



Committee on Fire and Criminal Justice Services, jointly with the Committee on Health Oversight – Health Care Delivery in New York City Jails: Examining Quality of Care and Access

Elizabeth Crowley, Chair; Corey Johnson, Chair

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Int 0440-2014 – A Local Law to amend the administrative code of the city of New York, in relation to health services in city correctional facilities.

**BROOKLYN DEFENDER SERVICES
EXECUTIVE SUMMARY**

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 and complicated health needs. 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 or other health needs 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 census 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. 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 City jails, programming and infrastructure can be implemented to meet the needs of this population. New York City should be a leader in the 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.

The legislation considered by the Council today is a welcomed first step towards improving transparency about health services at Rikers Island. We would ask that Council consider increasing the metrics requested from the Department of Health and Mental Hygiene, however, and have provided guidance based on other monitoring efforts nation-wide. The delivery of healthcare in correctional facilities of New York City is obviously substandard when compared to services available to our clients in the community. This legislation, which we support, is a useful measure to hold accountable both the contracted private company, Corizon, Inc., and the public agency overseeing the provision of healthcare.

GENERAL RECOMMENDATIONS TO IMPROVE HEALTHCARE DELIVERY

- A full audit of staffing and infrastructure resources to review, considering best practices, how many people could actually be cared for in a humane and appropriate manner in City jails.
- End Solitary Confinement
- 100 percent discharge planning to ensure continuity of care (currently 11%)
- Move public hospitals into correctional health care role
- Abandon failed RHUs, which are simply another form of solitary confinement
- Maintain strict medical confidentiality protocols at all time
- Any DOC obstruction with medical care provision should be cause for termination

ADDITIONAL RECOMMENDATIONS RELATING TO INT 0440-2014

- All metrics should be broken out by housing area, or at least housing type (punitive segregation, RHU, MO, GP, etc.)
- Number of “sick call” requests, broken into triage categories (emergent, urgent, routine); number of requests addressed and compliance with timeframes within triage designations; number of requests unfilled, reason
- Number of follow-up visits ordered, timeframes and compliance
- Number of specialty visits ordered, timeframes and compliance, explanations when non-compliant
- Medication delivery:., compliance rates, refusal rates, non-delivery rates, rates of follow up with provider after missed doses
- Psychiatry visits, frequency, compliance with ordered psychiatry follow-up when referred by physician.
- Mental health clinician visits, frequency for population broken out by housing types.
- Hospitalizations, reason, preventability, duration, treatment plan compliance upon return
- Mental health hospitalizations, reason, hospital type (DOC jail ward or upstate psych hospital), preventability, duration, treatment plan compliance upon return, housing placement upon return
- Discharge, rate of discharge medications ordered
- OB/GYN, number of requests, number of patients seen, follow ups ordered, compliance with follow ups

- Placements to suicide watch, duration, aftercare, changes in housing or treatment plan
- RHU, population in RHU, lengths of stay, program “level,” clinician visits, treatment usage rates
- Central punitive segregation units, population, lengths of stay, clinician visits, treatment usage rates

**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 who have been arrested, detained or incarcerated in New York City by the New York Police Department and the New York City Department of Correction. Thousands of our clients will spend time in a city jail, such as those on 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 provision of healthcare in local facilities in New York City.

BDS represents over 45,000 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 and brought into the custody of the Department of Correction (DOC) and the care of the Department of Health and Mental Hygiene (DOHMH). According to DOHMH about 25 percent of the City jail intakes present with some kind of mental illness, with about 5 percent presenting with serious mental illness such as schizophrenia. (This tracks, generally, the overall population). In addition to diagnosed mental illness, almost all of our incarcerated clients have healthcare needs – some, serious ones. Our experience leads us to believe that the incidence of mental illness is actually much greater than DOHMH reports, an understanding supported by off-line conversations with medical staff in city jails who report a serious problem with identifying health and mental health needs upon intake. Furthermore many otherwise healthy people develop mental health symptoms such as depression, suicidality and trauma while incarcerated, in addition to communicable illness.

