



TESTIMONY OF:

Brooke Menschel
BROOKLYN DEFENDER SERVICES

Presented Before

**The New York City Council Committee on Hospitals, Committee on Mental Health,
Disabilities and Addiction and Committee on Criminal Justice**

Oversight Hearing on Correctional Health

November 15, 2018

My name is Brooke Menschel and I am the Civil Rights Counsel for Brooklyn Defender Services. BDS provides comprehensive public defense services to nearly 35,000 people each year, thousands of whom are detained or incarcerated in City jails in connection with their criminal cases. Thank you for the opportunity to address the Council and share with you some of our concerns about medical and mental health care, based on the direct accounts of people we represent who are incarcerated in City jails.

Across the country, jails and prisons have become the largest provider of health care, including mental health care. New York City is no exception. Tens of thousands of people pass through our City's jails each year, many of whom have acute health needs or are otherwise especially vulnerable. A 2009 National Institutes of Health study noted that chronic conditions—including HIV and diabetes—are more prevalent among incarcerated people than in the general population.¹ These individuals frequently end up incarcerated specifically *because* they cannot access adequate care on the streets. Once a person is incarcerated, providing adequate care is no longer a choice: the City is obligated to ensure that adequate medical and mental health care is readily accessible. When they are ultimately released after any period of time, the City must ensure they can access care in their communities. The alternative is a vicious cycle that fuels problematic behavior in our communities and the NYC Department of Corrections remaining one of the largest medical and mental health care providers in the country for years to come.

The problem posed by lack of access to medical and mental health care in our City's jails is part of a continuum that starts long before people enter the criminal justice system and extends far

¹ Wilper AP, Woolhandler S, Boyd JW, et al. The health and health care of US prisoners: results of a nationwide survey. *Am J Public Health.* 2009;99:666–72

beyond their discharge. Disparities in healthcare options and outcomes disproportionately impact poor communities and communities of color, resulting in disproportionately high rates of chronic conditions. Similarly, inadequate community-based mental health and substance use treatment funnel people struggling with mental illness into handcuffs, jails and prisons. For these individuals, time in City jails frequently exacerbates their conditions, as illness and medical needs are all too often met with violence and isolation rather than appropriate care. After serving time in jail or prison, people who return to their communities frequently lack adequate healthcare infrastructure and affordable and supportive resources. These inadequacies lead to people falling through the cracks and too often tragic results – either irreversible sickness and death or the churning cycle of incarceration, lapses in treatment, homelessness, and recidivism.²

Mr. F suffers from paranoid schizophrenia that was not adequately controlled. While incarcerated, Mr. F decompensated further and began experiencing confrontations with custody staff, many of whom, lacking adequate training to de-escalate incidents involving individuals in his mental state, responded aggressively to Mr. F. During his incarceration, Mr. F received numerous infractions, lost various privileges, and spent several months in the solitary unit for people with mental illness at the George R. Verno Center (GVRC) on Rikers Island. This isolation caused Mr. F to decompensate further. Eventually, Mr. F's condition worsened and he was transferred into another isolation unit, this one for people with mental illness and deemed violent. There, Mr. F was isolated further and experienced worsening depression, anxiety, anger, lethargy, loss of appetite, frustration, hopelessness, insomnia, physical pain, and hallucinations associated with his schizophrenia. In no small part due to his prolonged isolation, Mr. F decompensated so profoundly that he was eventually found unfit to proceed in his criminal case and had to be hospitalized in order for him to advance his case. What is the purpose of pre-trial detention if not to ensure people make it to court?

As you consider how best to advance correctional health in New York City, we urge you to view access to care in jails and prisons in the context of the larger continuum. Decarceration while investing in healthy communities will result in a safer, healthier society that will benefit not only the people we represent but the community at large.

Access to care has long been and remains a fundamental concern for our clients.³ In a correctional setting, our clients' access to medical and mental health treatment is frequently

² The National Commission on Correctional Healthcare has recognized these dangers. See Nat'l Comm. On Corr. Healthcare, *About Us*, <https://www.ncchc.org/about> (recognizing that improving the quality of care in jails and prisons not only “improve[s] the health of their inmates,” but also “the communities to which they return”).

