New York City Council
Joint Hearing: Committee on the Justice System and
Committee on Mental Health, Disabilities, and Addiction

Re: Oversight- Preventing Recidivism for Individuals with Mental Illness and Int 0903 - In relation to funds remaining in inmate accounts when inmates are released
June 17, 2019
Written Testimony of The Bronx Defenders
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Chairs Lancman and Ayala, my name is Julia Solomons and I am the Senior Criminal Defense Social Worker focused on policy work at The Bronx Defenders. The Bronx Defenders ("BxD") has provided innovative, holistic, and client-centered criminal defense, family defense, immigration representation, civil legal services, social work support, and other advocacy to indigent people in the Bronx for more than 20 years. Our staff of close to 400 represents nearly 28,000 people every year and reaches thousands more through community outreach. The primary goal of our model is to address the underlying issues that drive people into the various legal systems and to mitigate the devastating impact of that involvement, such as deportation, eviction, the loss of employment and public benefits, or family separation and dissolution. Our team-based structure is designed to provide people seamless access to multiple advocates and services to meet their legal and related needs.

I. Introduction

I first want to thank you both, along with the rest of the committee members, for taking the time to listen to this testimony today. I also want to thank you and the rest of the City Council for dedicating time and energy to think creatively about how to best serve New Yorkers struggling with mental health concerns and, as a result, often cycling through the criminal legal system and city jails. We are excited about the possibility of expanding services for this population and taking a closer look at how to improve the services we currently have. Our recommendations include:

- Increasing access to free trauma-informed treatment options;
- Breaking down significant barriers to successful treatment; and
- Improving and expanding supportive housing programs.

We believe that increasing the city's capacity in these respects would greatly improve our ability to support our clients with mental health issues in their attempt to gain stability and work towards recovery.

II. Trauma-Informed and Trauma-Responsive Treatment Providers and Therapies

A. Defining SMI

As an initial matter, when we address the issue of mental illness in our communities and within the population of people currently incarcerated in our city jails, we are not just talking about those labeled as "severely mentally ill," or "SMI," by Correctional Health Services (CHS). Mental illness covers a much broader array of conditions. Notably, the National Institute of Mental Health (NIMH), defines SMI as "a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities."[1] Correctional Health, however, uses a narrower definition, further limiting the universe of people considered SMI to severely mentally ill individuals whom CHS is mandated by court order to help with discharge planning upon release (otherwise referred to as "Brad H"[2]). In order to qualify for these services, an individual must present with acute symptoms such as those of psychosis, suicidality, or a diagnosis that would have previously been labeled an Axis 1 diagnosis under the DSM IV. These diagnoses are most commonly: bipolar disorder, schizophrenia, and schizoaffective disorder. While people in custody labeled with those diagnoses or set of symptoms do make up a large percentage of the jail population, there are many people whose mental health disorders interfere with or limit "one or more major life activities" but may not meet CHS' exacting criteria. These people have often experienced complex trauma, and unfortunately, it is very rare that their struggle is correctly defined and appropriately addressed. As a result, many people who would benefit from this type of support during incarceration and upon release do not receive it.

B. Trauma Is Overlooked and Misunderstood

People with a history of trauma—and its attendant effects on their mental health—often fall through the cracks. In our work as Criminal Defense Social Workers at BxD, it is very rare that we work with a client who does not have a significant trauma history. While the research is limited and numbers underreported even within existing research, we know that rates of childhood and adult trauma among the justice-involved population is very high**.** One study found that over 56% of incarcerated men reported childhood physical abuse and one in six reported experiencing sexual or physical abuse before age 18.[3] Additionally, trauma looks different for

[1] Retrieved from https://www.nimh.nih.gov/health/statistics/mental-illness.shtml.
[2] For additional information on Brad H, et al. vs. the City of New York, et al. (2000), see https://mhp.urbanjustice.org/sites/default/files/The_settlement.pdf.
[3] Wolff N., Shi J., Siegel J. Patterns of victimization among male and female inmates: Evidence of an enduring legacy. Violence Vict. 2009;24:469–484.

