NYC Criminal Justice

Statement of Trish Marsik
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New York City Council
Committee on Fire and Criminal Justice Services
Committee on Public Safety
Committee on Courts and Legal Services
Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse, and Disability Services

May 12, 2015

Good morning, Chairperson Crowley and members of the Committee on Fire and Criminal Justice Services as well as members of the Committees on Public Safety, Courts and Legal Services, and Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services. My name is Trish Marsik and I am the Executive Director of the Mayor's Task Force on Behavioral Health and the Criminal Justice System.

Thank you for the opportunity to testify today. The Task Force on Behavioral Health and the Criminal Justice System is embedded in the Mayor's Office of Criminal Justice, which advises the Mayor on public safety strategy and, together with partners inside and outside government, develops and implements policies aimed at achieving three main goals: reducing crime, reducing unnecessary arrests and incarceration and promoting fairness.

These three goals are at the heart of the Task Force's work. In June of 2014, Mayor de Blasio launched a robust effort to address how the criminal justice and health systems can work together better to ensure that we are reserving criminal justice resources for the appropriate cases and deploying treatment and other proven effective remedies to interrupt those needlessly cycling through the system. Under the leadership of Deputy Mayor of Health and Human Services Lilliam Barrios-Paoli and Director of the Mayor's Office of Criminal Justice Elizabeth Glazer, the Task Force's executive committee included commissioners from City and State agencies, experts from the private sector, representatives from law enforcement and behavioral health agencies, district attorneys, defenders, judges and other court representatives, academics and service providers. The Task Force brought together over 400 leaders and participants in this work from across the City and the nation. Over a 100-day period, this group developed a comprehensive strategy to ensure that, when appropriate, people are diverted from the criminal justice system and that justice-involved individuals with behavioral health needs are connected to care and services at every point in the criminal justice process. The result is an unprecedented $130 million, four-year investment in targeted solutions that look not only at individual points in the system, but how the system as a whole operates. In implementing this plan, we are reducing the number of people with behavioral health needs cycling through the criminal justice system and connect them instead to interventions that could change the course of their lives.

I will discuss with you today the strategic imperatives driving these reforms as well as the mechanisms we are using to ensure that reforms are being fully and effectively implemented. Over the last twenty years, New York City has experienced the sharpest drop in crime anywhere in the nation. As crime has fallen so has the City's jail population – on the last day of 2014, there were fewer than 10,000

individuals detained at Rikers for the first time since the mid-1980s. While many factors contributed to this extraordinary achievement, at its heart, the success was due to a focused effort to identify who was committing crimes and where and then tailoring strategies to address those specific problems.

Despite our success in reducing the overall jail population, the number of people with behavioral health issues has stayed largely constant, with individuals with behavioral health issues comprising a bigger and bigger percentage of the total number incarcerated. While in FY 2010, people with mental illness were only 29% of the NYC jail population, today they represent 38% of the overall jail population; approximately 7% of the jail population is made up of individuals with serious mental illness, meaning that they suffer from diseases such as schizophrenia and bipolar disorder. In addition, approximately 46 percent of inmates in the NYC jail system report that they are active substance users, although we believe the actual prevalence of substance use to be much higher. Many justice-involved individuals with behavioral health needs cycle through the system over and over again, often for low-level offenses. For example, a group of approximately 400 individuals has been admitted to jail more than 18 times in the last five years. This same group accounted for more than 10,000 jail admissions and a collective 300,000 days in jail.

To address this population more effectively and efficiently, the Task Force's recommendations are rooted in the recognition that these kinds of entrenched and recurring problems can only be addressed if the system is looked at as a whole and if the strategy recognizes that each part of the system has an effect on the other. The goal of these strategies is to ensure that, when there is no public safety risk that individuals with behavioral health disorders: do not enter the criminal justice system in the first place; if they do enter, that they are treated outside of a jail setting; if they are in jail, that they receive treatment that is therapeutic, rather than punitive; and that upon release, they are connected to effective services. A key component of this approach involves plugging into Medicaid expansion, which gives us an opportunity to expand funding for supportive programming and treatment in the community while ensuring that those services lead to both better health outcomes and declining justice involvement. To that end, throughout the Task Force's work, we are focused on increasing enrollment in Medicaid, ensuring that Health Homes engage and retain those justice involvement and that we measure the success of the range of new Medicaid initiatives not only by how they reduce reliance on health crisis services but also the crises of justice involvement.

Here are a few examples of the Task Force's work to date:

- Achieving the Task Force's goals begins on the streets, where police and other first responders encounter those with behavioral health issues. The NYPD is currently finalizing curriculum that will expand training for police officers to enable them to better recognize the behaviors and symptoms of mental illness and substance use. The training will ultimately be integrated into the police academy curriculum. In the short term, it will be a stand-alone 36 hour training for 5,500 officers in the two areas where we will pilot public health diversion centers to provide an option that is not hospitalization or jail for people who do not pose a public safety threat.

- Additionally, on April 14, Mayor Bill de Blasio and Chief Judge Jonathan Lippman announced Justice Reboot, an initiative to modernize NYC's criminal justice system so it is fairer and more efficient. Central to this first round of reforms is a robust strategy to significantly reduce case processing times, a goal of the Behavioral Health Task Force. In developing better scheduling tools, more comprehensive databases of case information, and in creating borough-specific and city-wide workgroups, the City is well poised to reduce case processing backlogs. The Mayor and

Chief Judge have committed to clearing half of all cases that have been going on for more than a year within the first six months of the initiative.

- Behavioral health screening at arraignments will launch later this summer during selected hours in Manhattan. Nurse practitioners and other health professionals will pilot a process to identify those with immediate behavioral health needs, as well connecting to their treating providers for care and potential diversion.

- Efforts are also underway to adapt the questions currently used to screen veterans who enter the criminal justice system. Those identified will be flagged for Veterans Affairs (VA) so case management support and linkage to care can be activated.

- To date, the city has created two new specialized units to provide preventative services to inmates with behavioral health issues. The two sites have shown preliminarily promising results, and the following two sites are scheduled to be opened mid-2015. Additionally, expansions to substance use disorder treatment will launch in June, providing discharge plans to an additional 4,000 individuals. The Department of Corrections has successfully implemented the eight additional hours of training for all uniformed officer recruits in working with inmates experiencing mental health issues. Current officers will also receive this training as well.

- The City is currently engaging in extensive planning to make sure that discharge of individuals with behavioral health issues sets them up for successful re-entry through linkages with appropriate public benefits and supports, including public health insurance. The Task Force anticipates completion of expansions to existing discharge planning contracts (I-CAN) for 4100 slots will occur in May 2015. Further, to ensure minimal disruptions in public health insurance coverage, the City is identifying the various processes by which Medicaid enrollment occurs for those leaving jail. HRA and DOHMH are in the planning phases for additional staff to be added to these efforts and to create a Medicaid implementation team.

- Beginning in October, DOHMH is adding 120 permanent housing slots dedicated to justice-involved individuals to the Department's portfolio. A similar model, the Frequent Users System Engagement or FUSE program, was found to significantly decrease shelter, hospital and jail stays, generating an annual $15,000 public cost savings per housed participant when measured against a comparison group.

- Additionally, the Department of Probation is close to launching in-house behavioral health teams and will provide advisory services in the screening and assessment of the behavioral health needs of individuals on probation, connecting them to clinical and concrete community-based services.

Measuring impact and refining approach is baked directly into the DNA of the Task Force. Since the action plan was announced in December, the Mayor's Office has been leading multi-agency teams to ensure 1) implementation of both the projects outlined in this report as well as the ongoing planning efforts in several areas, 2) measurement of progress, and 3) accountability in achieving the goals laid out in the report. To ensure effective oversight and accountability, the Office of the Deputy Mayor for Health and Human Services and the Mayor's Office of Criminal Justice will be responsible for the oversight of this plan and will convene the leaders of the agencies directly charged with implementation and key stakeholders, including representatives from the provider and consumer communities, to

monitor the performance of the initiatives. The Mayor's Office will publish quarterly reports on the progress of the initiatives and related efforts. To ensure that we are using the right metrics to evaluative impact, implementation of all of the actions in the report will include establishing measures for process and substance outcomes as well as targets. These performance measures will be published in the second progress report and systematically monitored and reviewed. And to ensure that the City is getting the greatest public safety return on its investments, the City will conduct an ongoing cost-benefit analysis to ensure that the lives of people with behavioral health needs are improving, that the criminal justice system becomes more efficient at diverting people out of the system, and that as a result, costs for unnecessary incarceration decline and benefits to public health and safety are calculated. In addition, the pilot programs that are to be initiated will be evaluated to determine whether they should be adopted City-wide, modified, or replaced with alternative approaches.

The Task Force is one way in which this administration is enacting its commitment to continue to drive down crime, reduce unnecessary arrests and incarceration, and promote fairness. I am happy to take your questions.

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Testimony of Nashla Rivas Salas
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Before the New York City Council Committees on
Fire and Criminal Justice, Public Safety, Courts and Legal Services, and
Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services
Oversight Hearing on Behavioral Health and the Criminal Justice System:
Examining New York City's Action Plan

May 12, 2015

Good afternoon chairpersons Crowley, Gibson, Lancman, Cohen, and committee members. My name is Nashla Rivas Salas, and I am a senior budget and policy analyst for the New York City Independent Budget Office. I am joined by Paul Lopatto, Supervising Analyst for Social and Community Services. Thank you for the opportunity to testify today on Behavioral Health and the Criminal Justice System.

My testimony will not directly address the City's Action Plan but rather highlights some of the findings from a report our office released yesterday that bears directly on the subject of this hearing. Our report looked at correctional mental health spending since 2009 and the city's progress towards meeting its obligations to provide mental health and discharge planning services in jails.

More than a decade ago the city reached a legal settlement with plaintiffs in a case that became known as Brad H. The city agreed to provide inmates who were confined in its jails for at least 24 hours and who received treatment for mental illness during their time there with a plan for accessing ongoing services upon release. Although the average daily population in city jails continues to decrease, the number and share of inmates with a mental health diagnosis is growing.

In response to the recent turmoil in the city's jail system, the de Blasio Administration has adopted a number of new initiatives for addressing mental health services and other needs in the jails, including the "action plan" recommendations announced in December. As the city moves forward with these new efforts, it is worth looking back at how well the Departments of Correction and Health and Mental Hygiene met the obligations of the Brad H. settlement. IBO has compared spending in fiscal year 2009 (the earliest year the health department could provide data) and 2012 (the latest year most data was available at the time IBO made its request). Some of the service provision data analyzed was through 2013.

Among our findings:

- From 2009 through 2012, health department spending on mental health services in the city's jails remained flat, at about $35 million a year. Over that same period, the number of inmates with mental health diagnoses increased by nearly 10 percent, to more than 20,200 admissions in 2012 and comprised a larger share of the inmate population.

- Because health department spending on correctional mental health services had not kept pace with the increasing number of inmates with mental health diagnoses, per inmate spending on mental health services declined. The decline was particularly notable in spending on the administrative and support areas, purchase of psychotropic medications, and—to a lesser extent—discharge planning. With the de Blasio Administration's new initiatives, though, per inmate spending is likely to rise.
- In terms of the absolute number of services provided to inmates eligible under the Brad H. settlement, the health department delivered more services in 2013 than in 2009, including an increase of over 56 percent in the number of discharge plans completed, to 8,492 in 2013.
- But some of the 10 different types of discharge services identified under Brad H. were reaching a smaller share of eligible inmates in 2013 than in 2009, including referrals made, appointments scheduled for post-release care, and Medicaid and public assistance applications submitted.
- It is not possible to assess the effectiveness of the discharge services because neither the correction department nor health department tracks inmates with mental health issues post-release.

The report also compares data on the demographics, length of stay, and reasons for arrest for the inmates covered by the Brad H. settlement with the general inmate population.

Thank you for the opportunity to testify today. I am glad to answer any questions you may have.

New York City Independent Budget Office **Fiscal Brief**

May 2015

Looking Back at the Brad H. Settlement:

Has the City Met Its Obligations to Provide Mental Health & Discharge Services in the Jails?

Summary

The number of inmates in the city's jails coping with mental health issues has been growing in recent years. But questions involving the availability of services for these inmates are not new. More than a decade ago the city reached a legal settlement with plaintiffs in a case that became known as Brad H. The city agreed to provide inmates confined in its jails for at least 24 hours and who receive treatment for mental illness during their time there with a plan for accessing ongoing services upon release.

Despite the court settlement, concerns have persisted about the adequacy of mental health services for inmates in the jails as well as plans for aiding them after their release. In response to the recent turmoil in the jails, the de Blasio Administration has adopted new initiatives for addressing mental health services and other needs in the jails, including the "action plan" recommendations announced in December.

As these new efforts get underway, it is worth looking at how well the Departments of Correction and Health and Mental Hygiene met the obligations of the Brad H. settlement. IBO has compared spending and service provision in fiscal year 2009 (the earliest year the health department could provide data and 2012 (the latest year most data was available when IBO made its request). Among our findings:

- As of 2012, health department spending on correctional mental health services had not kept pace with the increasing number of inmates with mental health diagnoses. With the de Blasio Administration's new initiatives, though, the city will spend more on correctional health this year than was previously spent.
- From 2009 through 2012, health department spending on mental health services in the city's jails remained flat, at about $35 million a year. Over that same period, the number of inmates with mental health diagnoses increased by nearly 10 percent, to more than 20,200 admissions in 2012 and comprised a larger share of the inmate population.
- In terms of the absolute number of services provided to inmates eligible under the Brad H. settlement, the health department delivered more services in 2013 than in 2009, including an increase of over 56 percent in the number of discharge plans completed, to 8,492 in 2013.
- But more than half of the 10 different types of discharge services were reaching a smaller share of eligible inmates in 2013 than in 2009, including referrals made, appointments scheduled for post-release care, and Medicaid and public assistance applications submitted.
- It is not possible to assess the effectiveness of the discharge services because neither the correction department nor health department tracks inmates with mental health issues post-release.

The report also compares data on the demographics, length of stay, and reasons for arrest for the inmates covered by the Brad H. settlement with the general inmate population.

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New York City's jail system houses a larger and larger number of individuals with mental health issues every year. Caring for these inmates—many of whom require specialized services, some mandated as a result of litigation—is a growing and expensive challenge to the city's Departments of Correction (DOC) and Health and Mental Hygiene (DOHMH). In June 2014, Mayor de Blasio announced a new task force charged with addressing the issue of mental illness and substance abuse within the criminal justice system and their action plan was released in December. This was far from the first attempt to address the problem of how the city provides mental health services amidst one of the largest correctional facilities in the country.

As the result of a class-action lawsuit filed in the 1990s (*Brad H., et al. v. The City of New York, et al.*), the city has been required to provide discharge planning services to inmates with mental health diagnoses since 2003. The goal was to connect inmates with mental health care in the community prior to their release with the hope that this could help end the cycle of reoffending and reincarceration for many of those with untreated or poorly managed mental illnesses.

In order to assess the array of mental health services offered to city inmates and their associated costs, along with any improvement in outcomes associated with the Brad H.-mandated services, IBO requested data from both the Department of Correction, which runs the city's jail system, and the Department of Health and Mental Hygiene, which is responsible for the provision of all mental health services in the jails. Both departments provided data covering fiscal years 2009 and 2012, and in some cases 2013 (all years are fiscal years unless otherwise noted). We chose 2012 because it was the most recent year for which a full year of data was available at the time the request was made, and 2009 because it was the earliest year for which DOHMH was able to provide data. Thus, our analysis is confined to the period prior to the de Blasio Administration.

In the analysis that follows, we will first review the history of the city's and state's efforts since the Brad H. decision to provide services to mentally ill individuals within the criminal justice system, in order to provide context for more recent proposals. Next, we will use the data provided by DOC and DOHMH to examine the characteristics of the population with mental health diagnoses in city jails. Finally, we will detail the services and costs for this population and how they have changed over time. Most of the cost data presented in this fiscal brief concerns DOHMH spending rather than DOC spending. This is because of limited availability of relevant information from the corrections department. Where possible we have attempted to calculate DOC costs related to this population.

Background

New York City is home to one of the largest jail systems in the United States; second only to the Los Angeles jail system.[1] The New York City Department of Correction provides for the care of individuals accused of crimes as well as those convicted and sentenced to one year or less of jail time. Besides the holding facilities located in the criminal, supreme, and family court houses across the city, there are 15 different inmate facilities throughout New York: 10 are located on Rikers Island. The remaining five include the borough facilities in Manhattan, the Bronx (a five-story barge) and Brooklyn, as well as hospital wards at the Health and Hospitals Corporation's (HHC) Elmhurst and Bellevue facilities.[2]

The jail population has been on a steady decline since 2003, while the number of inmates with a mental health diagnosis has increased during the same period. In 2009, the daily population of city jails averaged 13,362 and of these 27 percent (3,607 inmates) had some kind of mental health diagnosis; in 2012, the average daily population of the jails had declined to 12,287, while the share of this population with a mental health diagnosis had increased to slightly more than a third (4,177 inmates).

A large and growing number of inmates with mental health diagnoses in correctional facilities is not unique to New York City, but rather is a problem throughout much of the country. Comprehensive national data on this problem are scarce; nor is there even a standardized definition or measure of mental illness in the correctional context. One often-cited 2006 study by the federal Bureau of Justice Statistics found that more than half of all prison and jail inmates incarcerated in the United States had some type of mental health problem, with the largest percentage found in local jails.[3] Three jails—Chicago's Cook County Jail, the Los Angeles County Jail, and New York City's Rikers Island—now comprise the three largest mental health institutions in the country.[4]

Brad H. Litigation and Settlement. City and state officials have been grappling with the problem of mentally ill individuals in the criminal justice system for at least the past 15 years. In 1999, the Urban Justice Center, Debevoise & Plimpton LLP, and New York Lawyers for the Public Interest filed a class-action lawsuit on behalf of seven plaintiffs who had all been arrested multiple times and received mental health treatment while incarcerated, but were never given a discharge plan upon release.

The lawsuit challenged New York City's practice of discharging people with psychiatric disabilities from the city jails in the middle of the night with only $1.50 and two subway tokens, and without any medication or referral to services. Failure to provide discharge planning in the jails was determined to be a violation of New York State Mental Hygiene Law 29.15, which mandates "providers of inpatient health services to provide discharge planning."[5]

A settlement with the plaintiffs was reached that took effect in 2003. The city agreed to provide comprehensive discharge planning to all inmates who qualify as a member of the protected class. A class member is defined as an inmate whose period of confinement in city jails lasts 24 hours or longer, and who during confinement receives treatment for a mental illness. However, individuals who see mental health staff only once or twice and are assessed as having no need for further treatment are excluded from the class.

All those covered by the settlement are entitled to have a comprehensive treatment and discharge plan in place for services while in jail and after they are released. Anyone who is on psychiatric medication is entitled to a 7-day supply of medication and a prescription for 21 days regardless of whether they are Medicaid eligible. Inmates who qualify for Medicaid must have Medicaid benefits activated or reinstated upon release in order for the inmate to have a way to pay for the services they will need. Inmates who lack active Medicaid, but are presumed eligible and have a Medicaid application completed within seven days of release, are entitled to obtain a Medication Grant Program (MGP) card, which provides them with financial assistance in order to purchase medication while they wait for their Medicaid to become active. Brad H. class members are also entitled to receive either a referral for mental health treatment and services (if the release date is unknown) or an appointment for the same (if the release date is known). Lastly, inmates who are homeless receive assistance in applying for supportive housing.

Inmates classified as having serious and persistent mental illness (SPMI) receive additional services.[6] SPMI inmates get assistance in applying for public assistance, food stamps, supportive housing, Supplemental Security Insurance, and veterans' benefits if eligible. (Note that non-SPMI inmates may also be eligible for some of these programs, excluding supportive housing, but DOHMH is not required to assist with their applications under the current interpretation of the settlement agreement.) SPMI inmates also receive case management, transportation, and follow-up calls for housing and mental health appointments. If needed they also get referrals to a mental health program shelter.

Who Are Brad H. Inmates?

The Number of Inmates with Mental Health Diagnoses. Using the data provided by DOHMH, there are two different methods for tallying the number of inmates with mental health diagnoses in the city's jail system. The first includes an unduplicated count of all individuals admitted to the jail system in a given year who have had a mental health status in that year or during any previous incarcerations. This metric shows that the number of inmates with mental health diagnoses increased by 9.8 percent from 2009 through 2012, from 18,463 to 20,279 admissions. The second method includes only those inmates with a consistent M-status in their medical record. An M-status indicates a mental health diagnosis and is used either when an inmate is referred for mental health services or if he or she is on a specific psychotropic medication. It can be removed from a patient's medical record if clinical staff later determines that he or she does not need follow up care. Filtering out all patients who later had their M-status removed, the number of inmates with mental health diagnoses in city jails was 15,171 admissions in 2009 and 16,265 in 2012, a 7.2 percent increase.

IBO has opted to use the first, more inclusive method of tallying inmates with mental health diagnoses for our fiscal analysis under the rationale that any inmate referred for mental health services will require some outlay of resources. Based on this broader metric, individuals with mental health diagnoses accounted for 33.6 percent of all unique jail admissions in 2012, up from 27.2 percent in 2009.

However, not all of these individuals require follow up care and/or discharge planning services under the terms of the Brad H. settlement. Therefore, in sections of this report that focus on the provision of these services we will use the narrower definition and look only at those individuals who qualify as Brad H. class members at the time of their release.

Types of Mental Health Diagnoses. The only information on specific mental health diagnoses that was provided to IBO by the Department of Health and Mental Hygiene was the number of inmates with a serious and persistent mental illness in 2009 and 2012. Inmates' SPMI status is determined by mental health staff in the jails based upon New York State Office of Mental Health guidelines. The guidelines state that in order to receive a SPMI designation, an individual must be at least 18 years of age and meet the criteria for a Diagnostic and Statistical Manual of Mental

Disorders, fourth edition (DSM-IV) psychiatric diagnosis.[7] In addition, he or she must also meet at least one of the following criteria:

- Enrollment in Supplemental Security Insurance or Social Security Disability Insurance due to mental illness
- Extended impairment in functioning due to mental illness, or
- Reliance on psychiatric treatment, rehabilitation, and supports.

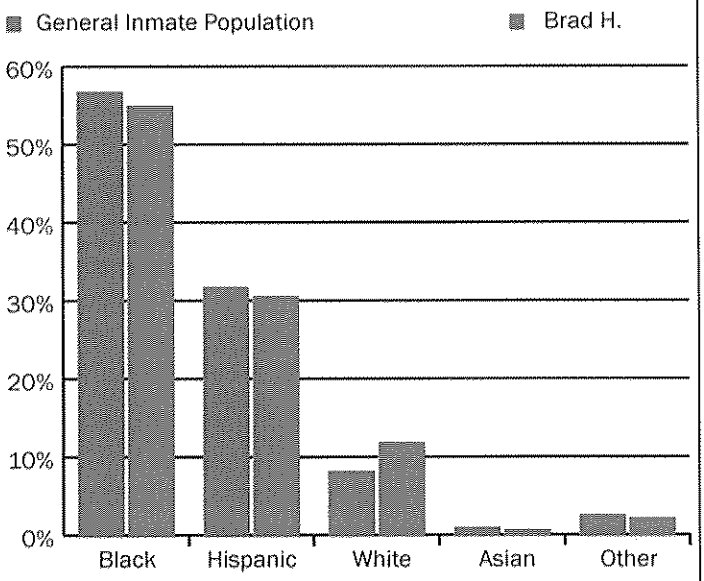
There has been a decline in the number of SPMI inmates over time, as well as in the share of Brad H. inmates classified as SPMI. Using the narrower definition of Brad H. class members described above, there were 4,331 seriously mentally ill individuals admitted to the jails—28.5 percent of all Brad H. inmates—in 2009 versus 3,808 (23.4 percent of Brad H. inmates) in 2012. Despite the decline in the number of SPMI inmates, the share of all inmates with serious and persistent mental illness was nearly identical in both years—6.4 percent and 6.3 percent, respectively.

Inmate Demographics. In 2012, DOC had 84,754 admissions with an average daily population of 12,287. IBO compared the demographics of inmates who are not class members (the general population) to those of inmates who are Brad H. class members and found that the share of women who are Brad H. class members was 16 percent, nearly double the share of women in the jails' general population (9 percent). Another major difference was in the racial composition of the two groups: 12 percent of Brad H. class members were white, compared with 8 percent of the general population of inmates.

Length of Stay. Inmates who are Brad H. class members tend to spend more time in jail than the general inmate population, which excludes Brad H. inmates. For inmates admitted in 2012, Brad H. class members were incarcerated 115.2 days on average compared with an average of 38.4 days for the general population; the difference in length of stay averaged nearly 77 days. Moreover, the length of stay for Brad H. class members increased from 2009, while length of stay for the general inmate population remained roughly constant throughout the period.

A Bureau of Justice Statistics report found that inmates with mental illness tend to experience more disciplinary problems and require more medical interventions because they either harm themselves or have some kind of substance abuse disorder.[8] These factors may explain why

Race/Ethnicity of Inmates Who Are Brad H. Class Members Compared with General Population of Inmates
Inmates admitted in 2012

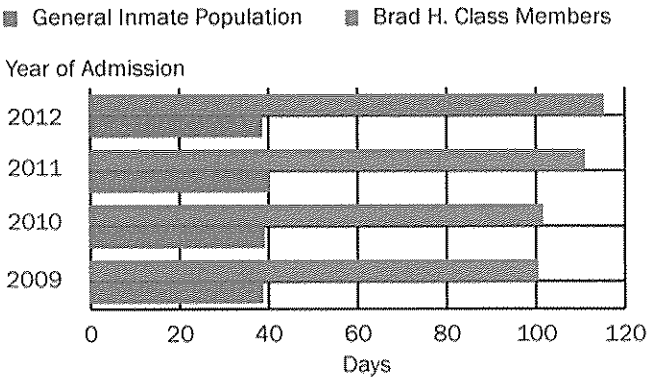


SOURCE: Department of Correction
NOTE: General Inmate population excludes Brad H. class members.
New York City Independent Budget Office

Brad H. class members average longer lengths of stay. Difficulty posting bail also contributes to the length of stay of the Brad H. population, according to a 2012 report by The Council of State Governments on New York City's criminal court and correction systems.[9]

Types of Charges. IBO looked at data on types of charges for both the general population of inmates and the Brad H. population at admission in 2012. Inmates who are Brad H. class members were somewhat more likely than the general population to be charged with more serious felony crimes such as robbery and drug felony sale. The general population

Brad H. Class Members Stay in City Jails More Than Twice as Long as General Inmate Population



SOURCE: Department of Correction
NOTE: General inmate population excludes Brad H. class members.
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Most Serious Charges at Admission for 2012

Felonies	Brad H.	General Inmate Population
Robbery	10%	6%
Drug Felony Sale	8%	5%
Other Felonies	5%	5%
Assault	5%	4%
Burglary	5%	3%
Drug Felony Possession	4%	5%
Grand Larceny	3%	2%
Murder/Attempted Murder/ Manslaughter	3%	1%
Weapons	2%	3%
Rape/Attempted Rape	1%	1%
Misdemeanors	**Brad H.**	**General Inmate Population**
Other Misdemeanor	11%	15%
Misdemeanor Larceny	8%	7%
Drug Misdemeanor	7%	12%
Misdemeanor Assault	5%	6%
Other Sexual Offenses	1%	1%
Loiter/Prostitution	1%	1%
Misdemeanor Weapons	1%	1%

SOURCE: Department of Correction
NOTE: General inmate population excludes Brad H. class members. Columns do not add up to 100 percent as some miscellaneous charges have been left out of the table.

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was somewhat more likely to be charged with misdemeanor crimes such as drug misdemeanor, misdemeanor assault, and other misdemeanors. It is likely that the differences in the severity of charges contribute to longer lengths of stay for the Brad H. population. However, DOC only provided us with aggregate level data which did not allow us to match length of stay and charge for specific individuals.

Services for Inmates with Mental Health Diagnoses

Almost all direct mental health care services New York City jail inmates receive are delivered by outside providers under contract with DOHMH, with most of the services provided by a single vendor. In contrast, many of the discharge planning services are provided by city employees. From 2009 through 2012, the number of mental health care staff supplied by Corizon Health—by far the largest contractor—rose by 7.5 percent and the number of DOHMH discharge planning staff declined by 9.9 percent. During this same period, the number of inmates admitted to the jails and who ultimately received mental health diagnoses rose by 9.8 percent and the number of Brad H. class members rose by 7.2 percent

Direct Mental Health Care. DOHMH is responsible for the oversight and provision of all medical and mental health care to inmates of New York City jails, along with policymaking in this area. Delivery of most of the medical and mental health services provided to inmates is contracted out to third-party vendors. All of the direct mental health care that inmates receive in the jails, along with their medical care, is provided by Damian Family Care Services and Corizon Health. Damian, a nonprofit health care provider, provides medical and mental health services in just one facility, the Vernon C. Bain Center, the Bronx-based jail barge. Damian's $38.9 million contract with DOHMH went into effect in September 2013 and covers three years' worth of services. Prior to that date, all direct health care services on the barge were provided by Health and Hospitals Corporation staff. Corizon's current contract with DOHMH, which covers both medical and mental health care in the remaining jails, is for $126.7 million over three years and expires in December.

Substantial questions have been raised about the care provided by Corizon, a for-profit company, both in New York and around the country. Minnesota's prisons dropped Corizon in 2013 after 15 years as the health care provider, as did prisons in Maine after 9 years. A number of upstate New York counties have also ended their relationship with Corizon due to concerns about the quality of care, inmate deaths, and overbilling.

In 2012, Corizon employed 178.7 full time equivalent (FTE) staff in mental health positions in New York City jails, a 7.5 percent increase over the number of mental health staff employed by Prison Health Services in 2009 (Corizon was formed in 2011 when Prison Health Services merged with another company). The most common job title in both years was mental health clinician, a position that requires both a state license and a master's degree in social work, psychology, or a related field. Among other duties, a mental health clinician is responsible for conducting patient evaluations, assessments, and crisis interventions, as well as providing individualized follow-up care and leading group therapy sessions, all while the patient is incarcerated. There was a small increase in the number of mental health clinicians over the 2009-2012 period (84.3 FTEs in 2009 and 88.4 FTEs in 2012).

Much of the increase in Corizon's mental health staffing, however, resulted from an increase in psychiatric coverage. The total number of its psychiatric staff in the jails went from 33.7 FTEs in 2009 to 45.0 FTEs in 2012, an increase of 11.3 FTEs, or 90.6 percent of the overall staffing increase. Specifically, most of the increase was attributable

to Corizon adding psychiatric nurses (in permanent and temporary positions) and psychiatric physician assistants, an increase of 17.4 FTEs from 2009 through 2012. In contrast, the number of permanent and temporary psychiatrists and senior psychiatrists, higher level positions that require a medical degree, state license, and board certification, decreased by 6.1 FTEs. (The number of psychiatrists fell by 8.3 FTEs, while the number of senior psychiatrists rose by 1.2 FTEs.)

The remainder of the direct mental health care received by inmates is provided by the city's Health and Hospitals Corporation. HHC supplies all psychotropic medication used in the jails and also maintains two off-site prison wards where inmates with psychiatric emergencies are sent. The larger unit, at Bellevue Hospital, has about 65 beds for male psychiatric patients, and the smaller unit, at Elmhurst Hospital, has space for up to 15 female psychiatric patients. Prior to September 2013, HHC also provided health care staffing inside the Bronx jail barge. Excluding money transferred from DOHMH's budget, HHC spent $52.6 million on correctional health in 2012, $29.1 million of which came from inpatient Medicaid reimbursements and $23.5 million from city subsidy. Available budget documents do not break out how much of this was for psychiatric versus other medical care.

