



ASSEMBLY STANDING COMMITTEE ON CORRECTION
ASSEMBLY STANDING COMMITTEE ON MENTAL HEALTH

Hearing on Mental Illness in Correctional Settings

**TESTIMONY OF LISA SCHREIBERSDORF,
EXECUTIVE DIRECTOR, BROOKLYN DEFENDER SERVICES**

My name is Lisa Schreibersdorf. I am the Executive Director of Brooklyn Defender Services (BDS), a public defense office that represents half of the people who are arrested in Brooklyn annually. I am here today to testify to our experiences representing people with mental illness who have been arrested, detained or incarcerated in New York City by the New York Police Department and the New York City Department of Corrections. Thousands of our clients will spend time in a city jail, such as Rikers Island, each year – the vast majority in pre-trial detention because they have been unable to post bail. Many of our clients also are sentenced to serve time in either New York City facilities or upstate prisons and others have been deported through cooperation between local agencies and Immigration Customs Enforcement. Our testimony today is about the local facilities in New York City.

BDS represents over 40,000 clients each year who are arrested in Kings County, of which about 6,000 are incarcerated at some point during the pendency of the case. While it is difficult to quantify the number of clients with mental health symptoms, it is fair to say that more than 50% of people who are incarcerated suffer from serious mental health symptoms either because they have been previously diagnosed with a mental illness or because the experience of incarceration has caused them to experience symptoms like depression, suicidality and trauma.

For clients who have diagnoses such as Schizophrenia or Bipolar Disorder, BDS has two specialized attorneys in a unit of our Criminal Defense Practice dedicated to addressing the cases of these clients. This unit includes other specialized staff to address the unique needs of these clients and their families. In addition to these Mental Health Attorneys, our other criminal defense attorneys (over 100 attorneys), work daily with clients who have obvious symptoms of mental illness as well as clients who later develop symptoms. Our expertise in the area of persons with mental illness is vast; our Family Defense Practice represents about 2000 families at all times, of which half are at risk of losing their children solely because of their mental illness. Our team of licensed social workers and a full time jail-based client liaison provide logistical support for our clients during their legal cases and provide supportive counseling as well – particularly critical for clients with mental health issues who are spending time incarcerated. These team members communicate with Department of Health and Mental Hygiene (DOHMH) staff persons to assist in advocating for, accessing, and coordinating mental health treatment for detained BDS clients with serious mental illness and transitioning clients to the community upon discharge. Similar to the rest of our caseload, our mental health cases arise

from a wide range of alleged criminal offenses ranging from trespass and drug possession to felony matters. We find that people who have a mental illness are unfortunately quite vulnerable to arrest and typically receive significantly worse outcomes at every step of the criminal legal process than other clients. This testimony reflects the collective experience of our tens of thousands of clients, as well as our team of social workers, our jail-based services liaison, and over 150 attorneys.

THE SWIFT DECOMPENSATION OF PEOPLE WITH MENTAL ILLNESS IN THE SYSTEM

Over the past decade there has been a dramatic increase in the number of people held in City jails who have a mental health diagnosis. Today this demographic represents some 40 percent of the overall population at Rikers Island. Often lacking the community ties to support a successful bail application, mentally ill New Yorkers are disproportionately pulled into pre-trial detention and held in City jails during the processing of their cases. While each of our clients arrives with a unique history and circumstances, different strengths and challenges, most of our incarcerated mental health clients share particular patterns of decompensation while in the custody of the New York City Department of Correction. These clients typically have a hard time adjusting to the distressing conditions of jail and struggle to follow the seemingly arbitrary and inconsistent rules that govern their behavior while they are locked up. Even if they have been receiving good care prior to incarceration, medication is the sole option for treatment once they are in jail. Clients suffer many breaks in their treatment, especially abrupt changes in the medication they were on and many stops and starts with medication while in jail. It is very common for our clients who are not getting the full breadth of treatment they need to decompensate very quickly. Many of our clients act out, disregard the orders of Correction Officers or commit minor jail infractions like failing to bath or not maintaining a tidy cell. Such clients can be frustrating to other inmates and are likely to be victimized while in jail. Clients who are expressing symptoms of mental illness may appear to be disobeying orders or even be perceived as aggressive by DOC staff. They are disproportionately placed in solitary confinement, which by its nature is guaranteed to exacerbate their mental health symptoms. They decompensate further, sometimes attempting suicide and always losing ground in the lifelong battle they wage with their illness. This lost ground may never be recovered as additional symptoms, diagnoses, physical injuries and mental trauma from the experience leave their indelible mark on these clients. When their case is resolved, they are, for all intents and purposes, cast back out into the neighborhoods of our borough, less able to manage their illness on their own, further disconnected from family, friends and without knowledge of how to continue their medication regimen or where to go should they want assistance. Often they were arrested for a minor crime and the end result is to leave them much worse off than they were before their arrest – at a tremendous financial cost to the City.