³ The reality of inadequate access to care is well-established in medical literature. See Wilper AP, Woolhandler S, Boyd JW, et al. The health and health care of US prisoners: results of a nationwide survey. *Am J Public Health*. 2009;99:666–72 (reporting the results of a nationwide study that showed that nearly 70% of individuals with persistent medical problems did not receive even a medical examination upon entering a local jail; more than 40% of people who were taking medication when they were first incarcerated stopped the medication once they entered the local jail; and approximately a quarter of the individuals who suffered a serious injury in a local jail were not seen by medical personnel following their injury)

hamstrung by distinct but interconnected issues: DOC practices, ostensibly in the interest of security, often come at the expense of access to care for clients in need; Physical design and staffing resources often impede clients' ability to readily access the treatment they require; and administrative hurdles frequently hamper clients in their attempt to access indicated medical or mental health services. We voice our support for the comments of directly impacted individuals and other organizations that are testifying today, including The Sylvia Rivera Law Project, The Legal Aid Society, and the Urban Justice Center. They each offer tremendous insight and expertise regarding the current state of affairs for clients incarcerated in New York City.

Access to Care as a Linchpin to Improving Security

Contrary to the assertions of DOC staff that security and access to care must be balanced, we strongly believe that the latter is essential to the former.

From protecting public safety to fighting disease and promoting physical and behavioral health, and from fine-tuning budgets that trim waste to investing in cost-effective programming with long-term payoffs, the health care that prisons provide to incarcerated individuals and the care that prisons facilitate post-release is a critical linchpin with far-reaching implications.⁴

The two central goals must coexist to ensure a safe, healthy, and effective system. Unfortunately, far too often our clients' mental health or medical needs take a backseat, allegedly because of DOC's security mission. Correctional staff regularly serve as an impediment, rather than a conduit, to care. Security alerts and classifications frequently interfere with access to vital treatment and services. Mental health and medical practitioners are stymied by security guidelines when providing indicated treatment.

Correctional Staff as Gatekeepers

Correctional officers serve in many respects as gatekeepers to medical and mental health care. Without the requisite knowledge or training, officers who block access to care pose serious dangers to the well-being of people in custody. For instance, to access medical care in a DOC facility, an individual must submit a "sick call" request to officers in their housing unit, who are responsible for forwarding requests to medical staff. Under this arrangement, correctional staff can and do fail to forward sick call requests to the medical staff, or falsely claim that an individual "refused" to be brought to their appointment, as a tool of control or punishment. Our clients have been denied sick call in retaliation for complaining about correctional staff, in response to misbehavior, and in an effort to ostracize those with high profile cases.

One BDS client who had filed complaints against correctional staff was repeatedly denied sick call as well as escorts to the medical clinic. Although he attempted to access care, correctional staff documented that he "refused" care. As a result of being denied timely medical treatment for a cut, the client developed gangrene which nearly required amputation. Denying access to medical care is a particularly cruel form of punishment that nearly cost a man his limb in this case.

⁴ Pew Charitable Trusts, Prison Healthcare: Costs and Quality, Oct. 2017, <https://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality>.

Regular and accurate reporting on the availability of sick call requests is an important step to making the system function better. **BDS supports Int. No 1236 and the Council's continued support for data collection.** Information pertaining to sick call is vital to understanding lapse in care and access to services for our clients. In addition to the information already required by the legislation, we urge the Council to require reporting on the "reason why sick call was not completed" and allow for a qualitative approach to why a person was not able to make it to an appointment. Far too often our clients' records reflect that they "refused" care because they were in court, visiting with family, or were never told of a medical appointment. These refusals impact our clients, who are then painted as malingering, lying or attention seeking.

Lockdowns Preventing Care

Similarly, correctional staff regularly delay or entirely prevent access to care for entire units allegedly in the name of security. For example, movement is frequently halted when a facility goes on lockdown, sometimes for extended periods. In its January 8, 2018 report on lockdowns, the Board of Correction revealed that, "Despite a 32% decrease in the DOC average daily population (ADP) since 2008, there has been an 88% increase in lockdowns." The Board found that lockdowns often result in violations of BOC's Minimum Standards. During lockdowns, people are confined to their cells and generally denied any and all access to programs and services. They cannot go outside for recreation, shower, use telephones or law libraries, access religious services, attend school, or receive family or counsel visits. They are often denied medical care, including mental health care. Some clients have reported being denied toilet tissue. Missed counsel visits can require cases to be adjourned, prolonging pre-trial detention. Missed mental health treatment can result in the rapid decompensation of vulnerable people. Lockdowns amount to group punishment, with little regard to the rights or needs of people in its custody.