Discharge Planning and Case Management Services. Under the terms of the Brad H. settlement, class members are entitled to comprehensive discharge planning services both inside and outside the jails. Although the number of Brad H. class members rose by 7.2 percent from 2009 through 2012, the number of DOHMH discharge planning staff inside the jails declined.

Inside the jails, planning services are provided by DOHMH discharge planning staff, whose numbers dropped from 81.0 FTEs in 2009 to 73.0 FTEs in 2012 (a 9.9 percent decline). Most of the decrease was among managers and support staff, while the combined number of caseworkers and social workers fell by just 1, from 49.0 to 48.0 FTEs. Caseworkers and social workers interact directly with the inmates and provide much of the front line discharge planning services they receive. Specifically, their responsibilities include collaborating with mental health staff in the development of a discharge plan and assisting inmates with obtaining referrals and appointments with community-based providers, supportive housing, Social Security Administration benefits, and public benefits such as Medicaid, public assistance, and food stamps.

DOHMH also directly employs a relatively small number of other correctional mental health staff, in titles such as administrative psychologist, program administrative associate, and attending physician psychiatrist. These personnel perform a variety of tasks, including executive leadership, program development, oversight of Corizon staff, program evaluation and data analysis, coordination with community providers, and administrative support. As of 2012, one of these positions was also devoted to assisting Corizon staff with direct patient care. The number of these staff whose responsibilities are unrelated to discharge planning also declined from 12.0 FTEs in 2009 to 9.0 FTEs in 2012. Thus the overall decrease in DOHMH's correctional mental health headcount was 11.0 FTEs, or 11.8 percent.

The health department also provides discharge planning and case management services to Brad H. inmates outside of the jails, but these tasks are outsourced rather than performed by DOHMH staff. The first of the two out-of-jail programs is called the Service Planning Assistance Network, or SPAN, and it provides discharge planning for inmates released directly from court or with short jail stays. Any class member can also receive services from SPAN within 30 days of his/her release from jail. The services include assistance obtaining medication along with assistance applying for Medicaid, or any of the other discharge planning services inmates should receive in the jails but may not have sufficient time to access prior to release. Provision of SPAN services is contracted out to the Bowery Residents' Committee, which provides drop-in centers for inmates near the courts in every borough except Staten Island.

The second program is called Link and it provides short-term, intensive case management services to SPMI inmates who are leaving jail. This program is contracted out to four different vendors, each operating in a different part of the city.

Housing and Staffing for Inmates with Mental Health Diagnoses

Inmates with mental health diagnoses may be housed in any jail within DOC's system, both on and off Rikers Island. Ten of these jails provide mental health services to inmates using on-site Corizon employees.[10] However, the extent of Corizon's mental health staffing varies by jail, as does the number of inmates needing mental health services. Each jail is divided into different units that are used to house different types of inmates, including those with a mental health diagnosis and those being punished for breaking rules.

Staffing and Population by Jail. Inmates with mental health diagnoses may receive care from HHC staff in the prison wards at Bellevue and Elmhurst hospitals, or in 2012, in the Bronx jail barge. There are 10 additional jails on and off Rikers Island in which inmates may receive mental health services provided by Corizon staff. IBO received data on the average number of all inmates—the general population and Brad H.—housed in each jail in 2012 from the Board of Correction, along with the specific number of inmates with mental health diagnoses housed in each jail as of June 30, 2012 from DOHMH. Additionally, we were able to obtain 2012 Corizon staffing data by jail, although it is important to note that these numbers indicate total staff assigned to these facilities, not the number on duty at any one time. These data show that both mental health staffing and inmate counts vary considerably by jail.

The Anna M. Kross Center had the largest inmate population, housing 2,286 total inmates on an average day in 2012 and 981 inmates with a mental health diagnosis at the end of 2012. It also had the greatest concentration of mental health staff (54.9 FTEs). Five other jails in the system housed between 1,000 and 1,500 total inmates, 300 to 525 of whom had mental health diagnoses, and had 14 to 22 Corizon mental health FTEs assigned to them.

Mental Health Staffing and Inmate Counts In 2012

	Corizon Mental Health Staff (FTEs)	Average Annual Daily Inmate Population	Inmates With M Status (6/30/12)
Anna M. Kross Center	54.9	2,286	981
George Motchan Detention Center	14.8	1,460	521
Otis Bantum Correcitonal Center	22.4	1,443	416
Eric M. Taylor Center	12.3	1,401	356
Robert N. Davoren Complex	13.7	1,259	309
George R. Vierno Center	18.5	1,105	467
Rose M. Singer Center	24.5	821	498
Manhattan Detention Complex	6.1	745	167
Brooklyn Detention Complex	4.5	487	148
North Infirmary Command	6.7	124	70

SOURCES: Board of Correction; Department of Health & Mental Hygiene
NOTES: Only those facilities with permanent on-site Corizon staff are included (other facilities may have Health and Hospitals Corporation or Damien staff). Corizon staffing numbers indicate total staff assigned to these facilities, not the total number on duty at any one time.
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There are four jails averaging fewer than 1,000 inmates, the two borough jails in Brooklyn and Manhattan and two on Rikers Island: the Rose M. Singer Center and the North Infirmary Command. The Brooklyn and Manhattan Detention Complexes housed 148 and 167 inmates with mental health diagnoses, respectively, as of June 30, 2012. Neither of these jails contains a Mental Observation unit (discussed on page 8), so inmates with significant mental health needs were typically housed elsewhere. However, both had a handful of mental health staff (4.5 FTEs in Brooklyn and 6.1 FTEs in Manhattan) on-site to assist inmates. The Rose M. Singer Center likewise houses less than 1,000 inmates on a given day, but a considerably higher number of these have mental health diagnoses—just under 500 at the end of 2012. This is because it only houses female inmates and as noted earlier, a higher share of female as opposed to male inmates have a mental health diagnosis. Accordingly, the Singer Center also has more Corizon staff (24.5 FTEs) than any jail but the Kross Center. Lastly, more than half of the inmates at the North Infirmary Command, which houses only those inmates requiring infirmary care or extreme protective custody, have mental health issues. As of June 30, 2012, the North Infirmary Command housed 70 Brad H. inmates who were served by 6.7 Corizon mental health FTEs.

Housing Units Within the Jails. Each jail is divided into different units that are used to house different types of inmates; in general, each unit houses fewer than 50 inmates. DOC places inmates who have committed jail infractions into punitive segregation units, more generally known as solitary confinement: single-occupancy cells for 23 hours per day, with 1 hour of recreation and access to daily showers in the unit. There are two types of punitive segregation units, one for the general inmate population and one for inmates with a mental health diagnosis. Since the fall of 2013, most inmates with a SPMI classification were no longer placed in punitive units and more recently it was also stopped for 16- and 17-year olds.

The first Mental Health Assessment Units for Infracted Inmates were opened in 1998 as a way to provide mental health services to inmates who have violated jail rules and would normally not receive these services while in punitive segregation. Amid mounting concerns about the use of punitive segregation for inmates with a mental health diagnosis, particularly those identified as having serious and persistent mental illness, the Department of Correction and the Department of Health and Mental Hygiene made a joint decision to close these units as of December 2013, in part to shift more of the focus from punishment to treatment.

Two new types of units were created to replace the assessment units: Clinical Alternatives to Punitive Segregation (CAPS) and Restricted Housing Units (RHUs).

The goal of the CAPS initiative, which began in July 2013, was to curb the use of solitary confinement for SPMI inmates. CAPS units are clinical and not punitive. CAPS units house both inmates with SPMI diagnoses who had previously been placed in punitive segregation and those with no jail infractions who had previously been placed in mental observation units and require a higher level of care. All infractions are set aside for those housed in CAPS (with no punitive segregation penalties imposed) and time in the unit is determined clinically while they remain at Rikers.

By September 2014 there were three CAPS units housing a total of 56 patients. At a budgeted health department cost of $3.8 million in 2014 and $3.4 million in 2015 this works out to roughly $60,600 for each CAPS bed in 2015.

The RHUs were designed to provide punitive housing (23 hour a day lock in) for Brad H. class members who had committed infractions, but who are not identified as SPMI. The RHUs featured a self-paced behavior modification program provided in a group setting by mental health staff from Corizon, through which participants have the opportunity to earn additional out-of-cell time. The RHUs began coming online in 2012 but have not met expectations and DOC is working with DOHMH to develop a new model for these units.

Most jails on Rikers also have Mental Observation (MO) units. These units are used for inmates who have significant mental health needs, such as those requiring closer clinical monitoring or medication administration, suicide watch, or evaluation. Mental Observation units are not considered punitive settings. MO units have mental health staff that work directly with inmates (as well as in the clinics) and also offer daily group therapy. The borough houses of detention and the barge in the Bronx do not have MO units.

Costs for Inmates with Mental Health Diagnoses

Most of the cost of providing mental health services to inmates in city jails is funded through the Department of Health and Mental Hygiene's budget. Including city, state, and federal funds, the health department spent just over $35 million on correctional mental health annually in 2009 and in 2012. In both years, more than half of this spending was for Corizon's mental health staff. Because DOC does not allocate costs between the general inmate population and inmates with a mental health diagnosis, it was not possible to break out the cost of guarding and transporting inmates with mental health diagnoses.[11] Our analysis did show that units housing inmates with mental health diagnoses tend to cost more than other housing units because they require additional correction officers.

Health Department Costs. The cost of providing mental health services to inmates in city jails is funded entirely through the DOHMH and HHC budgets. DOC does not provide any direct mental health services and is only responsible for the transport of inmates with mental health diagnoses to receive services. As discussed earlier, HHC's share of service costs is also comparatively small as their staff only serves inmates in a handful of facilities; in contrast the majority of mental health service costs are borne by the health department. Specifically, DOHMH spent a total of $35.3 million from all sources on correctional mental health in 2012, slightly less than the $35.6 million spent in 2009. In 2009, 55.8 percent of total spending was for Corizon staff and 27.2 percent was for Brad H.-mandated services, including discharge planning staff, the SPAN and Link contracts, and funding for the court-appointed monitors who scrutinize DOHMH's compliance with the Brad H. settlement. By 2012, these shares were 61.1 percent and 27.2 percent, respectively. The remainder of spending in both years was on DOHMH's other mental health staff and the purchase of psychotropic medications for inmates.

The majority of DOHMH's correctional mental health costs are city funded, but the department also receives considerable state and Medicaid funding for its Brad H.-mandated services.[12] In 2009 and 2012, direct city funds accounted for 12.1 percent and 12.4 percent of Brad H.-mandated spending respectively, and for 76.1 percent of overall correctional mental health spending. Specifically, discharge planners are entirely supported by Medicaid funds, and the Link contracts and the court monitors are entirely supported by state funding. The only Brad H.-mandated service that DOHMH directly supports with city funds is the SPAN contract. In comparison, all of Corizon's mental health staff inside the jails are paid for entirely with city funds. The state does provide matching funds for medical services provided by Corizon at 10 percent of total costs, but mental health services are not eligible for this type of funding. In addition, federal law prohibits the use of Medicaid funds for medical or mental health care provided within jails and prisons. In the correctional context, Medicaid funding may only be used for inpatient care received at off-site hospitals and for administrative purposes, for example, the DOHMH discharge planning staff that screen and enroll inmates in Medicaid prior to release.

An Increasing Share of Health Department Spending on Correctional Mental Health Is for Corizon Staff
Dollars in thousands

	2009				2012			
	Direct City	Direct State	Medicaid	All Sources	Direct City	Direct State	Medicaid	All Sources
Corizon Staff	$19,866			$19,866	$21,573			$21,573
Other DOHMH Staff	1,199			1,199	995			995
HHC Psych Medications	4,864			4,864	3,120			3,120
Brad H.-Mandated Services	1,165	5,396	3,104	9,665	1,187	5,036	3,385	9,608
DOHMH Discharge Planning Staff			3,104	3,104			3,385	3,385
Link Contracts		5,155		5,155		4,724		4,724
SPAN Contract	1,165			1,165	1,187			1,187
Court Monitors		241		241		311		311
Total Spending	**$27,094**	**$5,396**	**$3,104**	**$35,594**	**$26,875**	**$5,036**	**$3,385**	**$35,296**

SOURCE: Department of Health & Mental Hygiene
NOTES: Spending on Department of Health & Mental Hygiene staff excludes the cost of fringe benefits. Medicaid is jointly funded by the federal, state, and local governments.

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DOC Staffing and Other Costs. It was not possible for IBO to break out the exact cost of Brad H. inmates from DOC's budget as there are many fixed costs involved. It is clear, however, that housing units with inmates with a mental health diagnosis will cost more than other units because they require additional correction officers. Using the current average correction officer salary, IBO calculated an average annual cost per unit. Punitive units for the general inmate population (excluding Brad H.) have six officers per shift. Accounting for 3 shifts per day and making allowance for leave time, IBO assumes that each unit would require 30 correction officers on staff, with an annual payroll cost of about $2.1 million. Some types of punitive units that house inmates with a mental health diagnosis require 8 officers per shift, or 40 on staff. At that staffing level such units have an annual payroll of $2.8 million. These units have a higher number of officers assigned to them in order to handle the transfer to and from the inmates' cells to therapy sessions, medical appointments, and any other out-of-cell appointments they may have. In contrast, nonpunitive units such as general population and Mental Observation have fewer officers assigned to them. The number of officers assigned to nonpunitive units can range from 2 officers to 5 officers per shift, with annual payrolls of ranging from $700,000 to $1.7 million.

Another expense that is directly related to the provision of services to Brad H. inmates is an annual cost of $2.5 million for 32 correction officers to support mandated discharge planning services. In 2001, when the city was preparing to settle the Brad H. lawsuit, the department created the position of mental health discharge planning officer. Despite the title, these 32 uniformed staffers escort inmates from their housing areas to the clinics and do not actually provide discharge planning services.

Changes in Costs and Provisions of Service Over Time

DOHMH's average per inmate spending on correctional mental health services declined by 9.0 percent in 2012 from the 2009 amount. Most of this overall decrease was driven by areas other than direct service staff. Despite the funding drop, DOHMH made progress in expanding the

More Correction Officers Required for Housing With Inmates With a Mental Health Diagnosis

Type of Housing Unit	Number of Posts per Unit	Number of Officers	Average Annual Cost
Punitive			
Mental Health Assessment Unit for Infracted Inmates	8	40	$2,794,480
Restricted Housing Unit	8	40	$2,794,480
Central Punitive Segregation Unit	6	30	$2,095,860
Nonpunitive			
Mental Observation	3	15	$1,047,930
Clinical Alternatives to Punitive Segregation	5	25	$1,746,550
General Population	2	10	$698,620

SOURCE: Department of Correction
NOTE: Average cost per officer is $69,862 (does not include fringe benefits).

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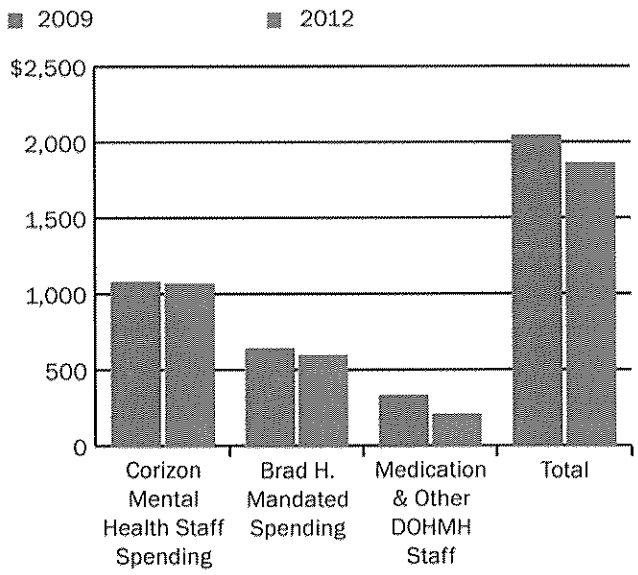
reach of some significant discharge planning services over this time period, most notably the completion of formal discharge plans. However, a number of other discharge planning services that should have been available to class members further along in their incarcerations were reaching fewer inmates in 2013 than in 2009.

Changes in Health Department Costs and Funding. In a comparison of 2012 with 2009, DOHMH's spending on correctional mental health dipped by 0.8 percent, while the total number of inmates with a mental health diagnosis at some point during their incarceration went up by 9.8 percent and the number of Brad H. class members increased by 7.2 percent. Because any inmate referred for mental health services will require some outlay of resources, IBO generally used the broader measure—inmates with a mental health diagnosis—to compare costs. The average per inmate cost was calculated by dividing total DOHMH spending on a given type of correctional mental health service in a year by the total number of unique inmates with a mental health diagnosis admitted during that same year. The one exception is for Brad H.-mandated services, where it was more appropriate to divide spending by the total number of Brad H. class members admitted during that year.

Using this methodology, IBO found that average total per inmate spending on correctional mental health services by the Department of Health and Mental Hygiene declined by 9.0 percent, from $2,041 in 2009 to $1,857 in 2012. Per inmate spending fell slightly for Corizon mental health staffing (from $1,076 to $1,064, a difference of 1.1 percent) and to a somewhat greater extent for Brad H.-mandated services (from $637 to $591, or about 7.2 percent). Together these two spending categories encompass all staff members providing direct services to inmates—the Corizon staff who offer clinical care and the DOHMH staff who provide discharge planning. Most of the overall decrease in per inmate mental health spending (from $328 per inmate to $203, or about 38.1 percent) was driven by areas other than direct service staff, including spending on DOHMH's administrative and support staff and spending on psychotropic medications.

The 7.2 percent decrease in per inmate spending for Brad H.-mandated services is not the full story, however. The number of discharge planning staff declined by a somewhat larger margin, falling 9.9 percent from 81.0 FTEs to 73.0 FTEs. Part of the reason spending has not gone down to the same extent as staffing is that salaries increased. The average salary for all discharge planning staff increased by 4.2 percent, from $48,000 in 2009 to $50,700 in 2012 (the increase for caseworkers was larger, growing by 4.2 percent, from $41,400 to $45,300). According to DOHMH, the salary increases were needed in order to attract more qualified candidates. The health department also spent more on the SPAN contract and court monitors in 2012 than in 2009, though less on Link contracts.

Decrease in Per Inmate Mental Health Spending Driven by the Cost of Medication and Support Staff



SOURCE: Department of Health & Mental Hygiene
NOTES: Based on all inmates with a mental health diagnosis. Spending on Department of Health & Mental Hygiene staff excludes the cost of fringe benefits.

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Funding sources for correctional mental health spending shifted somewhat over time. Direct city spending on correctional mental health remained roughly constant from 2009 through 2012, declining by 0.8 percent from $27.1 million to $26.9 million. Direct state spending declined by 6.7 percent, from $5.4 million to $5.0 million. In contrast, Medicaid spending on correctional mental health increased by 9.0 percent, from $3.1 million in 2009 to $3.4 million in 2012. Thus, Medicaid represented a larger share of the funding for correctional mental health in 2012 than in 2009—9.6 percent versus 8.7 percent. Medicaid has displaced state funding rather than city tax-levy dollars, with the city-funded share of correctional mental health spending remaining constant at 76.1 percent in both 2009 and 2012.

Changes in Discharge Planning Over Time. The city does not systematically track inmates with mental health diagnoses once they are released into the community. Therefore, the only data we were able to obtain to assess the impact of mental health services in the jails concern the

discharge planning process. In this case, however, we were able to obtain more recent 2013 data for our analysis.[13]

These data show that, in absolute numbers, the amount of discharge planning services DOHMH provided for Brad H. class members increased for 4 out of 10 services in 2013 compared with 2009. Specifically, the number of comprehensive treatment plans completed, which is the first step in the discharge planning process, increased from 9,787 to 10,117. The number of discharge plans completed, the second step in the process, rose more dramatically from 5,426 in 2009 to 8,492 in 2013. This represents a 56.5 percent increase in the number of discharge plans completed, a far larger change than the 5.9 percent increase in the number of Brad H. patients discharged. There were also small—in absolute terms—increases in the number of Medication Grant Program cards issued and supportive housing applications completed over this time period.

DOHMH's performance on other discharge planning metrics declined in 2013 from 2009 levels. In both absolute numbers and percentages, the largest decreases were in terms of the numbers of Medicaid prescreenings conducted and appointments scheduled. There were 2,327 Medicaid prescreenings conducted in 2013 (918, or 28.3 percent, fewer than in 2009) and 1,057 appointments scheduled (632, or 37.4 percent, fewer than in 2009). The numbers of referrals made, public assistance applications submitted, and Medicaid applications submitted each also fell by more than 13 percent in 2013 compared with 2009. However, evaluating DOHMH's performance solely in terms of these absolute numbers may be misleading for a number of reasons.

Under the terms of the settlement agreement DOHMH is not legally required to provide every service to every Brad H. class member. For example, only SPMI inmates are entitled to help in applying for public assistance and supportive housing. The Brad H. settlement agreement also includes a timeframe during which DOHMH must provide certain discharge planning services, and the agency is not legally required to provide services to inmates who are released from custody before this timeframe is up. For example, DOHMH has from 7 days to 15 days after the mental health intake visit to complete an inmate's comprehensive treatment plan (7 days if the inmate requires mental observation housing, or 15 days if he or she can be housed with the general population). They have an additional seven days after this to complete the class member's discharge plan. If an inmate is released from custody before this period is up, the health department is required only to give him or her access to the SPAN offices. DOHMH is also not required to provide services to Brad H. class members who refuse discharge planning. The data released to IBO did not include information on inmates who were released without discharge plans but who would have been eligible for Brad H. services if the time span allowed for completion of the treatment plan and discharge plan had been shorter.

Provision of Comprehensive Treatment and Discharge Plans Has Gone Up, While the Provision of Most Other Discharge Planning Services Has Declined

	2009	2013	Change	
			Number	Percent
Total Number of Brad H. Patients Discharged (SPMI & non-SPMI)	**14,763**	**15,633**	**870**	**5.9%**
Comprehensive Treatment Plans Completed	9,787	10,117	330	3.4%
Discharge Plans Completed	5,426	8,492	3,066	56.5%
Medicaid Prescreenings Conducted	3,245	2,327	(918)	-28.3%
Walking Medications Provided	2,224	2,213	(11)	-0.5%
Referrals Made	2,081	1,800	(281)	-13.5%
Appointments Scheduled	1,689	1,057	(632)	-37.4%
Medicaid Applications Submitted	576	419	(157)	-27.3%
Medication Grant Program Cards Issued	128	138	10	7.8%
Total Number of SPMI Inmates Discharged	**3,872**	**3,443**	**(429)**	**-11.1%**
Public Assistance Applications Submitted	421	254	(167)	-39.7%
Supportive Housing Applications Completed	129	183	54	41.9%

SOURCE: Department of Health & Mental Hygiene (including data from SPAN and Link)
NOTES: These numbers represent the number of services provided to Brad H. class members by incarceration date. Class members may receive multiple services; which services each person should receive depends on a number of variables including release date, Medicaid eligibility, and whether or not he/she refused services. Walking medications means an inmate was released with a 7-day supply of medication(s) plus a written prescription for another 21-day supply. A public assistance application is for both public assistance and food stamps.

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Trends in Share of Eligible Inmates Receiving Various Discharge Services Are Mixed					
	Total Required by Stipulation		Percent Completed		
	2009	2013	2009	2013	Improved in 2013
Services for all Brad H. Patients (SPMI & non-SPMI)					
Comprehensive Treatment Plans Completed	9,961	10,117	98.3%	100.0%	Yes
Discharge Plans Completed	7,548	8,630	71.9%	98.0%	Yes
Medicaid Prescreenings Conducted	3,266	2,356	99.4%	98.8%	Negligible Change
Walking Medications Provided	2,579	2,300	86.2%	96.2%	Yes
Referrals Made	2,215	2,183	94.0%	83.0%	No
Appointments Scheduled	1,731	1,154	97.6%	91.6%	No
Medicaid Applications Submitted	577	455	99.8%	92.1%	No
Medication Grant Program Cards Issued	138	150	92.8%	92.0%	No
Services for SPMI Inmates					
Public Assistance Applications Submitted	424	263	99.3%	96.6%	No
Supportive Housing Applications Completed	184	202	70.1%	90.6%	Yes

SOURCE: Department of Health & Mental Hygiene (including data from SPAN and Link)
NOTES: These numbers represent the number of services DOHMH provided and was required to provide to Brad H. class members by incarceration date. Class members may receive multiple services; which services each person should receive depends on a number of variables including release date, Medicaid eligibility, and whether or not he/she refused services. Walking medications means an inmate was released with a 7-day supply of medication(s) plus a written prescription for another 21-day supply. A public assistance application is for both public assistance and food stamps.
New York City Independent Budget Office

In addition, not every inmate who is legally entitled to receive discharge planning services would actually benefit from each of them. For example, public assistance and Medicaid applications are only submitted for those inmates who meet these programs' eligibility criteria. Thus, a decrease in submission rates may simply mean that there were fewer eligible individuals within the Brad H. class in 2013 than in 2009. There may also have been larger numbers of inmates entering the jail system with active Medicaid in 2013, and who required only reactivation of their benefits upon release. Likewise, a decrease in the share of inmates released with medications may mean that there were fewer class members requiring psychotropic medications in 2013 than 2009.

We can also look at the share of inmates discharged in 2009 and 2013 who received the services to which they were legally entitled. These numbers show that the share of eligible inmates receiving services has improved over time for 4 out of 10 discharge planning services. Most significantly, there was a large increase in the share of inmates released with discharge plans completed (from 71.9 percent to 98.0 percent). There was also an increase in the share of eligible inmates who had comprehensive treatment plans completed prior to release (from 98.3 percent to 100.0 percent) along with marked improvement for two less widely used services (supportive housing applications and walking medications). However, the share of eligible inmates receiving discharge planning services for the other six types of services examined by IBO declined from their 2009 levels. The largest declines were in terms of the number of discharged class members who received referrals for follow-up care (from 94.0 percent to 83.0 percent), had appointments for post-release care scheduled (from 97.1 percent to 91.6 percent), or had Medicaid applications submitted (from 99.8 percent to 92.1 percent).

In terms of both absolute numbers and the share of eligible inmates receiving services, DOHMH has made progress in expanding the reach of a few discharge planning services. Progress has been most notable in the completion of discharge plans. However, some other discharge planning services were reaching fewer inmates in 2013 than in 2009—both in terms of eligible and all class members. Most noteworthy are the declines in the numbers and shares of Brad H. class members receiving referrals or appointments for post-release care, as these make it easier for inmates with mental health needs to receive ongoing care. The decline in the share of eligible inmates with Medicaid applications submitted is also important, as Medicaid is the only means many of these inmates have to pay for care and medication in the community.

Conclusion

Although the average daily population in New York City jails continues to decrease, the number and share of inmates with a mental health diagnosis is growing. These inmates are more likely than the general jail population to be female and white, and tend to have longer lengths of stay than inmates in the general population.

Housing areas designated for inmates with mental health diagnoses require more DOC staff, which is more costly. As of 2012, health department spending had not kept pace with the increasing number of inmates with mental health diagnoses. Total per inmate spending for correctional mental health services fell by 9.0 percent. Most of the decline occured in spending for pyschotropic medications and for DOHMH administrative and support staff, and to a lesser extent for services to help inmates transition from jail to the community as mandated under Brad H. Per inmate spending for staff providing direct mental health services to inmates fell by 1.1 percent. However, given the recent funding of numerous new initiatives through DOHMH's budget, it is likely that the city will spend more money on correctional mental health in 2015 than it did in either 2009 or 2012.

Perhaps most important, it is difficult to gauge whether those services that inmates do receive are having an impact, as neither DOHMH nor DOC tracks inmates with mental health issues post-release. What we can tell from available data is that more than half of DOHMH's discharge planning services were reaching a smaller share of Brad H. class members in 2013 than in 2009, notably the provision of referrals and appointments for post-release care. This finding is critical because stabilizing mentally ill inmates within the jails only has a limited impact if they do not also receive continuing mental health care as they transition back into the community.

Appendix: Recent Initiatives

Although the main focus of this brief is a comparison of DOHMH spending in 2009 and 2012, since then there have been a number of initiatives addressing inmates' mental health. The Bloomberg Administration rolled out two new initiatives in 2013 and 2014. Subsequently, the de Blasio Administration announced $15.5 million in city funding for several additional initiatives targeting a similar population in the Adopted Budget for 2015. More recently, the November 2014 Financial Plan included $89.0 million in new city funding over four years for a series of correction and correctional-health-related initiatives. This was followed closely by the release of the Mayor's Task Force on Behavioral Health and the Criminal Justice System Action Plan, which detailed the use of these funds and pledged about $40 million from the Manhattan District Attorney's asset forfeiture fund. Most recently, the Mayor's Preliminary Budget for 2016 included funding for Enhanced Supervision Housing Units to house inmates determined to be "dangerous" or "at risk" for violence, some of whom will likely require mental health services. (This report was completed prior to the release of the 2016 executive budget.)

Court-Based Intervention and Resource Teams. In 2011, Mayor Bloomberg convened the Citywide Justice and Mental Health Initiative Steering Committee. The committee was tasked with developing policies to address the disproportionately high number of mentally ill inmates in city jails. It released a set of recommendations in late 2012, one of which called for the creation of Court-Based Intervention and Resource Teams. The goal of the court-based teams is to identify a subset of the mentally ill in the criminal justice system population and to divert them away from the jails and into Alternatives to Incarceration and Alternatives to Detention programs. More specifically, the teams are tasked with identifying and diverting from jail people who have been arrested, who meet certain criteria—such as a low risk of failure to appear or to reoffend—and who also have a mental health diagnosis.

According to DOHMH, the most optimistic estimate is that the court-based teams will divert about 3,000 people from the jails annually, but it is too early to measure the results. In terms of program costs, the program is funded through the budgets of both DOHMH and the Criminal Justice Coordinator. DOHMH's actual spending on the teams was $180,000 in 2014 and it is currently budgeted at $3.6 million in 2015, all in city funding.

Program for Accelerated Clinical Effectiveness. DOHMH received new funding in the 2015 adopted budget that will allow the department to convert four existing Mental Observation units into intensive mental health treatment units. These units will be structured similarly to the Clinical Alternatives to Punitive Segregation units, but will only house inmates without infractions. Unlike the clinical alternative units, the Program for Accelerated Clinical Effectiveness units will also house some non-SPMI inmates, though DOHMH expects these less seriously ill inmates to represent only about a third of the population served. These four units are expected to have a combined capacity of 110 inmates.

DOHMH received $5.2 million for 2015 with $6.5 million budgeted for subsequent years to hire new clinical and support staff for these units (primarily through Corizon).[14] The DOHMH-only cost for these new units will be $58,900 per bed in 2016, which is comparable to the department's 2015 per bed cost for the clinical effectiveness program units. Note that this is all new funding and is in addition to any resources reallocated from existing Mental Observation units.

Mental Health Training for Correction Officers. This year's adopted budget also included $4.2 million in new funding for DOC to provide all of their officers with an additional eight hours of mental health training. This training will be developed in conjunction with DOHMH and will be provided to all officers on a yearly basis.