DIVERSION

Below is a case example of one of our clients:

“Sarah”, a woman in her late twenties, has no prior arrests, but a long mental health history. She lived in the community, with the support of an ACT team and her family. Sarah had no history of violence. Her family noticed she was decompensating and petitioned for a Mental Hygiene Warrant for involuntary psychiatric evaluation. Prior to the execution of the warrant, Sarah had an altercation with a family member. The police responded to the situation by

arresting her. Unable to post bail at arraignments she was transported to Rikers Island where she swiftly began to decompensate further. She deteriorated rapidly and just a few weeks after arriving in City custody, she was admitted to Elmhurst Hospital prison ward for acute medical attention. Finally, her family, who never wanted her arrested in the first place, was able to secure her release on bail.

This client, with the support of family and an ACT team, could have been guided to proper hospitalization and treatment. Instead, law enforcement aggravated the already fragile relationships in this family and missed an opportunity for her to begin a course of treatment that could be sustainable and life-altering in a positive way.

Jerome Murdough, a homeless, mentally ill U.S. Marine Corps Veteran, died in Department of Correction custody earlier this year after being neglected in a mental observation unit at Rikers Island. He had been arrested for trespassing after attempting to sleep in the stairwell of a public housing building. His bail was set at \$2,500, an amount too high for him to pay. After approximately two weeks in Rikers Island he died as a result of a toxic combination of medication given him while in DOC custody, cell temperatures that exceeded 103 degrees and a lack of attention from medical and mental health staff during his incarceration.

These stories illustrate the most compelling problem we see on a daily basis—people with mental illness are arrested for low level offenses that could easily be a basis for hospitalization or other medical intervention. Yet instead they are taken into custody. They could be released by the court, but instead bail is set. Thousands of such people pass through Rikers Island without any thought to their individual health or safety nor any broader policies or principles that make any sense.

It is obvious to us that amount of money being spent to essentially exacerbate the problems of the mentally ill could easily be re-directed into community treatment options to address the health needs of these very same people. The current practice of utilizing jails and prisons as mental health “treatment” facilities, at an astronomical price, is not sustainable, effective or morally justifiable. Furthermore, the practices of New York City when it comes to incarcerating people who have committed nothing more than nuisance offenses has got to come to an end. There is no doubt that this type of charge is disproportionately used against people with mental illness who are unable to cope in our society and are trying to do what they can to survive—hurting no one in the process. We urge the New York State Assembly to reduce the number of people with mental illness in correctional custody and invest in community-based high-quality mental health care, housing, education and targeted preventative, diversion and reentry services.

THE NEED FOR PRE-ARREST DIVERSION

For our mental health clients, the disruption of treatment and the path to possible decompensation begins at the moment police respond to the scene. This is why we believe that diversion is an essential starting point for reforms.. We believe that the greatest good can be achieved by decided not to arrest individuals with mental illness if there is another safe and viable alternative, particularly in low level offenses. In New York City today, when a 911 call comes in requesting emergency assistance for what is commonly referred to as “Emotionally Disturbed Person (EDP),” the options of the first responder teams, which are typically comprised entirely of police, are very limited. These first response teams should be expanded to include

social workers and/or mental health clinicians trained to conduct critical assessments during moments of crisis. Additionally the police should be trained to interact with potentially mentally ill people and their families in a manner that de-escalates the situation. Linkages to treatment and hospitals or other service referrals should be the first steps before a consideration of further involvement by the criminal justice system.