everyone — in fact, it is defined by how a person experiences a given event.[4] It can range from a female client who was sexually abused throughout her childhood by a caregiver, to a young adult male who grew up in public housing surrounded by violence and saw his first dead body at six years old. These types of traumatic experiences change people's brain function in the same way that brain chemistry is affected by a mood or psychotic disorder, but the symptoms are not as easily identified, or at least identified correctly. For this reason, many of our clients either receive no treatment or they receive inappropriate diagnoses and treatment for their mental health conditions.

We believe that funding more trauma-informed and trauma-responsive mental health providers, both in our city jails and in the community, would dramatically reduce recidivism. Trauma-informed providers have an understanding of how trauma affects the brain and what behaviors manifest as a result, and are trained to respond appropriately to those exhibiting trauma responses when triggered. As of now, despite the high prevalence of trauma histories among incarcerated individuals, there are very few accessible, trauma-informed providers within New York City. The few that do exist, like the Crime Victims Treatment Center, often have extremely long wait times to be connected with a therapist, and even longer times to be connected to a psychiatrist and receive regular access to medication. This means that many people who could benefit immensely from this type of targeted mental health intervention often live for years with unaddressed complex trauma. It means they end up cycling through our hospital and jail systems without regular access to providers, being misdiagnosed and treated ineffectively. It means that often our only option for getting our clients connected with treatment providers in a timely manner is to connect them with anyone who has an available appointment, or any residential program with an available bed.

The majority of accessible providers are not trauma-informed or trauma-responsive, despite often labeling themselves as such, and this lack of understanding often ends up causing harm to our clients. For example, we had a client recently who was participating in substance abuse treatment and during the group sessions she read her bible to help her stay present in her body and in the group. It is common for people with a history of trauma to dissociate during difficult or triggering conversations, and for this client reading her bible served as a tool to prevent that. The program clinicians, however, did not have a trauma-informed approach and wanted to discharge her from the program for being non-compliant. Beyond the limited availability of trauma-informed clinicians, most treatment options in the city are not at all accessible to those who do not qualify for insurance. As a result, our clients struggle to find any therapeutic support, let alone a trauma-responsive provider. We call on the City to fund free trauma-informed and trauma-responsive mental health services, ideally those that provide wraparound services but at a bare minimum easy and expedited access to psychiatric as well as therapeutic interventions and continued support.

III. Break Down Barriers to Successful Treatment

[4] Substance Abuse and Mental Health Services Administration (SAMSHA), 2019. Retrieved from https://www.integration.samhsa.gov/clinical-practice/trauma

Homelessness is an acute challenge for a large percentage of New Yorkers struggling with mental illness. For many of our homeless clients in the Bronx who seek a treatment resolution for their criminal case, we see that they are typically only approved to be monitored by court-sanctioned alternatives to incarceration like Mental Health TASC if they are placed in a residential setting. Not only does that limit the pool to people with some type of co-occurring substance use disorder (as those are the only residential treatment settings that currently exist in New York City), it also all but eliminates that possibility for anyone that does not fit the traditional mold of residential treatment.

Existing residential treatment programs are extremely limited in who they are able to serve successfully. Many of these programs are not at all trauma-informed and they do not offer trauma-focused therapies. They are therefore often ineffective for people with significant trauma histories that affect their engagement with treatment. Additionally, we see the restrictions of "not mentally ill enough" range also to "too mentally ill," and result in an extremely small pool of people with mental health issues who actually qualify for residential treatment. If a client has any even semi-recently disclosed suicide attempts or suicidal ideation, for example, no program will take a risk on them. The same standard applies to anyone with active hallucinations or delusions — it is extremely difficult to find a residential program that is able to "meet their needs" as we are often told by program providers.