Mayor's Task Force on Behavioral Health and the Criminal Justice System Action Plan. The November 2014 Financial Plan allocated $89.0 million in city funds to DOC and DOHMH over a four-year period in conjunction with the task force's action plan. However, a substantial amount of this funding is devoted to initiatives that do not specifically target inmates with mental health diagnoses, such as increased DOC staffing in units housing adolescent populations and the extension of discharge planning services to inmates who are not Brad H. class members. While it is possible that funding allocations will change as the plan is further developed, at this stage IBO has identified just $15.4 million that is specifically earmarked for programs that focus on inmates with mental health issues.

The plan includes crisis intervention teams, which will provide correction officers with additional training on symptom identification and also pair them with 16 mental health clinicians who will offer tips on how to deescalate confrontations and help prevent the use of force. This

program is jointly funded through DOC's and DOHMH's budgets. Specifically, DOHMH is expected to spend $473,000 in 2015 and $1.7 million in 2016 and DOC's budget was increased by $2.6 million in both years for this program.

The other two initiatives funded through DOHMH's budget in the November 2014 Financial Plan focus on reaching individuals with mental health needs before they enter the jail system. One provides funding for a drop-in center where police officers can bring people with mental health or substance abuse issues as an alternative to arresting them or taking them to the emergency room; a second drop-in center will be funded by reallocating exisisting DOHMH resources. The other initiative provides funding to pilot a new enhanced pre-arraignment screening program at Manhattan Central Booking. The clinical staff conducting the screenings will provide information to judges on individuals who may benefit from mental health or substance abuse services rather than incarceration. Including a small state funding match, these two programs are budgeted at a combined $419,000 in 2015 and $1.2 million in 2016.

Additional Staffing for Enhanced Supervision Housing Units. The Mayor's Preliminary Budget for 2016 included funds for health and mental health staffing at a new type of correctional housing unit to be known as Enhanced Supervision Housing Units. There will be 5 such units, each with capacity for 50 inmates, in 2 jails on Rikers. Initial plans call for adding 24 FTEs in the DOHMH, including 6 mental health clinicians and 1 supervising psychiatrist, at a cost of $2.0 million in 2015 and $3.5 million in subsequent years. Inmates will be assigned to these units who are determined to be "dangerous" or "at risk for violence" based on predictive measures developed by DOC.

Report prepared by Nashla Rivas Salas & Christina Fiorentini

Endnotes

[1]"The top 10 largest local jail jurisdictions in the US" http://www.correctionsone.com/facility-design-and-operation/articles/2076453-The-top-10-largest-local-jail-jurisdictions-in-the-US/
[2]"About DOC" http://www.nyc.gov/html/doc/html/about/about_doc.shtml
[3]U.S. Department of Justice, Bureau of Justice Statistics, Mental Health Problems of Prison and Jail Inmates, revised December 2006. Note that "mental health problem" as used in the study included a recent clinical diagnosis of mental illness, recent treatment by a mental health professional, or symptoms of a mental health disorder. Symptoms of a mental disorder were based on criteria specified in the DSM-IV
[4]Ibid; International Association for Forensic and Correctional Psychology, "Revised Standards for Psychology Services in Jails, Prisons, Correctional Facilities, and Agencies Published in Criminal Justice and Behavior," July 2010.
[5]New York Mental Hygiene Law S 29.15, (b) 14 NYCRR 587, et seq.
[6]Serious mental illness, or SMI, is also used to describe this population.
[7]American Psychiatric Association (2000), Diagnostic and Statistical Manual of Mental Disorders (4th ed).
[8]U.S. Department of Justice, Bureau of Justice Statistics, Mental Health Problems of Prison and Jail Inmates, revised December 2006.
[9]The Council of State Governments Justice Center, "Improving Outcomes for People with Mental Illnesses Involved with New York City's Criminal Court and Correction Systems", December 2012, http://csgjusticecenter.org/wp-content/uploads/2013/05/CTBNYC-Court-Jail_7-cc.pdf
[10]The five jails without permanently assigned on-site Corizon staff are: the James A. Thomas Center (currently closed), the West Facility for inmates with infectious diseases, the Vernon C. Bain Center (services provided by Damian staff), the Elmhurst Hospital Prison Ward (services provided by HHC staff), and the Bellevue Hospital Prison Ward (services provided by HHC staff).
[11]The majority of DOC's budget consists of fixed costs such as employee salaries, fringe benefits, and capital costs. It is very difficult to allocate these types of costs to specific programs or inmates and DOC does not do so.
[12]All state and Medicaid funds go to support Brad H.-mandated services, specifically discharge planning staff, the court monitors, and the Link contracts. While the city contributes to the overall cost of Medicaid, the amount it pays annually is now capped and does not vary based on usage. Therefore a greater reliance on Medicaid funding has no fiscal impact on the city.
[13]While we had originally planned to analyze inmate outcomes—including recidivism and adherence to treatment regimen after release—this was not possible given the data that DOHMH was able to provide. Discharge planning data was provided to IBO by the Department of Health and Mental Hygiene in the form of aggregated tables. The court monitors and plaintiffs' attorneys in the Brad H. litigation, who receive similar data from DOHMH on an ongoing basis, have raised questions about its accuracy and usefulness. An April 2014 court order extending the terms of the Brad H. settlement agreement also included a provision that DOHMH improve its quality assurance practices in regards to data reporting. IBO's experience working with the DOHMH data confirmed some of these concerns.
[14]DOC received an additional $6.1 million in 2015 and $6.7 million a year through 2019 for correction officer staffing within these new units. At a combined DOHMH and DOC cost of $13.2 million in 2016 (all in city funds), the total cost for one bed in a Program for Accelerated Clinical Effectiveness unit will be roughly $120,200 a year (excluding fringe benefit costs for city employees staffing these units).

Cyrus R. Vance, Jr.
New York County District Attorney

Testimony Submitted to the New York City Council
Committees on Fire and Criminal Justice Services, Public Safety, Courts and Legal Services, and Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

"Oversight: Behavioral Health and the Criminal Justice System: Examining New York City's Action Plan"

Tuesday, May 12, 2015

I thank the New York City Council for allowing me to submit this testimony regarding behavioral health and the criminal justice system.

My job as the Manhattan District Attorney is to keep the public safe, and to ensure that the criminal justice system is fair for all individuals who come before the court. Even as crime rates in New York City remain at historic lows, the sad reality is that our jails and prisons have become virtual warehouses for people who struggle with behavioral health issues. According to the Department of Correction's Fiscal 2015 Preliminary Budget Report, people with mental illness represent approximately 38 percent of the overall New York City jail population. It is critical that law enforcement – working with our elected leaders – find intelligent and effective ways to prevent offenders who struggle with behavioral health issues from repeatedly cycling through our system for crimes committed as a result of an untreated treated mental illnesses.

I want to discuss two initiatives that my Office has undertaken to address this critical issue: 1) the Mayor's Behavioral Health Task Force; and 2) the Manhattan Mental Health Court.

Mayor's Task Force on Behavioral Health and the Criminal Justice System

My Office is working with Mayor Bill de Blasio's office to implement the Task Force on Behavioral Health and the Criminal Justice System's Action Plan, a project aimed at reducing the number of people with behavioral health needs who cycle through the criminal justice system.

Senior members of my Office and I took part in the Task Force's meetings last summer, where we put forth a series of recommendations to develop new and innovative methods for responding to people with behavioral health needs at multiple points in the criminal justice system. In addition, my Office has committed more than $40 million to the $130 million project to support the following:

Expanding training for police officers to enable patrol to better recognize the behaviors and symptoms of mental illness and substance use when making street encounters.

- **Designing and implementing a scientifically-validated risk assessment tool** to inform decision-making around pre-trial detention and other decisions.
- **Creating the capacity to perform universal screening of all defendants for physical and mental health needs before arraignment.** Some with behavioral health needs will be flagged for possible diversion to services rather than incarceration, except where safety issues prevent diversion.
- **Expanding pre-trial supervised release** by 2,300 slots citywide to safely divert appropriate defendants from jail. This type of programming involves ongoing face-

to-face and telephone contact during the pendency of the case and increased access to substance abuse and mental health services for those determined to be in need.

- **Launching a scatter-site supportive housing program** focused on individuals with behavioral health needs and a history of cycling through criminal justice system and chronic homelessness. The effort will create nearly 300 permanent housing slots with supportive services, including mental health and substance abuse services.

The ultimate goals of this initiative are to reduce unnecessary arrests and incarceration, redirect criminal justice resources to maximize their greatest public safety impact, and increase fairness in the criminal justice system. I thank Mayor de Blasio for his leadership and commitment to this project, and I look forward to working with the Mayor's Office on Criminal Justice on its implementation.

Manhattan Mental Health Court

I now want to discuss an initiative with a four-year record of success in addressing the specialized needs of certain defendants with behavioral health needs. In 2011, together with Chief Judge Jonathan Lippman and the Office of Court Administration, my Office created Manhattan's first Mental Health Court. This specialized court part is dedicated to handling cases involving offenders suffering from a major mental disorder and who, at least initially, committed non-violent felony offenses. Since then, the Mental Health Court also has been expanded to offenders who committed crimes involving violence, sex offenses, and guns on a case-by-case basis.

The Manhattan Mental Health Court provides comprehensive oversight and mental health treatment to eligible defendants. The Court utilizes its judicial authority to encourage

offenders with mental illness to participate in treatment plans. Through a system of intensive judicial monitoring of defendants' progress, in conjunction with a support network, the Court ensures that offenders have the resources available to facilitate successful engagement with treatment programs, while maintaining compliance with Court mandates.

Located within the New York State Supreme Court, cases are referred to the Mental Health Court by judges, prosecutors, defense attorneys, and others. The program is voluntary, but a defendant is accepted into the program only after the Mental Health Court determines that the defendant's behavior can be stabilized through a community-based treatment – whether through in-patient or out-patient programs. Each treatment plan is individualized, and takes into account both the defendant's needs and public safety concerns.

To be eligible, the defendant's mental illness must have a significant impact on his or her social adaptive functioning, and must have contributed to the behavior that resulted in the arrest. The offender also must agree to treatment and enter into a plea agreement. In appropriate circumstances, eligible defendants are placed in treatment programs, monitored by the court and linked to valuable services and housing providers, reducing the chances of recidivism and increasing safety in New York City.

Since its inception, hundreds of cases have been referred to the court, 114 individuals have been accepted, 43 have graduated, 32 have failed to fulfill the requirements of the program, and 43 have pleaded guilty and are currently being monitored. I believe this is a strong start in reforming the way our criminal justice system handles defendants with behavioral health needs.

I thank the City Council for your continuing support of law enforcement, and for helping to ensure that New York remains the safest big city in the country.

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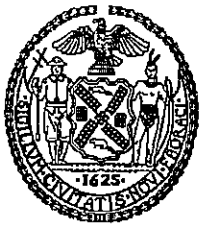

Richard A. Brown
District Attorney

TESTIMONY OF

DOUGLAS L. KNIGHT, DIRECTOR

ALTERNATIVE SENTENCING

QUEENS COUNTY DISTRICT ATTORNEY'S OFFICE

BEFORE THE

NEW YORK CITY COUNCIL COMMITTEES ON
FIRE AND CRIMINAL JUSTICE SERVICES, PUBLIC SAFETY,
COURTS AND LEGAL SERVICES, MENTAL HEALTH,
DEVELOPMENTAL DISABILITY,
ALCOHOLISM, SUBSTANCE ABUSE AND DISABILITY SERVICES

May 12th, 2015

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Good afternoon, I would like to thank Council members Elizabeth Crowley, Chair of the Committee on Fire and Criminal Justice Services, Vanessa Gibson, Chair of the Committee on Public Safety, Rory Lancman, Chair of the Committee on Courts and Legal Services and Andrew Cohen, Chair of the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services for giving me the opportunity to testify at this hearing on behalf of Queens District Attorney Richard A. Brown.

My name is Douglas Knight and I am the Director of Alternative Sentencing at the Queens District Attorney's Office. I have a Master's Degree in Criminal Justice and am a Credentialed Alcohol and Substance Abuse Counselor with over 25 years of alternative sentencing experience.

Our office has had both a misdemeanor and felony Mental Health Court for many years and we offer a variety of alternative sentencing options to individuals whose criminal activity is motivated by mental health issues. These include programs targeted to assist young offenders, veterans, those who are dually diagnosed with substance abuse and mental health problems and trafficking victims.

At present, we seek to identify at the earliest time possible defendants who may be in need of mental health services. It is our view that the earlier someone enters treatment the more likely that they will be successful. Identifying those in need of mental health services, however, is not always easy. There is currently no mechanism in place to conduct an independent, professional and comprehensive mental health assessment of all defendants entering the criminal justice system. Consequently, aside from those cases where the defendant's mental health issues are so substantial that they are immediately obvious to all, we have surprisingly little information at the time of a defendant's arraignment about his or her mental health needs. Such information might be provided by the defendant's family or defense counsel, but it is equally likely that no one present at arraignment will have access to any information about whether the defendant has been hospitalized in the past, whether he or she is currently on medication or whether he or she has been diagnosed with a particular mental illness.

As a result, it may not be until the defendant is assessed at Rikers Island or speaks with a defense attorney after arraignment if he or she is ROR'd that a mental health assessment may occur. Our office will affirmatively reach out to defendants who are non violent and whom we believe may safely participate in

community-based treatment programs. If a defendant is interested in participating in a diversion program, he or she will undergo a comprehensive mental health assessment conducted by Mental Health TASC (Treatment Alternatives to Safer Communities), a well known and well respected not for profit organization. TASC will then facilitate a thorough and objective psychological assessment. This will include not only an clinical interview with the defendant but will also include a review of defendant's psychiatric history, medical records, school records, medications, and conversations with relevant persons who can provide information about defendant's clinical history, behavior and ability to obtain stable housing, including family members, treating doctors and correctional personnel. TASC will also help investigate a defendant's eligibility for various benefits including SSI, SSD, Medicaid and health insurance. At the end of this assessment, TASC will make a recommendation as to whether the defendant is in need of treatment and what type of treatment program would be most beneficial for his or her individual needs.

Once a defendant is recommended for an appropriate level of treatment, we attempt to place them in a specific treatment program which may

be outpatient or residential depending on need. However, this can sometimes be a slow and difficult process for a variety of reasons. Treatment programs may be wary of accepting defendants with serious criminal histories or prior arson or sex crimes convictions. It may take some time for homeless defendants to obtain documentation necessary for various entitlements. Defendants whose mental status deteriorates while waiting for a treatment placement may wind up in a psychiatric hospital for stabilization or Mid Hudson for a competency assessment. Defendants who do not speak English may have difficulty finding a treatment program that can meet their needs. Young offenders may be delayed in obtaining treatment when parental consent for both assessment and treatment purposes cannot be obtained promptly. And defendants who are undocumented may have difficulty accessing services because they cannot obtain insurance coverage.

Defendants who enter treatment through the criminal justice system will enter into a plea agreement that permits the judge and the attorneys in the treatment court an opportunity to monitor their progress in treatment. Upon successful completion, the criminal charges against the defendant are either reduced or in some cases dismissed.

We believe that our ability to provide mental health services to those in need in Queens County could be improved in a number of ways. In many of our treatment courts, it has been extraordinarily helpful to have trained clinicians available in the courtroom who can work with defense counsel to identify those in need of treatment and begin the assessment process quickly. Enabling TASC to have representatives at arraignment for those interested in assistance could greatly facilitate our ability to identify mental health clients early.

It would also be enormously helpful to expand the pool of treatment programs available - particularly programs that provide residential care to individuals with serious and chronic mental illness. Additional options would also be welcome for young offenders. There are simply not enough residential treatment slots available for seriously ill high risk youth under the age of 21. In Queens County, the most diverse county in the nation, there are few mental health programs available for non-English speaking defendants. And it is very difficult to find appropriate treatment for many others with special needs including pregnant women, individuals with developmental disabilities or those who need medical accommodations.

Accommodating criminal justice involved defendants with behavioral health issues is extremely challenging, however, we continue to work tirelessly to assist them in accessing appropriate clinical services which best meet their needs. I thank you for the opportunity to speak before you today and I am happy to answer any questions you may have.

Kenneth P. Thompson
District Attorney

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April 7, 2015

Honorable Andrew Cuomo
Governor
Executive Chamber
Albany, New York 11224

Dear Governor Cuomo,

I am writing this letter in support of the Greenburger Center for Social Justice's application to obtain a license from the New York State Office of Mental Health for the development of a secure facility that will provide treatment for felony offenders who have serious mental illness.

The Brooklyn District Attorney's Office is a staunch supporter of the development of alternatives to incarceration for offenders who suffer from serious and persistent mental illness as well as co-occurring disorders. This commitment is evidenced in our unwavering support of the Brooklyn Mental Health Court and of the Educational Assistance Corporation, each of whom provide felony and misdemeanor non-violent offenders community-based mental health services in lieu of incarceration. Our work with these stakeholders has not only provided criminal offenders with needed treatment and the opportunity to be better citizens but has positively informed the criminal justice community that treatment reduces the incidence of future hospitalizations and re-arrests.

The Greenburger Center seeks to further enhance this treatment commitment by developing a facility that will provide mental health treatment for between 30-60 offenders who do not qualify for community-based treatment in a non-secure setting. Their proposal will provide the criminal justice system with a resource which has the potential of greatly reducing the incarceration of the mentally ill.

I would urge you to look favorably upon their license application.

Sincerely,

Kenneth P. Thompson

Greenburger ATI Treatment Center & On-Site Outpatient Clinic Satellite Program and Budget Summary May 11, 2015

PROGRAM: An Alternative to Incarceration program that is a long-term (one-to-two year expected length of stay) residential program with two discrete units of 36 beds for men and 24 beds for women, for a total of 60 beds. The residential program will be operated by the Greenburger Center as a Residential ATI (hereinafter "ATI"), that is transitional, congregate housing, to be funded in part by the NYS DCJS ATI Program as set forth below. Continuous programming will be provided in the ATI to address violence reduction, promote life skills, and improve interpersonal communication among residents and staff. Social work and clinical staff will be on site 24 hours a day to provide these services and overnight coverage.

This initiative also includes an outpatient clinic satellite (hereinafter "the Clinic") that will have an Operating Certificate from NYS OMH and joint licensure from NYS OASAS, with the capacity to treat individuals with both serious mental illnesses and co-occurring substance abuse disorders. The Clinic to be operated by an established provider will be located within close proximity to the ATI, within a secure perimeter that will be maintained by the Greenburger Center. Some staff, such as a psychiatrist will likely provide services at both the Clinic and the ATI. For example, one psychiatrist may serve as the prescribing physician at the clinic and as a psychiatric consultant at the ATI.

POPULATION of FOCUS: Young adults between eighteen and thirty-five years of age, with serious mental illness and co-occurring substance abuse, facing a multi-year sentencing to a NYS prison and not eligible for any currently existing ATI program.

CONTRACTING and LICENSING: The ATI will be contracted by NYS DCJS as a Residential ATI Program. The Clinic will be licensed by NYS OMH, with joint licensure from NYS OASAS, having the capacity to serve individuals with both serious mental illnesses and co-occurring substance abuse disorders.

SITING & SERVICE AREA: The ATI and Clinic will be located in NYC and will serve defendants whose crimes originated in any of the five boroughs.

EVIDENCE-BASED PRACTICE: The ATI will feature separate residential programs for men and women provided in a trauma-informed environment. Clinical and social worker staff will provide mindfulness and meditation, violence reduction, restorative justice programs, and life skills training, including job/education services incorporating on-line course work for Skills Certification programs offered by CUNY Community Colleges.

The Clinic will provide formal trauma counseling; psychiatric and nursing care; medication management for opiate dependence as well as for psychiatric conditions; and cognitive and dialectical behavioral therapy.

COMMUNITY/RE-ENTRY PARTNER AGENCIES: Nonprofit organizations with extensive community experience with the Population of Focus will provide three major services: 1) evaluation, motivational counseling, referral to residential programs; 2) family education, support, and reconciliation services; and 3) re-entry/recovery support, and case management services.

Supreme Court
of the
State of New York

MATTHEW J. D'EMIC
JUDGE OF THE COURT OF CLAIMS
ADMINISTRATIVE JUDGE FOR CRIMINAL MATTERS
SECOND JUDICIAL DISTRICT

COPY

CHAMBERS
320 JAY STREET
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April 13, 2015

Honorable Andrew M. Cuomo
Governor of the State of New York
Executive Chamber
Albany, NY 11224

Dear Governor Cuomo:

I am writing in support of the application of the Greenburger Center for Social and Criminal Justice for a license to open a secure mental health facility as an alternative to incarceration program for criminal defendants.

Such a facility would be the first of its kind in New York State and would fill a void in treatment alternatives. For although residential treatment facilities exist, they are not secure. and defendants sent there may leave. For this reason judges and prosecutors are reluctant to take a chance on defendants deemed too dangerous to release to such programs. As a judge presiding in a mental health court, I have experienced this first hand.

Only recently I received a letter from the father of a defendant suffering from a mental illness, asking for an alternative to incarceration program for his son, while acknowledging that his son is too dangerous without treatment for release to the community but acknowledging "I know that if we don't get him the help he needs, he will lash out again. I'm not asking to release him or lessen his time, but to make his time work for him and for society because that's who's at risk."

It seems that a secure alternative to incarceration mental health facility would allow prosecutors and judges an option for defendants like this man's son.

I believe the Greenburger Center's proposal is worthwhile and worth a try.

Thank you for your courtesy.

Very truly yours,

Matthew J. D'Emic
Administrative Judge
for Criminal Matters

cc: Commissioner Ann Marie Sullivan
NYS Office of Mental Health
44 Holland Avenue
Albany, NY 12229

Cheryl Roberts
Executive Director
Greenburger Center for Social and Criminal Justice
55 Fifth Avenue, 15th Floor
New York, NY 10003

Testimony of Cheryl A. Roberts, Executive Director
Greenburger Center for Social and Criminal Justice
before the
New York City Council
Committee on Courts and Legal Services

May 12, 2015

Good afternoon. Thank you for this opportunity to present testimony before your Committee. I am Cheryl Roberts, Executive Director of the Greenburger Center for Social and Criminal Justice. The Center is a 501(c)(3) not-for-profit corporation and advocates for needed criminal justice reforms.

The Center's work focuses on the plight of justice-involved people with serious mental illness. In short, we believe mental illness is a public health issue, not a criminal justice problem. Yet today, people suffering from serious mental illness are 10 times as likely to be in a local jail or state prison than in a psychiatric hospital. [1] Nationwide, approximately 1.26 million adults with mental illness are in our jails and prisons.[2] One of those 1.26 million people is Mr. Greenburger's oldest son. Mental illness played a significant role in his arrest and conviction on charges of attempted robbery and arson. His son spent two years at Rikers awaiting disposition of his case and is now incarcerated in an upstate prison for the remainder of a five-year sentence.

Places like Rikers and prisons are not equipped to provide the services that people with mental illness need. Corrections Officers are not equipped and should not be charged with caring for those with serious mental illness. Nevertheless, tens of thousands of people with serious mental illness are living in jails and prisons, turning places like Cook County Jail in Chicago and Rikers into two of the largest

[1] http://www.treatmentadvocacycenter.org/storage/documents/backgrounders/how-many-individuals-with-a-serious-mental-illness-are-in-jails-and-prisons.pdf
[2] http://www.bjs.gov/content/pub/pdf/mhppji.pdf

mental health hospitals in the country[3]. In 1955, approximately 550,000 severely mentally ill patients were in public psychiatric hospitals. By 1994, this number had been reduced to about 70,000.[4] Today, only 40,000 psychiatric beds exist, for a US population that has doubled since 1955.[5]

Locking up people for being mentally ill because we lack the political will or humanity to provide effective treatment is shameful — it's also costly. It can cost more than double to incarcerate mentally ill versus non-mentally ill people. Spending on medication alone can cost more than feeding prisoners. Increased costs are also due to average lengths of stay. At Rikers, the average incarceration period is 42 days. But people with mental illness stay locked up for an average of 215 days because they often cannot follow strict prison rules, which results in added time to their sentence as punishment.[6] [7]

Not only is our current policy inhumane to those incarcerated with mental illness and costly to taxpayer, it does not promote public safety. Ninety eight percent of those incarcerated return to society, and those with serious mental illness often return more traumatized. The status quo serves no one's interests and in fact, makes us all less safe.

Because available and effective treatment alternatives to incarceration simply do not exist for justice-involved adults with serious mental illness who do not qualify for un-secure community-based alternatives, the Center intends to pilot a secure residential treatment facility – The Greenburger Treatment Center - for this high need population. Clients will choose to enter the GTC to engage in an intensive course of treatment in lieu of incarceration as part of a plea agreement – a mandated

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[3] http://thinkprogress.org/health/2013/07/12/2293471/cook-county-jail-mental-health-provider/

[4] http://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html

[5] http://murphy.house.gov/uploads/Summary.pdf

[6] http://www.treatmentadvocacycenter.org/storage/documents/backgrounders/how-many-individuals-with-a-serious-mental-illness-are-in-jails-and-prisons.pdf

[7] http://www.treatmentadvocacycenter.org/storage/documents/backgrounders/how-many-individuals-with-a-serious-mental-illness-are-in-jails-and-prisons.pdf

court order or disposition agreed to by the client, defense attorney, the local district attorney, and the judge.

The Greenburger Treatment Center will provide a multi-model program that begins with a one-to-two- year intensive residential treatment phase in a locked setting, followed by one or more step-down phases matched to their treatment needs. These step down or re-entry phases will range from a highly-supported community-based treatment program to independent community living, bolstered by case management services, appropriate ongoing treatment and other supports. The Center intends to partner with The Fortune Society and Argus Community, Inc., among others to provide these re-entry services. A two page summary of our proposal is attached.

Because members of our target population often have co-occurring substance use issues, physical health needs and complex social dynamics the Greenberger Treatment Center will utilize a range therapeutic modalities including, evidence-based and informed psychiatric symptom and disease management treatments; trauma-informed care; mindfulness and meditation; cognitive-behavioral care; integrated substance use recovery; and therapeutic and restorative justice approaches to address impulsive and violent behaviors as well as to re-build connections to community and family supports and address victim impact and offender responsibility.

We anticipate providing the Medicaid eligible services in partnership with a licensed provider through a satellite clinic. We think we can provide these services at a significant cost savings to the City and, when at scale, the State with much better overall and lasting results.

Ultimately we believe people with mental illness should have access to effective treatment to avoid criminal justice involvement from the outset. Until that time, however, we are committed to providing treatment options for the subset of people

with mental illness who currently have no alternative to incarceration, and at a cost savings to the public and with safer outcomes for all.

The Fortune Society
BUILDING PEOPLE, NOT PRISONS

TESTIMONY OF
THE FORTUNE SOCIETY

Committee on Fire and Criminal Justice Services jointly with the Committee on Public Safety and Committee on Courts and Legal Services and Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

RE: Oversight: Behavioral Health and the Criminal Justice System: Examining New York City's Action Plan.

May 12, 2015

Presented by: Barry Campbell

The Fortune Society
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Good morning. My name is Barry Campbell. I am testifying today on behalf of the Fortune Society, but I would like to first start by thanking the various members of the Committee on Fire and Criminal Justice Services, the Committee on Public Safety, the Committee on Courts and Legal Services and the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services for convening this important public hearing regarding **Oversight: Behavioral Health and the Criminal Justice System: Examining New York City's Action Plan**. I would especially like to thank the Legislative Counsel for inviting The Fortune Society ("Fortune") to testify.

We agree with Mayor de Blasio and our friends and colleagues, who drafted the 2014 *Mayor's Task Force on Behavioral Health and the Criminal Justice System Action Plan*, in that together we can achieve what is most effective to help rebuild lives and communities as well as improve upon public health and public safety in all NYC neighborhoods. Key to doing this is reducing the number of people incarcerated, with special focus on those who are mentally ill, and addressing the issues during incarceration that feed violence and trauma. But first, I'd like to share with you a bit about Fortune's history. In 1967, David Rothenberg produced the off-Broadway play "*Fortune and Men's Eyes*." Written by John Herbert, a formerly incarcerated playwright, the play captured the experience of people living in prison. Since its founding shortly after the off-Broadway play, Fortune has served as a primary resource for New Yorkers released from jails and prisons seeking to build constructive lives in their communities; it now serves some 5,000 men and women with criminal justice histories annually. All of our programs are designed and implemented to meet the unique needs of this population through skilled, holistic and culturally competent assessments, and appropriate service provision.

We build an initial relationship with clients that fosters trust and safety to begin the healing; often a crucial prerequisite to providing service for people with justice involvement; this is further reinforced by the degree to which our staff reflects many shared life experiences of our clients. 70% of our staff are themselves either formerly incarcerated or in recovery. We believe in the importance of this cultural competency; however, it is this same cultural competency, specifically, the narratives told by our staff and clients regarding their experiences within correctional facilities, which allows us a deeper understanding of the degrading, inhumane, and unhealthy experiences in such settings. Fortune has educated policymakers and advocated on behalf of criminal justice issues since our founding in 1967. Wee started the David Rothenberg Center for Public Policy (DRCPP) seven years ago to increase the dedicated resources that we devote to sharing this experiential knowledge and unique understanding of the criminal justice system to shape and inform policy and practices.

Now, I would like to share my personal experience of Rikers Island in the 1980s and make some comparisons to the situation today:

I was an adolescent in the 1980s incarcerated on Rikers Island. I know it is an environment where you are quite literally either **"predator or prey"** – a place where you cannot trust authority to protect you from danger. However, at least back at that time, there were many more therapeutic and educational programs available – beyond just GED classes. For example, there were mental health and substance use disorder treatment programs, tutoring programs, and more opportunities for positive engagement and interactions. I had direct experience in solitary confinement – **being isolated while incarcerated is a nightmare!** Many men and women either develop mental illness symptoms or have current mental health challenges exacerbated as a result of their experiences while being incarcerated. Men and women living with mental illness spend twice the amount of time in jail compared to those men and

women living without mental illness.[1] Currently, New York City has one of the highest rates of solitary confinement in history, and the DOC has more punitive segregation cells than it did in the 1990s.[2] I also know firsthand the barriers and challenges, which men and women face when they come home from prison or jail and return to our NYC communities. Men and women with mental illness or substance use disorders are especially vulnerable to being rearrested and going back to jail or prison. More often than not, their behavioral health only worsens. Also, accessing housing, work, and health care can be very hard. Moreover, it has been far too long a wait for positive change and reform and thousands of lives – including my own – have been negatively impacted by the damaging consequences of criminal justice involvement and incarceration for so many years.

For the past 48 years, Fortune has provided comprehensive wrap-around reentry services to people with criminal records as well as alternatives to incarceration. We do this through a holistic, one-stop model of service provision that currently features, among other services: education, employment services, housing, licensed substance abuse and mental health treatment, health services, family services, alternatives to incarceration (ATI), discharge planning, case management, benefits enrollment, systems navigation, food and nutrition, an extensive referral network, and lifetime aftercare.

Fortune is grateful to be part of a community of social service agencies as well as policy advocates who understand and seek to assess and address the potential mental health challenges as well as other barriers facing justice-involved women upon intake, during incarceration, and during the reentry period. Fortune operates two major programs on Rikers Island, including a program for individuals with HIV preparing for release and the Individualized Corrections Achievement Network (I-CAN) program for detainees and sentenced men and women. Also, Fortune was awarded the Queens Court-based Intervention and Resource Team (CIRT) program for individuals in custody who present with mental health issues and are assessed as posing low to moderate flight and recidivism risks.