Around the country there are various models, including multi-disciplinary “Crisis Intervention Teams,” (CIT) which create better outcomes during the initial contact with the criminal justice system for people with mental illness. This model includes the possibility of going to a hospital rather than being arrested, diverting the person from the criminal justice system entirely. We are encouraged by the State’s commitment to fund a CIT pilot program, and hope the program will be implemented broadly in the future should it prove effective. If people are identified as having a mental illness, community-based services, not the legal system, is the best first option whenever possible.

The state should also review mandatory arrest policies. Many police calls come from family members or loved ones seeking crisis mental health services, referrals and assistance, not a criminal justice response. Discretion has been eliminated from the police in many matters, especially those that can be categorized as “domestic violence”. Even if the police believe the mentally ill person should go to the hospital rather than jail, they are not permitted to do anything other than arrest the person. This is discouraging because many families call the police in the hopes of receiving help and feel betrayed by the arrest of their loved one. We believe this dynamic contributes to the dangerous escalation of some situations and adds to the tense relations between the police and the communities served by our office.

By giving the police more options and more discretion regarding the response to people with mental health issues, especially on lower-level offenses, the moment of contact can be an opportunity to begin treatment rather than the start of a slide backwards.

MEETING TREATMENT NEEDS AT ARREST

Under current practices, when our clients are arrested, they spend about 20 hours at the precinct and at central booking before they are arraigned by the court. During this time, most of our clients have not been given their medication. This critical period of time between arrest and arraignment must be looked at carefully by the legislature.

Our experience is that police officers are generally unwilling to give ANY of our clients ANY medication while they are in custody immediately after arrest. There are hundreds of stories about family members at the Precinct begging the officers to give their loved one blood pressure or asthma medicine to get them through the next 24 hours with little success. Last year an elderly female client of ours died right after her arraignment because she was not provided with diabetes medicine during her stay in custody even though her sister came to the precinct with the insulin. Clients who themselves ask to see a doctor or go to the hospital are discouraged and even threatened by the officers, resulting in few seeking treatment during this time. These practices are unacceptable on their face and result in serious harm and death on a shockingly regular basis. For people with a mental illness, this unwillingness to meet the medical needs of arrested people results in significant decompensation which could take three weeks or more to remedy.

We recommend that the committee review policies and practices at the time of arrest and until the police turn over custody of the individual. Certainly any person who needs medication should be able to receive this medical treatment even though they have been arrested.

BAIL

Issues such as homelessness and substance abuse which frequently co-occur with serious mental health issues can leave this demographic more likely to have bail set. It is not uncommon for clients who have been identified with serious mental illness at arraignment and are charged with low-level, non-violent offenses to be detained and sent to City jails. The legislature should analyze and review the information regarding why people are in custody prior to conviction and consider significant changes to the current practices and policies surrounding the application of bail. There are many suggestions we can make about bail for misdemeanor cases, but some that would have the biggest impact on the mental health clients are (1) supervised release as an alternative to bail; (2) regular review of bail by the court with a presumption that bail should be lowered or eliminated if a person cannot post that bail; (3) presumptive release for a person with a mental illness if they are going to a treatment facility or a valid treatment plan has been proposed to the court; (4) amendment of the Mental Hygiene Law to allow judges to civilly commit a person charged with a misdemeanor without requiring the consent of the District Attorney.

