Mixed					
	Total Required by Stipulation		Percent Completed		
	2009	2013	2009	2013	Improved in 2013
Services for all Brad H. Patients (SPMI & non-SPMI)					
Comprehensive Treatment Plans Completed	9,961	10,117	98.3%	100.0%	Yes
Discharge Plans Completed	7,548	8,630	71.9%	98.0%	Yes
Medicaid Prescreenings Conducted	3,266	2,356	99.4%	98.8%	Negligible Change
Walking Medications Provided	2,579	2,300	86.2%	96.2%	Yes
Referrals Made	2,215	2,183	94.0%	83.0%	No
Appointments Scheduled	1,731	1,154	97.6%	91.6%	No
Medicaid Applications Submitted	577	455	99.8%	92.1%	No
Medication Grant Program Cards Issued	138	150	92.8%	92.0%	No
Services for SPMI Inmates					
Public Assistance Applications Submitted	424	263	99.3%	96.6%	No
Supportive Housing Applications Completed	184	202	70.1%	90.6%	Yes

SOURCE: Department of Health & Mental Hygiene (including data from SPAN and Link)
NOTES: These numbers represent the number of services DOHMH provided and was required to provide to Brad H. class members by incarceration date. Class members may receive multiple services; which services each person should receive depends on a number of variables including release date, Medicaid eligibility, and whether or not he/she refused services. Walking medications means an inmate was released with a 7-day supply of medication(s) plus a written prescription for another 21-day supply. A public assistance application is for both public assistance and food stamps.
New York City Independent Budget Office

In addition, not every inmate who is legally entitled to receive discharge planning services would actually benefit from each of them. For example, public assistance and Medicaid applications are only submitted for those inmates who meet these programs' eligibility criteria. Thus, a decrease in submission rates may simply mean that there were fewer eligible individuals within the Brad H. class in 2013 than in 2009. There may also have been larger numbers of inmates entering the jail system with active Medicaid in 2013, and who required only reactivation of their benefits upon release. Likewise, a decrease in the share of inmates released with medications may mean that there were fewer class members requiring psychotropic medications in 2013 than 2009.

We can also look at the share of inmates discharged in 2009 and 2013 who received the services to which they were legally entitled. These numbers show that the share of eligible inmates receiving services has improved over time for 4 out of 10 discharge planning services. Most significantly, there was a large increase in the share of inmates released with discharge plans completed (from 71.9 percent to 98.0 percent). There was also an increase in the share of eligible inmates who had comprehensive treatment plans completed prior to release (from 98.3 percent to 100.0 percent) along with marked improvement for two less widely used services (supportive housing applications and walking medications). However, the share of eligible inmates receiving discharge planning services for the other six types of services examined by IBO declined from their 2009 levels. The largest declines were in terms of the number of discharged class members who received referrals for follow-up care (from 94.0 percent to 83.0 percent), had appointments for post-release care scheduled (from 97.1 percent to 91.6 percent), or had Medicaid applications submitted (from 99.8 percent to 92.1 percent).

In terms of both absolute numbers and the share of eligible inmates receiving services, DOHMH has made progress in expanding the reach of a few discharge planning services. Progress has been most notable in the completion of discharge plans. However, some other discharge planning services were reaching fewer inmates in 2013 than in 2009—both in terms of eligible and all class members. Most noteworthy are the declines in the numbers and shares of Brad H. class members receiving referrals or appointments for post-release care, as these make it easier for inmates with mental health needs to receive ongoing care. The decline in the share of eligible inmates with Medicaid applications submitted is also important, as Medicaid is the only means many of these inmates have to pay for care and medication in the community.

Conclusion

Although the average daily population in New York City jails continues to decrease, the number and share of inmates with a mental health diagnosis is growing. These inmates are more likely than the general jail population to be female and white, and tend to have longer lengths of stay than inmates in the general population.

Housing areas designated for inmates with mental health diagnoses require more DOC staff, which is more costly. As of 2012, health department spending had not kept pace with the increasing number of inmates with mental health diagnoses. Total per inmate spending for correctional mental health services fell by 9.0 percent. Most of the decline occured in spending for pyschotropic medications and for DOHMH administrative and support staff, and to a lesser extent for services to help inmates transition from jail to the community as mandated under Brad H. Per inmate spending for staff providing direct mental health services to inmates fell by 1.1 percent. However, given the recent funding of numerous new initiatives through DOHMH's budget, it is likely that the city will spend more money on correctional mental health in 2015 than it did in either 2009 or 2012.