Limitations on Treatment as a Punishment

All too often, individuals incarcerated in City jails are denied the opportunity to access particular programs or treatment because of high security classifications, housing placements, or disciplinary consequences. These programs, which serve as powerful evidence that a person is productive, engaged and wants to participate in their own defense and well-being, are all-too-often unavailable to our clients because of alleged security concerns. One glaring example is drug treatment programs, which include a critical flaw. Broad groups of people are denied access to important programs that support people with substance use disorders because they are classified as high security by DOC or as a result of unsubstantiated gang allegations, based on no standard of evidence and with no meaningful opportunity to appeal. For instance, the substance use treatment program "A Road Not Taken" provides a supportive environment for people struggling with addiction who are housed among peers and participate in extensive programming.⁵ Yet individuals identified by DOC as high classification are ineligible to participate.

⁵ Selling, D., Lee, D., Solimo, A., Venters, H. (2015), 'A Road Not Taken: Substance Abuse Programming in the New York City Jail System', in: *Journal of Correctional Health Care* 21(1) pp. 7-11

In a recent case, one BDS criminal defense attorney successfully advocated that her client, who had a history of substance use, would serve reduced jail time if he participated in the ARNT program. Despite agreement of the client's parole officer and the District Attorney, the attorney learned from Correctional Health Services that the client was denied entry into the program because of his high classification, the result of a 2007 incarceration where DOC identified him as gang affiliated. Although the client was not in a gang and was fully committed to participating in the program and turning his life around, he was not able to move forward with the agreement because of the classification.

Participation in these programs can and does impact people's ability to fight criminal cases in court, helping them overcome disorders, participating more effectively in their own defense, and in demonstrating to the court their commitment to change. Correctional Health Services should make their programming available to all who may benefit medically, regardless of classification or sentence. Situating access to treatment and medical decision-making as the exclusive domain of healthcare providers, not DOC, is essential.

Likewise, BDS supports Res. No. 581 and encourages the City Council to support expanded treatment for people in our jails and prisons. Although the Key Extended Entry Program (KEEP) facilitates detox and manages methadone treatment for people with opioid dependency in New York City jails, people facing state prison time are excluded from the program. State prisons, which do not currently offer methadone management, should expand their program to include methadone treatment and other medication assisted treatment (MAT) as an important step towards creating healthier communities. In this era of skyrocketing opioid overdose deaths, research has shown that MAT can cut the mortality rate among addiction patients by a half or more.⁶ Further, many people facing state prison time "on paper" will likely never be sent to state prison once the case reaches sentencing. Even though the parties may all be aware that prison time is unlikely, prosecutors often wait until pleas are entered to withdraw the most serious charge. One collateral consequence of this practice is that many people who need methadone treatment are excluded from KEEP. More honest prosecutorial practices would benefit public safety, as people maintained on methadone are more likely to continue treatment in the community and avoid relapse. MAT in jails and prisons and other public health approaches to addressing opiate addiction should be expanded across jurisdictions, according to best practices of community-based healthcare.

Relatedly, we are concerned about the knee-jerk embrace of Vivitrol among corrections officials as an alternative treatment for opiate addiction. We urge the City to confront addiction issues by tackling the root causes that lead people to use drugs in the first place – poverty, trauma, desperation, and other factors. We urge the state to maintain a critical perspective on drugs peddled as a "magic bullet" for addiction. Rather, we support committing greater resources to treatments that have been subjected to adequate study and been found to sustainably manage opiate addiction, prevent overdoses and improve public health.⁷

⁶ German Lopez, There's a Highly Successful Treatment for Opioid Addiction. but Stigma Is Holding It Back., Vox, Oct. 18, 2017 at , <https://www.vox.com/science-and-health/2017/7/20/15937896/medication-assisted-treatment-methadone-buprenorphine-naltrexone>.

⁷ See Goodnough, A., and Zernike, K., 'Seizing on opioid crisis, a drug maker lobbies hard for its product', The New York Times, 11 June 2017.

Medical Complications Due to Staff Brutality and Disciplinary Consequences

BDS is equally troubled by the frequent and persistent use of disciplinary mechanisms that cause significant medical and mental health complications. For example, DOC exposes our clients to pepper spray indiscriminately, without provocation, and without regard to the medical ramifications of exposure.