CURRENT STATUS OF MENTAL HEALTH TREATMENT FOR CLIENTS IN CITY CUSTODY

The provision of mental health care in City jails has become so abysmal that the New York City Council is considering voiding the contract of the private medical company, Corizon, that services Rikers Island. Already, arrest and arraignment processes typically ensure that our mental health clients will be without their medication for more than 24 hours before they are seen by Department of Health and Mental Hygiene staff at intake to City jails. Many clients report that even once they are in DOC custody they do not promptly receive a mental health evaluation or medications. In addition, there is not an appropriate range of mental health care options for people housed in City jails. There are problems with medication continuity and delivery, a lack of individualized assessment and programming and inadequate confidential treatment space. Along with the questionable medical treatment, there is also a stark lack of safety—housing units are rife with inmate violence and there is no shortage of harmful and violent responses from Correction Officers.

Medication remains the only “treatment” for nearly all of our clients in City jails irrespective of their mental health needs that require other interventions. Our clients report that they rarely receive the opportunity for group or individualized therapy, dual-diagnosis therapy, or treatment from specialists in trauma, posttraumatic stress, sexual violence, adolescence, family or other discrete fields even though such modalities are considered part of, not supplemental to, medically appropriate treatment. One client summed it up like this recently: “Once a month someone renews my pills and asks me if I want to kill myself.”

There are concerns with the medication as well. Medication should only be prescribed by a psychiatrist who spends adequate time with a patient. In our experience this is not the typical experience at Rikers Island. Not only are there not enough psychiatrists, the quality of doctors

who work there is quite low. They are also limited in what they will prescribe; keeping to low-cost medications that are not what the client was previously taking and which may not be medically appropriate. When they do get medication, most clients report disruption from their regimen at some point during their incarceration in city custody. This occurs due to a variety of reasons, starting with delay or denial in the first instance. Once on medication, clients report failure by staff to renew medications, difficulty getting medications due to escort restrictions or facility lockdowns, transfer between facilities, and housing restrictions—all causing interruptions in medication. Many medications must be given consistently to work. Any break can have drastic consequences, such as rapid decompensation, which then results in the cycle described in our introduction.

Another issue is that the physical infrastructure of Rikers Island makes it ill-equipped to provide mental health services. Confidential treatment space is extremely limited in DOC facilities; many mental health visits are performed at cell-front, or in dorms within earshot of other patients or DOC staff. In punitive segregation units these interviews are done through a small slot in a closed cell door. Information significant to mental health treatment is at times withheld by our clients as a means of self-protection. Something as routine as discussing the side-effects of a particular medication can create a safety risk if overheard and our client is determined by other inmates to be vulnerable or potentially unable to defend themselves while in jail. Security and escort protocols also create barriers to adequate mental health services. There are often not enough Correction Officers on a unit to provide escorts to the clinic or medication window in a timely manner. There is also widespread indifference by mental health professionals working in City jails of the traumatic effects that incarceration itself is having on their patients.

SOLITARY CONFINEMENT and VIOLENCE

A report¹ was issued on September 5, 2013 by the New York City Board of Correction (BOC), written by two mental health experts who determined that the City was not in compliance with its own Minimum Standards of care for people with mental health diagnoses. The doctors, James Gilligan and Bandy Lee, concluded that the DOC's use of "prolonged punitive segregation of the mentally ill violates" the standards. The report recommended that the Restrictive Housing Units (RHUs) that were created by the DOC under pressure by advocates in 2013 to provide housing for people with mental illness, "be eliminated because it is a punitive rather than therapeutic setting for people with mental illness." Recently our staff visited the RHU in the adolescent facility at Rikers Island and were horrified by the conditions there, which included filthy cells and tables set up for waist and leg chains for the few moments of free time enjoyed by the sixteen and seventeen year-olds in the unit.