Fortune's health services team offer non-medical services, including HIV testing, prevention education, case management, and connections to community-based treatment and care, for people living with, or at risk for developing, HIV/AIDS. Fortune has been providing licensed outpatient substance use treatment services to justice-involved New Yorkers for over 24 years. In addition, Fortune clients have access to a full spectrum of mental health services through the Better Living Center (BLC), which is the first NYS Office of Mental Health-licensed Article 31 mental health clinic with services tailored specifically to the unique and complex needs of justice-involved men and women. In addition to creating the highest quality behavioral health services for our client population, Fortune has also become a leader in driving forward best practices in criminal justice-focused behavioral health services in high profile public policy forums. As part of a DOHMH-funded project, Fortune also supports providers in delivering culturally competent HIV prevention, treatment, and care services to justice-involved women and men.

Both Fortune's NYS Office of Alcoholism and Substance Abuse Services (OASAS) Part 822-4 Outpatient Services license and our NYS Office of Mental Health (OMH) Article 31 Outpatient Program license were recently renewed. Our new OASAS license was recently renewed based on over two decades of superior service delivery. In May 2013, after a site visit, NYS OASAS Commissioner Gonzales-Sanchez stated, "What a wonderful testimony to your program that many individuals who

[1] The Council of State Governments. Improving outcomes for people with mental illnesses involved with New York City's criminal court and corrections systems. 2013. http://csgjusticecenter.org/wp-content/uploads/2013/05/CTBNYC-Court-Jail_7-cc.pdf. Accessed May 11, 2015.
[2] New York Advisory Committee to the U.S. Commission on Civil Rights. The solitary confinement of youth in New York: A civil rights violation. December 2014. http://www.usccr.gov/pubs/NY-SAC-Solitary-Confinement-Report-without-Cover.pdf. Accessed May 11, 2015.

were once participants have come back as staff members to make a difference in the lives of others. This kind of loyalty and inherent peer-to-peer interaction is invaluable and commendable." Likewise, Fortune's OMH license was renewed, pursuant to a rigorous audit, which found that the clinic adhered to exemplary standards in walk-in services and in providing immediate psychiatric care to patients. The auditors stated that this was "above and beyond quality care." The auditors also noted that the premises were clean, friendly, inviting, and welcome, creating a very "family"-like environment. Fortune has emerged as a leader in mental health service provision as well as in related policy and advocacy efforts.

In 2014, Fortune's CIRT ATI/Alternatives to Detention (ATD) program implemented a peer counselor/advocate model, which Fortune plans to expand into the Better Living Center and our substance use treatment clinic in 2015. Peers will be trained in the Howie the Harp (HTH) Peer Training Program designed for people with mental health conditions who wish to use this lived experience to support others seeking recovery services in the mental health care system. This highly regarded, comprehensive program offers students the opportunity to gain the professional, personal and interpersonal skills that support gainful long-term employment as well as personal wellness. It also strengthens our recovery-oriented, person-centered model of mental health care. By the end of 2015, we expect to expand this initiative to our substance use treatment clinic. All peer interns will be encouraged to build upon their HTH training by doing the Peer Specialist Certification training and ultimately taking the certification exam. As peer specialists, they will be able to work as paid staff providing off-site care to Fortune's behavioral health clients.

During the summer of 2014, executive, directorial, and managerial staff across Fortune participated in five working groups that convened as part of Mayor Bill de Blasio's Task Force on Behavioral Health & the Criminal Justice System, and Fortune's CEO, JoAnne Page, played a leadership role in the process. As a result, a memorandum regarding proposed recommendations was issued to working group participants in August 2014, which can be summarized as follows:

- Pre-Arrest Working Group: Develop alternatives to arrest and/or hospitalization.
- Pre-Arraignment to Disposition: Increase diversion options, alternatives to detention, and alternatives to incarceration for arrested individuals who are struggling with behavioral health needs.
- Inside DOC: Improve services and care for inmates with behavioral health needs in both the general population setting and in mental health observation units.
- Release & Reentry: Ensure early enrollment in health insurance/Medicaid and access to clinical care; successfully connect individuals to mental and behavioral health services, including Health Homes; and successfully connect individuals to services and programs in the community that they need and want.
- Back in the Neighborhood **(co-chaired by Fortune's President & CEO, JoAnne Page)**: Ensure that any individual leaving the criminal justice system is enrolled and has access to Medicaid, health insurance, government identification, and entitlements; ensure a low-threshold safety net that offers peer support and "no wrong-door" access for individuals re-entering the community; facilitate access to employment for individuals re-entering the community and address issues of employment discrimination; provide access to appropriate, sustainable housing for individuals reentering the community.

The *Mayor's Task Force on Behavioral Health and the Criminal Justice System Action Plan,* which was released in the fall of 2014, memorialized these findings and reiterated Mayor de Blasio's

commitment to reduce unnecessary arrests and incarceration, as well as his desire to see people with behavioral health issues diverted into treatment before they ever reach a jail cell.[3] Of note, Fortune's behavioral health services already reach across all of the recommendation areas, which exemplify the model not only in theory, but in practice.

A severe lack of community-based mental health services, which were largely defunded the past few decades, combined with the criminalization of behavioral manifestations of substance use and mental disorders have contributed to our current high levels of mass incarceration and untreated mental illness. Both within city and state jails and prisons, men, women, youth, and children living with mental illness are severely overrepresented and receive little to no effective treatment. We are all too painfully familiar with the substantial evidence of neglect and abuse of mentally ill individuals at Rikers, which has recently come to greater light. Dr. James Gilligan and Bandy Lee prepared a 2013 report for the Board of Correction and DOHMH, which underscores the role of jails as *de facto* mental hospitals during the latter part of the twentieth century.[4] Dr. Lee and Gilligan also state that the DOC's use of prolonged punitive segregation of the mentally ill violates the Mental Health Minimum Standards.

Further disturbing, vulnerable populations, including individuals with mental illness, physical disability, or physical injury as well as victims of sexual assault, transgender women, and young adults, are at increased risk for experiencing violence, trauma and abuse within the walls of prison or jail. As the above passages demonstrate, when at all possible incarceration should be avoided. Alternatives to incarceration or detention as well as connection to appropriate medical and social services should be prioritized in order to avoid incurring harm and further stressful and traumatic life experiences. Prisons and jails are extraordinarily damaging environments for those struggling with mental illness and should be avoided whenever possible. We need to facilitate healing and wellness rather than subject our vulnerable friends, family members, and neighbors to violence and abuse laden, counter-rehabilitative, hyper-punitive, and often inhumane conditions within jails and prisons. We have unsuccessfully relied so heavily on this paradigm of punishment to punish symptoms rather than address the underlying causes and conditions of involvement with the criminal justice system.

We applaud the progress that has been made in recent decisions and trends, and the commitment of the Mayor and commissioners and City Council to keep that momentum going. Reductions in the number of people incarcerated at Rikers Island have been occurring and are more than welcome. Commissioner Ponte's decision to stop using punitive segregation for adolescents was a huge step forward in preventing the kind of damage that I suffered when I was placed in solitary confinement as a young man. We are seeing questioning of the overuse of solitary confinement, unnecessary detention of low-risk individuals who cannot make bail, conditions that foster violence at Rikers Island, and the disproportionate incarceration of mentally ill individuals…all hopeful signs that reforming our broken system of overreliance on incarceration under conditions that damage vulnerable individuals and communities is a priority for City leadership.

Ongoing community engagement among diverse stakeholders was crucial to drafting the *Mayor's Task Force on Behavioral Health and the Criminal Justice System Action Plan.* Community-based organizations and peer-based efforts were instrumental in educating various constituencies and

[3] City of New York, Mayor Bill de Blasio. "Mayor's Task Force on Behavioral Health and the Criminal Justice System, Action Plan." 2014. Available at: http://www1.nyc.gov/assets/criminaljustice/downloads/pdf/annual-report-complete.pdf. Accessed May 11, 2015.
[4] Gilligan J, Lee B. Report to the New York City Board of Correction. September 13, 2013. http://solitarywatch.com/wp-content/uploads/2013/11/Gilligan-Report.-Final.pdf. Accessed May 11, 2015.

developing the action plan. Fortune successfully incorporates cultural competence into reentry services and advocacy efforts, which reflect the experiences, knowledge, and realities of justice-involved men and women of all ages. Consultation and engagement with the communities -- to which 95% of those currently incarcerated will return -- are key. Fortune and other agencies have been working side by side with families and communities of those who have been justice-involved for decades. Plus, we have collaboratively served on numerous city, state and federal task forces designed to improve the health and well-being of some of our city's most vulnerable populations. Community-based organizations should be continually involved in: implementation of projects outlined in the report and ongoing planning efforts; measurement of progress; and accountability in achieving the goals laid out in the report, which we contributed to producing. We encourage sustained levels of community involvement in respect to further stages of program implementation as well as program oversight activities. Fortune looks forward to continuing our support of implementing this important action plan, which benefits our community as well as all of NYC.

Fortune understands all too well the role that coordinated, culturally competent, centralized, recovery-oriented, and person-centered services may play in preventing recidivism, relapse, and poorer health outcomes. Each year, we serve thousands of individuals with criminal histories, all of whom have been incarcerated at some point in their lives. We are trying to help these individuals rebuild their lives in the community through reentry services, as well as alternatives to incarceration (ATI) and alternatives to detention (ATD). However, the devastating impact of being incarcerated makes our work so much harder than it should be, because the trauma, violence, isolation, neglect, and limited opportunities that they have behind those walls cause huge damage and is, itself, reinforcement for criminogenic behavior, retraumatization, and poor mental health.

In general, justice-involved men and women face considerable health challenges during intake, incarceration, and upon reentry even in the best of circumstances. Young men of color from under-resourced communities are disproportionately represented in both prison and jail systems. The repeated incarceration of young people of color also further strains low income communities, where poverty, violence, health disparities, as well as lack of jobs and opportunity, exist. The decrease in Riker's average daily inmate population from 20,000 to 10,000 over the past twenty years, demonstrates commendable movement towards positive change and a trend that needs to be continued.[5] It is well-documented that approximately 40% of Rikers inmates are living with mental illness.[1,2] Unfortunately, justice-involved individuals are unlikely to access adequate, comprehensive substance use treatment while incarcerated, and risk relapse, recidivism, and even death after release.

We realize you are already familiar with the high levels of violence and counter-rehabilitative conditions within New York prisons and jails. For instance, the Associated Press obtained documents, which "raise serious questions about the quality and timeliness of the medical care many of these inmates received, with the treatment, or lack of it, cited as a factor in at least 15 deaths over the past five years."[6] The 2014 Department of Justice report details systematic violence, including a "deep-seated culture of violence against inmates" and deplorable mistreatment of women and men incarcerated on Rikers Island.[7] "The core problem and the heart of [their] findings: use of excessive and unnecessary force by correction officers…and the lack of accountability for such conduct." There are systemic failures in preventing correctional staff's use of excessive, unnecessary, and improper

[5] Schwartz M, Winerip, M. New plan to shrink Rikers Island population: Tackle court delays. *The New York Times*. April 13, 2015. http://www.nytimes.com/2015/04/14/nyregion/mayor-de-blasios-plan-to-shrink-rikers-population-tackle-court-delays.html. Accessed May 11, 2015.
[6] Medical care questioned in 15 Rikers Island deaths. *CBS New York*. http://newyork.cbslocal.com/2014/10/22/ap-rikers-island-deaths-suggest-poor-medical-treatment-of-inmates/. Accessed May 11, 2015.
[7] U.S. Department of Justice. CRIPA Investigation of the New York City Department of Correction Jails on Rikers Island. August, 04, 2014. http://www.justice.gov/usao/nys/pressreleases/August14/RikersReportPR/SDNY%20Rikers%20Report.pdf. Accessed May 11, 2015.

force, which occurs in extraordinarily high frequencies and includes excessive and inappropriate use of prolonged punitive segregation.

Here in New York City, we were shocked and dismayed by the death of Bradley Ballard, who was living with diabetes and mental illness, and found naked and covered in feces after being locked in a cell for six days without appropriate care or medication. We all understand that incarceration is a far more expensive and far more harmful option in comparison to ATI or ATD, diversion, or other alternatives. The significant financial investment could be better leveraged towards enhancing alternative responses to incarceration and increasing much needed supports and services, such as educational opportunities, job training programs, substance abuse and mental health treatment, health literacy, and creative arts classes and workshops. Notably, cognitive and behavioral interventions targeting violence prevention, problem solving skills, and anger management may provide necessary tools to process and heal conditioned tendencies that may fuel anger into violent acts and assist in fostering health and wellness as opposed to further mental health deterioration. First, last and foremost, incarceration should be the last of a continuum of interventions, used only when other alternatives are not appropriate. To quote Fortune Board member and prior NYC Department of Correction Commissioner Marty Horn, "The problem with the NYC jails is the jails themselves." In short, we lock up too many people for too long, many of whom should not have been locked up at all.[8]

The Fortune Society's mission is to support successful reentry from prison and jail, and promote alternatives to incarceration, thus strengthening the fabric of our communities. We do this by believing in the power of individuals to change; building lives through service programs shaped by the needs and experiences of our clients; and changing lives through education and advocacy to promote the creation of a fair, humane, and truly rehabilitative correctional system. As both a service and advocacy agency, we seek to transform the response to people's needs and problematic behaviors, from deprivation and retribution, to additional support, programs, and therapy. As a society, we at Fortune believe that we can we can do better and go farther in improving the health and well-being of justice-involved men and women, plus their families and communities.

Specifically, as the action plan details we must make a commitment to drastically decrease the number of men and women incarcerated in prisons or jails, especially for low-level offenses or behaviors associated with mental illness or related symptoms. Reform of NYPD and bail policies, so as to assist men and women in being guided towards health and social service interventions rather than relegated to jail, is fiscally and socially responsible. We can also support and help affected families and communities by expanding ATI/ATD programs, and by exploring options for incarcerating men and women closer to home when incarceration is necessary. We must put a stop to having our jails and prisons serve as de facto mental health hospitals. We must ensure that justice-involved men and women receive the supports and services they need, including more educational opportunities, job training programs, substance abuse and mental health treatment while incarcerated, as well as solid discharge planning and needed services upon release. Linking clients to and partnering with community-based service providers, which specialize in serving and caring for justice-involved men and women, as well as facilitating holistic, coordinated, and integrated care, are crucial to successful health and reentry outcomes.

Fortune is eager to work closely with the NYC City Council, other city officials, and other partners to be part of the solution to this entrenched problem. We applaud outstanding efforts

[8] Horn, M. Commentary. Fixing Rikers Island: A former corrections chief says critics are missing the point. *The Marshall Project.* January 21, 2015. https://www.themarshallproject.org/2015/01/21/fixing-rikers-island. Accessed May 11, 2015.

towards genuine comprehensive reform, increased transparency, and more community involvement in designing, implementing, and providing oversight in relation to these crucial reforms that make sure people receive necessary services and that jail time is reserved for only those who truly pose a public safety threat. We understand all too well the potential of the City Council's efforts to affect those incarcerated, their families, those recently released and larger communities. We are particularly grateful to the dedication and care exhibited by those city councilmembers serving on the Committee on Fire and Criminal Justice Services, the Committee on Public Safety, the Committee on Courts and Legal Services, and the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services. With programs both inside and outside Rikers Island for those impacted by the criminal justice system – Fortune stands ready to provide many of the supports that justice-involved individuals need. With increased funding for positive programming directed toward this population and special attention to addressing both detected and undetected mental illnesses, we could do even more.

We urge city councilmembers to learn more about the men and women impacted by visiting our ATI/ATD, discharge planning, and other reentry programs and to interact directly with those, like myself, who have been incarcerated. Many of us have spent time in several different jails and facilities where we have seen mental illness worsen rather than improve. Listen to the trauma and pain that we at Fortune hear every day doing this human-centered recovery focused work. Then, let us work together to address underlying challenges while maintaining and strengthening positive ties to families and communities. At Fortune, we have built our programming and supportive services around cultural competency and meeting people "where they are at" through an open door policy that rarely turns anyone away. Moreover, we aim to support you in creating more therapeutic settings as part of addressing challenges, building on strengths, and alleviating barriers to accessing and sustaining treatment, prevention, and care, which improve health and recidivism outcomes.

Over time, we have seen that whether it relates to mental health recovery or other challenges facing justice-involved men and women – hurt people hurt people, whereas healed people heal people. Experiences of poverty, discrimination, and incarceration can greatly hurt individuals and their communities…but at Fortune we are building people not prisons and committed to recovery-oriented, person-centered mental health care delivery. Let us work together with the multi-agency teams and take the next steps outlined in the *Mayor's Task Force on Behavioral Health and the Criminal Justice System Action Plan* in order to build better lives and communities.

Respectfully Submitted,

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MHA - NYC
Innovations in Mental Health

Oversight: Behavioral Health and the Criminal Justice System: Examining New York City's Action Plan

Honorable Elizabeth Crowley
Committee on Fire and Criminal Justice Services

Honorable Vanessa L. Gibson
Committee on Public Safety

Honorable Rory I. Lancman
Committee on Courts and Legal Services

Honorable Andrew Cohen
Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

Testimony by Lynn Kaplan, Psy.D.,
LifeNet Project Director
Here to Help Connect
Mental Health Association of New York City

Tuesday May 12, 2015

The Mental Health Association of New York City
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Chair Crowley, distinguished Committee Chairs, and members of the Committees, thank you for giving us the opportunity to testify before you today on Behavioral Health and the Criminal Justice System: Examining New York City's Action Plan. My name is Lynn Kaplan, and I am the LifeNet Project Director at the Mental Health Association of NYC.

LifeNet, operated by MHA of NYC since 1996 through a contract with the New York City Department of Health and Mental Hygiene, is New York City's only 24/7/365 nationally accredited, multi-lingual mental health information and referral, support, and crisis and suicide prevention hotline. LifeNet is the single point of access for New York City's Mobile Crisis Teams. LifeNet also responds to calls from call boxes on all major bridges in the New York City Metropolitan area to allow people contemplating suicide on area bridges to connect directly with a counselor in their hour of need. LifeNet is recognized as one of our Nation's leading crisis hotlines, and has helped shape the national model for Crisis Hotline Collaboration with 911 and emergency services. New Yorker's calling LifeNet are connected with culturally-sensitive, multilingual, trained behavioral health professionals who provide person-centered, culturally-competent service, and connect callers to appropriate mental health interventions within the broad continuum of care, including crisis services and suicide prevention resources. By doing so, LifeNet counselors bridge crucial mental health service gaps, and minimize overuse of emergency departments. In order to best meet the needs of the community, LifeNet's services have recently expanded to include chat and text based counseling.

MHA-NYC commends NYC for developing a comprehensive, ambitious strategy to divert people with behavioral health issues into treatment, when appropriate, and to ensure that justice-involved individuals with behavioral health needs are connected to care at every point in the criminal justice process. MHA-NYC is supportive of the recommendations that have been set forth in the Action Plan, which will help to ensure that we appropriately address the behavioral health issues that have led many into contact with the criminal justice system in the first place. MHA-NYC is eager to serve as a collaborative partner as NYC continues to put these recommendations into action.

Through LifeNet, as well as through various policy and public education initiatives, MHA-NYC has maintained a long history of collaborating with public and private partners, including the New York Police Department, in connecting community members to the level of care that most appropriately meets their need. To this end, LifeNet has remained continually involved in training NYPD sergeants and cadets on mental health crises and management of emotionally disturbed persons; these training initiatives reinforce the use of LifeNet as a free resource that the police can offer when responding to

individuals in need of mental health care. MHA-NYC and LifeNet are also committed to collaborating with key partners on newly formed strategies such as Crisis Intervention Teams. We also look forward to integrating newly developed resources, including the community-based drop off centers, into the continuum of services to which we're able to connect individuals, in order to help ensure every New Yorker is able to access the most appropriate level of care which best promotes his/her health, wellness, and recovery.

On behalf of my colleagues at the Mental Health Association of NYC, I would like to thank you all, esteemed members of our City Council, for your attention to the intersection of behavioral health issues with the criminal justice system, and for the opportunity to speak before you today. We have shared with you brochures about LifeNet. We hope that you will help spread the word that help is available for New Yorkers in their darkest hour and help further our mission to improve New Yorkers' access to mental health care. We also hope that when you have a constituent in need of mental health supports, you will remind them to call 1-800-LifeNet to speak with a trained mental health professional.

Thank you for the opportunity to testify today. Please feel free to call on us anytime for assistance regarding how to address the behavioral health needs of New Yorkers.

THE COALITION OF BEHAVIORAL HEALTH AGENCIES, INC.

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REMARKS OF JAMIN R. SEWELL
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THE COALITION OF BEHAVIORAL HEALTH AGENCIES

OVERSIGHT:
"MAYOR DE BLASIO'S BEHAVIORAL HEALTH AND THE CRIMINAL JUSTICE SYSTEM: EXAMINING NEW YORK CITY'S ACTION PLAN"
May 12, 2015

Good Morning, Chairman Cohen and members of the NYC Council Commitee on Mental Health, Developmental Disabilties, Alcoholism, Substance Abuse and Disability Services, Council Member Lancman and members of the Committee on Courts and Legal Services, Council Member Crowley and members of the Committee on Fire and Criminal Justice Services, and Council Member Gibson and members of the Committee on Public Safety.

I am Jamin R. Sewell, Counsel & Managing Director for Policy and Advocacy for The Coalition Of Behavioral Health Agencies. The Coalition is the umbrella advocacy organization of New York's behavioral health community, representing over 130 non-profit community-based behavioral health and substance abuse agencies that serve more than 350,000 clients/consumers throughout NY. Our member agencies are on the ground, front-line safety net providers. We treat some of the most needy individuals, including those with dual diagnoses of mental health and substance abuse problems. Our providers serve the homeless and the formerly incarcerated as well as victims of trauma and abuse. The agencies we are represent are in every Council District and neighborhood in the city.

On behalf of our Chief Executive Officer, Phillip Saperia, who regrets that he cannot attend today, and the Coalition Board, I would like to thank you for this opportunity to present our thoughts on the Mayor's Behavioral Health and the Criminal Justice System: Examining New York City's Action Plan ("Action Plan").

In full disclosure, both Mr. Saperia and I served on work groups that were charged with developing recommendations for the Action Plan. The process seemed fairly inclusive, with many different stakeholders in the government and provider sectors represented. It could have benefitted from participation from formerly incarcerated inviduals with mental

illness histories, although my workgroup did have a family member of such an individual participating.

The Coalition firmly supports the recommendations of the Task Force on Behavioral Health and the Criminal Justice System (the "Task Force") that are presented in the Action Plan. Specifically, we strongly advocate for the following approaches recommended by the Task Force to reduce the number of incarcerated people with behavioral health issues from the jail population including diversion to appriopriate care settings for people with mental illness that commit low-level, non-violent crimes, providing therapeutic treament rather than punitive treatment if such individuals are in fact incarcerated and ensuring that individuals are connected to services upon release.

It appears that the Mayor's executive budget begins to fund the implementation of the Action Plan, e.g. the $1.7 million for mental health and substance abuse programming for all youth at Rikers Island. The process of treating individuals with behavioral health issues as consumers rather than criminals requires a fundmental shift and influx of resources particularly in the communities where individuals return upon release. Community-based behavioral health organizations are in the best position to deliver these services. Our members such as CASES, CUCS, the Fortunte Society, the Bridge and the Osborne Society have been delivering behavioral health services to formally incarcerated individuals for many, many years.

Although, the Action Plan is somewhat vague regarding the vehicle(s) for delivering services to individuals upon release, community-based behavioral health agencies not only have the relevant experience with the population, but also are best located to deliver services in a convenient, non-threatening environment where people live.

There are successful models to draw upon for serving people with behavioral health issues and court-involvement. For example, the City Council is providing funding this fiscal year for a new initiative called Mental Health Services for Court-Involved Youth which was championed by Council Member Debi Rose. Thorough this initiative 9 community-based providers have made new partnerships with Family Court, the NYC Deparments of Corrections and Probation as well as ACS to provide behavioral health screenings and treatment to youth involved with the various juvenile systems. The Coalition has played a role as well, in that we have provided training for these providers and others who are contemplating or currently working with justice-involved youth.

We thank the Council for funding this initiative and encourage a restoration (and perhaps and enhancement) of this worthwhile and ultimately cost-saving initiative. I say cost-saving because the interventions that our providers are making with these youth we strongly believe will reduce recidivism making our communities safer and bringing a better quality of life to the youth served.

Again, thank you for convening this hearing on the Mayor's Behavioral Health and the Criminal Justice System Action Plan. We look forward to working with the Council and the Administration to ensure that our safety net providers continue to provide the high quality of services that will allow individuals with behavioral health issues to thrive in our communities.

THE LEGAL AID SOCIETY

TESTIMONY

The Council of the City of New York

Committee on Courts and Legal Services
Rory Lancman, Chair

Jointly with the

Committee on Fire and Criminal Justice Services
Elizabeth S. Crowley, Chair

Oversight – Behavioral Health & the Criminal Justice System:
Examining New York City's Action Plan

May 12, 2015
New York, New York

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Introduction

The Legal Aid Society, the nation's oldest and largest not-for-profit legal services organization, is an indispensable component of the legal, social and economic fabric of New York City – passionately advocating for low-income individuals and families across a variety of criminal, civil and juvenile rights matters, while also fighting for legal reform. We have performed this role in City, State and federal courts since 1876. With its annual caseload of more than 300,000 legal matters, Legal Aid takes on more cases for more clients than any other legal services organization in the United States, and it brings a depth and breadth of perspective that is unmatched in the legal profession. Legal Aid's law reform/social justice advocacy also benefits some two million low-income families and individuals in New York City, and the landmark rulings in many of these cases have a national impact. Legal Aid accomplishes this with a full-time staff of nearly 1,900, including more than 1,100 lawyers working with over 700 social workers, investigators, paralegals and support and administrative staff through a network of borough, neighborhood, and courthouse offices in 26 locations in New York City. The Legal Aid Society operates three major practices — Criminal, Civil and Juvenile Rights — and receives volunteer help from law firms, corporate law departments and expert consultants that is coordinated by the Society's Pro Bono program.

The Criminal Practice Special Litigation Unit (SLU) engages in an active litigation practice to protect the rights of clients of the Criminal Practice, and regularly advises and supports the attorneys of the Criminal Practice on a wide variety of subjects, particularly those that present novel or difficult issues. The Unit's litigation includes both individual and class action litigation designed to remedy systemic problems in the criminal justice system. Legislative advocacy is another important function of the SLU. The Unit has played a crucial

role in the enactment of Rockefeller Drug law Reform and it continues to urge the adoption of additional measures that would allow more people to enter treatment programs and be diverted away from prison

The social work department at the Legal Aid Society includes licensed social workers who work as part of the defense team. With over one hundred social workers providing services to adolescents and adults involved in the justice system, the Legal Aid Society's social work department is an indispensable part of our team.

Legal Aid's Prisoners' Rights Project (PRP) protects the legal rights of persons in the City jails through litigation and through advocacy with the Department of Correction and with the Correctional Health Bureau of the Department of Health and Mental Hygiene, which supervises the provider of medical and mental health services in the jails. PRP is familiar with problems experienced by individuals housed in the City jails including individuals with behavioral health needs. PRP receives dozens of calls and letters daily both from individuals housed in the jails and from their attorneys and family members. PRP advocates for appropriate medical and mental health treatment, protection from violence by staff and others, limitations on the use of punitive segregation and all other issues that affect individuals in our City jails and can be particularly difficult for individuals with behavioral health needs.

The breadth of The Legal Aid Society's representation places us in a unique position to address the issue before you today. Our perspective comes from our daily contact with people who can experience life altering consequences as a result of an arrest and criminal conviction.

EFFECTIVE DIVERSION OF INDIVIDUALS WITH BEHAVIORAL HEALTH ISSUES IS ESSENTIAL

A number of extremely constructive steps are now being taken to address the problems of persons with mental illness in the criminal justice system. However, Legal Aid believes that some essential pieces are missing from the City's program, as set forth at the end of this section.

Problems of Individuals with Behavioral Health Issues in the Criminal Justice System

For almost two decades the NYPD engaged in an aggressive stop, frisk and arrest practice that focused on large numbers of arrests for low level crimes. This practice caused a loss of trust in the Police Department, particularly in communities of color.[1] The emphasis on arrests resulted in the incarceration of many people with behavioral health issues at a tremendous social and fiscal cost. Many people with untreated or inadequately treated behavioral health problems were arrested for low level offenses. Lack of adequate treatment within the criminal justice system often meant that they repeatedly cycled between the street and the City jails.

The policy that emphasized aggressive police interaction and frequent arrests had a number of serious consequences for individuals with mental illness, for the police, and for the criminal justice system itself. Inadequate training on the interaction between the police and individuals with mental illness resulted is a series of tragic incidents. A 2013 incident in Times Square, involving a disoriented man lurching amid traffic, resulted in the shooting of two innocent bystanders by the police.[2] This incident was one of a great number where something went horribly wrong when the NYPD interacted with a person with an emotional disturbance. Over the years other highly publicized police interventions resulted in the deaths of people with

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[1] Fratello, Rengifo, Trone and Velazquez, *The Coming of Age in Stop and Frisk,* Vera Institute of Justice, September, 2013

[2] Michael Schwirtz and J. David Goodman, "Police Bullets Hit Bystanders, and Questions Rise Yet Again," *The New York Times,* September 15, 2013

psychiatric disabilities, e.g., Eleanor Bumpurs,[3] Gidone Busch and Kevin Cerbelli, who were disturbed and agitated at the time of the police call. Many less publicized calls for help on behalf of individuals with emotional disturbances have resulted in the arrest and incarceration of the person in need of help and the injury of those who went to the scene to provide assistance. Problems with interactions between the police and people with mental illness continue to the present day.[4]

A 2012 study by the Council of State Governments reported on the impact of the arrest practice on the criminal justice system. The Council reported that, on average, 25% of individuals in the City jails (40% of women) had some level of mental illness. The average length of stay in City DOC for individuals with mental illness is over twice as long as for the rest of the population and for young people the disparity is even more pronounced. Individuals with mental illness are less able to post bail than arrestees without a mental health diagnosis even for similarly situated crimes. The differences exist regardless of gender or borough.[5]

The aggressive arrest and jail practice for low level misdemeanor crimes that has incarcerated an increasing percentage of individuals with mental illness is an expensive one. According to a study of the City Independent Budget Office it costs an average of $167,731 to feed, house and guard each individuals housed at Rikers Island.[6] For those with mental illness who require the services of mental health professionals in jail and who remain in jail twice as long as others, the costs are undoubtedly higher. The costs to the affected person can be very

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[3] Selwyn Raab, "State Judge Dismisses Indictment of officer in the Bumpurs Killing," *The New York Times,* April 13, 1985, available at http://www.nytimes.com/1985/04/13/nyregion/state-judge-dismisses-indictment-of-officer-in-the-bumpurs-killing.html.

[4] See "Suspect Fatally Shot by Detective in East Village Had Mental Illness and a Troubled Past," *The New York Times*, April 26, 2015, available at http://www.nytimes.com/2015/04/27/nyregion/suspect-fatally-shot-by-detective-in-east-village-had-mental-illness-and-a-troubled-past.html.

[5] Justice Center, The Council on State Governments, *Improving Outcomes for People with Mental Illnesses Involved in New York City's Criminal Court and Correction Systems,* December 2012.

[6] Marc Santora, "City's Annual Cost Per Inmate Is $168,000, Study Finds," *The New York Times,* August 23, 2013.

high indeed, since individuals with mental illness in the jails are often victimized both by staff and others, with consequences that are on occasion fatal.[7] The arrest practice also creates additional costs for the court, prosecution and the defense.