One officer flew into a rage during a verbal disagreement with a young BDS client. Despite no physical threat to the officer or others, the officer unleashed her MK9 pepper spray as she chased our client through the mess hall, dousing everyone else in the area. The excessive pepper spray triggered a severe asthma attack which left our client coughing up blood. He was taken to intake where he waited several hours before receiving medical care. The incident likely sent many bystanders to the clinic as well.

Similarly, any use of restrictive housing poses serious, and lasting, dangers to our clients' health and, in turn, their communities. Physiological conditions brought on by locking a person in a cell for 23-24 hours a day include gastrointestinal and urinary issues, deterioration of eyesight, lethargy, chronic exhaustion, headaches and heart palpitations among others.⁸ The psychological trauma, including severe depression, anxiety, insomnia, confusion, emotional deterioration, and fear of impending emotional breakdown, is broadly recognized.⁹ In addition to hallucinations and delusions,¹⁰ studies consistently find that prolonged solitary induces bouts of extreme anger and diminished impulse control, leading to violent outbursts;¹¹ invoking the very behavior it purports to manage.

A 2014 study revealed that people subjected to solitary confinement in New York City jails were 6.9 times more likely to engage in acts of self-harm than those who were not.¹² The suicide rate in DOCCS' Special Housing Units (SHU) is nearly six times higher than that of the General Population (GP).¹³ These tragic facts confirm what mental health experts have long concluded, namely that solitary is "inherently pathogenic; [...] one of the most severe forms of punishment that can be inflicted on human beings short of killing them."¹⁴ Organizations and institutions around the world, including the United Nations, multiple states, medical organizations, and

⁸ Shalev, S. (2008), A sourcebook on solitary confinement. (London: Manheim Centre for Criminology, London School of Economics), p. 15.

⁹ Haney, C. (2003) 'Mental health issues in long-term solitary and "Supermax" confinement', in: Crime & Delinquency, 49(1) pp. 133-136.

¹⁰ Id.; Grassian, S. (1983), 'Psychopathological effects of solitary confinement', in: American Journal of Psychiatry, 140(11), p. 1452.

¹¹ Haney, 2003, p. 133; Grassian, 1983 p. 1453; Gilligan, J., Lee, B., (2013), 'Report to the [New York City] Board of Corrections', [online] (Available at <http://solitarywatch.com/wp-content/uploads/2013/11/Gilligan-Report-Final.pdf> [accessed 11 August 2017]), p. 6.

¹² Venters, H., Kaba, F., Lewis, A., Glowa-Kollisch, S., Hadler, J., Lee, D., Alper, H., Selling, D., MacDonald, R., Solimo, A., Parsons, A. (2014), 'Solitary confinement and risk of self-harm among jail inmates', in: American Journal of Public Health, 104(3), p. 445.

¹³ Statistics provided by DOCCS

¹⁴ Gilligan and Lee, 2013, p. 6.

correctional associations, have moved away from relying on harmful restrictive housing and we urge the City to follow suit.¹⁵

Physical Design and Inadequate Resources as Hurdles to Care

The resources available inside New York City jails—physical design, staffing options, and technical capacity—present additional hurdles to providing adequate care.

Physical Plant as a Barrier to Treatment

Despite the significant healthcare needs of the population they house, jails are not constructed like hospitals, which prioritize clinical space and access to providers. For instance, the Anna M. Kross Center – the jail on Rikers Island which houses many of the system’s most high-needs patients – was built haphazardly over many years. As each new wing of the jail was added, the corridor connecting the housing units to the central clinic became longer and longer. Now many patients must be escorted close to a mile to access treatment. In an emergency, the problems with this arrangement are obvious, but even for routine medical visits; such distances create bureaucratic and staffing headaches. Although healthcare staff have established “mini-clinics” closer to housing units, these measures are merely a stop gap, and these spaces are often cramped, lack infrastructure to maintain hygiene, and do not allow for confidentiality.

More broadly, our City jails lack adequate confidential treatment spaces. The scarcity of dedicated treatment spaces near housing units is particularly detrimental to effective mental healthcare delivery. Many people are understandably unwilling to candidly reflect on their struggles within earshot of other incarcerated people and custody staff, and they shouldn’t be asked to in order to receive treatment. Clinical sessions in converted utility closets or on the dayroom floor are a far cry from the therapeutic setting patients with serious mental health conditions need and deserve. Even when people are seen in a central clinic, privacy is very often compromised by security staff who linger in the room, or because patients are brought in groups and crowd treatment spaces.