The BOC report found the prolonged solitary confinement that is practiced at Rikers Island to be "one of the most severe forms of punishment that can be inflicted on human beings short of killing them." The SHU Exclusion Law, which restricts the use of solitary confinement in upstate facilities, has no jurisdiction in county jails, such as Rikers Island. While there have been efforts to reform housing units for people with mental illness, they have not had sufficient reach to this point. While our clients typically decompensate while in DOC custody, no matter their housing assignment, those in solitary confinement decompensate much more rapidly. Mental health symptoms such as paranoia, psychosis, and suicidal ideation are exacerbated by the conditions of

¹ Gilligan, James and Lee, Bandy (2013). *Report to the New York City Board of Corrections*. New York City.

solitary confinement, described by the special U.N. rapporteur as torture. Meanwhile mental health services are severely restricted in these punitive units, leading our clients to decompensate even further and impeding their chances of recovering when returned to a less restrictive unit or discharged from jail. A March 2014² study found that self-harm, suicidality, is seven times more likely to occur in solitary confinement, when compared to other housing units. Despite the growing knowledge about the dangers of these practices, no concrete steps have been taken, at any level of government, to limit or eliminate the use of these practices in our city facilities.

Another significant concern is the level of violence that our clients are subjected to while in city jails. Because of their vulnerability and the frustration their symptoms can cause to others, individuals with mental health diagnoses are more likely to be subjected to violence in jail, including rape and serious assaults. Many of our clients are harmed by other inmates without any intervention by corrections officials. In addition, corrections officers use physical violence quite often against such clients.

Here is one client example:

“Sam” is a twenty-two year old client who suffers from mental illness. In many ways his story exemplifies the experiences of people with mental illness on Rikers Island – he was a victim of violence; he decompensated periodically due to his incarceration; and he faced harsh punishments when disagreements with staff were not effectively de-escalated. While in General Population housing designated for people with mental illness, Sam was the victim of slashing and burning attacks because he resisted pressure to join gangs in the unit. Staff was unable to protect him and others from violence that has become a daily reality for many on Rikers Island. When he had disagreements with staff about lost property during transfers between jails, conflicts quickly escalated and he was issued infractions. Eventually Sam was moved into the Restrictive Housing Unit (RHU), a unit closely resembling solitary confinement where people with mental illness are housed. While in the RHU, his mental health symptoms worsened; he began to more regularly experience auditory and visual hallucinations, and he became increasingly depressed and hopeless. When he expressed his feelings of hopelessness, he was placed on suicide watch under extremely harsh conditions. After he was released from suicide watch back into the RHU, he was stripped of all the limited privileges he had earned – he was no longer permitted to leave his cell a few hours per day, could not participate in mental health groups, and received welfare checks at cell-front from mental health staff during the 23 hours each day he spent in his cell. He was released directly in to the community from these deplorable conditions, no longer able to care for himself following the traumatic experience of incarceration.

In our opinion solitary confinement should not be used for anyone at all, but particularly must be eliminated for anyone with a mental illness or anyone who is not able to mentally cope with the isolation. As it is now, there are regulations that say that a person who is placed in solitary must be found to be mentally fit prior to placing them in isolation. However, there are no concrete standards to define mental fitness to withstand solitary confinement. We have never had a client sentenced to solitary who was not placed in segregation due to mental health symptoms despite

² Kaba, F., Lewis, A., Glowa-Kollisch, S., Hadler, J., Lee, D., Alper, Venters, H. (2014). September Death of Mentally Ill Rikers Island Inmate Ruled a Homicide. *The American Journal of Public Health*, 104(3).

numerous cases where clients have tried to commit suicide or are so decompensated that they are rocking in the corner of their cell and not eating.

One area that could be considered by the legislature would be creating legal avenues of redress for people to contest their placement in solitary confinement. One reason there are truly draconian practices taking place on Rikers Island is that there is only an extremely limited right of judicial review. We suggest creating a right of review for the amount of time a person is sentenced to solitary, a right of writ of habeas corpus to release an inmate from solitary if they are mentally unfit to stay isolated and an expanded role for the criminal courts to order an inmate to be released from solitary based on information brought to their attention in court. It would be helpful if these decisions could be reviewed by an appellate court in an expedited fashion as well.