Beyond the limiting qualifications of who needs treatment enough but not too much, there are a host of other barriers that bar large groups of our clients from accessing effective treatment, especially residential treatment. The same barriers often apply to outpatient treatment as well. Among these barriers are gender identity, language access, and sex offender status, to name only a few:

- With regard to gender identity, we see our transgender clients being rejected for residential programs for the sole reason that they don't outwardly present as the gender with which they identify. The rates at which transgender clients experience trauma are astronomical, yet they have one of the most challenging experiences of attemping to access gender-affirming treatment options.

- With regard to language and cultural sensitivity, despite the diversity of our population in New York City, mental health providers in both outpatient and residential treatment programs are very rarely able to accommodate clients who speak a language beyond English and Spanish. For example, we have had situations in which everyone involved in a case (the client and his defense team, the judge, and the prosecutor) is in agreement that a non-English speaking client presents with an acute need for mental health treatment but for whom no one is able to find appropriate services that can accommodate specific language needs.

- Perhaps the most stigmatized subset of justice-involved individuals with mental health needs are those on the sex offender registry. The only long-term residential treatment program in the city that accepts those on the sex offender registry is not staffed as a "mentally ill and chemically addicted (MICA)" program, meaning it is unable to

accomodate those substance users with even the most mild of mental health needs. It is our experience and belief that there are no long-term residential programs in New York City that can currently accommodate someone with mental health needs on the sex offender registry. This means that if someone ends up on the registry for committing an offense that may have correlated with unmet mental health needs, the likelihood of that person ending up incarcerated again for a similar offense is high. Barring them from receiving what may be a critical intervention does not effectively keep the public safe nor does it prevent them from cycling back through our city jails.

IV. Improve and Expand Supportive Housing Systems

We were excited to hear of Speaker Johnson's plan to fund one-hundred additional beds in transitional housing for justice-involved men. This is an important first step, and we hope to offer support in shaping this new system and any additional supportive housing efforts to be as efficient and effective as possible. Homelessness is a huge barrier to stability for New Yorkers struggling with mental illness. Lack of stable, accessible housing in our city is undeniably a contributor to the revolving door of justice involvement for this population. In 2013, one third of the homeless population in New York City was identified as having at least one serious mental illness, 50-70% of which also suffered from a co-occurring substance use disorder.[5] We suspect that this number is underreported and, due to the increasing scarcity of housing, may have increased since this study was conducted.

A. Supportive Housing Is Difficult to Access

Even within the small universe of available beds, the numbers of people accessing supportive housing and remaining stably housed are even lower than they could be due to barriers that exist within our existing supportive housing system for people with mental health concerns. The centralized application form for supportive housing, for example, commonly known as the 2010e, is required as a first step to obtain permanent housing. Unfortunately, only a limited number of mental health providers in the city have access to this online system. Part of the reason for this is that completing applications is a very lengthy, involved process for which not many social service organizations have capacity. It involves up-to-date psychiatric evaluations and psychosocial assessments that must have been conducted within the past six months, and if that time elapses they must be submitted all over again. Once all the necessary documents are obtained, the packet goes through an approval process and is then submitted to various agencies that provide the housing and interviews are scheduled. The whole process takes several months and requires that the individual be in active contact with the service provider throughout in order to complete the packet, attend the interviews, and ultimately be placed, and given the transient nature and many barriers for this particular population, making it successfully through this process is very difficult without significant assistance.

[5] Groton, D. (2013). Are housing first programs effective? A research note. *Journal of Sociology and Social Welfare, 40*(1), 51-63.