Inadequate or Inappropriate Staffing Prevents Access to Care

Relatedly, even well-intentioned officers regularly serve as a barrier to care simply because they are unavailable. Because every incarcerated person requires an escort by a correctional officer to visit and leave the clinic, our clients are frequently stuck in limbo, unable to access treatment they know is unavailable. The unavailability of uniformed staff, who are occupied with other tasks, or otherwise unwilling to help, lead to escort shortages. In turn, those shortages frequently result in missed appointments and treatment delays. One potential fix to overcoming the inevitable competing demands on correctional staff is to create roving medical escort posts during day-shifts for officers who are not assigned to other tasks. This could be achieved at present staffing levels through more efficient staff management, ensuring adequate escorts, and limiting instances in which staff are pulled away from crucial security positions.

Similarly, healthcare staff in the City jails face dual loyalty challenges, which can interfere with providing compassionate and appropriate care. Although medical and mental health providers are

¹⁵ The United Nations Standard Minimum Rules for the Treatment of Prisoners, the “Mandela Rules,” expressly prohibit prolonged solitary confinement beyond 15 days as a form of torture or cruel inhuman or degrading treatment.

ethically bound to treat patients, they face an understandable pull towards their colleagues – correctional staff who they rely on to ensure the providers’ safety. This dynamic can lead providers to doubt their patients’ credibility and to feel hesitant to speak out when they witness or suspect abuse on the part of correction officers.

We urge the City Council to empower correctional healthcare officials to weigh in on management decisions and have unfettered authority with regard to treatment matters for all people in our city jails, unless a genuine, immediate security emergency is at play. Simultaneously expanding de-escalation and mental health first aid training among corrections staff, especially those who are in non-mental health designated units posts, can help officers better understand how treatment interventions work and why they should be given priority.

Inaccessible Medical and Mental Health Care During Intake

Upon entering Department of Correction’s custody, our clients’ first stop is an intake unit, where they wait to be seen by Correctional Health Services for an initial medical and mental health assessment. Intake units consist of large cages, solely designed to hold people while they await their assessment with CHS and a transfer to a more appropriate housing within the facility. Regardless of medical or mental health needs, people may be held in these intake units for periods lasting as long as a week without access to a beds, sheets, showers, phones, and most importantly, medication. CHS does not provide treatment during intake but rather waits until people are assigned to a housing unit. One story outlines the horrors that can occur when housing location and lack of priority on behalf of the Department takes place:

Mr. C, who struggled with a seizure disorder and diabetes, was suffering from withdrawal when he was arrested. Due to concern about reduced insulin levels, his attorney bought him a candy bar before his arraignment. At the prosecutor’s urging, the judge set bail beyond what Mr. C could afford, and he was taken into custody. His attorney requested medical attention and our office followed up with DOC. When our client appeared in court five days later, he was visibly sicker and said he thought he would die. He had been sleeping on the floor and relying on other people’s insulin because he had not yet been examined. He was truly afraid for his life until he was released.

Our clients regularly wait several days after being taken into custody before they receive crucial medicines. Often, they do not receive the requisite care until our office advocates on their behalf. Similar lapses occur when individuals travel between jails. Whether high blood pressure medicines, inhalers, or anti-psychotic medications, these lapses can have devastating consequences.

These dangers are compounded for our clients with developmental disabilities and intellectual disabilities, who are among the most vulnerable in jail and prison settings. They are frequently the targets of violence, sexual violence, extortion, and abuse from staff and other incarcerated people. The intake process in the City jails does not provide any mechanism to keep these individuals safe, provide accommodations, or direct them to necessary services. Frequently, these individuals have masked their disabilities during the course of their lives and may not feel safe or able to affirmatively offer up information about their needs. Even worse, they may have

an impairment that has not been identified in the community, but which nonetheless necessitates accommodation and services.

