**Testimony of**
**Phillip A. Saperia**
**on behalf of**


**before the**

**New York State Assembly Standing Committee on Mental Health, Mental Retardation and Developmental Disabilities**

**New York State Assembly Standing Committee on Alcoholism and Drug Abuse**

**New York State Assembly Standing Committee on Correction**

**New York State Assembly Standing Committee on Codes**

**March 2, 2000**

***Mental Hygiene Services in Local Correctional Institutions***

Chairmen Brennan, Aubrey, Weisenberg, Lentol, distinguished Committee members, good afternoon. My name is Phillip A. Saperia and I am the Executive Director of The Coalition of Voluntary Mental Health Agencies, Inc. For those of you who are not familiar with our work, The Coalition is New York City's advocacy organization representing a network of over 100 nonprofit community-based mental health agencies. Taken together, The Coalition's member agencies serve more than a quarter of a million clients and deliver the entire continuum of mental health care in practically every community and neighborhood of our very diverse New York City.

I would like to thank you for holding this hearing on what we consider to be an extremely important issue. As growing numbers of people with mental illness are incarcerated, connecting released prisoners to appropriate treatment in the community is of ever-growing importance.

According to the Department of Correctional Services, five percent of their population has a severe psychiatric disability and another 10% has a significant psychiatric disability. Even without taking into account the likely under reporting, over 10,000 New Yorkers with severe and persistent mental illness are currently incarcerated in State prisons. Transition back into community living is difficult for people being released from incarceration; for people with serious mental illnesses it is even more difficult.

I would like to talk to you today about two things that the legislature can do to facilitate return to the community by inmates with psychiatric disabilities: provide presumptive Medicaid eligibility and ensure sufficient and appropriate discharge plans. Before I discuss what could be, please allow me a moment to discuss the system currently in place.

If we tried to craft a system that would induce relapse and encourage recidivism, we would be hard pressed to come up with a better one than we have now. We know that the first 30-90 days after discharge are the most difficult period for a person with a mental illness as they try to readjust to community living. We know that reincarceration is more likely for those who are unable to access appropriate community-based care.[1] We know that expanded access to case management services, both within and outside of jails, helps people with mental illness live in the community and avoid the need for additional detentions.[2]

Despite this knowledge, the system currently in place denies people Medicaid eligibility for 30-90 days after discharge, making it additionally difficult to access community based treatment. The system is set up to provide case management services to only a small portion of the people with mental illness released from jails and prisons. Perhaps they get a phone number of a community-based agency that they can call. Perhaps they get a one or two week supply of the medication they were receiving while incarcerated. Perhaps they are among the fortunate few who have somehow accessed a link or bridger program to connect them to services in the community. Most, however, get nothing more than a two-ride Metrocard and $1.50 upon their release from Rikers Island, one of the two largest providers of mental health services in the nation (along with the L.A. County jail). The system needs to change.

The most important thing the legislature can do to enable people with mental

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[1]Draine, M.S.W., Jeffrey, Solomon, Ph.D., Phyllis and Meyerson, M.D., Arthur, *Predictors of Reincarceration Among Patients who Received Psychiatric Services in Jail*, Hospital and Community Psychiatry, Feb. 1994, 45(2), 163-167.

[2]Ventura, Ph.D., Lois, Cassel, Ph.D., Charlene, Jacoby, Ph.D., Joseph E., Huang, Ph.D., Bu, *Case Management and Recidivism of Mentally Ill Persons Released from Jail,* Psychiatric Services, Oct. 1998, 49(10), 1330-1337.

illness to access the care they need when they are released from jail or prison is to provide them with presumptive Medicaid eligibility. Many of you, I know, are already familiar with this issue, so I will try to be brief.

When an individual is incarcerated their liberty is not the only thing they lose. Their Medicaid coverage is also lost. This causes no problems while they are imprisoned, they receive medical treatment while they are confined. Once they are released, however, this causes tremendous problems.

Individuals with mental illness returning to the community from stays in jails, prisons, and I should add hospitals, need immediate access to psychiatric care and medication. In order to transition from these settings back into the community, they must have access to medication, case management, treatment services and appropriate housing. Immediate access to these services is the best way to guarantee a safe return to the community for this population, and reduce the reincarceration rate.

Most hospitals give patients a two weeks' supply of medication upon discharge, but beyond that, the patient must rely on his/her own ability to negotiate the system to obtain medication and services without insurance coverage. The situation is worse for mentally ill prisoners leaving prison and jail, for they are given little or no medication upon release, and are seldom referred to mental health treatment in the community. Without immediate access to Medicaid insurance, even good discharge plans fail, leading to a senseless waste of human potential and money: a revolving door of homelessness, hospitalization, incarceration and tragedy.