For clients who have diagnoses such as Schizophrenia or Bipolar Disorder, BDS has two specialized attorneys – plus dedicated support staff – in a unit of our Criminal Defense Practice dedicated to addressing the cases of these clients. In addition to these Mental Health Attorneys, our other criminal defense 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 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 DOHMH staff to assist in advocating for, accessing, and coordinating health treatment for detained BDS clients with serious mental illness and

transitioning clients to the community upon discharge. 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, and over 150 attorneys. It is important to note that the health crisis currently playing out in City jails is not independent of other social policies and priorities in New York City. Access to housing, education, community healthcare, childcare and employment, for example, should all be considered building blocks to reducing the healthcare load at City jails.

THE NEED FOR FEWER ARRESTS

The surest way to ease the healthcare burden at City jails is reduce the population in the City's custody. Serious crime in New York City has never been lower, yet arrests, despite moderate decreases since 2010, remain high. There were roughly 350,000 people arrested in 2013, the vast majority for misdemeanors and violations and another 450,000 people summonsed. The very factor of arrest, independent of incarceration, can have a negative effect on the health of our clients. Moreover, recent studies have shown that this negative effect spreads from the individual who was arrested to their broader community. According to the Vera Institute of Justice, arrest and incarceration is one of the major contributors to poor public health in certain communities. Due in part to racially discriminatory policing practices, the negative health burdens fall heaviest on specific communities in New York City, making this system-wide failure a civil rights issue of the highest order. Black New Yorkers are jailed at a rate of nearly 12 times that of their White neighbors, with Latinos jailed at five times the rate of Whites; recent studies have proven that race alone is a cognizable factor in driving prosecution decisions in at least Manhattan courts. More than half of admissions to City jails are for misdemeanor charges.

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 received any medication they were taking in the community. Many clients with health needs are treated dismissively by police officers. Only those people with what are deemed critical healthcare needs typically have a chance to gain access to hospital care. In an attempt to gain more information about this process our office has filed a Freedom of Information Act request to both the FDNY (which provides Emergency Medical Services screening at bookings) and the NYPD more than six months ago with no response. In October, a client of ours, Jasmine Lawrence, 22, died in police custody because of a failure to receive medical care.

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. In 2013 Kyam Livingston died in Brooklyn Central Bookings after being denied needed medical care by officers who watched her perish rather than call an ambulance. In Ms. Livingston's case she was told by officers at Central Booking that her arraignment would be intentionally delayed by them, that they would "lose her papers" if she continued to make requests for a doctor.

Like Ms. Livingston, our clients who ask to see a doctor or go to the hospital are discouraged and even threatened by officers, resulting in few seeking treatment during this time. These practices are unacceptable on their face and result in serious harm (and even 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. We recommend that the committee review policies and practices at the time of arrest and until the arresting officer turns 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.

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 deciding 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. The recommendations of the Mayor’s Task Force on Behavioral Health are promising, but implementation will be challenging if we continue to rely solely on the police to respond to community needs.

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.

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 commitments 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, are the best first option whenever possible. The impact of incarceration on public health cannot be overstated; being locked up negatively affects family and community ties, employment, housing options, treatment access, and the experience of incarceration often leads to new trauma. We are grateful that the health committee is taking a look at the intersections between the criminal justice system and health.

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 and thus be incarcerated due to poverty. 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 City Council 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 our mental health clients are (1) voluntary 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.

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 Assertive Community Treatment (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.

Of course by now you have heard of Jerome Murdough, a homeless, mentally ill U.S. Marine Corps Veteran, who died in Department of Correction custody in 2014 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. Our clients 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 are proportionate to the alleged wrongful act and the condition of our client.

It is obvious to us that the amount of money being spent to essentially exacerbate the problems of sick, poor people in New York City 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 or effective. It has never been morally justifiable. Furthermore, the practices of New York City when it comes to incarcerating people who have committed nothing more than nuisance offenses must 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. Neither severity of charge, nor financial resources has proven to be at all reliable predictors of public safety or return to court rate. We urge City Council to reduce the number of people in correctional custody and invest in community-based high-quality mental health care, housing, education and targeted preventative, diversion and reentry services.