Because of DOC's limited screening process, developmental and intellectual disabilities typically go unnoticed until our office identifies them to because our clients need accommodations. Yet because lawyers are not often clinically trained to identify such conditions and an arraignment interview is not the proper setting to do so, we likely underidentify individuals in need. Those individuals who are identified are placed in General Population housing units or in Mental Observation housing units with people who do not have the same needs. Almost without exception our clients with developmental and intellectual impairments are victimized in these settings. Additionally, because certain disabilities make it difficult to follow instructions or obey jail rules, people with developmental and intellectual disabilities may be more likely to have altercations with staff and suffer placement in solitary confinement. The result is that many clients with developmental and intellectual disabilities are victimized not only by other individuals but by the system at large.

Mr. W, who suffers from a severe intellectual impairment, was charged with a misdemeanor and initially released on bail. However, when he was found to be too intellectually disabled to participate in his own defense, the judge, over vociferous objections, remanded him to City jail pending placement with the Office for People with Developmental Disabilities (OPWDD). It took OPWDD approximately two months to ensure Mr. W's release. At that point, OPWDD referred him for outpatient services at the very same facility at which he had received services in the past and his charge was dismissed. During his needless two-month incarceration, Mr. W was assaulted in his housing unit, suffering blows to his head and eye. Even though OPWDD determined Mr. W could safely and appropriately live in the community, he became a victim of the very criminal justice system allegedly designed to keep communities safe.

We know the Board of Correction is working with the Department to house people more efficiently and provide people with immediate access to necessary essentials like a bed and blankets. Nonetheless, our clients still face inhumane, deprecating conditions that are not only unsanitary but they prevent people from accessing basic needs, including medication and medical and mental health treatment.

Discharge Planning and Continuity of Care To Enhance the Health of Communities

Finally, in order to truly improve the health and safety of our communities, the City should ensure that treatment while in DOC custody is part of a continuum of care that starts before arrest and arraignment and continues upon discharge or release. Such a commitment will lead to healthier and safer communities and thousands of people who avoid incarceration. To that end, **BDS supports the Council's effort to improve the continuity of care upon discharge through Int. No 1236.** Discharge planning should be made available, on a voluntary basis and not mandated as a condition of release or housing, to all people in the jail system. Because Health + Hospitals already plays an important role in discharge planning for many individuals in the jail system, their role should be expanded and their expertise should guide discharge planning for all people with medical and mental health conditions. Furthermore, we would welcome

enhanced discharge services for individuals released from court, particularly those people with serious medical and mental health needs.

Administrative Barriers to Accessing Care

Among the most readily fixable of the barriers to accessing care are countless rules, guidelines, policies, and practices that prove to be unnecessary and inappropriate hurdles to our clients who seek medical or mental health treatment.

Logistical Complications Prevent Mandated Treatment

One of the most common problems that our clients face is the need for treatment and appointments with outside specialty providers. While prisons and jails cannot staff a full range of specialists full-time, outside specialty appointments and follow up visits are often equally inaccessible. Logistical and security complications involved with transporting people to and from outside clinics are a central challenge. For instance, when correctional escort officers are absent or reassigned to other posts, a chain reaction can delay an appointment for months. Even when clients are transported to appointments, they are often left waiting hours in the jail intake for their escort, arrive late for appointments, and are ultimately told that they arrived too late to be seen that day. Similarly, clients who have upcoming follow-up appointments scheduled with specialists before their arrest often miss those appointments. H + H too often fails to promptly schedule and deliver follow-up visits, despite being informed of the situation by the patient and our office. Rescheduling missed appointments only compounds delays in treatment. Sufficient escorts and dedicated specialty schedulers who interface between correctional staff and specialty clinics are fundamental to address specialty care delays.

One BDS client had 2 stents around his kidneys which were scheduled to be removed after only 2 weeks. His arrest delayed the necessary operation and healthcare staff in the jail ordered an assessment before moving forward. Despite significant advocacy from our office, approximately 5 months went by without a response or any specialty appointment being scheduled. Eventually, the client developed an infection which had to be treated, further delaying the operation to remove the stents. Meanwhile, our client suffered extreme pain and became lightheaded when urinating. His appearance declined and his skin became pale. He ultimately had to be transferred to the hospital where he finally received treatment.

Forced Choices Between Safe Housing and Necessary Treatment

Transgender housing is perhaps chief among these categories. The Department must account for the increased vulnerability of transgender people in our penal system. The Department's decision to move the Transgender Housing Unit to the Rose M. Singer Center, the sole women's facility on Rikers Island, earlier this year is a positive step. It is vital that the Department recognizes transgender woman as women and treats them accordingly. Nonetheless, implementation of this change presents serious concerns. All incarcerated women, including transgender women, should be held in a women's facility, regardless of their disciplinary history or treatment needs. DOC must ensure that treatment options for transgender women are readily available whether they choose to apply, stay or leave the Transgender Housing Unit on Rikers Island.