Towards Solutions: the Mayor's Task Force on Behavioral Health and the Criminal Justice System

The Mayor's creation of a Task Force on Behavioral Health and the Criminal Justice System was intended to assess and propose solutions for these serious problems. Seymour James, the Attorney-in-Chief of The Legal Aid Society, was a member of the Task Force. Several members of Legal Aid's staff contributed to the Task Force's working groups and we continue to participate in them. The September 2014 Task Force Action Plan recognized that, even as the population of the New York City Department of Correction continued to decline, the percentage of people with behavioral health issues continued to increase at each point from the initial arrest, through a series of criminal case adjournments until the ultimate disposition of the criminal case.

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[7] The death of Bradley Ballard: Bradley Ballard, a Legal Aid Society client, died on September 11, 2013 at Elmhurst Hospital when clinical and uniformed staff at the AMKC Mental Health Center on Rikers Island left him locked in a cell and did nothing as they watched him deteriorate. Mr. Ballard was remanded to jail as a parole violator, where he died, for *failing to report a change of address.*

On September 4, after it was reported that he made a lewd gesture to a female correction officer, he was locked in his cell for seven days and not let out at all. After seven days of unauthorized isolation, lack of medications and complete neglect, Mr. Ballard was found naked and unresponsive in the cell. He was covered in feces, his genitals swollen and badly infected. On his last day alive, no clinical staff conducted the required twice daily rounds of the specialized mental health unit. He was taken by ambulance to Elmhurst Hospital, where he was pronounced dead shortly after he arrived.

The death of Jerome Murdough: On February 15, 2014, Mr. Murdough, a 56-year-old homeless veteran who suffered from bipolar disorder and schizophrenia, was left alone in a mental health observation area in AMKC when he was supposed to be on a constant suicide watch. At Mr. Murdough's intake on February 8, the screening for suicide prevention found that he was on psychotropic medications, feeling hopeless, and was depressed and suicidal. A supervisor was notified and "constant supervision" should have been ordered as is required by regulations. On February 9, Mr. Murdough's mental health intake was completed and his expression of suicidal ideation was noted along with the fact that he had previously attempted suicide. No enhanced supervision was ever instituted for Mr. Murdough.

On February 15, DOC staff left Mr. Murdough alone in his cell in an area of the jail that had a malfunctioning heater. DOC logbooks falsely claim that there were tours of the area at thirty minute intervals. The DOC staff member responsible for the area abandoned her post in the mental health observation unit and Mr. Murdough was left alone for at least four hours. The homeless ex-Marine, taking psychotropic medications that can make one more vulnerable to heat-related illness, died alone and neglected in his overheated cell.

The criminal justice system has become the default for addressing problems presented by people with behavioral health issues. Many people with behavioral health issues could be better treated and protected from harm, and community safety could be better addressed, if their underlying conditions were addressed more effectively. The plan called for diversion of some people before entry into the criminal justice system; for others who do enter the system, treatment outside of a jail setting; for those in jail, treatment that is therapeutic rather than punitive; and upon release, a connection to effective services.[8]

A number of specific steps were planned to facilitate diversion as an alternative to an arrest. Clinical advice to first responders is planned in the form of expanded training for police officers to learn techniques to de-escalate crises and the tools to assess appropriate alternatives to jail. Two community based, non-hospital drop off centers that will provide an alternative to arrest and/or hospitalization are also planned. This model is based on successful pre-booking diversion programs that exist in many other cities around the country.

For those who are arrested a detailed risk assessment instrument was to be developed that would help judges to assess the risk of flight and risk to public safety for those who might be placed into the community instead of jail. Expanded supervised release has the potential to greatly reduce the use of pre-trial detention. Screening for physical and mental health problems was to be expanded to help facilitate physical and mental health needs. Veterans were to be identified and access to veteran support services initiated. The use of monetary bail was to be reduced. Case processing times should be reduced.

Because they have greater difficulty in finding the resources to post bail, bail reform has great potential for improving the criminal justice system for those with behavioral health issues.

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[8] City of New York, Mayor Bill de Blasio, *Mayor's Task Force on Behavioral Health and the Criminal Justice System Action Plan,* September 2014.

The current bail practice in our City penalizes people, not because they have committed some serious crime or are a danger to our community, but because they are poor and cannot afford bail. By allowing people with money to get out of jail while incarcerating those who cannot afford even small amounts of bail we create unfair distortions between rich and poor in our criminal justice system. Bail has become an important factor driving mass incarceration of youth of color.[9]

The fact is that for the vast majority of those involved in the criminal justice system the setting of even a small amount of bail will cause the individual to remain in jail after the arraignment. A recent Human Rights Report that studied misdemeanor arrests in New York City showed the consequences of setting even small amounts of bail for low level offenses. When bail is set at $1,000 only 11.3% of those detained were able to post bail. When bail is set at $500 only 17.6% of those detained could post bail.[10] Almost Half (48%) of those who could not post bail at the arraignment will remain in custody until a disposition on the case.[11]

The ability to post bail can make all of the difference in a criminal case. For the person without enough money getting out off of Rikers Island can become a goal that is more important than guilt or innocence on the criminal charge. Pre-trial detention has a clear negative impact on felony and non-felony case outcomes. New York's Criminal Justice Agency reports that those who are released have a 50% conviction rate. Those detained have a 92% conviction rate.[12] Those who are too poor to post bail languish on Riker's Island, where they face physical violence, lasting damage to family and community relationships, the loss of employment and, a

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[9] Maya Schenwar, "Too Many People in Jail? Abolish Bail", *The New York Times*, Op Ed, May 9, 2015.

[10] Jamie Fellner, Human Rights Watch, *The Price of Freedom*, 2010, p. 21.

[11] Mary T. Phillips, New York City Criminal Justice Agency, *Bail, Detention and Nonfelony Case Outcomes,* May 2007.

[12] Phillips, *Bail, Detention and Nonfelony Case Outcomes,* p. 5

significant disadvantage in the plea-bargaining process. Many individuals who sit in jail for long periods eventually reach the conclusion that it is more beneficial to plead guilty, and get released, than it is to continue to wait for a trial in jail. That is not justice.

What Is Missing from These Proposed Solutions?

The Legal Aid Society believes that the planned initiatives for the diversion of individuals with behavioral health issues out of the criminal justice system, whether before or after arraignment, are steps in the right direction. The City is moving aggressively to establish a pilot "drop off" community diversion center in Manhattan. The plan is to have this center up and running in the fall. The second drop off center should open next year.

The City has also taken steps to strengthen its pre-arraignment medical screening. A pilot project that enhances services in the Manhattan central booking is planned to open soon. We have a meeting tomorrow to discuss the services that will be offered. To clear the way for this project, last month, the City worked with the Legal Aid Society to modify a court order in the case of *Grubbs v. Safir*, 92 Civ. 2132, which established rules for medical screening for pre-arraignment detainees. As a result of the modified court order the City now has greater flexibility to employ higher qualified medical practitioners who can do more in depth assessment and evaluation in the pre-arraignment central booking areas of the courthouses. Our hope is that one day a limited range of medications might get dispensed by these practitioners on site. This would speed up the arraignment process and save the city the considerable cost of trips to hospital emergency rooms for essential medication.

While we agree that the City is on the right track in terms of increasing the diversion of individuals with mental illness out of the criminal justice system, we do have concerns about the scope of the effort. Two drop off centers serving a few precincts should be the initial steps

toward a system that will eventually serve the needs of the entire City. A medical prescreening pilot project in Manhattan that covers about half of the arraignment shifts should be expanded to the entire City once we have evaluated the lessons learned from the pilot project.

We also think that more can be done to help first responders in recognizing and coping with behavioral health needs. The current short term plan is to train 5,500 police officers to recognize symptoms of mental illness, to engage in de-escalation techniques and to assess the appropriate available alternatives. While a more informed police force is an important and necessary step, lessons learned from other communities indicate that a police partnership with the local mental health treatment community is the most effective way to increase community safety. It is this partnership with the mental health community that is missing from the current plan. We are concerned that the NYPD has opted for a go it alone approach.

Experience shows that successful approaches that increase community safety have a number of common elements. All begin with the approach that community mental health resources must be partnered with the police to enhance the health and safety of everyone involved. Police officers are trained in how to work with individuals with symptomatic mental illness (such as active psychosis). They are equipped to provide crisis intervention services and act as liaisons to the mental health system. Many cities have formed Crisis Intervention Teams which partner police and mental health professional co-responders to incidents involving individuals with mental illness. Mental health consultants can provide both on site and telephone consultation backup to officers.

Other jurisdictions have successfully implemented models that divert individuals with mental illness who commit low level offenses from the criminal justice system. These models are designed by the Police Department, in cooperation with mental health professionals, to achieve a

variety of important goals: reduced arrest rates, improved services for people with mental illness, and improved efficiency for law enforcement. This is achieved by reducing the time spent on calls for individuals in crisis and improved effectiveness for law enforcement. Other goals of the use of these models include decreased recidivism by repeat offenders, diversion of individuals from the criminal justice system to systems better equipped to meet their needs, reduction of officer and civilian injuries, improved officer knowledge about mental illness and the formation of more effective partnerships with the mental health community.[13]

The City recognizes that working with mental health professionals through Crisis Intervention Teams (CIT) is an essential component of the plan to help individuals with mental illness who are incarcerated by the Department of Correction. Yet the existing plan mentions only training and not the introduction of CIT for improvement of NYPD interactions on the street. We do not understand this omission. CIT should be incorporated into the NYPD plan.

DEFENSE BASED SOCIAL WORKER RESOURCES ARE AN ESSENTIAL PART OF THE SOLUTION

The social work intervention model of the Legal Aid Society is uniquely situated to address those recommendations of the Mayor's Task Force on Behavioral Health that will reduce the prevalence of, and improve the outcomes for, people with mental illnesses involved in the criminal justice system. Expansion of these resources will greatly assist the accomplishment of the Task Force objectives. Currently, Legal Aid social work programming assists in cases City-wide with the goals of diverting clients with mental illness from the criminal justice system, identifying appropriate treatment options outside of the jail setting, and connecting clients with new or previously known treatment services in the community. This is accomplished through

the Misdemeanor Arraignment Project, the Mentally Ill Chemically Addicted Project, and the Defender Services Program.

Misdemeanor Arraignment Project

The Misdemeanor Arraignment Project (MAP) provides an early intervention inter-disciplinary legal team in selected city wide arraignments parts to represent defendants with mental illness or substance abuse issues. The Project aims to better identify, assess and represent individuals with mental illness facing criminal charges. These legal teams, which include a licensed clinical social worker (LCSW), work collaboratively with the Legal Aid Society attorneys to provide essential social services to better screen, assess and effectuate the best legal outcome for clients. The goals of the program are to:

- Provide an inter-disciplinary public defender arraignment team in New York, Kings, Bronx and Queens County Criminal Courts;
- Improve the identification of mentally ill clients in arraignments;
- Increase the arraignment diversion opportunities for clients with mental illness, and;
- Identify the needs of both diverted and non-diverted clients.

Initiated in Manhattan as a pilot project in 2010, MAP now serves clients in Brooklyn, the Bronx, Manhattan, and Queens, and is scheduled to be up and running in Staten Island in the near future. We have successfully diverted a large percentage of the clients assessed and have educated defense counsel, assistant district attorneys, and judges as to the importance of early diversion for this population. In addition to favorable outcomes for those diverted, the program has created overall an increased ability to provide appropriate linkages to treatment and supports for those who are non-divertible. MAP is the only program of this kind in the country – a defender based, in-arraignment, early diversion model which pairs social workers with attorneys.

It is recognized both locally and nationally that individuals with mental illness are over-represented in both the jail and prison populations. While the daily jail census in New York City

has dropped over the past ten years, the percentage of individuals with mental illness, both men and women, has increased as cited earlier in this report. Individuals with mental illness tend to stay in jail longer (about twice as long), are less likely to make bail, and are more likely to violate parole or probation than other defendants. Through our MAP program and early diversion, either avoiding detention pending determination of the case, or avoiding incarceration completely through an Alternative to Incarceration, we can and do make a difference. We have shown through MAP that for our mentally ill clients, linkage to treatment and support can stop this trend of incarceration of the mentally ill.

MAP improves the legal representation and outcomes of defendants with mental illness at the first point of contact with the courts, arraignments, improves placement into community based treatment programs, with an expanded benefit to the individual and the community. Finally, the project reduces the disruption of continuity of treatment and recovery, housing options, and community supports.

The number of clients served and our outcomes are impressive, considering that we have only one licensed clinical social worker for each borough, each spending approximately three-quarters of their time physically in court. We assessed 1237 clients, and diverted a total of 869 at arraignments or shortly thereafter. This data powerfully supports our original premise – that with early assessment and intervention, clients with mental illness can be diverted. Additionally, we have collected data in Manhattan to measure recidivism rates for those serviced by MAP. For calendar year 2013-2014, for the borough of Manhattan,, the total number of arrests prior to MAP intervention was 724 for all clients assessed. For the same group of individuals, one year after MAP intervention, the number of arrests was 528. This preliminary assessment indicates a 27% decrease in the number of arrests following the involvement of MAP social work services.

Currently, MAP will work in concert with the Mayor's new CIRTS (Court-based Intervention Resource Team) in each borough, strengthening all of our join efforts city-wide to assist those with mental illness from unnecessary involvement with the criminal justice system.

Mentally Ill Chemically Addicted (MICA) Project

Since 2002, the Society's Enhanced Defense-MICA Project has provided legal and community support services to some of the most vulnerable defendants in New York City's criminal justice system. These individuals, struggling to live with co-occurring serious mental illness and addiction problems, are often underserved and victimized while incarcerated in our jails and prisons. As cited above, those with mental illness are more apt to be arrested, detained longer in jail and sentenced more severely than those with similar charges without a mental illness. Correctional facilities fail to properly treat the mentally ill and do even less to prepare for their re-entry into the community. Our failure to adequately address this issue is ruining lives and fueling the rate of incarceration of this population.

The MICA Project's holistic model partners mental health attorneys with licensed clinical social workers to provide expert legal representation and social services. Our main focus is to secure alternatives to incarceration for clients who can be legally diverted from jail/prison into community based treatment. Once a client is receiving community treatment, our unique defense-based bridge case management approach enables us to provide 18-24 months of community social services and monitoring which helps prevent clients from "falling through the cracks." In addition to providing direct client services, the Project is committed to addressing the systemic issues facing the MICA population; we do this through extensive consultative services, advocacy efforts and training. Currently the MICA Project functions in each of the five boroughs of New York City. Our analysis of measures of services received and recidivism rates indicate a

positive impact on individuals as well as on the system as a whole. For the most recent period of data analysis which includes individuals referred to the Project from March 2014-March 2015, 51% of project clients have had no re-arrest after their referral, while only 26% of those refusing or withdrawing from services avoid re-arrest. This represents a 25% reduction in re-arrests. Further, a review of arrests for clients who did not receive custodial sentences shows that those who had the benefit of MICA participation were re-arrested at significantly lower rates even after they were no longer in the program. The average number of arrests for MICA "graduates" is 0.7 in the two years following their program participation, compared to 1.8 for those who withdrew or were not accepted into the program. These findings exemplify how the MICA Project's inter-disciplinary model of service provision to mentally-ill and chemically-addicted clients has changed lives and reduced criminal justice involvement. Our services promote client stability, community safety, and prove financially advantageous as it breaks a cycle of costly criminal justice system involvement.

Defender Services Program

The Defender Services Program of the Legal Aid Society includes social work professionals, both clinical and masters level licensed social workers (LMSW, and LCSW), who work as a team with an attorney to assess, identify and facilitate the delivery of appropriate services to our clients. Social workers meet with clients to conduct biopsychosocial assessments in order to uncover and present mitigation in the hopes of providing DA's and/or judges information that individualizes clients and allow possibilities for clients to enter alternatives to incarceration or serve lesser sentences. Clients are screened and assessed for appropriate treatment options. Social workers interview clients at correctional facilities, at Legal Aid offices, in client's homes, schools, or treatment facilities. Interviews are conducted with collateral

sources including family members, employers, and community based program staff, while the retrieval and analysis of supporting life history records is completed. Poverty, trauma, sexual abuse, physical abuse, substance abuse, unequal access to education and employment, and undiagnosed mental illness are often part of a client's history. Through written or oral advocacy the goal is to provide stakeholders with information and recommendations to meet the needs of clients that are often not identifiable through the rap sheet. After assessment social workers also arrange for program placement. They are also involved in community advocacy, training, and policy change. Legal Aid social workers educate attorneys and the court about our clients and facilitate communication for clients with mental illness, developmental disabilities, or substance abuse issues, in order that the individual's needs be met appropriately and effectively.

INDIVIDUALS WITH BEHAVIORAL HEALTH NEEDS INSIDE JAIL

The Legal Aid Society actively participates in the "Inside DOC Working Group" of the Mayor's Task Force on Behavioral Health and the Criminal Justice System (Task Force). The Task Force's Action Plan[14] for the City jails focuses appropriately on ensuring that individuals with behavioral health needs who are housed in the jails receive treatment that is therapeutic rather than punitive in approach, and that upon release they are connected to effective services. The elements of the Task Force action plan are sensible and valuable on their face. However, not all of the important recommendations from the Task Force's "Inside DOC Working Group" are part of the City Action Plan. In addition, several current initiatives by the City concerning the

[14] The Action Plan is available online at http://www1.nyc.gov/assets/criminaljustice/downloads/pdf/annual-report-complete.pdf.

jails are ill-conceived, and are detrimental to the improved and therapeutic approach promised by the Task Force.[15]

Task Force Jail Action Plan

- Crisis Intervention Teams (CIT) inside the jails.
- Reduction in the use of punitive segregation
- Revisions to the Department of Correction (DOC) use of force policy
- Creation of Program for Accelerating Clinical Effectiveness (PACE)
- Training for DOC staff
- Specialized services for 16 & 17 year olds
- Expansion of substance use treatment
- Expansion of programming

Crisis Intervention Teams (CIT)

Crisis Intervention Teams (CIT) will consist of jointly trained teams of DOC and clinical mental health staff. The personnel will be trained in de-escalation and behavioral health symptom identification.[16] The adaptation and use of multi-disciplinary crisis intervention teams in the City jails will, if successful, reduce injury and violence as it has done successfully for police departments who utilize these teams for street encounters.[17] CITs in the City jails would be able to respond to crises involving individuals with behavioral health needs instead of the

[15] In addition to the Action Plan from the Mayor's Task force on Behavioral Health and Criminal Justice, the City announced a 14 Point Plan to Address Violence in the Jails. The press release is available at http://www.nyc.gov/html/doc/downloads/pdf/press-releases/MAYOR_DE_BLASIO_COMMISSIONER_PONTE_ANNOUNCE_14_POINT_RIKERS_ANTI_VIOLENCE_AGENDA.pdf. On May 6, 2015, we received a document dated April 2015 titled "DOC Antiviolence Reform Agenda: 14-point plan to combat violence and promote safety," which is marked as "Preliminary" and "confidential and proprietary, pre-decisional," but that was provided by DOC to City Council at a hearing on May 6. This document is cited herein as "DOC Antiviolence Agenda."

[16] The Action Plan also includes training for New York City police officers on recognizing behavioral health needs and expands the options for alternatives to arrest by creating two clinical drop-off community centers to assess needs and provide short-term care.

[17] The need for training and inter-disciplinary teams to de-escalate situations and avoid tragedy inside and outside of the jails remains apparent. See "Suspect Fatally Shot by Detective in East Village Had Mental Illness and a Troubled Past," *The New York Times*, April 26, 2015, available at http://www.nytimes.com/2015/04/27/nyregion/suspect-fatally-shot-by-detective-in-east-village-had-mental-illness-and-a-troubled-past.html.

DOC probe team.[18] It is our understanding that some CIT training has begun and that adaptation of the National Alliance on Mental Illness (NAMI) CIT curriculum is under way. It is also our understanding that the development of policies and procedures necessary to implementing CIT in the City jails is not yet complete.

The New York City Council is considering a bill to require the establishment of CIT in the City jails. The Legal Aid Society supports the passage of Int. No. 770, which requires the Department of Correction and the Department of Health and Mental Hygiene to implement CIT in the City jails and to publicly report on the use and results of CIT in the jails.

Reduction in Use of Punitive Segregation

It is well settled that the use of isolated confinement, called "punitive segregation" in our City jails, causes serious physical, psychological and developmental harm.[19] New York City has finally,[20] due to new jail minimum standards passed by the New York City Board of Correction ("Board") in January, 2015, joined in a national trend to reduce the harmful use of isolation.

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[18] De-escalation should be the goal of any crisis response in the jails and de-escalation training should be provided to all DOC staff.

[19] *Jones'El v. Berge*, 164 F.Supp.2d 1096, 1101 (W.D. Wisc. 2001), p. 1101 (isolated confinement is "known to cause severe psychiatric morbidity, disability, suffering and mortality [even among those] who have no history of serious mental illness and who are not prone to psychiatric decompensation."); *Koch v. Lewis*, 216 F.Supp.2d 994, 1001 (D. Ariz. 2001) (experts agreed that extended isolation causes "heightened psychological stressors and creates a risk for mental deterioration"); *Ruiz v. Johnson*, 37 F.Supp.2d 855, 907 (S.D. Tex. 1999), *rev'd on other grounds*, 243 F.3d 941 (5th Cir. 2001), *adhered to on remand*, 154 F.Supp.2d 975 (S.D. Tex. 2001) (the court described administrative segregation units as "incubators of psychoses-seeding illness in otherwise healthy inmates and exacerbating illness in those already suffering from mental infirmities"); *Langley v. Coughlin*, 715 F. Supp. 522, 540 (S.D.N.Y. 1988) (citing expert's affidavit regarding effects of SHU placement on individuals with mental disorders); *Baraldini v. Meese*, 691 F. Supp. 432, 446–47 (D.D.C. 1988) (citing expert testimony on sensory disturbance, perceptual distortions, and other psychological effects of segregation), *rev'd on other grounds sub nom. Baraldini v. Thornburgh*, 884 F.2d 615 (D.C. Cir. 1989); *Bono v. Saxbe*, 450 F. Supp. 934, 946 ("Plaintiffs' uncontroverted evidence showed the debilitating mental effect on those inmates confined to the control unit."), *aff'd in part and remanded in part on other grounds*, 620 F.2d 609 (7th Cir. 1980); *Madrid v. Gomez*, 889 F. Supp. 1146, 1235 (N.D. Cal. 1995) (concluding, after hearing testimony from experts in corrections and mental health, that "many, if not most, inmates in the SHU experience some degree of psychological trauma in reaction to their extreme social isolation and the severely restricted environmental stimulation in the SHU") *rev'd in part on other grounds*, 190 F.3d 990 (9th Cir. 1999).

[20] DOC expanded its punitive segregation capacity by 27% in 2011, and another 44% in 2012. resulting in more punitive segregation cells than it had in the 1990's when DOC housed many thousands more people than it does today.

Evidence of this needed reform was overwhelming.[21] Prior to the Board amendments, DOHMH and DOC did institute some reforms in the creation of Clinical Alternative to Punitive Segregation (CAPS) units for individuals with serious mental illness and Restricted Housing Units (RHU) for individuals with "non-serious" mental illness who have broken DOC rules. The CAPS unit provides a therapeutic setting with enhanced treatment services and appears to be succeeding at housing individuals who were unable to adapt to general population or MO housing. The RHUs continued to be extremely punitive in nature, failing to provide the out-of-cell treatment and programming that was supposed to occur and was needed to provide a respite to long terms of isolation for the individuals with mental illness housed in them. However, it is currently unclear whether the RHU will be more successful now, after the changes in the Board standards.

Per the newly adopted Board standards, punitive segregation is now limited to 30 days for any single infraction, and 30 consecutive days overall, with 7 days out before the person may

[21]Kaba, Lewis, Glowa-Kollisch, Hadler, Lee, Alper, Selling, MacDonald, Solimo, Parsons & Venters, *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 Am.J. Public Health 442, 445 (2014) (study conducted by employees of DOHMH makes numerous findings that illustrate that solitary confinement is a dangerous and self-defeating practice and indicates a need to reconsider the use of solitary confinement as punishment in jails). See also Andrea Lewis to Homer Venters, Memorandum, March 14, 2012, "Medical Informatics, New York City Department of Health and Mental Hygiene and Correctional Health Services." (According to information gathered by DOHMH, incarcerated individuals with mental illness were more likely than others to be injured while in custody and more likely to end up in punitive segregation). In September 2013, a report to the New York City Board of Correction by their mental health experts, Drs. James Gilligan and Bandy Lee, recommended that no individuals with mental illness should be placed in solitary confinement, that *no individuals at all* should be subjected to the prolonged solitary confinement in use in the City jails because *"it is inherently pathogenic – it is a form of causing mental illness*." Gilligan, Lee, *Report to the New York Board of Correction* (Sept. 2013) at p. 16, available at: http://www.nycjac.org/storage/Gilligan%20Lee%20Report%20%20Final.pdf. The Department of Justice ("DOJ") issued a report concerning adolescent males on Rikers Island in August 2014. In the report, DOJ identified and reported on the dangerous over-utilization of punitive segregation in the City jails stating that "the DOC relies far too heavily on punitive segregation as a disciplinary measure, placing adolescent inmates – many of whom are mentally ill – in what amounts to solitary confinement at an alarming rate and for excessive periods of time." Department of Justice, "CRIPA Investigation of the New York City Department of Correction Jails on Rikers Island," at p. 3 (August 4, 2014). The DOJ cautioned that its "focus on the adolescent population should not be interpreted as an exoneration of DOC practices in the jails housing adult inmates. Indeed, while we did not specifically investigate the use of force against the adult inmate population, our investigation suggests that the systemic deficiencies identified in this report may exist in equal measure at the other jails on Rikers." *Id.* The report is available at
http://www.justice.gov/usao/nys/pressreleases/August14/RikersReportPR/SDNY%20Rikers%20Report.pdf.

be returned to punitive segregation. No one can be held in punitive segregation for more than 60 days within a six-month period unless the person continues to engage in "persistent acts of violence" that can't be addressed by placement in an enhanced supervision housing unit (ESHU). People with grade 2 offenses and non-violent grade 1 offenses must get 7 hours out-of-cell a day in punitive segregation. And the practice of making individuals serve "owed time" from prior incarcerations is eliminated. The new Board standards also exclude young people from *both* punitive segregation and ESHU: all 16 and 17 year olds are excluded, and the exclusion will extend to "young adults" 18-21 years old by January 1, 2016, if necessary funding is available. Also excluded are individuals with disabilities, meaning anyone with serious mental or serious physical disabilities or conditions.[22]

Revised Use of Force Policy

As the Council is no doubt aware, the City's use of force policies, including its tracking of data concerning use of force, are currently the subject of litigation in *Nunez v. City of New York,* No. 11-Civ.-5845 (S.D.N.Y. (LTS) (JCF)). The plaintiffs in *Nunez*—a certified class comprised of all individuals in the City jails not already under court order (represented by our office and two law firms), with the United States Department of Justice intervening on behalf of younger inmates—are seeking reforms of the use of force practices in the jails to redress a pattern and practice of unconstitutional brutality by correction staff. The parties are currently engaged in very detailed settlement discussions that all parties hope to complete within a matter of weeks.

[22] The new Board standards are available at:
http://www.nyc.gov/html/boc/downloads/pdf/BOCRulesAmendment_20150113.pdf

Program for Accelerating Clinical Effectiveness (PACE)

The DOC along with DOHMH is creating four PACE units that provide a higher level of behavioral health treatment to individuals who are housed in general population. Creating these new housing units provides an essential alternative to MO housing for individuals who require a more therapeutic environment. The PACE units are modeled after the CAPS unit and will provide needed treatment *before* an individual psychiatrically decompensates (and possibly gets into disciplinary trouble) in general population. There are currently two PACE units in operation. One is a hospital return unit at AMKC, where individuals who enter the jail from a psychiatric hospital are housed. The second PACE unit is at GRVC and is used to house individuals who are escalating on a scale of acuity – becoming more symptomatic.

Training for DOC staff

Training DOC staff to work with individuals with mental illness and other behavioral health issues in an appropriate and humane manner rather than in a punitive (and all too commonly violent) manner is essential to changing the culture in the City jails. It is our understanding that new recruits are receiving specialized mental health training and that the DOC is providing 8 hours of training to all DOC officers. While this is commendable and an improvement over past practice, it is essential that multi-disciplinary training about mental and behavioral health is ongoing and includes annual training for all staff. Training should bring clinical staff together with security staff so that positive relationships and communication skills can be developed between the two. Clinical staff can provide training on positive reinforcement as an alternative to punishment and instruction on how security staff can observe changes in behavior, identify risks, and relay information to colleagues on the next shift and to clinicians.

Specialized Services for 16 & 17 Year Olds

The Legal Aid Society actively participates in the DOC Adolescent and Young Adult Advisory Board. We are, therefore, aware that in addition to ending the use of punitive segregation for 16 and 17 year olds, DOC is working with the Department of Education, DOHMH, other agencies and advocates to develop appropriate treatment and programming for these young people. Improvements have been made in staffing levels and in committing and training dedicated steady staff to work with the youth population. There is ongoing development of policies and training requirements. Specialized training is essential so that the correction officers who have daily contact with incarcerated young people understand adolescent development and behavior and have the tools to interact with teenagers in a constructive way. Jail is an inherently stressful environment. Exposure to overly punitive conditions while incarcerated can exacerbate the effects of teenagers' prior damaging traumatic life experiences. We believe that if the staff is better trained and given the tools to understand the context of the teenagers' behavior, their interactions with the youth will be more effective, jail management will improve, program participation will increase and violence will decrease.

Expansion of Substance Use Treatment and Expansion of Programming

It is universally understood that reducing idleness with constructive activity is an important tactic for reducing violence, as well as having value in its own right.[23] The public health opportunity to provide substance abuse treatment and to inform and connect individuals with community substance abuse services will help reduce recidivism as will providing education and vocational training opportunities.

[23] See Thigpen, Beauclair, Hutchinson, *Inmate Behavior Management: The Key to a Safe and Secure Jail*, U.S. Dept. of Justice, National Institute of Corrections (August 2009) available at https://s3.amazonaws.com/static.nicic.gov/Library/023882.pdf.

City Initiatives Detrimental to Improvement of Our Jails

Several current initiatives by the City concerning the jails are ill-conceived, and are detrimental to the improved and therapeutic approach promised by the Task Force.

Withdrawal of CIT as an Anti-violence Measure

When the Mayor announced the 14-Point Anti-violence plan, the press release included "Developing crisis intervention teams to respond more quickly to inmate-on-inmate violence."[24] The jail CIT is no longer included in the Plan.[25] The current draft DOC Antiviolence Agenda instead discusses increasing the effectiveness of the Emergency Services Unit ("ESU"). The ESU differs significantly from the CIT. The CIT would be facility based, have knowledge of the individuals involved in an incident or crisis, and be trained in de-escalation and behavioral health symptom recognition. The ESU is a unit of correction officers unaffiliated with a particular facility that responds to security incidents in any facility on Rikers Island and conducts many housing area and facility searches. Many incidents of staff-inmate violence have arisen from the activities of the ESU. They sometimes operate in an almost military fashion which is not conducive to de-escalation. We do not oppose improving the ESU, increasing their training, and monitoring their actions. However, we are concerned that CIT is no longer included in the plan as a first line incident responder, that training the ESU in de-escalation of violence is not mentioned, and the involvement of clinical mental health staff—perhaps the crucial feature of the

[24] The press release is available at http://www.nyc.gov/html/doc/downloads/pdf/press-releases/MAYOR_DE_BLASIO_COMMISSIONER_PONTE_ANNOUNCE_14_POINT_RIKERS_ANTI_VIOLENCE_AGENDA.pdf.