An individual discharged into the community without Medicaid must take it upon

him/herself to apply, most often without the help of jail or prison staff. It takes between 45 and 90 days for the Department of Social Services to determine eligibility according to State Social Service law. This means that even under the best of circumstances, if an individual applies for Medicaid on the day s/he enters the community, if the application is correct and complete the first time around, if everything goes as smoothly as possible, at best Medicaid eligibility will be granted in a month and a half. The period of time most critical to success, when treatment and services are most desperately needed is the same period during which we deny people Medicaid coverage.

Presumptive eligibility eliminates the waiting period that occurs while Medicaid eligibility is verified by local Social Services district staff and replaces it with a 90-day assumed eligibility period. This enables people to access the intensive care and treatment they need during the difficult transitional period.

This program should replace the county-operated medication management program proposed in the Executive Budget. First and foremost, medication is not treatment. Providing a person with pills alone is a stopgap and ineffective way to treat a serious mental illness. It is safer and more efficient to allow access to all Medicaid services for this population than to guarantee access to medication unaccompanied by any other Medicaid treatment.

Additionally, presumptive eligibility maximizes the impact of the State's dollars. The proposed medication management program relies entirely on State funds, while presumptive eligibility will draw down Federal subsidies. Furthermore, the medication grant program is proposed to be implemented on a county-by-county basis. In counties that choose not to participate, consumers will be excluded from the program. In order to participate, counties must set up an entirely new layer of

bureaucracy, drawing scarce resources away from the consumers who need them.

Furthermore, once a determination of eligibility is made, Medicaid will reimburse for services up to 3½ months prior to the date of initial application. This means that for consumers who are ultimately deemed eligible, no general fund dollars are necessary. The provision of presumptive eligibility will maximize the benefit of State dollars to people with mental illness and provide the continuity of care that they need.

The other critical area that the legislature must address is the case management and discharge planning that bridges the treatment gap between incarceration and the community. Continuity of care is exceptionally important for people with mental illness. While it is impossible to provide completely continuous care to a person who is moving from the criminal justice system to the community, it is essential that everything possible is done to connect the care received on the inside to the care needed on the outside.

Here in the City we have a program called New York City Link. This innovative model not only provides people coming out of jail with the necessary linkages to community-based providers, but also follows them into the community for two years to ensure that they remain engaged in affordable, accessible treatment. Now instead of a one-week supply of medication, a list of mental health providers and a pat on the back, some people with psychiatric disabilities are introduced to a case manager who will accompany them upon release to a care provider, help them secure their entitlements, connect them to peer support groups, ensure their access to psychiatric medications and facilitate the necessary communication between the jail treatment team and the community-based provider.

The benefits of this approach are manifold. Not only does it diminish the suffering of people with psychiatric disabilities, but it saves the State money as well. Without appropriate linkages, people fall through the cracks and may end up homeless, decompensating, presenting at psychiatric emergency rooms and shelters and all too often rearrested and reincarcerated. If linked to the needed treatment and housing services the cost of providing care is significantly lower than the cost of homeless shelters of jail cells.

Of 118 clients linked to services by the NYC Link program between July 1997 and June 1998, only seven were rearrested. These outcomes are very encouraging and to the credit of the State Office of Mental Health, they are expanding it. It is not, however, perfect, and I would like to highlight a few ways the program could be improved.

First and foremost, even with the expansion, the capacity of the program is desperately inadequate. Currently the Link program has the capacity for approximately 1200 clients per year. Even if the program were expanded ten-fold, there would still be thousands of people with mental illness discharged from jails and prisons who would not have access to the Link program. Every year State prisons and City jails discharge over 22,000 people with psychiatric disabilities.

Another peculiarity of the system under which the Link program runs is that the pre-work-up of the clients is not done by the Link provider, but by the City Health and Hospitals Corporation. This is a golden opportunity lost. If the Link provider did the pre-screen, not only would it be consistent with the post-release care, but they would also develop a relationship with the client before they are discharged. This would cast them in a position of a helper who will engender some degree of loyalty from the client that would be very helpful in ensuring compliance after

release.

Another problem with the Link program is not unique to it, but is symptomatic of the general crisis in community mental health. The director of the program here in Manhattan indicated to me that her staff turns over completely once every two years. Staff leave at an alarming rate because the salaries offered are so uncompetitive. Absent a trending mechanism that allows salaries and other expenses to keep pace with inflation, it is impossible to keep qualified staff in the program. Unless this problem is addressed we will never have the mental health system New York deserves.

If we provide presumptive Medicaid eligibility, and adequate resources for appropriate discharge planning to people with psychiatric disabilities coming out of jails and prisons we will be able to break this vicious cycle of incarceration, release, relapse and reincarceration that is claiming the lives of so many New Yorkers.

The Coalition of Voluntary Mental Health Agencies looks forward to working with these Committees and the rest of your colleagues to craft a mental health care delivery system that is responsive to the needs of consumers coming out of jail and prison. Thank you.