With regard to re-entry, CHS' discharge planning department is, thankfully, one of the service providers in the city that has access to the 2010e application. Unfortunately, however, the likelihood of accessing the application while incarcerated, even for the limited number of SMI individuals who receive discharge planning support, is slim. The services provided to our clients by discharge planning vary greatly by facility, by individual CHS social worker, and by individual client. In our experience, there are some discharge planners and some instances where the process of submitting a 2010e application for the client begins almost immediately after their initial mental health assessment upon intake, and other instances where despite our fiercest advocacy, clients who are otherwise eligible to be approved for supportive housing languish for months in the city jail system without ever having an application completed. In one case, after following up with my client's assigned discharge planner several times about beginning the 2010e, I was told that though my client was technically assigned the "SMI" designation and thus received discharge planning services, she was in category in which her mental health status was not "severe enough" to qualify for discharge planning assistance with the 2010e. Even though she would likely be approved for the housing assistance should the application be completed, she was not "sick enough" to receive help completing the application.

B. Once Housed, Residents Do Not Often Receive Adequate Support

Not only are the barriers to successfully being placed in supportive housing significant, but once housed in one of the buildings run by a supportive housing agency, the conditions for this extremely vulnerable population are often not structured to result in long-term stability. We hear countless reports from our clients in supportive housing that they do not have regular, reliable access to the case management support they are supposed to receive. Additionally, when they are struggling with issues directly related to their housing and safety, such as problems with another resident, they find it very difficult to get any assistance. The case management staff are often overworked and overburdened, and the bureaucracy that clients have to navigate in order to make any necessary changes to their housing is nearly impossible to achieve without extremely persistent advocacy. For example, we have had clients report that when they have a neighbor who is not on their medication and may be actively symptomatic and threatening to harm them, they receive little to no response on the part of the agency managing their housing. Requests to move units are in large part ignored but those that are not take far too long to happen, especially if a situation is acutely dangerous for that client and a threat to their stability. We also see this in situations where clients in recovery from substance use are placed in a housing site that, meaning they might have completed drug treatment and be in recovery but their neighbor is actively using drugs — a direct threat to their sobriety and therefore stability. Unfortunately, it is not uncommon for us to witness how the stigma of being a person who lives with mental health issues affects their ability to successfully advocate for themselves in situations like these. Providers often do not view our clients as credible historians given their own history of active hallucinations or delusions despite being currently stable and clear-headed.

We hope that with the creation of new systems for both transitional and supportive housing can come smoother processes for our justice-involved clients with mental health concerns, as well as more structure and active support in place within these agencies given the vulnerable nature of their residents and the many complications that come along with housing such a high-needs

group of people together in one location. At this critical juncture, we must remember that it is not only quantity of available beds, but also quality of life and of service provision that will bolster stability and reduce recidivism for this population in the long-term.

V. BxD supports Int 0903

Before closing, I want to briefly address the proposed legislation, Int 0903, regarding the accounts of people in custody after they've been released. The Bronx Defenders' supports this proposed local law requiring the Department of Corrections to release inmate account funds to the formerly incarcerated person in a timely manner as these funds are often critical to achieving post-release stability and may be the only immediate source of income they have, especially if that person's public benefits were temporarily frozen during their incarceration and there is a slight delay getting them back on. We are encouraged by this legislation and are hopeful to see it go into effect as soon as possible.

IV. Conclusion

There are innumerable opportunities to improve and expand our mental health treatment systems that would help reduce recidivism for people struggling with mental illness. The expansion of understanding around what mental illness looks like and who needs and deserves effective treatment and the subsequent funding and creation of more accessible trauma-informed therapeutic interventions is critical for making positive change in this arena. Additionally, breaking down some of the most egregious barriers to accessing treatment for vulnerable or otherwise stigmatized populations would greatly expand the numbers of people able to access treatment, both as an alternative to detention or incarceration and also upon re-entry to society after a period of incarceration. Moreover, careful analysis of the existing supportive housing systems and programs within those systems in the consideration of expanding and improving our clients' access to housing stability is critical. We encourage the City Council to take great care in thinking through these complicated issues, and to regularly consult with and receive feedback from those New Yorkers with lived experience of mental illness and subsequent justice involvement. Finally, we support Int 0903, believing it to be urgent that people returning to the community receive the funds in their immediate accounts as soon as possible.

Thank you again for taking the time to address these important issues today and we look forward to next steps.