[25] The DOC Antiviolence Agenda, cited above at n. 15, provided to the City Council on May 6, appears to be the most recent version of the Plan. It does not mention the CIT at all.

CITs—is also not mentioned. We are concerned that the elimination of CITs from the Antiviolence Agenda and emphasis on the ESU will perpetuate violence rather than reduce it.[26]

Visiting

When the Mayor announced the 14-Point Anti-violence plan, the press release indicated that DOC desires "new rules for visitors that DOC will seek from the Board of Correction, its oversight body. These rules will seek to limit the physical contact incarcerated individuals may have with visitors, broaden the criteria for restricting visitors, and establish a visitor registry." The current draft DOC Antiviolence Agenda is not so specific but includes changes to visitation among the points listed.[27] If the DOC intends to seek changes to visiting as were described in March at the press conference, we strongly oppose these further restrictions on visiting as counter-therapeutic, contrary to improving outcomes for individuals in our jails, unduly restrictive without evidentiary basis, and contrary to law. It was just a few months ago that the Board of Correction rejected such limits on visiting proposed for individuals placed in the new Enhanced Security Housing units.[28] Imposition of such restrictions as a blanket policy for the entire jail population cannot be countenanced.

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[26] An example of our concerns is the recent highly publicized incident in which a number of officers and captains were criminally charged by the Bronx District Attorney and terminated by the Department of Correction for abusing prisoner Jahmal Lightfoot. The head of the correction officers' union was quoted on the union web site as stating: "The COs were defending themselves against an assault the way they were trained to defend themselves. They called out the Emergency Service Unit. When you call out the Emergency Service Unit, you're not calling out the Cub Scouts." (available at http://www.cobanyc.org/correction-unions-blast-inmate-beating-charges).

[27] We support the part of the new draft DOC Antiviolence Agenda which calls for relocating lockers outside of the facilities for both staff and visitors.

[28] *See* New York City Board of Correction, Notice of Adoption of Rules, approved January 13, 2015, at 9. The Department had requested the denial of contact visits to all persons held in the newly authorized Enhanced Supervision Housing (ESH), but the Board approved the deprivation of contact visits only based on an individualized finding at a hearing. The Board also rejected proposals to limit visits to individuals in ESH to a pre-approved list (*i.e.,* a visitor registry) and to limit those persons who can visit. The Department apparently intends to repeat its request and make it applicable to *all* individuals in the jails even though it was rejected for people housed in the ESH.

The Board heard a chorus of disapproval from the public and advocates in their testimony for the December 19, 2014 hearing on the proposals to limit visitation.[29] It was clearly expressed, and supported by data, that individuals who maintain close family ties are less like to be repeat offenders, and that the jail system should not be taking action to interfere with family relations by limiting visiting or making it more difficult or unpleasant. According to the American Bar Association:[30]

> Maintaining personal connections through contact visits improves the lives of incarcerated individuals, their families, and the community in three important ways. First, people who receive visits from and maintain relationships with friends and family while incarcerated have improved behavior during their time in custody,[31] contributing both to a safe and more rehabilitative atmosphere in the facility. Second, individuals who maintain relationships have more successful transitions back to society than those who do not.[32] For example, the Minnesota Department of Corrections found that prisoners who were visited were 13 percent less likely to be reconvicted of a felony and 25 percent less likely to return to prison on parole violation.[33] Third, families and children that are able to visit their relatives in jail benefit greatly

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[29] The hearing transcript, written testimony and tapes from the hearing are on the Board of Correction website at http://www.nyc.gov/html/boc/html/meetings/RuleChanges_2015.shtml.

[30] Letter, American Bar Ass'n Governmental Affairs Office to Chairperson, Committee on the Judiciary and Public Safety, Council of the District of Columbia (June 19, 2013), pp. 2-3, available at http://www.americanbar.org/content/dam/aba/uncategorized/GAO/2013june19_dcvisitation_l.authcheckdam.pdf. This letter was written in support of allowing contact visits in the District of Columbia jails in addition to video contact.

[31] See ABA Standards for Criminal Justice: Treatment of Prisoners, Standard 23-8.5 cmt. at 260. See also Virginia Hutchinson et al, U.S. Dep't of Justice, Nat'l Inst. of Corr., *Inmate Behavior Management: The Keys to a Safe and Secure Jail*, 8 (August 2009) (noting that maintaining contact with family and friends (including visitation) is integral to behavior management in the jail setting and that a failure to meet this important social need can lead to depression and inappropriate behavior in the under-custody population); Karen Casey-Acevedo & Tim Bakken, "The Effects of Visitation on Women in Prison", 25 *Int'l J. Comp. & App. Crim. Just.* 48 (2001); Richard Tewksbury & Matthew DeMichele, "Going to Prison: A Prison Visitation Program", 85 Prison J. 292 (2005); John D. Wooldredge, "Inmate Experiences and Psychological Well-Being", 26 Crim. J. & Behav. 235 (1999).

[32] *See* Jeremy Travis et al, Urban Institute, *From Prison to Home: The Dimensions and Consequences of Prisoner Reentry* 39 (June 2001) ("Studies comparing the outcomes of prisoners who maintained family connections during prison through letters and personal visits with those who did not suggest that maintaining family ties reduces recidivism rates.") (internal citation omitted).

[33] *See* Minnesota Dept. of Corr., *The Effects of Prison Visitation on Offender Recidivism* (Nov. 2011), pp. 18-21.

> from maintaining family ties during a time that can often cause family trauma.[34]

The ABA's conclusions are consistent with those of other research finding that people who maintain family ties during incarceration and benefit from the support of family after release have better reentry outcomes than those who are unable to do so,[35] and that maintaining family ties with a parent who is in custody also has significant, salutary effects on the child's well-being, including possibly improving the child's chances of staying out of the criminal justice system.[36] Against this background, and with specific reference to contact visits, the ABA has stated in its Criminal Justice Standards for Treatment of Prisoners (emphasis supplied):

> For prisoners whose confinement extends more than [30 days], correctional authorities should allow contact visits between prisoners and their visitors, especially minor children, absent an individualized determination that a contact visit between a particular prisoner and a particular visitor poses a danger to a criminal investigation or trial, institutional security, or the safety of any person.[37]

The provision of contact visits absent an individualized determination is also required by the state Constitution. The New York Court of Appeals has held that pre-trial detainees have a state constitutional right to contact visits, subject to reasonable security precautions, and that any

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[34]See Hairston, C.F. *Family Ties During Imprisonment: Important to Whom and for What?* 18 Journal of Sociology and Social Welfare 87-104 (Mar. 1991) (literature review of research showing maintenance of family ties improves mental health of inmates' children and increases likelihood of family reunification after release).

[35]Travis et. al., *Families Left Behind: The Hidden Costs of Incarceration and Reentry*, 6 (Urban Institute 2005) ("Studies comparing the outcomes of prisoners who maintained family connections during prison through letters and personal visits with those who did not suggest that maintaining family ties reduces recidivism rates") (internal citation omitted).

[36] *See* Allard & Greene, *Justice Strategies: Children on the Outside*, 22-23 (Justice Strategies 2012) (noting that self-worth and connectedness impact risk of criminal justice involvement and recommends facilitating prison visits to boost those feelings); Nickel et. al., *Children of Incarcerated Parents: An Action Plan for Federal Policy Makers*, 13 (Council of State Governments 2011) ("Strong parent-child relationships may aid in children's adjustment to their parents' incarceration and help to mitigate many of the negative outcomes for children that are associated with parental incarceration") (citation omitted).

[37]ABA, Criminal Justice Standards for Treatment of Prisoners, Standard 23-8.5(e) (Visiting), available at http://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/Treatment_of_Prisoners.authcheckdam.pdf, p. 259.

denial of contact visits must be done based on individualized consideration, not meted out in wholesale lots. *Cooper v. Morin*, 49 N.Y.2d 69, 81 n.6 (1979). This right is embodied in the State Commission of Correction Minimum Standards at 9 NYCRR § 7008.6 (a) ("Physical contact shall be permitted between a prisoner and his visitors."). **The City Council should guarantee individuals housed in the City jails their right to contact visits, absent a compelling individualized reason.**

The Board of Correction was correct to reject earlier attempts to limit and restrict visits. The Council should not support this part of the draft DOC Antiviolence Agenda. Restricting visits is unlikely to produce the desired outcome of reducing violence. The lack of a connection between visit restrictions and violence reduction is reinforced by the recent Board of Correction study which found that "the vast majority of weapons are found in areas other than intake and visits and that the majority of weapons found in the jails are inmate - made or fashioned from materials already inside the jails."[38] The data suggest that further restricting the already heavily supervised visiting process will not be of much help in reducing the prevalence of weapons in the jails, and the human cost of restricting visits will be great.

[38] New York City Board of Corrections, *Violence in New York City Jails: Stabbing and Slashing Incidents*, at p. 7 (April 22, 2015), available at http://www.nyc.gov/html/boc/downloads/pdf/reports/Slashings_stabbings_CRP_2015_04_27_FINAL.pdf.

CONCLUSION

Far too many individuals with behavioral health issues are involved in our criminal justice system. Many people with behavioral health issues could be better treated and protected from harm, and community safety could be better addressed, if their underlying conditions were addressed more effectively. Solutions must include increasing diversion, increasing treatment opportunities in the community, and providing alternatives to incarceration. For those in jail, treatment that is therapeutic rather than punitive, and upon release, a connection to effective services. To make these changes in an effective manner, there must be coordination between stakeholders in the courts, service providers, and treatment providers. We offer the foregoing comments to support the Council's effort to make these improvements possible and to suggest measures that may make the improvements more effective.

Dated: May 12, 2015

New York, New York

New York City Council Hearing

Committees on Courts & Legal Services; Fire & Criminal Justice Services; Public Safety; and Mental Health, Developmental Disability, Alcoholism, Drug Abuse and Disability Services

Oversight Hearing – Behavioral Health and the Criminal Justice System: Examining New York City's Action Plan

Tuesday, May 12, 2015
City Hall, Council Chambers

Testimony of Mary Beth Anderson
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The Urban Justice Center Mental Health Project (MHP) has focused on the needs of people with mental illness in the criminal justice system for more than 15 years. We are deeply familiar with the difficulties people with mental illness have within the criminal justice system, including the problems they face while in correctional facilities as well as those they face in accessing essential mental health services, housing, and benefits upon release.

MHP also supports the work of the New York City Jails Action Coalition (JAC), a coalition of activists that includes formerly incarcerated and currently incarcerated people, family members, and other community members working to promote human rights, dignity, and safety for people in the City jails.

We commend the City Council for convening this hearing. It is critical that the Council provide oversight of the action plan for people with behavioral health issues who become involved in the criminal justice system.

We are hopeful that Mayor de Blasio's action plan will achieve the goals of the various members of the task force that came together to help to shape this plan. We commend the Mayor's office for developing a comprehensive approach to the problems people with behavioral health needs face when they come in contact with the criminal justice system.

We are especially optimistic about the pre-booking diversion programs that will be implemented later this year. We are grateful to the New York City Police Department and the prosecutors' offices for their willingness to develop pre-booking diversion programs.

We are also exceedingly grateful that both the Department of Correction and the New York City Police Department are adopting Crisis Intervention Team (CIT) models to assist people who are experiencing mental health crises. We encourage both agencies to employ cross-disciplinary training in implementing their CIT models. Cross-training, where law enforcement and mental health providers have the opportunity to learn about CIT, is essential. It not only assists the law enforcement professionals to understand the work of mental health providers; it also helps mental health professionals understand the challenges that law enforcement face when dealing with people who are in emotional crisis.

We commend the Departments of Health and Mental Hygiene and Correction for implementing CAPS and PACE units for people with mental illness who are detained in city jails. We encourage the Departments to ensure that all people with mental illness are provided access to placement in a PACE unit. We have long opposed solitary confinement of people with mental illness and we encourage the Department to ensure that people with mental illness are never placed into solitary confinement and that other people in jail without mental illness are never confined in solitary more than 15 days.

In spite of all these promising changes, the city still, sadly, falls significantly short when it comes to discharge planning.

As one of the lead plaintiffs' counsel in *Brad H. v. the City of New York*, the Mental Health Project has been monitoring the settlement of this litigation since 2003. The city has been unable to comply with essential terms of the settlement. I'd like to highlight a few of the more frustrating aspects of noncompliance.

People entitled to discharge planning are being released without active Medicaid. The practice of suspending Medicaid when a person is in jail has made the problem even worse, as the reinstatement process, which requires action by the Department of Correction, State Department of Health, and Human Resources Administration, results in delays in people having access to Medicaid after their release. Providing people with a Medication Grants Program card fills in some of the gaps in that it allows people to obtain essential medications, but it not a substitute for active Medicaid.

People leave city jails without essential identity documents. Often this is because they are released from court. If released from court, people need to make an appointment through 311 to obtain any property that is held in the jail. Sometimes property that is in a person's jail housing area is stolen before it can be boxed up by DOC staff to be held for safe-keeping. Sometimes identity documents were vouchered by the police and never transferred to the Department of Correction. Many people released from our city jails lack access to phones or computers, and thus have no way to schedule appointments with 311. Some lack the funds to return to the jail to attempt to retrieve their property. Many don't know to whom they can turn for assistance.

People who are homeless upon entry to our jails generally leave homeless, with a referral to the general assessment shelter. Many of them are not able to negotiate the shelter assessment process, due to fear, paranoia, prior bad experiences, or a combination of these. Thus they return to living on the streets. We know that 125 new beds are to be set aside for people exiting jails, with another 267 to be added in the future. The need is so much greater than that. MHP's criminal justice advocate, who interviews approximately 40 Brad H. class members a week, reports that more than half of class members are homeless. At bare minimum, these class members should be assigned to an appropriate shelter with mental health supports upon discharge; they should not have to be subjected to the general shelter assessment process. And when I state people should be assigned to an appropriate shelter with mental health supports, I mean a shelter that has privacy as well as access to treatment. Many class members cannot tolerate sleeping in large dorm-type settings.

Reforms must be made to the processes by which people with mental illness obtain supportive mental health housing. Currently, obtaining supportive housing is a bit like trying to put together a jigsaw puzzle without a picture of how the puzzle will look when complete.

Individuals seeking supportive mental health housing must first be approved for such housing by the Human Resources Administration. Then, depending on whether the individual belongs to a "priority population," the person may locate a bed or may be placed on a waiting list. However, there is no centralized waiting list nor is there a centralized process to locate housing. A person who qualifies for mental health supportive housing may end up interviewing at a dozen housing providers, and being placed on a dozen waiting lists. There is no easy way to ascertain one's place on these waiting lists. People who interview poorly (for example, people who do not possess good "insight" into their illness) or who have been convicted of arson charges or sex offenses may remain on the streets or in the shelter system for years. How is society safer by not providing housing to people in these categories? This is not a moral issue. We cannot ask whether people who have convictions for fire setting or offending sexually "deserve" housing. This is a public safety issue. People who are homeless and who have prior contact with the criminal justice system are more likely to be rearrested than people who have homes.

Any new supportive housing that is created needs to be geared to provide either efficiency units for single people or for couples who are married or partnered or must have additional sleeping rooms for the children of people with mental illness. We should not be asking people who are not related to one another or not romantically involved to share a room. While housing providers tell our clients that this arrangement is "like sharing a dorm room while going to college," this explanation is duplicitous. Students sharing dorm rooms are engaged in the pursuit of a degree; they live with other students to save money and to share aspects of the student experience. Adults with mental illness deserve to have a secure space of their own, where they can work with treatment providers and peers to achieve better measures of recovery.

We commend the Department of Correction for starting to provide enhanced training on mental health to correction officers. Last summer, MHP's director of social work and I were privileged to partner with law enforcement officers to assist with the Mental Health First Aid Training of

the incoming class of correction officers. We look forward to further collaboration with DOC and perhaps the NYPD to provide additional Mental Health First Aid training.

We encourage the Department of Correction to modify the model of correctional care currently in place to one that employs principles of trauma-informed care. Many, if not most, people who are in our jails have experienced trauma, and correctional systems that implement a trauma-informed approach to correctional care not only experience fewer incidents where force must be used, they also see better medical outcomes in the people who are in detention. A study performed by the TAPA Center in 2009 showed that among detainees with serious mental illness, 96% of women and 92% of men had experienced trauma during their lifetimes. People who had experienced current trauma (trauma within the past year) included 58% of men and 65% of women. Thus, there is solid evidence to make the change to a trauma-informed model of correctional care, particularly in units that house people with mental illness.

We have one final comment: We urge the city not to extend the Corizon contract, which expires this year. Some of the clinicians employed by Corizon are caring, skilled individuals. Many are not. It is time for the city to take direct responsibility for the health care provided to the people we detain in our jails.

Thank you for this opportunity to present testimony on the Mayor's plan of action for people with behavioral health issues who become involved in the criminal justice system.

LEGAL

SERVICES

INCORPORATED

TESTIMONY

"Oversight: Behavioral Health and the Criminal Justice System: Examining New York City's Action Plan"

PRESENTED BEFORE:

THE NEW YORK CITY COUNCIL'S
COMMITTEE ON FIRE AND CRIMINAL JUSTICE SERVICES, COMMITTEE ON PUBLIC SAFETY, COMMITTEE ON COURTS AND LEGAL SERVICES, AND COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITY, ALCOHOLISM, DRUG ABUSE, AND DISABILITY SERVICES

PRESENTED BY:

DINAH LUCK
SENIOR STAFF ATTORNEY
MFY LEGAL SERVICES, INC.

May 12, 2015

I. Introduction

MFY Legal Services, Inc. ("MFY") envisions a society in which no one is denied justice because he or she cannot afford an attorney. To make this vision a reality, for over 50 years MFY has provided free legal assistance to residents of New York City on a wide range of civil legal issues, prioritizing services to vulnerable and under-served populations, while simultaneously working to end the root causes of inequities through impact litigation, law reform and policy advocacy. We provide advice and representation to more than 10,000 poor and working poor New Yorkers each year benefitting over 20,000 people.

The Mental Health Law Project at MFY seeks to prevent homelessness, stabilize income, support employment, and promote recovery for adults living with mental illness in the five boroughs of New York City. Since 1983, the Mental Health Law Project has received support from the NYC Department of Health & Mental Hygiene, and our attorneys work in partnership with inpatient and outpatient behavioral health providers throughout the city. The Mental Health Law Project serves more than 1,800 people with mental illness each year.

This testimony is being submitted to comment upon the Action Plan developed by the Mayor's Task Force on Behavioral Health and the Criminal Justice System. We applaud the Mayor for developing the Task Force, and we strongly support the Task Force's focus on ensuring that people with behavioral health needs 1) do not enter the criminal justice system, 2) are treated outside of a jail setting if they do enter the system, 3) if in jail, receive therapeutic rather than punitive treatment, and 4) are connected to effective services upon release.

Because both our experience and the evidence has shown that stable, affordable housing is crucial to positive outcomes for people with behavioral health needs, we will focus our comments on the impact on housing on two of the "points of contact" described in the Action Plan.

II. From Arrest to Disposition

1. Decreasing the amount of time individuals with behavioral health needs are detained increases their ability to maintain affordable housing

MFY supports the Action Plan's goal to reduce crime and unnecessary incarceration. Our experience is confirmed by the evidence, which illustrates that people with mental illness often experience an exacerbation of their symptoms when arrested and incarcerated.[1] A reduction in arrest and incarceration will result in a decrease in mental health-related symptoms.

Avoiding or reducing the time people with mental illness spend incarcerated will also help preserve housing. Just like other New Yorkers, people with mental illness live in a variety of housing, including rent-regulated apartments, NYCHA apartments, 2- and 3- family homes, and Mitchell Lama and other cooperatives. In order to maintain their housing, people with mental illness, like all other New Yorkers, must make monthly rent, maintenance, and/or mortgage

[1] Mayor's Task Force on Behavioral Health and the Criminal Justice System, *Action Plan*, 2014, fn xvii, p. 19.

payments. It goes without saying that when an individual is incarcerated – particularly someone living alone or on the margins – he is not able to pay rent or comply with any obligations of tenancy. In the City today, landlords will pounce on any interruption of rental payment to bring an eviction proceeding and generally prevail if the tenant is unable to go to Housing Court to defend himself.

For those individuals with behavioral health needs who are employed, avoiding incarceration prevents a reduction in wages or a loss of a job. Subsequently, those individuals, who through new supervised release and non-monetary bail reforms are not detained, now will be able to continue to pay their rent and maintain their housing.

For individuals with behavioral health needs who do not work, or whose employment is supplemented by public benefits, avoiding or reducing the amount of time spent incarcerated will also minimize disruptions to crucial benefits, including Medicaid, food stamps, federal disability benefits (Supplemental Security Income (SSI) and Social Security Disability), and public assistance (cash benefits and the shelter allowance). Ensuring uninterrupted access to benefits will preserve housing by maintaining the safety net supports on which many people with mental illness rely for financial and housing stability.

2. **Individuals who are homeless or lack stable, permanent housing may not be able to access pre-trial supervised release programs.**

MFY supports the use of risk assessment tools to decrease unnecessary pre-trial incarceration, but we recommend that the committees consider whether people with mental illness who are homeless or living in unstable, transient housing situations will be able to access pre-trial supervised release. People with mental illness who are homeless or in unstable housing are more likely to come in contact with the criminal justice system, and this vulnerable population may not benefit from the pre-trial reforms recommended in the Action Plan.

Specifically, the Action Plan indicates that a verifiable address and ties to community are factors that are considered when determining if someone will be eligible for a supervised release program.[2] The Action Plan also proposes implementing a supervised release program that is similar to the one the City has used successfully to reduce juvenile detention. Supervised release requires face-to-face and telephone contacts and the connection to substance abuse and mental health treatment.[3] People with mental illness who do not have stable housing are likely to be either found ineligible for supervised release or struggle to comply with the regular contacts and treatment requirements.

The Action Plan must ensure that people with mental illness who are homeless have meaningful access to pre-trial supervised release programs.

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[2] Mayor's Task Force on Behavioral Health and the Criminal Justice System, *Action Plan*, 2014, fn xii.
[3] Id. at 10.

III. Back in the Community

1. The City has a severe lack of housing available for people with behavioral health needs

People with disabilities are more than twice as likely to live in poverty than people without disabilities. In New York, the poverty rate for people with disabilities is 28.6%.[4] Many New Yorkers with disabilities rely on public assistance or Supplemental Security Income (SSI) for financial support. Public assistance provides only a $215 monthly allowance for shelter, an amount that has not increased since 1990 and is grossly inadequate.[5] SSI beneficiaries receive $820 monthly, which includes an $87 supplement paid by New York State.[6] A 2012 report found that an SSI recipient in the New York City area would have to pay 152% of her income for the average efficiency apartment.[7] People with disabilities are employed at lower rates than other New Yorkers, but even full time work at minimum wage only pays approximately $1,400 monthly. With rents increasing faster than wages, many people with disabilities, even those who are employed, simply cannot afford New York City rents.[8]

2. The City must increase the amount of housing available to people with mental illness and other behavioral health needs

While the Action Plan mentions housing in the "Back in the Community" section, the lack of affordable housing for people with mental illness in New York City is a pervasive problem that affects all stages of a person's interaction with the criminal justice system. Studies of the Housing First model, in which people are provided with housing without barriers or restrictions such as requiring active engagement in substance abuse or mental health treatment, have shown that the model provides benefits that far exceed simply a place to live. People with mental illness who are in Housing First programs have reduced medical and psychiatric costs, reduced shelter stays, and reduced interactions with the criminal justice system.[9] People with mental illness who are in permanent housing are also less likely to be evicted because they can work or maintain their benefits.

The lack of safe, affordable options for very low income single adults has led to an underground cottage industry of unlicensed housing in New York City, a phenomenon documented by a

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[4] Press Release, Gov. Andrew M. Cuomo, *Governor Cuomo Signs Executive Order Establishing Commission to Create Employment First Policy for New York* (September 17, 2014) available at http://www.governor.ny.gov/news/governor-cuomo-signs-executive-order-establishing-commission-create-employment-first-policy-new.

[5] *Jiggetts v. Grinker*, 75 N.Y.2d 411, 416 (1990).

[6] New York State Office of Temporary and Disability Assistance, *SSI and SSP Benefit Levels Chart effective January 1, 2015* (October 30, 2014) available at http://otda.ny.gov/policy/directives/2014/INF/14-INF-12-Attachment-1.pdf.

[7] Technical Assistance Collaborative Inc., *Priced Out in 2012: The Housing Crisis for People with Disabilities* (May 2013), p. 30.

[8] Mayor Bill de Blasio, *Housing New York: A Five-Borough, Ten-Year Plan.*

[9] Julian Somers et al., *Housing First Reduces Re-Offending Among Formerly Homeless Adults with Mental Disorders: A Randomized Controlled Trial*, PLOS ONE (September 2013); United States Interagency Council on Homelessness, *Frequent Users Systems Engagement (FUSE)*, available at http://usich.gov/usich_resources/solutions/explore/frequent_users_systems_engagement_fuse.

recent study by the Prisoner Reentry Institute at John Jay College of Criminal Justice.[10] These so-called "three quarter houses" are usually small buildings that hold themselves out as transitional residences that will assist individuals coming out of prisons and jail and substance abuse programs as they work to rebuild their lives.[11] The houses are one of the few options available for thousands of single adults who rely on the $215 HRA shelter allowance to pay for their housing. The houses tend to be drastically overcrowded, with multiple housing code violations.[12] The houses are rife with harassment and abuse, including illegal lockouts and mandated substance abuse treatment programs even for residents who do not need treatment.[13] There appears to be a financial relationship between the houses and the outpatient treatment programs, which bill Medicaid. A tenant who fails to attend a program or who successfully completes it is unlawfully evicted with no notice and no court process, enabling the house to bring in a new Medicaid-eligible tenant.[14] This revolving door creates instability and disruption in the lives of individuals attempting to rebuild their lives following incarceration, substance abuse treatment and homelessness.

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[10] Prisoner Reentry Institute, John Jay College of Criminal Justice, *Three Quarter Houses: The View from the Inside* (hereinafter "PRI Report") 5-6 (October 2013), *available at* http://johnjayresearch.org/pri/files/2013/10/PRI-TQH-Report.pdf. For background on policies that fed the growth of three quarter houses, *see* Coalition for the Homeless, *Warehousing the Homeless: The Rising Use of Illegal Boarding Houses to Shelter Homeless New Yorkers* (hereinafter "Warehousing the Homeless") 5-7 (January 2008), *available at* http://coalhome.3cdn.net/ddc8dd543ded03ff12_lpm6bh1cr.pdf.

[11] Id. Seventy-two percent of the respondents in the PRI Report were formerly incarcerated, 51% had previously been in residential substance abuse treatment, and 19% percent were currently on parole. For accounts of the dominant role of three quarter houses in housing individuals being released from incarceration, *see also* Coalition for Women Prisoners, *A Place to Call My Own: Women and the Search for Housing after Incarceration, Introduction* (2013*), available at* http://www.correctionalassociation.org/wp-content/uploads/2013/10/CA-AP2CMO-FINAL-print-ready-August-8-2013.pdf; Lisa Riordan Seville and Graham Kates, *A Home of Their Own*, THE CRIME REPORT (hereinafter "A Home of Their Own"), available at: http://www.thecrimereport.org/news/inside-criminal-justice/2013-07-a-home-of-their-own (noting that New York State Department of Corrections and Community Supervision (DOCCS) records showed that 425 parolees were being housed in sober houses operated by one particular entity); Patrick Arden, *Deep Concerns About 'Three-Quarter' Housing*, CITY LIMITS, March 7, 2012 (hereinafter "Deep Concerns") *available at* http://bkbureau.org/2012/03/07/deep-concerns-about-three-quarter-housing/(quoting a DOCCS spokesperson's statement that the agency approves three quarter house placements before release).

[12] PRI Report *supra* note 1 at 6-7, citing an analysis by the Furman Center for Real Estate and Urban Policy, finding that of 317 known three quarter house addresses, 88% had a building code complaint between 2005 and 2012 that resulted in at least one violation or stop-work order by the New York City Department of Buildings.

[13] Jake Bernstein, *Inside a New York Drug Clinic, Allegations of Kickbacks and Shoddy Care*, ProPublica (September 9, 2013) (detailing complaints by former staff at an outpatient program of payments to a three quarter house operator); PRI report *supra* note 1 at 25-26; *Davidson v. House of Hope*, 19600/12, N.Y.L.J. 1202579307267 (Kings Cty. Civ. Ct. 2012); *Gregory v. Crespo*, 801290/2012, N.Y.L.J. 120254557895 (Civ. Ct., Bx. Cty. 2012).

[14] Jake Bernstein, *Inside a New York Drug Clinic, Allegations of Kickbacks and Shoddy Care*, ProPublica (September 9, 2013) (detailing complaints by former staff at an outpatient program of payments to a three quarter house operator); PRI report *supra* note 1 at 25-26; *Davidson v. House of Hope*, 19600/12, N.Y.L.J. 1202579307267 (Kings Cty. Civ. Ct. 2012); *Gregory v. Crespo*, 801290/2012, N.Y.L.J. 120254557895 (Civ. Ct., Bx. Cty. 2012).

IV. Recommendations

The Action Plan created by the Mayor's Task Force on Behavioral Health and the Criminal Justice System marks progress for New York City. MFY makes the following recommendations to improve the Action Plan.

- Analyze the risk assessments used to evaluate eligibility for pre-trial release to ensure that individuals who are homeless or lack stable, permanent housing are able to access supervised release programs.

- Create a specialized rent subsidy through the Human Resources Administration for people with mental illness, similar to the FEPS and HASA subsidies. The current $215 shelter allowance for single adults cannot pay for safe, permanent housing anywhere in New York City and contributes to the instability of this population.

- Lobby the state for an across-the-board increase in the Public Assistance shelter allowance. The public assistance shelter allowance must be raised. For a single adult, public assistance pays only $215 per month, making it impossible for recipients to find safe, legal housing. While housing costs increase annually, the shelter allowance has not increased in 26 years.

- Lobby the state to increase the state supplement to SSI to increase the monthly income of people with mental illness who rely on SSI as their sole or primary source of financial stability.

- Lobby the state for increased commitments to build supportive housing as part of the NY/NY 4 agreement.

- Make supportive housing more accessible. In order to access supportive housing, individuals must meet the definition of "chronically homeless," which requires the individual to spend a full year on the street or in shelter or have four documented episodes of homelessness in the past three years. This required showing of "chronic homelessness" doesn't include time spent in City or State facilities or unstable housing such as three quarter houses, and thus, doesn't capture high need individuals who have been cycling between homelessness and incarceration or unstable housing for years.

- Lift the ban on new SRO construction. Single room occupancy ("SRO") housing provides fundamental housing of last resort for very low-income adults. The current law prevents the legalization of rooming house arrangements and the construction of new units, contributing to the dearth of housing for single adults in New York City. As a result, New York City has been unable to replenish the more than 150,000 SRO units lost since 1950.

V. Conclusion

MFY Legal Services strongly supports the Action Plan and the Mayor and the City Council's commitment to addressing the crisis facing people with mental illness and other behavioral health needs who interact with the criminal justice system. Housing is not only closely intertwined with criminal justice issues, it is the central foundation on which stability and recovery are built. Therefore, MFY encourages the Mayor and the Council to increase the housing options available for people with mental illness and other behavioral health needs. The benefits to this vulnerable population and to the City will be significant.