CURRENT STATUS OF HEALTHCARE DELIVERY FOR CLIENTS IN CITY CUSTODY

People held in correctional facilities are the only demographic in the U.S. with a constitutionally mandated right to healthcare. However, the healthcare currently provided in City jails is deplorable. With intakes of 80,000 each year, City jails could provide an opportunity to connect people, many suffering from poor health, with care. Unfortunately, here in New York City, people often leave City jails in worse shape than when they arrived. This should not be surprising because jails are not equipped, either in staffing or infrastructure, to meet the various health needs of the population.

Our social workers and jail services staff are able to advocate for our clients who are not receiving adequate care under the supervision of DOHMH. Not every incarcerated person has advocates working with them, however. The result is the now frequent horror stories in the media about health-care neglect. Our social work team makes hundreds of referrals to DOHMH personnel each year, after being alerted by clients of serious medical needs. These include people whose methadone treatment is interrupted causing painful withdrawals, interruptions to medication regimens due to facility transfers, failure by medical staff to take seriously suicidal ideations and depression, medical staff at Rikers Island informing clients that they need treatment at a hospital and not providing for that transportation, a lack of responsiveness to filling orders for glasses or hearing aids, and most of our female clients are concerned about the poor quality of OB/GYN care. While referrals to DOHMH typically provoke a speedy response, on several occasions in the past year alone we have had to make four or more contacts with DOHMH to secure treatment for a serious condition such as asthma, seizures or diabetes. Pressure by outside advocates to ensure basic healthcare should not be the procedure relied upon by medical staff to meet the needs of their patients, many of whom lack any supportive structure on the outside.

Some case examples:

On September 2, a BDS social worker contacted DOHMH personnel following a visit with Enrique George, 17, who was at that time exhibiting suicidal ideations and severe depression. One week later the social worker followed up with our client who reported that he received no treatment from DOHMH and that he was accused by a clinician of fabricating his mental health symptoms. This prompted a second referral to mental health services after reevaluating our client’s condition. Finally our client was given some

treatment, although this was filled solely by medication. Our client took his medication faithfully during the rest of his stay at Rikers Island until the disposition of his case. Upon being released, our client contacted the social worker to inform her that he was not discharged with any medication or a prescription. Again the social worker contacted DOHMH, and the medical staff recommended that our client go to an Emergency Room to receive treatment.

Mike Gilchrist, a victim of childhood sexual assault, began his stay at Rikers Island at the Anna M. Kross Center where he was jailed in a mental health unit. There he received medication for bi-polar disorder and schizophrenia. Eventually he was transferred to a different facility at Rikers Island, but his medication regimen did not follow him there. For ten days he was without needed medication and received no relief from medical staff. One night he woke up to find another person standing over him in a threatening manner. He responded by starting a physical altercation with the individual leaving the other man with a fractured jaw. He would not have responded in this manner had he been properly treated with medication. However, even though it was the fault of DOHMH that his medication got lost, Mr. Gilchrist was charged with assault and picked up another case.

We have noticed a serious deterioration in care since the City began contracting with Corizon, Inc. New York City must review this firm, which has proven that it cannot capably manage the health needs of the incarcerated local population. A recent review of the death of Bradley Ballard by the New York State Commission of Correction stated:

“The medical and mental health care provided to Ballard by NYC DOC’s contracted medical provider, Corizon, Inc. during Ballard’s course of incarceration, was so incompetent and inadequate as to shock the conscience as was his care, custody and safekeeping by NYC DOC uniformed staff, lapses that violated NYS Correction Law and were directly implicated in his death.”

During Ballard’s final two days of life, there were at least 46 separate violations of state law that played a role in his death, according to the report. At least ten medical workers were listed in the report as having violated the law, and many correction officers were implicated as well, though any identifiers of this group were redacted. Correction officers that violated state law and contributed to Ballard’s death ranged in rank from officer up through Captain and Assistant Deputy Warden. The Commission implied that DOHMH were less than forthright in their explanation of their patient’s death. Quannell Offley died just weeks after Ballard in the same jail facility.

Any positive changes to City jails hinge on the medical provider, which by any imaginable measuring stick has proven itself to be incompetent. Corizon, Inc., is the largest private correctional health provider in the country, and is quickly moving itself right into the center of the growing controversies in City jails due to recurring patient deaths and everyday neglect and failure to care.