Perhaps most important, it is difficult to gauge whether those services that inmates do receive are having an impact, as neither DOHMH nor DOC tracks inmates with mental health issues post-release. What we can tell from available data is that more than half of DOHMH's discharge planning services were reaching a smaller share of Brad H. class members in 2013 than in 2009, notably the provision of referrals and appointments for post-release care. This finding is critical because stabilizing mentally ill inmates within the jails only has a limited impact if they do not also receive continuing mental health care as they transition back into the community.

Appendix: Recent Initiatives

Although the main focus of this brief is a comparison of DOHMH spending in 2009 and 2012, since then there have been a number of initiatives addressing inmates' mental health. The Bloomberg Administration rolled out two new initiatives in 2013 and 2014. Subsequently, the de Blasio Administration announced $15.5 million in city funding for several additional initiatives targeting a similar population in the Adopted Budget for 2015. More recently, the November 2014 Financial Plan included $89.0 million in new city funding over four years for a series of correction and correctional-health-related initiatives. This was followed closely by the release of the Mayor's Task Force on Behavioral Health and the Criminal Justice System Action Plan, which detailed the use of these funds and pledged about $40 million from the Manhattan District Attorney's asset forfeiture fund. Most recently, the Mayor's Preliminary Budget for 2016 included funding for Enhanced Supervision Housing Units to house inmates determined to be "dangerous" or "at risk" for violence, some of whom will likely require mental health services. (This report was completed prior to the release of the 2016 executive budget.)

Court-Based Intervention and Resource Teams. In 2011, Mayor Bloomberg convened the Citywide Justice and Mental Health Initiative Steering Committee. The committee was tasked with developing policies to address the disproportionately high number of mentally ill inmates in city jails. It released a set of recommendations in late 2012, one of which called for the creation of Court-Based Intervention and Resource Teams. The goal of the court-based teams is to identify a subset of the mentally ill in the criminal justice system population and to divert them away from the jails and into Alternatives to Incarceration and Alternatives to Detention programs. More specifically, the teams are tasked with identifying and diverting from jail people who have been arrested, who meet certain criteria—such as a low risk of failure to appear or to reoffend—and who also have a mental health diagnosis.

According to DOHMH, the most optimistic estimate is that the court-based teams will divert about 3,000 people from the jails annually, but it is too early to measure the results. In terms of program costs, the program is funded through the budgets of both DOHMH and the Criminal Justice Coordinator. DOHMH's actual spending on the teams was $180,000 in 2014 and it is currently budgeted at $3.6 million in 2015, all in city funding.

Program for Accelerated Clinical Effectiveness. DOHMH received new funding in the 2015 adopted budget that will allow the department to convert four existing Mental Observation units into intensive mental health treatment units. These units will be structured similarly to the Clinical Alternatives to Punitive Segregation units, but will only house inmates without infractions. Unlike the clinical alternative units, the Program for Accelerated Clinical Effectiveness units will also house some non-SPMI inmates, though DOHMH expects these less seriously ill inmates to represent only about a third of the population served. These four units are expected to have a combined capacity of 110 inmates.

DOHMH received $5.2 million for 2015 with $6.5 million budgeted for subsequent years to hire new clinical and support staff for these units (primarily through Corizon).[14] The DOHMH-only cost for these new units will be $58,900 per bed in 2016, which is comparable to the department's 2015 per bed cost for the clinical effectiveness program units. Note that this is all new funding and is in addition to any resources reallocated from existing Mental Observation units.

Mental Health Training for Correction Officers. This year's adopted budget also included $4.2 million in new funding for DOC to provide all of their officers with an additional eight hours of mental health training. This training will be developed in conjunction with DOHMH and will be provided to all officers on a yearly basis.

Mayor's Task Force on Behavioral Health and the Criminal Justice System Action Plan. The November 2014 Financial Plan allocated $89.0 million in city funds to DOC and DOHMH over a four-year period in conjunction with the task force's action plan. However, a substantial amount of this funding is devoted to initiatives that do not specifically target inmates with mental health diagnoses, such as increased DOC staffing in units housing adolescent populations and the extension of discharge planning services to inmates who are not Brad H. class members. While it is possible that funding allocations will change as the plan is further developed, at this stage IBO has identified just $15.4 million that is specifically earmarked for programs that focus on inmates with mental health issues.

The plan includes crisis intervention teams, which will provide correction officers with additional training on symptom identification and also pair them with 16 mental health clinicians who will offer tips on how to deescalate confrontations and help prevent the use of force. This

program is jointly funded through DOC's and DOHMH's budgets. Specifically, DOHMH is expected to spend $473,000 in 2015 and $1.7 million in 2016 and DOC's budget was increased by $2.6 million in both years for this program.