MENTAL HEALTH COURTS

As an original stakeholder in Brooklyn Mental Health Court, BDS supports the mental health court model, which affords defendants an opportunity to participate in community-based mental health treatment, improves their overall quality of life and seeks to avoid the collateral consequences of felony and criminal convictions.

Under the current paradigm mental health court provides excellent criminal justice outcomes for many of our clients, but we ask the committee to consider that in order for our clients to be accepted into the program they must be ready for placement in the community and willing to plead guilty to the charges before them. For clients who are innocent or who do not recall the event, this is not always a fair request. It also forces people to waive their legal rights, such as to contest the legitimacy of the arrest.

Another problem is the long wait for services. There is an extreme shortage of treatment beds in most facilities our clients need to go to from jail. This causes longer stays in jail facilities than our other clients face. Many clients give up on treatment solely because they have to wait in jail for a treatment bed. Also, for these clients, the delays often result in their conditions deteriorating. We have lost an opportunity for a placement many times because a client previously accepted into a program subsequently became too symptomatic due to their extended stay in jail.

See the following client story:

Robert, a person living with schizophrenia, was arrested on a non-violent felony. He reported experiencing auditory and visual hallucinations and a competency examination was ordered shortly after his arraignment. He was subsequently found unfit to proceed with his court case. He was ordered committed pursuant to C.P.L. 730.50. The delay for transfer from New York City Department of Corrections to the forensic psychiatric center for evaluation took 6 weeks³. Robert remained at the forensic psychiatric center for approximately two months. Upon his return to Rikers Island, Robert lingered there awaiting approval for an alternative to incarceration offer from the prosecutor. By the time his case had been approved for a mental health program offer Robert had

³ This is not an uncommon delay for C.P.L. 730.50 defendants

decompensated mentally and been the victim of serious assaults while at Rikers Island. His mental health deteriorated to the point that he had to be hospitalized at Bellevue Hospital Prison Ward. This destabilization prevented Robert's inclusion in mental health court.

CONCLUSION

Correctional facilities were never intended to function as primary mental health treatment providers, yet they currently house overwhelmingly large populations of individuals with serious mental illness. Treating and stabilizing serious mental illness is a delicate medical process that is deeply compromised by jail and correctional environments that frequently *trigger* and *exacerbate* many common symptoms of a variety of mental illnesses. Confinement is not therapeutic. Jails are not hospitals, triage or respite centers, or by their very nature, therapeutic environments. Comprehensive and individualized care is not provided to detained BDS clients as it would be in the community at a hospital, mental health clinic, or treatment program, and our clients with serious mental illness suffer tremendously as a result. In fact, psychotropic medication has become the default treatment form in city jails. However, medication management without the supplement of supportive mental health services (i.e. individual or group therapies, case management services, supportive housing) which exist in the community is not complete or medically sufficient care. This is a phenomenon experienced across the country, but is especially true here in the New York City jails and Rikers Island.

As this testimony reflects, Brooklyn Defender Services has seen some positive results with the mechanisms provided by and alternatives available through the mental health court and Crisis Intervention Teams. Jail-based reforms to reduce the number of beds in mental observation dorms, more frequent reevaluation of housing needs for mentally ill people, reducing obstacles to proper and continuous treatment such as escort rules would all bring significant improvements to local jails. We support the passage of the HALT Solitary Confinement Act to mandate the improvement of mental health services for people living with mental illness in confinement. Retraining of DOC staff so they can maintain safe, humane living spaces for people in their care and can provide mental health first aid and employ de-escalation techniques rather than brute force during conflicts would also be welcomed. However the primary driver of reform must be prioritizing the use of correctional facilities as a last resort only and reinvesting the savings produced by declining jail populations into the communities from which our clients come. By reducing the number of people incarcerated in state prisons and county jails, programming and infrastructure can be implemented to meet the needs of this population. New York should be a leader in the prison/jail reform and decarceration movement, rather than continue misguided policies that deny our neighbors, many with sicknesses that are not in their own control, basic human rights. Thank you sincerely for your prompt attention to this urgent matter.

Sincerely,

Lisa Schreibersdorf