BDS worked with a transgender woman who was being held in a male facility. This woman requested the Transgender Housing Unit immediately after she was taken into DOC custody. She did everything she was supposed to do and more, including identifying and outing herself to DOC staff in an effort to ensure her own safety. Unfortunately, her placement in the THU was delayed due to necessary substance use treatment. Because the treatment is only available in one male facility and one female facility on Rikers Island, and neither of those housed the THU, our client could not access both necessary medical treatments. Because DOC identified our clients as a man, she was confined to a male facility where she was in danger every day, including being the victim of sexual and verbal harassment. Fortunately, she was accepted into the THU after her substance use treatment was completed, but the inability to access two necessary treatments posed a grave danger.

We urge the City Council to ensure treatment is not denied or that people are not forced to choose between their physical and medical safety. Treatment should never be bared simply based on location and mis-gendering.

Conclusion

To improve healthcare in our City’s jails, we urge you to consider treatment in jail as part of the continuum of care and view the broader context that allows substandard healthcare to be the norm for incarcerated people.

A landmark article published in the New England Journal of Medicine asks – and answers – whether “health professionals [should] be accountable not only for caring for individual Black patients but also for fighting the racism — both institutional and interpersonal — that contributes to poor health in the first place? Should we work harder to ensure that black lives matter?”¹⁶ It notes that “the rate of premature death is 50% higher among Black men than among white men” and that “[b]lack women in New York City are still more than 10 times as likely as white women to die in childbirth.” The author, Dr. Mary Bassett, was the Commissioner of the New York City Department of Health and Mental Hygiene, and relied upon her own department’s statistics to support her findings.

The article does not explicitly address correctional healthcare, but Dr. Bassett explains that her work was inspired by another matter of the criminal legal system: police killings of unarmed Black people – with no legal sanctions – and the public uprisings that followed. The same racism that afflicts law enforcement in our communities also underlies many healthcare deficiencies in our prisons and jails, which are disproportionately populated by people of color and poor people.

We urge New York City to view Dr. Bassett’s article as a wake-up call and reevaluate the ways in which race impacts medical care that is needed and delivered before, during, and after incarceration. Despite assurances from City officials, including DOC Commissioner soon after she was appointed, DOC supervisors regularly refer to our clients as packages, at best, or animals, expletives, or racial slurs.

¹⁶ Mary T. Bassett, M.D., M.P.H., #BlackLivesMatter — a Challenge to the Medical and Public Health Communities, 2015 New Eng. J. Med. (2015), <http://www.nejm.org/doi/full/10.1056/NEJMp1500529#t=article>.

Disparities and biases are not limited to race, but regularly result from any demographic feature or personal identifying characteristic, including sexual orientation and gender identity or expression. Our clients are forced to rely on transphobic correction officers to access medical appointments relating to hormone therapy. Likewise, medically-assisted treatment for drug addiction is stigmatized as somehow “less than” other forms of medical care, with different standards of access. Although society continues to treat non-conforming identities and substance use and abuse as pathological behaviors, the true sickness is our habitual use of inhumane and ineffective prisons and jails, which are governed through deprivation, humiliation, abuse and neglect.

In “A Plague of Prisons: The Epidemiology of Mass Incarceration in America,” Ernest Drucker reframes mass incarceration as an epidemic – one like any other widespread infectious disease – that exploded in the 1970’s through the 1990’s and onto today. Indeed, while it is critical to provide the highest quality of care to any and all people in state custody, it is also important to recognize that incarceration is both inherently pathogenic and, itself, a disease. That is why policymakers must focus on decarceration and closing Rikers Island now.

BDS is immensely grateful to the Committee on Criminal Justice, Committee on Hospitals, and Committee on Mental Health, Disabilities and Addiction for hosting this critical hearing and shining a spotlight this issue. Thank you for your time and consideration of our comments. We look forward to further discussing these and other issues that impact our clients. If you have any questions, please feel free to reach out to Jared Chausow, our Senior Advocacy Specialist, at 718-254-0700 ext. 382 or jchausow@bds.org.