The other two initiatives funded through DOHMH's budget in the November 2014 Financial Plan focus on reaching individuals with mental health needs before they enter the jail system. One provides funding for a drop-in center where police officers can bring people with mental health or substance abuse issues as an alternative to arresting them or taking them to the emergency room; a second drop-in center will be funded by reallocating exisisting DOHMH resources. The other initiative provides funding to pilot a new enhanced pre-arraignment screening program at Manhattan Central Booking. The clinical staff conducting the screenings will provide information to judges on individuals who may benefit from mental health or substance abuse services rather than incarceration. Including a small state funding match, these two programs are budgeted at a combined $419,000 in 2015 and $1.2 million in 2016.

Additional Staffing for Enhanced Supervision Housing Units. The Mayor's Preliminary Budget for 2016 included funds for health and mental health staffing at a new type of correctional housing unit to be known as Enhanced Supervision Housing Units. There will be 5 such units, each with capacity for 50 inmates, in 2 jails on Rikers. Initial plans call for adding 24 FTEs in the DOHMH, including 6 mental health clinicians and 1 supervising psychiatrist, at a cost of $2.0 million in 2015 and $3.5 million in subsequent years. Inmates will be assigned to these units who are determined to be "dangerous" or "at risk for violence" based on predictive measures developed by DOC.

Report prepared by Nashla Rivas Salas & Christina Fiorentini

Endnotes

[1]"The top 10 largest local jail jurisdictions in the US" http://www.correctionsone.com/facility-design-and-operation/articles/2076453-The-top-10-largest-local-jail-jurisdictions-in-the-US/
[2]"About DOC" http://www.nyc.gov/html/doc/html/about/about_doc.shtml
[3]U.S. Department of Justice, Bureau of Justice Statistics, Mental Health Problems of Prison and Jail Inmates, revised December 2006. Note that "mental health problem" as used in the study included a recent clinical diagnosis of mental illness, recent treatment by a mental health professional, or symptoms of a mental health disorder. Symptoms of a mental disorder were based on criteria specified in the DSM-IV
[4]Ibid; International Association for Forensic and Correctional Psychology, "Revised Standards for Psychology Services in Jails, Prisons, Correctional Facilities, and Agencies Published in Criminal Justice and Behavior," July 2010.
[5]New York Mental Hygiene Law S 29.15, (b) 14 NYCRR 587, et seq.
[6]Serious mental illness, or SMI, is also used to describe this population.
[7]American Psychiatric Association (2000), Diagnostic and Statistical Manual of Mental Disorders (4th ed).
[8]U.S. Department of Justice, Bureau of Justice Statistics, Mental Health Problems of Prison and Jail Inmates, revised December 2006.
[9]The Council of State Governments Justice Center, "Improving Outcomes for People with Mental Illnesses Involved with New York City's Criminal Court and Correction Systems", December 2012, http://csgjusticecenter.org/wp-content/uploads/2013/05/CTBNYC-Court-Jail_7-cc.pdf
[10]The five jails without permanently assigned on-site Corizon staff are: the James A. Thomas Center (currently closed), the West Facility for inmates with infectious diseases, the Vernon C. Bain Center (services provided by Damian staff), the Elmhurst Hospital Prison Ward (services provided by HHC staff), and the Bellevue Hospital Prison Ward (services provided by HHC staff).
[11]The majority of DOC's budget consists of fixed costs such as employee salaries, fringe benefits, and capital costs. It is very difficult to allocate these types of costs to specific programs or inmates and DOC does not do so.
[12]All state and Medicaid funds go to support Brad H.-mandated services, specifically discharge planning staff, the court monitors, and the Link contracts. While the city contributes to the overall cost of Medicaid, the amount it pays annually is now capped and does not vary based on usage. Therefore a greater reliance on Medicaid funding has no fiscal impact on the city.
[13]While we had originally planned to analyze inmate outcomes—including recidivism and adherence to treatment regimen after release—this was not possible given the data that DOHMH was able to provide. Discharge planning data was provided to IBO by the Department of Health and Mental Hygiene in the form of aggregated tables. The court monitors and plaintiffs' attorneys in the Brad H. litigation, who receive similar data from DOHMH on an ongoing basis, have raised questions about its accuracy and usefulness. An April 2014 court order extending the terms of the Brad H. settlement agreement also included a provision that DOHMH improve its quality assurance practices in regards to data reporting. IBO's experience working with the DOHMH data confirmed some of these concerns.
[14]DOC received an additional $6.1 million in 2015 and $6.7 million a year through 2019 for correction officer staffing within these new units. At a combined DOHMH and DOC cost of $13.2 million in 2016 (all in city funds), the total cost for one bed in a Program for Accelerated Clinical Effectiveness unit will be roughly $120,200 a year (excluding fringe benefit costs for city employees staffing these units).