JUSTICE COMMITTEE

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Testimony of Yul-san Liem
On Behalf of the Justice Committee

Submitted for Hearing on Behavioral Health and the Criminal Justice System
May 12, 2015

My name is Yul-san Liem. I am a Co-Director of the Justice Committee, a community-based organization that serves poor and low-income Latino/as and other New Yorkers of color who are impacted by the NYPD's discriminatory and abusive practices and policies. We focus much of our working on supporting families who have lost loved ones to the police. We also organize teams of neighborhood residents to monitor police misconduct, educate 100s on their rights every year, and are a leading organization of Communities United for Police Reform.

My testimony today will focus on the NYPD's treatment of New Yorkers with psychological/cognitive disabilities and those who are in distressed, often referred to as emotionally disturbed persons, or EDPs.

I'm going to begin by telling you about Iman Morales, a 35-year old Puerto Rican man. I never knew Iman, but gained a glimpse of who he was through the stories of his family members, with whom the Justice Committee has worked for many years.

Iman was a loving son, who helped his low-income mother secure a beautiful apartment on Roosevelt Island. He was a caring brother, who helped his younger siblings with school and job applications. He was a good neighbor, who brought food to a homeless man who slept on his stoop. He was a human being, who on a daily basis struggled with and overcame the challenges of his mental illness.

On Nov. 24, 2008 Iman began having a negative reaction to new medication. His mother, like Mohamed Bah's mother and Shereese Francis' sister, wanted to get him help and called 911. As with Mohamed Bah and Shereese Francis, when the NYPD responded to the call, rather than offering assistance, they dealt with Iman aggressively, as if he was a criminal, or worse, an animal. Eventually, Iman fled out his window onto the awning of the storefront below. Against NYPD protocol, which calls for the use of air bags when tasering someone who is elevated, Officer Nicholas Marchesona tasered Iman. He was immediately immobilized, fell to the ground, landing on his head and died. Marchesona was not held accountable in any way and was, in fact, promoted soon after.

- Luis Baez (killed in 1979)
- Eleanor Bumpers (killed in 1984)
- Gideon Busch (killed in 1999)
- Khiel Coppins (killed in 2007)
- Sheerese Francis (killed in 2012)
- Mohamed Bah (killed in 2012)
- Rexford Dasrath (killed in 2013)

These are all names of human beings who, like Iman, needed care. Instead they received hostility and aggression from the NYPD, ultimately resulting in their deaths. In none of these cases were the officers responsible held accountable by the criminal justice system.

Addressing the NYPD use of excessive – and too often deadly – force should be an overall priority for the City Council and particular attention should be paid to the department's long history of disrespect and blatant dehumanization of those with disabilities and those who are in distress.

To address this problem, we must treat emotional and mental health concerns correctly. Those with disabilities or who are in distress are human beings who need care and assistance and should be treated as such. Disability should not be criminalized. It is extremely problematic to assume that the NYPD – with its tendency to shoot first and ask questions later – will respond appropriately in situations involving emotionally disturbed persons. For this reason, the Justice Committee supports the use of Crisis Intervention Teams comprised of trained medical and mental health professionals as first responders to such incidents. These teams should make use of de-escalation techniques and should not rely on the use of weapons, including those sometimes referred to as "non-lethal," such as tasers.

There must also be accountability for police misconduct and abuse, particularly when its targets have increased vulnerability, as is the case with emotionally disturbed persons. Time and time again we see officers who have killed or brutalized community members remain on the force collecting a paycheck. At best, discipline includes a slap on the wrist – lost vacation days or a reprimand. In many cases, there is no discipline of officers at all.

Lack of accountability contributes to a culture within the NYPD that allows officers to act as though they are above the law. This means that for some New Yorkers – low-income people of color as well as EDPs (particularly if they are people of color) – the presence of NYPD officers does not mean greater safety. It means danger.

Internally, the Department must develop a comprehensive accountability system that includes clear consequences in NYPD disciplinary procedures for officers who utilize unjustified excessive or deadly force and for those who break protocol, especially when interacting with emotionally disturbed persons.

Within the broader criminal justice system, to rectify the systemic conflict of interest District Attorneys have when prosecuting officers, we need a special prosecutor who can handle deadly force cases. For this reason, we're asking the City Council to support families who have lost loved ones to the police in their call for the Governor to issue an executive order for a special prosecutor for all police killings.

Testimony of Hawa Bah, Mother of Mohamed Bah

For May 12, 2015 Hearing on Behavioral Health and the Criminal Justice System

My name is Hawa Bah. I am the mother of Mohamed Bah, a son who gave me great pride. He was a student at ~~Manhattan~~ Bronx Community College who had never committed a crime in his life. NYPD officers took him from me on Sept. 25, 2012.

Mohamed was sick and I knew he needed help. I called 911 to get an ambulance to take him to the hospital. The police came instead. Instead of helping him, they treated him like a criminal.

The police knew Mohamed was in distress and not well when they responded to the call. People who are trained to offer care and assistance in this kind of situation should have come and calmly addressed my son. Instead, the police violently escalated the situation. They should have allowed me to speak with my son and help get him to open his apartment door. Instead, they refused my help, broke down the door and shot Mohamed to death.

There was a grand jury, but no indictment. None of the officers responsible for my son's death have been held accountable.

As you know, the senseless death of my son is not an isolated incident. There are far too many other mothers and family members who have lost loved ones and there is almost never any accountability or justice.

That is why I am here today. I do not want any more families to go through the pain I feel. We need change now. This is a matter of life and death for Black and Brown New Yorkers.

Our families deserve fairness and justice. However, there is a conflict of interest when District Attorneys prosecute our loved ones' cases, because the DAs work with the police everyday. We need someone who is independent of local police departments and local politics to investigate and prosecute these cases.

Mothers and other family members who have lost loved ones are coming together because we don't want anyone else to suffer in the way we have had to. Families from across the state are asking Governor Cuomo to sign an executive order to establish a special prosecutor for all cases of police killings. I ask the New York City Council to support the families' call and urge the Governor to take action.

There is another pressing need my son's story brings to light: The NYPD's failure to institute policies and practices aimed at helping people in distress and emotionally disturbed persons, or EDPs.

This failure is well documented. The NYPD shooting of Eleanor Bumpurs in 1984 is one example. The killing of Gidone Busch in 1999 is another.

In 2007, the NYPD killed Khiel Coppin in a hail of 20 bullets. Earlier in the day, Khiel's mother had called 911 to get him help. Officers said they thought he had a gun, but he was only holding a hairbrush.

In 2008, against NYPD protocol, police tasered Iman Morales while he was standing on an awning 10 feet off the ground, without an airbag below. He fell to his death.

In 2012 officers suffocated Shereese Francis on her bed in an effort to subdue her.

In 2013 officers shot and killed Rexford Dasrath in front of his home.

In all of these cases, the victims needed help and deserved to be treated with care. Instead NYPD officers treated them as criminals and escalated the situations until they became fatal.

These tragedies point to the desperate need for adequate police policies and training for situations involving EDPs. The NYPD policy does not currently require mental health professionals to be sent to incidents involving EDPs.

Many other police departments are using a model that relies on Crisis Intervention Teams (CITs). CITs include officers who have undergone special training and local mental health providers, in order to ensure responses to incidents with EDPs are appropriate. As of now that NYPD still has not adopted this model.

What happened to my son can be prevented in the future, but we need our elected officials to be courageous and enact real, systemic changes. This is why I am urging you to support the families' call for an executive order for a special prosecutor and support the call for the NYPD to adopt the CIT model for use in cases involving EDPs.

Callous and Cruel

MAY 12, 2015

Callous and Cruel

Use of Force against Inmates with Mental Disabilities in US Jails and Prisons

Summary

Key Recommendations

Methodology

A Note on Terminology

I. Background

Disproportionate Representation of Individuals with Mental Disabilities in Jails and Prisons

Mental Disabilities

II. Life Behind Bars for Persons with Mental Disabilities

Neglect

Inadequate Mental Health Treatment

Rule-Breaking by Prisoners with Mental Disabilities

Institutional Responses to Rule Breaking

Disciplinary Systems

Solitary Confinement

The Case of Jermaine Padilla

III. Approaches to Use of Force

Prison and Jail Policy and Practice

Special Policies for Inmates with Mental Disabilities

Putting Policies into Practice

Mental Health Training for Staff

Collaboration between Custody Staff and Mental Health Staff

IV. Types of Force Used and their Harms for Prisoners with Mental Disabilities

Physical Force & Cell Extractions

Harm from Physical Force

Chemical Agents

Harm from Chemical Agents

Electronic Stun Devices

Harm from Stun Devices

Full Body Restraints

Summary

Across the United States, staff working in jails and prisons have used unnecessary, excessive, and even malicious force on prisoners with mental disabilities such as schizophrenia and bipolar disorder.

Corrections officials at times needlessly and punitively deluge them with chemical sprays; shock them with electric stun devices; strap them to chairs and beds for days on end; break their jaws, noses, ribs; or leave them with lacerations, second degree burns, deep bruises, and damaged internal organs. The violence can traumatize already vulnerable men and women, aggravating their symptoms and making future mental health treatment more difficult. In some cases, including several documented in this report, the use of force has caused or contributed to prisoners' deaths.

Prisons can be dangerous places, and staff are authorized to use force to protect safety and security. But under the US constitution and international human rights law, force against any prisoner (with mental disabilities or not) may be used only when—and to the extent—necessary as a last resort, and never as punishment.

As detailed in this report, staff at times have responded with violence when prisoners engage in behavior that is symptomatic of their mental health problems, even if it is minor and non-threatening misconduct such as urinating on the floor, using profane language, or banging on a cell door. They have used such force in the absence of any emergency, and without first making serious attempts to secure the inmate's compliance through other means. Force is also used when there is an immediate security need to control the inmate, but the amount of force used is excessive to the need, or continues after the inmate has been brought under control. When used in these ways, force constitutes abuse that cannot be squared with the fundamental human rights prohibition against torture or other cruel, inhuman, or degrading treatment or punishment. Unwarranted force also reflects the failure of correctional authorities to accommodate the needs of persons with mental disabilities.

There is no national data on the prevalence of staff use of force in the more than 5,000 jails and prisons in the United States. Experts consulted for this report say that the misuse of force against prisoners with mental health problems is widespread and may be increasing. Among the reasons they cite are deficient mental health treatment in corrections facilities, inadequate policies to protect prisoners from unnecessary force, insufficient staff training and supervision, a lack of accountability for the misuse of force, and poor leadership.

It is well known that US prisons and jails have taken on the role of mental health facilities. This new role for them reflects, to a great extent, the limited availability of community-based outpatient and residential mental health programs and resources, and the lack of alternatives to incarceration for men and women with mental disabilities who have engaged in minor offenses.

According to one recent estimate, correctional facilities confine at least 360,000 men and women with serious conditions such as schizophrenia, bipolar disorder, and major depression. In a federal survey, 15 percent of state prisoners and 24 percent of jail inmates acknowledged symptoms of psychosis such as hallucinations or delusions.

What is less well known is that persons with mental disabilities who are behind bars are at heightened risk of physical mistreatment by staff. This report is the first examination of the use of force against inmates with mental disabilities in jails and prisons across the United States. It identifies policies and practices that lead to unwarranted force and includes recommendations for changes to end it.

Mental Disability and Misconduct

Most jails and prisons are bleak and stressful places in which few prisoners are able to engage in productive, meaningful activities. Staff seek to ensure institutional safety and smooth operations through regimentation, control, and an insistence—backed up by discipline and force—on unquestioned, immediate prisoner obedience to rules and orders. Prison is challenging for everyone, but prisoners with mental disabilities may struggle more than others to adjust to the extraordinary stresses of incarceration, to follow the rules governing every aspect of life, and to respond promptly to staff orders. In the trenchant words of Professor Hans Toch, people with mental health problems behind bars can be "disturbed and disruptive," "very troubled and extremely troublesome."[1]

Prisoners with mental disabilities misbehave and are sanctioned for disciplinary infractions at higher rates than other prisoners. Nationwide, among state prisoners, 58 percent of those who had a mental health problem had been charged with rule violations, compared to 43 percent of those without such problems. [2] In New York City, for example, inmates with mental health problems represent 40 percent of the jail population but are involved in 60 percent of all incidents of misconduct. [3]

Some prisoners with mental health conditions engage in symptomatic behavior that corrections staff find annoying, frightening, and provocative, or which, in some cases, can be dangerous. For example, they may refuse to follow orders to sit down, to come out of a cell, to stop screaming, to change their clothes, to take a shower, or to return a food tray. They may smear feces on themselves or engage in serious self-injury—slicing their arms, necks, bodies; swallowing razor blades, inserting pencils, paper clips, or other objects into their penises. Sometimes prisoners refuse to follow orders because hallucinations and delusions have impaired their connection with reality. An inmate may resist being taken from his cell because, for example, he thinks the officers want to harvest his organs or because she cannot distinguish the officer's commands from what other voices in her head are telling her.

Correctional officers and jail deputies (also referred to as "security staff" or "custody staff" in this report) are rarely taught how to recognize the symptoms of mental illness and to understand how they can affect behavior. Custody staff are also rarely trained in and required to use verbal de-escalation techniques or to seek the intervention of mental health staff before resorting to force against inmates with mental disabilities. Force can be the staff response to misconduct even when it is symptomatic of a mental health condition, even when that condition prevents the prisoner from being able to comply with staff orders, and even when skilled verbal interventions might obviate the need for force.

Mental Health Services

Many prisoners with mental disabilities are not receiving mental health treatment that could promote recovery, ameliorate distressing symptoms, and increase their skills and coping strategies to better handle the demands of life behind bars as well as, once they are released, life in the community. Deficiencies in correctional mental health services are pervasive across the country. Because of funding shortages and lack of political support, corrections agencies lack sufficient numbers of properly qualified mental health professionals.

Inmates are often not properly diagnosed, do not have timely access to mental health professionals, and do not receive care based on individualized treatment plans. Treatment is often limited to medication and typically does not include other effective therapeutic mental health interventions and psychiatric rehabilitation programs. In the absence of robust mental health services, some corrections agencies use solitary confinement and force as the default response to the behavioral symptoms of mental illness.

Inmates diagnosed with mental illness are disproportionately represented in the isolation units to which prison officials send their more difficult inmates. The harsh conditions of being held alone in a cell 23 hours or more a day with little or nothing to do, coupled with the paucity of mental health treatment characteristic of such units, can lead to an increase in symptoms, more episodes of psychosis, and further misconduct. Experts say that use of force is more common in solitary confinement units than elsewhere in correctional facilities.

Use of Force Policy and Practice

Prison and jail staff interact with prisoners on a daily basis and around the clock. Some respond professionally and even with compassion and sensitivity to prisoners who have mental health problems, including when they are behaving erratically or breaking the rules. They may try to calm an agitated prisoner locked in his cell or give him time to "cool down." They refrain from force unless there is no alternative.

Such responses, however, are unlikely absent carefully constructed and effective use of force policies, training programs, and supervisory and accountability systems. Even when policies clearly limit the use of force to situations in which serious danger is imminent or a significant disruption must be addressed, staff may turn much too quickly to force, use more than is needed, or use it for punitive purposes. As evidenced in recent class-action litigation challenging the constitutionality of excessive use of force against prisoners with mental illness and Department of Justice investigations, patterns of unwarranted and abusive force, including against prisoners with mental health problems, arise from serious deficiencies in use of force policy and practice. Experts consulted for this report believe such deficiencies are widespread.

In jails and prisons across the country officials fail to ensure one or more of the following: sound and comprehensive use of force policies; effective training for and supervision of staff on the proper use of force; special provisions to protect prisoners with mental disabilities from unnecessary force; strict compliance with reporting policies; effective supervisory review of all use of force reports; thorough investigations of questionable use of force incidents; and meaningful disciplinary measures for

staff who violate policies and procedures.

Abuse Is Not Inevitable

Corrections facilities differ significantly in their conditions of confinement and the degree to which inmates are treated with respect. The misuse of force is more likely in facilities that are overcrowded, have abysmal physical conditions, and lack educational, rehabilitative, and vocational programs for inmate. Force is also more likely where custody staff are too few in number relative to the number of prisoners, are poorly paid, are poorly trained in inter-personal skills and conflict resolution, or are poorly supervised.

In some facilities—for example the New York City jail on Rikers Island—a culture of violence has taken hold and persisted for decades. Staff have used force to assert their power and to punish prisoners who displeased, provoked, or annoyed them, and they have done so with impunity. The malicious infliction of pain became an affirmative strategy of control. In such facilities, even if senior officials did not condone the abuse, they took few steps to end it. They abdicated their responsibility to enforce use of force policies and to hold accountable staff who violate them.

Our research leaves no doubt that unwarranted or malicious use of force against men and women with mental disabilities is more prevalent in more violent facilities in which all prisoners are at heightened risk of abuse. It is more prevalent in facilities which rely on force instead of mental health treatment to respond to rule-violating behavior that is symptomatic of a clinical condition. And it is more prevalent in poorly managed facilities: a badly run jail or prison will almost always have more instances of force against inmates, including those with mental disabilities, than one which is well-run.

An isolated instance of unnecessary force can occur in any correctional facility. But when corrections officials fail to establish and enforce a commitment to minimize the use of force, patterns of abuse can emerge. Good use of force policies in and of themselves are not enough to prevent such abuse. Effective leadership is required to ensure policies are reflected in practice. Leadership is essential in any institution, but is particularly important in jails and prisons because they are operated as hierarchical organizations subject to a quasi-militaristic chain of command and there is little external pressure for the humane treatment of prisoners. Without leadership determined to minimize the use of force and to promote prisoner well-being, the best use of force policies can be a dead letter.

Litigation cannot be counted on to ensure appropriate use of force policies and practices. When individual prisoners sue corrections agencies because of staff abuse, they typically seek monetary damages or protection for themselves as individuals and not facility-wide remedies that would require agencies to change their policies and practices. While a class action case may result in court ordered or court-approved protections for prisoners, such cases are enormously expensive, time-consuming, and rare. Moreover, even when the plaintiffs in a class action prevail or secure a desirable settlement agreement, it may take years and even decades before the mandated changes are fully implemented.

In addition to private litigation, the Department of Justice can also mount investigations and bring cases to protect prisoners from abuse. Pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997a, the Special Litigation Section of the Civil Rights Division of the US Department of Justice (Special Litigation Section) reviews conditions and practices in facilities, including but not limited to jails and prisons, in which people are institutionalized. It uses expert consultants to undertake comprehensive investigations, including onsite inspections, document reviews, and interviews with officials and prisoners. According to the Department of Justice website, if there are systematic civil rights violations, "we may send the state or local government a letter that describes the problems and that says what steps they must take to fix them. We will try to reach an agreement with the state or local government on how to fix the problems. If we cannot agree, then the Attorney General may file a lawsuit in federal court."[4]

The Department of Justice currently has 30 pending CRIPA matters involving practices in state or local correctional facilities (almost all of the cases address a single facility), some but not all of which involve the use of force. Important as the work of the Special Litigation Section is, it does not have the resources to address rights violations in even a tiny fraction of the thousands of local jails and state prisons in the country.

While private litigation and the Department of Justice have important roles to play to protect US prisoners, it is ultimately the responsibility of public officials to ensure that the men and women they confine, including those with mental disabilities, are treated humanely and with respect for their fundamental human rights. And it is the responsibility of elected officials to ensure that corrections agencies have the resources and political support they need to fulfill that mandate. The evidence marshaled in this report suggests that those responsibilities are too often ignored: prisoners with mental disabilities continue to suffer grievously and unnecessarily from the unwarranted and punitive use of force.

Key Recommendations

At the end of this report we provide detailed recommendations. In brief, we urge federal, state, and local executive branch and legislative officials to:

1. Enact the Comprehensive Justice and Mental Health Act of 2015 in the U.S. Senate and House of Representatives (S. 993 in the Senate, HR 1854 in the House), and similar state and local legislation to increase collaboration among the criminal justice, juvenile justice, mental health treatment, and substance abuse systems. Such legislation should also support and authorize funding for programs and strategies to ensure appropriate interventions for persons with mental health problems at every stage of the criminal justice system.
2. Reduce the number of persons confined in prisons and jails who have mental disabilities including by increasing the availability of community mental health resources and access to criminal justice diversion programs.
3. Improve conditions in prisons and jails to provide all inmates with more humane and safe conditions of confinement.
4. End solitary confinement for persons with mental disabilities confined in jails and prisons.
5. Improve mental health services in prisons and jails by ensuring that there are sufficient numbers of qualified mental health professionals, adequate treatment resources, and levels of care that meet community standards.
6. Ensure that prisons and jails have sound use of force policies that are enforced through training, supervision, reviews, investigations, and holding staff

accountable for violating the policies. Use of force policies should include provisions specifically addressing the unique needs and vulnerabilities of prisoners with mental disabilities.

7. Ensure that corrections agencies are led by officials committed to operating safe facilities in which all inmates, including those with mental disabilities, are treated with respect and in which unnecessary, excessive, or punitive use of force is not tolerated.

Methodology

This report is based primarily on Human Rights Watch interviews, filings and judgments from recent court cases from across the United States and reports of investigations or complaints filed by the Special Litigation Section of the Civil Rights Division of the Department of Justice.

Beginning in March, 2014, we conducted interviews in person, by telephone, and by email with more than 125 current and former prison and jail officials, current and former correctional mental health professionals, use of force and mental health experts, lawyers, disability rights advocates and academics with relevant expertise. Many of the people we interviewed have firsthand knowledge of conditions in a large number of jurisdictions because they have served as monitors or experts in many federal, state and local facilities and agencies. Some of our interviews occurred during visits in July 2014 to the Washington State Department of Corrections headquarters and one of its prisons and to the Ada county jail in Boise Idaho.

The interviews provided invaluable information and insights into the nature, causes, and consequences of the use of force against prisoners with mental disabilities, and illuminated the difficult set of interrelated problems that play out in jails and prisons across the country. They also pointed toward necessary components of reform.

This report also draws on detailed information about the use of force against particular individuals or classes of individuals and about facility- or agency-wide use of force policies and practices that are revealed in documents filed and evidence presented during litigation. We reviewed thousands of pages of pleadings by plaintiffs and defendants, and evidence they have submitted to the courts (for example, deposition transcripts and expert reports), hearing transcripts, court decisions, and settlement agreements from recent cases. We present information from some of those cases to demonstrate the nature of the problems that our research suggests exist in many facilities across the country. The documents filed in federal cases to which we refer are publicly available on Public Access to Court Electronic Records (PACER), an electronic public access service that allows users to obtain case and docket information online (https://www.pacer.gov).

The report also draws on facts documented by the Special Litigation Section in recent investigations into patterns and practices of unnecessary, excessive, or malicious use of force in state prisons and local jails. The findings of and complaints filed by the Special Litigation Section are publically available on the Department of Justice website, http://www.justice.gov/crt/about/spl/findsettle.php.

Prisons and jails do not operate transparently. Most corrections agencies surround their operations with a wall of silence and, citing prisoners' privacy interests, refuse to discuss incidents involving individual prisoners. Information from court cases and detailed investigations by the Special Litigation Section offer invaluable descriptions and analyses of individual incidents and more widespread practices that would otherwise remain hidden to the public.

A Note on Terminology

Although the term mental disability can embrace a wide range of conditions, including cognitive disabilities, in this report we use it solely to refer to mental health conditions such as bipolar disorder, schizophrenia, and depression that may cause intense distress, be accompanied by psychosis, or substantially interfere with or limit one or more major life activities.

The Convention on the Rights of Persons with Disabilities recognizes that disability is an evolving concept and that it results from the interaction between persons with impairments and social, cultural, attitudinal and environmental barriers that prevent their full and effective participation in society on an equal basis with others. The mental impairments that can lead to mental disabilities include psychological conditions commonly referred to in the United States—particularly by mental health professionals, courts, lawyers, corrections officials and the media—as mental illness or mental disorders. International disability rights advocates increasingly use the term "psycho-social disability" to emphasize that the disability reflects the interaction between an individual' s psychological characteristics and society's response to them.

I. Background

> We have replaced the hospital bed with the jail cell, the homeless shelter and the coffin.
>
> —Rep. Tim Murphy, R-PA[5]

Disproportionate Representation of Individuals with Mental Disabilities in Jails and Prisons

Persons with mental disabilities are heavily and disproportionately represented in US jails and prisons. In 2003, Human Rights Watch estimated there were 300,000 men and women with mental illness in US jails and prisons.[6] The Treatment Advocacy Center recently estimated there were 356,000 persons with mental illness behind bars.[7] Jails and prisons in the United States are *de facto* mental health facilities, housing three times as many individuals with mental health problems as do state mental hospitals.[8]

An estimated 4.1 percent of adults aged 18 or older in the United States has a "serious mental illness."[9] By contrast, "studies and clinical experience indicate that somewhere between 8 and 19 percent of prisoners have significant psychiatric or functional disabilities and another 15 to 20 percent will require some form of psychiatric intervention during their incarceration."[10] In a federal survey conducted in 2011-2012, an estimated 36.6 percent of prison inmates and 43.7 percent of jail

inmates reported they had been told by a mental health professional they had a mental health disorder, and 8.9 percent of prisoners and 12.8 percent of jail inmates reported an overnight stay in a hospital or other mental health facility prior to their current incarceration.[11] In an earlier federal survey, over a third of state and jail prisoners reported major depressive or mania symptoms and approximately 24 percent of state inmates, 15 percent of federal inmates, and 24 percent of jail inmates reported symptoms of psychosis, (delusions or hallucinations).[12]

The National Commission on Correctional Health Care has estimated that on any given day "between 2.3 and 3.9 percent of inmates in State prisons are estimated to have schizophrenia or other psychotic disorder, between 13.1 and 18.6 percent major depression, and between 2.1 and 4.3 percent bipolar disorder (manic episode.)"[13] The American Psychiatric Association has estimated that up to 5 percent of prisoners are actively psychotic at any given moment.[14]

In specific correctional systems the proportion of individuals in the jail or prison population diagnosed with a mental illness or who are on the mental health caseload may range from 20 to nearly 40 percent.[15] Among jails, for example, the proportion in New York City's Rikers Island is 40 percent;[16] in Dallas County, 20 percent; [17] and in California's jails, 23 percent.[18] Among state prison systems, in Indiana the figure is 22 percent; in Iowa, 41 percent;[19] in South Carolina, 17 percent;[20] and in California, 28 percent.[21]

The reasons for the disproportionate incarceration of persons with mental disabilities include: the closure of so many public psychiatric hospitals following de-institutionalization—the movement of persons with mental illness out of the hospitals in which they had been involuntarily confined—that some communities now lack sufficient beds for voluntary inpatient treatment; the lack of sufficient community-based voluntary outpatient and residential treatment programs; aggressive policing of minor crimes, including drug crimes; and the lack of programs to divert people with mental disabilities who commit minor offenses from the criminal justice system.[22] States continue to reduce the number of mental hospital beds and cut funding for inpatient and outpatient mental health care.[23]

Unless they have significant personal or family financial resources or comprehensive health insurance policies, people with psycho-social disabilities in the United States may get little or no care.[24] Some use drugs, and end up arrested for buying or selling them.[25] Untreated or undertreated, some end up in a mental health crisis and engage in disorderly or unlawful behavior that leads to police intervention. Unless police have the skills and training to identify psychiatric crises, and have alternatives to incarceration in their jurisdiction such as access to emergency care facilities or criminal justice diversion programs, officers may simply arrest and book these individuals in jail, unaware of or ignoring the role that mental illness played in the suspects' conduct.

Mental Disabilities

People in US jails and prisons have the full range of mental health conditions present in the community. Some have mental disorders, defined by the American Psychiatric Association as "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities."[26]

In this report we use the term mental disability to refer to mental disorders or illnesses (the terms are used interchangeably in the United States) such as such as bipolar disorder, schizophrenia, and depression that may cause intense distress, be accompanied by psychosis, or substantially interfere with or limit one or more major life activities. The Convention on the Rights of persons with Disabilities (discussed at greater length in Chapter VI), which the United States has signed but not yet ratified, recognizes that disability results from the interaction between persons with impairments and the social and cultural attitudes that lead to social disadvantage, discrimination and stigma.

The ability of an individual with a mental illness to participate fully and equally in society depends on biological and genetic factors, the individual's socio-economic circumstances, the support received from family and community, access to treatment and support services, and the presence or absence of abusive, discriminatory, or marginalizing social, economic, and institutional dynamics.[27] Many of the people behind bars with mental health conditions have experienced forms of poverty, inequality, homelessness, or discrimination that no doubt have contributed to, or even decisively shaped their mental disability.[28]

In prison as in the community, the symptoms of some individuals with mental health conditions may be subtle, discernible only to clinicians. Prisoners with serious depression, for example, may appear merely withdrawn and unsociable. The conditions of others may be readily evident: they are agitated, cannot talk coherently, bite themselves aggressively, repeatedly bang their heads against walls, or call out for help against unseen persecutors. Some live in a world constructed around their delusions.

The diagnosis of a mental disorder is not the same as a decision that treatment is needed, and similarly, an individual may not meet all the criteria for a mental disorder but nonetheless may want treatment.[29] In prison as in the community, the degree of disturbance, dysfunction, and distress can vary dramatically from individual to individual, and within the same individual at different times. Some individuals with clinical conditions have periods of relative stability during which symptoms are minimal, interspersed with periods of psychiatric crisis. Some recover. Some adjust to life with their symptoms with relatively little impairment in their ability to have strong family connections and successful work. Others are profoundly impaired in their ability to undertake ordinary life activities for prolonged periods. An individual with bipolar disorder, for example, may at different times be able to live in the community and at other times may benefit from the care provided in a hospital.

II. Life Behind Bars for Persons with Mental Disabilities

Life behind bars is difficult for everyone, but it is particularly difficult for individuals with mental health problems that impair their thinking, emotional responses, impulse control, and ability to cope.

Prisoners with mental disabilities, like all prisoners, struggle to maintain their self-respect and emotional equilibrium in correctional environments commonly marked by rigid rules; the often aggressive and hostile attitudes of officers and other inmates; violence; lack of privacy; stark limitations on family and community contacts; and a paucity of opportunities for education, meaningful work, or other productive, purposeful activity.[30] Inmates with mental health conditions are more likely to be

victimized by other inmates.[31] Physical conditions in some facilities are abysmal—filthy, beastly hot or frigid, infested with vermin.[32]

As one study put it, the:

> absence of privacy adds tension and stress to the daily existence of each inmate. Inmates with serious mental illness have fewer resources with which to cope with added turmoil. Anxious, depressed, psychotic and suicidal inmates are at increased risk of deteriorating emotionally and of having impaired judgment in such settings.[33]

Many prisoners with mental health conditions are incarcerated in correctional environments and subject to rules and regimes that are, at best, counter-therapeutic, at worst, dangerous to their mental as well as physical well-being. Many inmates with mental disabilities deteriorate behind bars, their symptoms worsening, their suffering increasing.

There are competent and committed professionals working in corrections who struggle to improve the conditions of confinement for such prisoners, including providing them with medical and mental health treatment. Nevertheless, as Judge William Wayne Justice observed in a case that arose in Texas, "whether because of a lack of resources, a misconception of the reality of psychological pain, the inherent callousness of the bureaucracy, or officials' blind faith in their own policies," many officials have been insufficiently attentive to the unique needs of individuals with mental illness when they are confined in correctional facilities.[34]

Mental health professionals have little say over prison rules, even when they compromise or prevent therapeutic efforts. Indeed, mental health treatment is almost always subordinated to custodial and security concerns. Prison policies may permit practices such as solitary confinement and the use of force that directly threaten prisoners' mental health, above and beyond the toxic prison environment itself. The institutional culture within many corrections facilities is antithetical to—indeed hostile to—accommodating the needs of prisoners with mental disabilities.