Over the past five years Corizon has been sued 660 times, an apparent lightning rod for malpractice, yet the City seems as invested as ever in the company, INCREASING their budget

in the 2016 preliminary contract. Meanwhile the State of Florida is considering voiding Corizon's \$1.2 Billion contract with the state unless they improve the delivery of care there. Washington D.C. recently walked back their \$66 million three-year contract with the firm. In Florida the company is accused of withholding information or outright lying to state officials about deaths in custody. A recent lawsuit alleges that the company did the same at Rikers Island, and lied to families of people who died there about cause of death. Corizon is being sued in Maine, DOC Commissioner Joseph Ponte's old stomping grounds, for racial discrimination.

Contrary to the testimony of DOHMH, many of our clients report that they do not promptly receive a mental health evaluation or medications once committed to City custody. In addition, there is not an appropriate range of mental health care options for people who are noticed to have needs by medical staff. Medication remains the only "treatment" for nearly all of our clients in City jails irrespective of 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 is widespread indifference by mental health professionals working in City jails of the traumatic effects that incarceration itself is having on their patients.

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 low. They are limited in what they will prescribe; keeping to low-cost medications that are not necessarily what the client was previously taking on the outside 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. 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. Pain medication is frequently withheld by medical staff who accuse our clients of drug-seeking rather than having a reasonable health need.

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 through which a clinician and patient must actually yell to each other in order to communicate. 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, such as drowsiness, can create a safety risk if overheard and our client is determined by his peers or corrections officers to be vulnerable or potentially unable to defend themselves while in jail.

DOC personnel are often part of the failure to deliver quality care. A lack of escorts is frequently given as an excuse for why an incarcerated individual might not get timely care. There is widespread brutality in the jails, guards frequently assault and otherwise attack our clients, and

then threaten them to “hold it down,” which means not seeking medical attention. People have been beaten by correction officers following suicide attempts. In at least one recent case medical staff did not properly document or treat a person who had had his teeth knocked out, in an apparent attempt to downplay or obfuscate the conditions of brutality.

SOLITARY CONFINEMENT AND VIOLENCE

Solitary confinement remains a stringent barrier to health care delivery in City jails. Under the new administration, there are still at least six people serving sentences longer than one year, and an additional 22 people serving sentences of longer than six months, according to the DOC. This is cause for embarrassment and a major health concern. There are roughly 1,000 solitary confinement beds at Rikers Island, in addition to 250 new isolation beds in the Enhanced Supervision Housing Units. Recent limits on sentences set at 30 days do not bring any of the DOC facilities in line with international norms, which dictate a 15-day maximum for sentenced individuals, due to the permanence of psychological effects of isolation. Solitary confinement of any kind is a violation of international law when used against pregnant women, juveniles, persons with mental disabilities, or pre-trial detainees, according to the United Nations and the Convention Against Torture, the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights. There is no research to indicate that 30 or 60 days in solitary confinement is ever indicated for the purpose of maintaining safety in correctional facilities. Instead nearly every single study over the past two decades has shown that subjecting anyone to solitary confinement for periods as short as ten days can have permanent emotional, cognitive, social and physical pathologies.

Solitary confinement, and other restrictive housing such as the Restricted Housing Unit, leads directly to lapses in medication and care, a total end to confidentiality, includes many people with serious mental illness who are not sufficiently screened out of these units, inappropriate cell-side treatments, DOC staff harassment and high rates of suicidality. These conditions make quality healthcare delivery an absolute impossibility. Yet, despite well-documented failures, Corizon has become the purported lynchpin to “reforms” in the practices of solitary confinement in City jails. Corizon alone will be responsible for determining who is eligible and ineligible for solitary confinement, and the subsequent poor healthcare that comes with that. In many cases this is a decision that can mean the difference between life and death and that Corizon has largely failed at so far.

Today’s hearing comes at an opportune time as the DOC has just released its first pass at record-keeping in solitary confinement following the passage of Local Law 42 last fall. The results, to an outsider unused to the failures of correctional healthcare, would be shocking. In just one jail, the Otis Bantum Correctional Center, there were 30,166 requests for medical care over one quarter; the number of people who actually received care was less than 50 percent. The data also show that only about one-third of individuals in solitary confinement at OBCC received their daily shower, and less than 10 percent received their daily hour of recreation. Requests for access to the law library and congregate religious services were also met less than 50 percent of the time. Each of these missed entitlements constitutes a separate violation of State Correctional Law and City Law by way of the Board of Correction minimum standards. Falsifying the data is also a criminal offense.

A report¹ by the Board of Correction (BOC) was issued on September 5, 2013, 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 mentally ill 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 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.

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 their peers without any intervention by corrections officials. In addition, corrections officers use physical violence quite often against such clients. Seventy-seven percent of serious injuries – fractures, stitches and head injuries – are suffered by someone with a mental health diagnosis.

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.

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

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. Attempts by DOHMH to screen people have not thus far been effective. 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. Our clients there rapidly lose weight, develop insomnia and anxiety, become agitated and easily frustrated and generally decompensate. Any discussion on healthcare in City jails must begin by considering the ways that the conditions of confinement actually create or exacerbate the existing healthcare burden. Despite regulations empowering DOHMH to request that people be removed from isolation if at risk of self-harm or other significant decompensation; people remain isolated on suicide watch for weeks in isolation units. During the February 10, 2015 Board of Correction meeting, the Board noted that such incidents occurred in at least June 2014, November 2014, and January 2015.

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.

Healthcare in City jails often complicate mental health court applications. A typical prerequisite for consideration for a mental health court disposition is compliance with medications while incarcerated. However, due to the widespread failures of Corizon to ensure consistent medical care delivery, many of our clients miss appointments and doses and, although no fault of their own, are penalized by the court.

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 weeks². Robert remained at the forensic psychiatric center for approximately two months. Upon his return to Rikers Island, Robert awaited 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 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.

GENERAL RECOMMENDATIONS TO IMPROVE HEALTHCARE DELIVERY

- A full audit of staffing and infrastructure resources to review, considering best practices, how many people could actually be cared for in a humane and appropriate manner in City jails.
- End Solitary Confinement
- 100 percent discharge planning to ensure continuity of care (currently 11%)
- Move public hospitals into correctional health care role
- Abandon failed RHUs, which are simply another form of solitary confinement
- Maintain strict medical confidentiality protocols at all time
- Any DOC obstruction with medical care provision should be cause for termination

ADDITIONAL RECOMMENDATIONS RELATING TO INT 0440-2014

- All metrics should be broken out by housing area, or at least housing type (punitive segregation, RHU, MO, GP, etc.)
- Number of “sick call” requests, broken into triage categories (emergent, urgent, routine); number of requests addressed and compliance with timeframes within triage designations; number of requests unfilled, reason
- Number of follow-up visits ordered, timeframes and compliance
- Number of specialty visits ordered, timeframes and compliance, explanations when non-compliant
- Medication delivery – compliance rates, refusal rates, non-delivery rates, rates of follow up with provider after missed doses

² This is not an uncommon delay for C.P.L. 730.50 defendants

- Psychiatry visits – frequency, compliance with ordered psychiatry follow-up when referred by physician.
- Mental Health clinician visits: frequency for population broken out by housing types.
- Hospitalizations: reason, preventability, duration, treatment plan compliance upon return
- Mental health hospitalizations: reason, hospital type (DOC jail ward or upstate psych hospital), preventability, duration, treatment plan compliance upon return, housing placement upon return
- Discharge: rate of discharge medications ordered
- OB/GYN: number of requests, number of patients seen, follow ups ordered, compliance with follow ups
- Placements to suicide watch: duration, aftercare, changes in housing or treatment plan
- RHU: population in RHU

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 and complicated health needs. 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 or other health needs 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 census 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. 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 City jails, programming and infrastructure can be implemented to meet the needs of this population. New York City should be a leader in the 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.

The legislation considered by the Council today is a welcomed first step towards improving transparency about health services at Rikers Island. We would ask that Council consider increasing the metrics requested from the Department of Health and Mental Hygiene, however. The delivery of healthcare in correctional facilities of New York City is obviously substandard when compared to services available to our clients in the community. This legislation, which we support, is a useful measure to hold accountable both the contracted private company, Corizon, Inc., and the public agency overseeing the provision of healthcare.

Sincerely,
Lisa Schreibersdorf
Executive Director Brooklyn
Defender Services