Neglect

There have been shocking recent cases of staff neglect, mistreatment, and even cavalier disregard of the wellbeing of prisoners with mental health problems. In some cases, including two described below, prisoners have become gravely ill and died because staff allegedly failed to attend to their basic needs for food, water, or medical care.

Anthony McManus

Anthony McManus died in a Michigan prison shortly after his 38th birthday in September, 2005. His estate filed a lawsuit against officials and staff of the Michigan Department of Corrections. The following account of McManus' death is based on the court's ruling denying certain defendants' motions for summary judgment.

According to the court, at the time of his death McManus weighed 75 pounds, having dropped from 140 pounds in five months. A nurse observed that he looked like a concentration camp prisoner.

McManus had arrived in the Michigan prison system eight years earlier to serve a sentence for indecent exposure. Although he had a history of schizophrenia and bipolar disorder for which he had previously received treatment, he was confined in a prison which did not have a psychiatry department.

In the year preceding his death, McManus' mental health deteriorated. He became more difficult to manage and was placed in segregation. He behaved strangely, was frequently irritable, profane, and by turns up-beat or depressed. During the last six months of his life, he was constantly disruptive and noisy, was difficult to communicate with, talked about the devil, and would cover his body with food he had chewed up. He would also spread feces and urine around his cell and on himself and even mixed it with his food. Although he would not eat, he begged for food. McManus' estate asserted in the lawsuit that during the final weeks of McManus' life, officials sometimes turned off the water in his cell and restricted his access to food in order to control his behavior. The court notes that when McManus received food, he often smeared it over his cell or rolled it into little balls to keep in his pocket.

According to the court, three days before McManus died, he flooded his cell and pushed a mixture of feces, urine, and water under his door into the hallway. The unit manager who came to the cell said McManus was incoherent and "babbling." He ordered McManus to come to the door but McManus did not comply. The officer subsequently ordered McManus to remove his clothes to show he had no weapons. When McManus refused, the officer pepper sprayed him. McManus then removed his clothes and officers entered the cell and escorted him out. The officer who sprayed him observed, "What's going on with this man? He's dying." A video of the pepper spaying was introduced as evidence in the case, and the court stated that the video revealed a "very emaciated, naked individual who appears to be in great discomfort, who is verbalizing in an incoherent manner and who eventually makes repeated clear requests for water and help." During the taped footage, no one provides him with water.

Three days after the pepper spraying, on September 8, 2005, McManus was found dead in his cell. His cell floor was covered with an inch of standing water, toilet paper, feces, and other debris. The autopsy identified the causes of death as myocarditis (heart disease), emaciation, and clinical history of polysubstance abuse and mental disorder.

The court noted that while the various expert opinion reports submitted by the plaintiff regarding the care McManus received, "all generally agreed that various individuals could have done more to prevent Mr. McManus' unfortunate death, one line from an expert prison official...stands out, '[a]nimals in animals shelters are generally given more attention and better care than was afforded to McManus.'" The court also pointed out that "even the inmate across the hall, an obvious layperson...could tell that Mr. McManus was suffering," testifying in his deposition that "you could see that his eyes was [sic] turning yellow. His cheeks were sunken in, the skin on his frame was just hanging off his bones like clothes on a hanger." According to the court, the warden agreed in his deposition that it was "obvious to him" and "it should have been obvious to anyone that Mr. McManus needed medical attention." The court also noted that the internal affairs investigation by the Michigan Department of Corrections concluded that health care and custody staff failed to provide basic medical/psychological care to McManus, and this failure led to his death.

The court concludes that McManus received so little food and water that he finally succumbed to death. It states that although McManus clearly had "serious psychological issues," he was confined in a facility that "did not provide its inmates with psychiatric treatment or medications to treat mental illness" and "not a single defendant made a serious attempt to have him transferred to a facility that could treat his obvious mental illness."

Christopher Lopez

According to a lawsuit brought by his estate, Christopher Lopez was a 35-year-old man who died in a Colorado prison on March 17, 2013 because of staff negligence and mistreatment. This account of the final hours of his life comes from the complaint filed in his case and a video filmed by prison staff.[35]

Lopez had been diagnosed with schizophrenia and had been involuntarily committed a dozen times to a mental health hospital because of psychotic episodes. In 2010, he began serving a four year sentence for having kicked a correctional officer during an earlier incarceration. Because of hallucinations and delusions, Lopez was sent twice to the San Carlos Correctional Facility in Colorado, a facility operated by the Colorado Department of Corrections to provide treatment for prisoners with mental illness. His second tenure at SCCF began in May 2012 and he remained there until his death. According to the complaint in his lawsuit, he was kept isolated in his cell 22-24 hours a day. Although Lopez was given antipsychotic medication, he was placed on frequent mental health watches due to increasing suicidal thoughts and his mental health continued to deteriorate.

On March 17, 2013, at approximately 3:30 a.m., correctional officers found Lopez lying on his stomach on the floor of his cell. Lopez was barely able to lift his head in response to officer commands. Staff started a video recording of Lopez which tracked the following six hours until his death.

When Lopez continued to remain unresponsive to commands to move and to cuff up, to "show some cooperation," a cell extraction was authorized to forcibly extract Lopez from his cell and place him on "special controls" status.[36] According to the complaint, the shift commander in his use of force report described Lopez as "psychologically intimidating" because staff did not know why he was refusing orders, because of his past history, and that Lopez engaged in "passive resistance" because he "refused to acknowledge staff directives" and just lay on the floor.

The events depicted in the video are summarized below. Officers suited up in riot gear with helmets, face masks, and pads enter Lopez's cell, strip him to his underwear, place his wrists in handcuffs attached to a stomach chain, chain his ankles together, and tie him to a restraint chair. They also place a spit mask over his face. Lopez is limp, semi-conscious and breathing loudly and rapidly during this procedure. Lopez is then taken to another cell for observation. He appears to have a seizure and slumps sideways in the restraint chair. Later, officers remove Lopez from the restraint chair and placed him on the floor of the cell, still shackled in ankle restraints with handcuffs attached to a belly chain. He turns over onto his stomach, and lying prone he begins to groan intermittently and his breathing becomes even more labored.

Shortly before 8:00 a.m., a nurse gives Lopez an injection of psychotropic drugs. According to the complaint, neither she nor anyone else ever took Lopez' vital signs, performed any sort of medical assessment or took any steps to address his medical crisis. The edited video does not show any medical treatment being provided to Lopez. Just prior to 9:00 a.m., Lopez appears to have another seizure. At 9:10, he appears to stop breathing. None of the staff ostensibly watching him seemed to notice, and the video indicates they continued to talk among themselves and tell jokes. A mental health nurse arrives soon after Lopez has seemed to stop breathing, opens the food tray slot of the cell door and yells, "what are you doing," "what is going on," and "why are you acting this way." She then says, "I can see you breathing" and tells him to open his eyes. She then closes the food tray slot and begins laughing and talking with other staff in the area.

As the video shows, approximately 20 minutes after he seems to have stopped breathing, custody staff enter the cell to take him back to his cell. Only after they lift his body off the floor and place it in the restraint chair do they indicate that Lopez may not be breathing. They call for medical back-up, but it is too late.

An autopsy revealed Lopez had died of severe hyponatremia, a condition that can occur when too much psychotropic medication leads to an abnormally low level of sodium in a person's blood. It is a condition that is easily diagnosed with a blood test and easily treatable with prompt and adequate medical attention.

The lawsuit brought by Lopez' family resulted in a settlement from the Colorado Department of Corrections. The department acknowledged the settlement in a brief statement. "We wish to reiterate that Department does not condone the actions or omissions of the employees involved. Their actions were well outside of the Department's established training, policies, and practices."[37] The Department also fired three staff involved in the case, including the mental health nurse who had "talked" to Lopez after he had died, and disciplined five others.[38]

Inadequate Mental Health Treatment

"[H]aving stripped [prisoners] of virtually every means of self-protection and foreclosed their access to outside aid, [society may not look away and let] the state of nature take its course." – *Farmer v. Brennan*, 511 U.S. 825 (1994)

Mental health treatment can alleviate painful symptoms, facilitate recovery, and help prisoners with mental disabilities strengthen or develop the resilience and coping skills needed to handle incarceration and to have the lives they want once they are back in the community. The nature and the level of mental health services that are helpful to any given individual depend on the specific nature of the individual's condition, the duration and degree of functional impairment, and the amount of suffering and distress the individual experiences.[39]Mental health services not only can help improve the quality of individual prisoners' lives, but they also promote safety and order within the prison by reducing rule-breaking and decreasing the need for custody staff to use force.

Prisoners have a constitutional right to treatment for serious mental illness.[40] Depriving prisoners of needed mental health care "is incompatible with the concept of human dignity and has no place in civilized society."[41] Prisons and jails are constitutionally required to make treatment available to inmates, but the basic components of an adequate mental health system are poorly implemented or functionally non-existent in many facilities.[42] Gains that may have been made in mental health staffing, programs, and physical resources have often ended up swamped by a tsunami of prisoners with serious mental health needs.[43] Many prisoners cannot obtain mental health services and support, much less services provided in an atmosphere of empathy by qualified staff who respect their dignity.[44] Mental health interventions are often limited to medication oriented to responding to immediate crises and not tailored to the individual prisoner's needs, strengths, and goals for recovery.[45]

Impossibly large caseloads often frustrate the ability of mental health professionals to provide appropriate, individually tailored services to prisoners who want them. Mental health staff often fail to discuss with prisoners the nature, purpose, risks, and benefits of different types of treatment so that the prisoners can make informed decisions on whether or not to consent to the treatment. The effectiveness of their work is also often impeded by antagonistic relations between prisoners and custody staff which "destroy trust and create an atmosphere of fear, frustration, helplessness, and anger."[46]

Mindful of budget constraints and scant public support for investments in services beneficial to prisoners, elected officials have been reluctant to provide the funds needed to ensure that prisons and jails have mental health resources commensurate with the size of the inmate population that could benefit from them.[47] As a result,

correctional mental health services are often inadequately staffed and resourced.[48]Three recent examples follow:

- A medical expert reported that mental health care is "grossly sub-standard" with "extreme and unacceptable deficiencies in essentially every aspect of the mental health care system" in the Eastern Mississippi Correctional Facility, a prison with the ostensible mission of housing prisoners with serious mental illness.[49]
- In South Carolina, a court recently concluded that "inmates have died in the South Carolina Department of Corrections for lack of basic mental health care, and hundreds more remain substantially at risk for serious physical injury, mental decompensation, and profound, permanent mental illness." The mental health program was "inherently flawed and systematically deficient in all major areas." There were far too few psychiatrists, clinical psychologists, and counselors, and many of the counselors were not qualified. Inadequate staffing created deficiencies in screening, treatment programs, access to higher levels of care, and administration of medication.[50]
- An expert concluded that because of profoundly inadequate staffing levels at the Orleans Parish Prison in New Orleans, "[n]umerous prisoners receive no treatment whatsoever, resulting in worsening of their condition and making future treatment less likely to succeed. Failure to treat also increases acting out resulting in harm and increased risk of harm to both self and others."[51]

Adverse working conditions can leave correctional mental health staff burned out, feeling "exhausted, cynical, ineffective, and wish[ing] they could find work elsewhere. The more burned out staff become, the harder it is to be caring and conscientious."[52] Some correctional mental health staff become quick to see malingering or manipulation among prisoners and to overlook mental illness.[53]

The US Department of Justice found that in one Pennsylvania prison, there was a "disturbing tendency by many of the [prison] clinicians to describe almost all disruptive conduct as purely willful and behavioral, and to overlook the role of the prisoner's mental instability in causing the conduct. Our consultants found cases of maladaptive behavior rooted in mental instability that ... the mental health staff members incorrectly characterized as 'manipulative' or 'malingering' behavior."[54] In New Orleans' jails, mental health staff often dismissed self-harm as manipulative efforts by prisoners to change their housing assignments and failed to provide mental health services to prisoners who engaged in it.[55]

Few corrections agencies have established mental health interventions programs designed for people with personality disorders.[56] Correctional mental health staff typically provide little or no mental health services to prisoners they have diagnosed with personality disorders such as anti-personality disorder and borderline personality disorder.[57] Indeed, even though those prisoners may be deeply distressed and impaired in their ability to function, staff may dismiss their symptoms and concerns as manipulative or malingering.[58] The diagnosis of a personality disorder often reflects a character judgement under the guise of a clinical one. Faced with particularly difficult or troublesome inmates who may not respond to standard treatment protocols, clinicians may dismiss them, in essence, as "bad, not mad."[59]

Rule-Breaking by Prisoners with Mental Disabilities

> Treatment works. Mental health and custody staff need to work together. It reduces aberrant behavior, improves staff lives, improves inmates' lives.
>
> —Steve Cambra, former warden, California Department of Corrections and Rehabilitation.[60]

> Prisoners with mental health problems may act out and break rules more frequently than other prisoners, but the behavioral manifestation of their illness will decline as the quantity and quality of mental health treatment increases.
>
> —Bruce Gage, M.D. Chief of Psychiatry, Washington State Department of Corrections.[61]

Many prisoners with mental disabilities pose difficult management challenges for correctional staff. Their mental health problems can make it difficult for them to adapt to an extremely regimented life in an unsupportive, hostile and frequently violent environments.[62]Especially when not receiving appropriate mental health services, they may engage in violent or disruptive conduct, act out in ways staff consider bizarre, frightening or challenging, and engage in dangerous behavior such as self-injury or striking out at staff.[63]Persons with schizophrenia may experience prison as a particularly frightening, threatening environment and as a consequence some behave dangerously towards themselves, staff, or other prisoners.[64] Persons with bipolar disorder in a manic phase can be disruptive, quick to anger, provocative, and dangerous.[65] Some prisoners can become extremely violent. According to a detailed study by the *New York Times*, for example, Michael Megginson, a 25 year old who has been in and out a psychiatric hospitals since he was 6 and is at times severely psychotic, is one of the most violent inmates at New York City's jail on Rikers Island:

> In his 18 months there, he was constantly involved in some kind of disturbance, his records show. He fought with other inmates and officers; spit and threw urine at them; smashed windows and furniture and once stabbed an officer in the back of the head with a piece of glass.... He also repeatedly hurt himself, cutting his body all over, banging his head against walls and tying sheets and clothing around his neck in apparent suicide attempts.... He had 70 physical confrontations with officers.[66]

Prisoners with psychotic disorders such as schizophrenia may find it next-to-impossible to abide by, or even to understand, prison regulations when delusions and hallucinations distort their understanding of reality. According to correctional mental health expert Dr. Jeffrey Metzner:

> A small percentage [of prisoners] don't understand the rules. They're the ones who are psychotic. Prison rules don't mean much to someone hearing voices. A person with paranoid schizophrenia may, on a literal level, understand a rule but nevertheless view a request to abide by that rule as being part of a conspiracy directed against him. It's less of not understanding and more of acting on distortions.[67]

Use of force expert Steve J. Martin points out that some "inmates don't really understand what's going on, they don't really know what they are being asked to do. They often perceive the officers' orders as threats, as an attempt by some force to do something bad to them, so they retreat, and they refuse to comply."[68]

The available data indicates that nationwide, inmates with mental illness commit from one-and-a-half to five times more infractions (violations of the rules) than other inmates.[69] A national survey found that among state prisoners, 58 percent of those who had a mental health problem had been charged with rule violations, compared to 43 percent of those without such problems.[70] According to that survey, an estimated 24 percent of state prisoners with mental health problems had been charged with physically or verbally assaulting correctional staff or other inmates compared to 10.4 percent of state prisoners without such problems.[71]In New York City, prisoners with mental health problems in 2013 represented 38 percent of the jail population but were involved in 60 percent of all "incidents;" and the "acutely mentally ill" constituted 6 percent of the jail population but were involved in 16 percent of all misconduct incidents.[72] In one California prison, 99 percent of the rules violations were issued to inmates with mental disorders who comprised only 34 percent of the population; in another facility, 84 percent of the violations were issued to inmates with mental disorders who comprised 43 percent of the population.[73]

Institutional Responses to Rule Breaking

The assumption that prisoners make rational choices infuses the culture of corrections. If an inmate refuses to come out of his cell when ordered to do so or swears at an officer, staff are likely to assume he is deliberately breaking the rules. They also are likely to assume that failure to force the inmate to comply or to punish him for doing so would be tantamount to sanctioning defiance, would encourage others to engage in similar misconduct, and would promote a general breakdown in order. They find it difficult to understand—or to accept—the role mental illness can play in prisoners' ability to follow the rules behind bars.

Our research suggests the typical correctional response to difficult, disruptive, or dangerous behavior by prisoners with mental illness differs little from the response to any other inmate who breaks the rules—punishment, solitary confinement, and the use of force. In some facilities, these responses are the default mechanisms for responding to the inadequacies of mental health services for prisoners in the United States.

Disciplinary Systems

In many prisons and jails, custody staff issue a "ticket" to inmates for disciplinary infractions, and officers then hold a disciplinary hearing to determine the sanction to be imposed.[74] The sanctions for prisoners with mental disabilities are usually the same as those imposed on other prisoners, and typically include restrictions on visits or telephone calls for a period of time, or confinement in disciplinary segregation. These measures are usually imposed without regard to the cause of the behavior, the efficacy of the measures, or the impact of the measures on particular mental conditions.[75]

In some places, mental health professionals provide information to hearing officers about misconduct by one of their patients and may recommend that it be treated as a mental health problem and not a cause for discipline. They may also urge that sanctions be tailored to take into consideration the individual needs and vulnerabilities of the prisoner. But being able to present views is no guarantee they will be listened to.[76] The California Department of Corrections and Rehabilitation, for example, refused to divert prisoners from the disciplinary process even when their behavior— such as disobeying an order to be handcuffed—reflected psychosis rather than willful disobedience.[77] The punishment imposed on them for breaking the rules was, in effect, punishment for their illness.

An approach that more successfully accommodates mental illness is reflected in a recent agreement by the Department of Justice concerning polices at the Muscogee County Jail in Georgia, which requires that a qualified mental health professional should review disciplinary charges against inmates with serious mental illness to ensure that such illness "is used as a mitigating factor, as appropriate, when punishment is imposed and to determine whether placement into segregation is appropriate."[78] In addition, jail staff are to "consider suggestions by mental health staff for minimizing the deleterious effect of disciplinary measures on the mental health status of the inmate. Any punishment must work within the inmate's mental health treatment plan."[79]

Solitary Confinement

According to the Department of Justice, a prisoner it identified as Prisoner AA, had a mood disorder, an IQ of 66, was on the Pennsylvania Department of Corrections' mental health roster, and had been subjected to prolonged solitary confinement in Pennsylvania prisons. He attempted to hang himself after more than five months in solitary confinement. He was removed from solitary for a day and then returned for another five months, after which he again attempted to hang himself. Prisoner AA said that while in solitary he became hypersensitive to sights and sounds, became extremely depressed, and his feelings of hopelessness made him want to kill himself and act out against the guards. He also experienced visual hallucinations. For instance, he recalled sometimes seeing his deceased brother encouraging him to cut himself and to "come join me."[80]

Corrections officials across the country rely on solitary confinement—which they usually call "segregation"—to punish prisoners who have broken the rules and to isolate those whom they deem difficult, disruptive, or dangerous, regardless of whether the behavior reflects mental health problems.[81]

Because they are more likely to break the rules and more likely to develop reputations of being unable to function in the general prison population, significant proportions of prisoners with mental disabilities are held in solitary confinement.[82] Indeed, compared to other prisoners, they are disproportionately at risk of being confined in solitary. In Pennsylvania, for example, prisoners with mental illness are placed in solitary at twice the rate of other prisoners.[83] Similarly, in South Carolina, an inmate with mental illness is twice as likely to be placed in segregation as other inmates, and more than three times as likely to be assigned to security detention, the most restrictive form of segregation in that prison system.[84]

High rates of isolation of prisoners with mental illness often reflect the failure of correctional agencies to provide them with adequate mental health treatment. After an investigation that documented systemic deficiencies in the Pennsylvania Department of Corrections' mental health services, the US Department of Justice concluded that if the department were able to provide better mental health care to its prisoners, fewer would deteriorate to the point of having to be placed in isolation. "Too often, instead of providing appropriate mental health care, [the Pennsylvania Department of Correction's] response to mental illness is to warehouse vulnerable prisoners in

solitary confinement cells."[85] In South Carolina, a court concluded prisoners were placed in segregation and subjected to use of force "in lieu" of treatment.[86]

Prisoners placed in solitary either for disciplinary or administrative reasons can spend months, years, and even decades locked up 23 to 24 hours a day in small cells that frequently have solid steel doors. They live with extensive surveillance and security controls, the absence of ordinary social interaction, abnormal environmental stimuli, often only three to five hours a week of recreation alone in caged enclosures, and little, if any, educational, vocational, or other purposeful activity.[87] The stress, lack of meaningful social contact, and lack of activity in isolation can be psychologically harmful to any prisoner, with the nature and severity of the impact depending on the individual, the duration, and particular conditions.[88] But the adverse psychological effects of isolation are especially significant for persons with mental conditions characterized by psychotic symptoms and/or significant functional impairments.[89]

Prisoners are also harmed by the grossly inadequate mental health care typical in isolation units. Mental health services in such units are frequently limited to psychotropic medication, a mental health staff person periodically stopping at the cell front to ask how the prisoner is doing (often derisively called "walk-bys"), and occasional meetings in private with a clinician. Because of prison rules requiring prisoners to remain in their cells and the limited numbers of custody staff available to escort prisoners out of their cells, individual or group therapy and structured educational, recreational, and life-skill enhancing activities are usually not available.[90]

All too frequently, the deprivations of solitary confinement exacerbate symptoms of mental illness or provoke a recurrence. Prisoners with mental illness may decompensate so markedly—their symptoms may become so severe and their ability to function become so impaired—that they require crisis care or hospitalization. Many simply will not get better as long as they are isolated.[91]

According to international treaty bodies and human rights experts, including the Human Rights Committee, the Committee against Torture, and the UN special rapporteur on torture, prolonged solitary confinement may amount to torture or cruel, inhuman, or degrading treatment prohibited by international human rights treaties.[92] Because solitary confinement may severely exacerbate previously existing mental health conditions, the special rapporteur on torture believes that imposition of solitary confinement on persons with mental disabilities of any duration is cruel, inhuman, or degrading treatment.[93]

Since the ground-breaking 1995 case of *Madrid v. Gomez*, US federal courts in class action cases have consistently rejected as unconstitutionally cruel the prolonged round the clock isolation of prisoners with serious mental illness.[94] The potential for grave psychological harm has also prompted health associations to call for changes in the use and conditions of segregation for inmates with mental illness.[95] In what the Department of Justice calls "landmark restrictions on the use of solitary confinement," an agreement signed January 16, 2015 between it and the Columbus Consolidated Government of Columbus, Georgia, which operates the Muscogee County Jail in Georgia, provides that segregation "shall be presumed contraindicated" for inmates with serious mental illness. If an inmate has a "serious mental illness" or other acute mental health contraindications to segregation, that inmate shall not remain in segregation absent extraordinary and exceptional circumstances."[96]

Housing inmates with mental disabilities in isolation can be counterproductive to the goals of safety and security: as their mental health deteriorates they can become more difficult to manage.[97] Rather than ending misconduct by persons with mental disabilities, solitary confinement may prompt more. For example, according to his lawyer, Jerry Williams is a 58-year-old schizophrenic, developmentally disabled man serving a 28-year term for low level crimes who has spent more than eight years in solitary confinement in North Carolina state prisons. Because he constantly receives:

> disciplinary infractions for misbehavior related to the symptoms of his mental illness, he remains in solitary confinement year after year. Any psychological professional would be unsurprised to hear that a schizophrenic patient, locked within a small, dim, concrete box, might resort to shouting, using profane language, banging on the cell door, or throwing food and liquid. Yet, when Jerry does so, he is consistently disciplined with yet new extended terms of solitary confinement.[98]

Since isolation can have the perverse effect of making inmates with mental disabilities more likely to engage in rule violations, it also increases the likelihood of staff use of force. Indeed, the use of force may be more common in isolation units than elsewhere in correctional facilities.[99] As summarized by correctional expert Steve J. Martin, when a prisoner with a mental disability is placed in solitary confinement, "you have placed that offender in a situation in which he simply cannot cope on a daily basis without decompensating, without struggling more and more, which again leads to efforts to manage the offender with force."[100]

As part of the 2012 settlement ending five years of litigation, the Massachusetts Department of Correction agreed to maintain two maximum security mental health treatment units as alternatives to segregation.[101] One of the special units is for prisoners with serious mental illnesses such as schizophrenia or bipolar disorder, and the other is for prisoners with severe personality disorders.[102] Prisoners in either unit receive a total of at least 25 hours weekly of time out of cell for structured and unstructured programming and recreation. An array of mental health interventions are offered to promote recovery, help inmates manage the symptoms of their illness, and help inmates develop the social skills and behaviors needed to transition successfully back to the general population or to the community after their sentences have been served. Custody staff volunteer for and are individually selected for work on the units. They receive mental health training that includes information on the nature and symptoms of mental illness as well as on techniques for defusing and de-escalating volatile situations.

As an incentive to good conduct, prisoners can rapidly earn additional privileges (e.g., more yard time or access to television); the consequence for misconduct is the brief loss of privileges. Disciplinary reports, assaults on staff, and suicide watch placements for prisoners on these units have reportedly dropped significantly from what they were previously. The use of force has reportedly dropped 60 percent.

JEROME LAUDMAN

> "That shouldn't be part of his punishment to say hey, you gonna lay back here and die in your own feces and starve to death. That's beyond punishment."[103]

Jerome Laudman died in 2008 at age 44 after 10 years in South Carolina prisons. His estate filed a lawsuit alleging cruel and unusual punishment, excessive use of force and failure to provide medical care.[104]

Because of mental illness, including bipolar disorder and paranoid schizophrenia, Laudman had been in psychiatric hospitals 13 times in the five years before his death. Each time, however, he was returned to South Carolina prisons. In 2014, a South Carolina state judge ruled the state's prisons provided grossly deficient mental health care.[105]

According to the estate's complaint, Laudman was placed in a crisis intervention cell in the Special Management Unit (SMU), a solitary confinement unit, at Lee Correctional Institution on December 7, 2007 because he was displaying severe emotional problems and had been refusing medications, screaming, experiencing visual hallucinations and he appeared psychotic. In January a psychiatrist observed Laudman exhibiting unusual behavior and talking to himself, with his cell in disarray. The psychiatrist prescribed various antipsychotic medications and ordered a follow-up visit in two weeks. The follow-up allegedly never occurred.

On February 7, Laudman was transferred to the special Supermax (segregation) unit within the SMU, which the complaint characterized as a unit designed to punish and provide intensive supervision to assaultive inmates.[106] According to the administrator of the Supermax, Laudman had been transferred because he had been "trashing" his room, was uncooperative, and was parading around naked.[107] After he refused to back up to his cell door to be handcuffed for the transfer to the new cell, Laudman was gassed with chemical spray.[108]

Plaintiff alleges that Laudman's physical and mental health rapidly deteriorated after he was transferred to the Supermax because he did not receive necessary medical attention or care there. According to the complaint, Laudman refused to take his medication, refused meals, ingested fecal matter, and smeared feces on himself. A sergeant at the facility told the investigator with the South Carolina Department of Corrections that on February 11 he looked in on Laudman and "he was sitting and stopped over like he was real weak or sick."[109] The officer also stated he saw food trays piled up, that Laudman was naked, and his room was bare. The investigator's review of prison medical records revealed that there were only five medical entries from January 1, 2008 until his death. [110] According to the complaint, Laudman had been stripped of his clothing and bedding and for a week, between February 11 to February 18, and lay naked on the cold concrete floor. By February 18, Laudman had lost a lot of weight, and had numerous sores, cuts, and bruises on his body.

The complaint continues that on February 18 a nurse received a call from a correctional officer reporting that Laudman "was down." She went to his cell and found Laudman lying naked on the floor in feces, urine, and vomit, still alive but breathing shallowly. There were 15-20 food trays with decaying food in the cell and the stench was terrible. Laudman was transported to the prison medical center alive but unresponsive, and he was then taken to a hospital. Medical notes from the hospital indicated Laudman was covered in dirt, urine, and feces when he was brought to the emergency room, and his core body temperature was 80.6 degrees, indicating hypothermia.[111] He went into cardiac arrest and died a few hours later.[112]

The Case of Jermaine Padilla

In early 2012, Jermaine Padilla began serving a 10-month prison term in California for a parole violation. According to a lawsuit Padilla filed,[113] he had a lengthy history of mental illness and periods of hospitalization for inpatient mental health treatment. In May 2012 he was housed in the administrative segregation unit of Corcoran State Prison designated for prisoners who are considered unable to function in the general prison population because of "acute onset or significant decompensation of a serious mental disorder."[114] Shortly after being transferred to CSP-Corcoran, mental health staff noted he manifested auditory hallucinations, his thought process became illogical, he began to refuse medication, and his mental state declined. The complaint states that mental health notes for the first two weeks of June indicate Padilla expressed paranoia, appeared psychotic, delusional, illogical and was responding to internal stimuli. On July 1 he was transferred to the prison's Mental Health Crisis Bed (MHCB) unit. When a psychiatrist in the MHCB unit began treating Padilla, he considered Padilla to be "gravely disabled," according to testimony he provided in court.[115] Padilla's complaint indicates MCHB treatment team records showed he had diagnoses of schizoaffective disorder, bipolar disorder, and depression.

Over the course of the next three weeks, Padilla's mental health continued to deteriorate. The complaint alleges that treatment notes over this period indicated that Padilla took off his clothes and stayed naked, talked as if he were responding to internal stimuli, and sometimes screamed. He urinated on his mattress and on the floor of his cell, smeared feces, peanut butter and food remains upon a dried puddle of urine. According to the psychiatrist, Padilla was completely unresponsive to any treatment efforts. Padilla also refused to eat. On July 24, he smeared himself with feces. The psychiatrist testified in court that he decided that Padilla presented an emergency situation and he asked custody staff to remove Padilla from his cell so that he could be involuntarily medicated. He stated that he believed Padilla would have died without the involuntary medication.[116]

As seen in a video that plaintiffs introduced as evidence in the class action case *Coleman v. Brown,* a mental health staff member spoke to Padilla briefly—for about half a minute—trying to get him to voluntarily "cuff up" (voluntarily submit to being restrained in handcuffs) so that he could be escorted from his cell.[117] When that effort failed, a member of the prison medical staff cleared the use of chemical agents against Padilla, that is, she indicated he had no medical conditions such as asthma that should preclude the use of the agents. A cell extraction team assembled in front of Padilla's cell wearing gas masks, suited head to toe in biohazard suits, and armed with handcuffs, leg irons, batons, a full-length plastic body shield, and fire-extinguisher-sized canisters of pepper spray. The extraction team leader read Padilla a warning that if he did not cuff up he would be forcibly extracted as well as disciplined. Padilla refused.

The video shows that custody staff proceeded to spray Padilla with OC (oleoresin capsicum) six times over a period of approximately six-and-a-half minutes. A psychiatrist working as an expert for plaintiffs in the class action case *Coleman v. Brown* who watched the video of Padilla's cell extraction said that although it appeared that Padilla could "not understand or comply with such orders, each failure by [him] to 'cuff up' [was] met by another injection of OC spray into the cell. Even as [Padilla] [was] repeatedly crying for help, there [was] no further attempt by officers or clinicians to engage him. Rather, they administer[ed] more OC spray."[118] The video shows Padilla screaming in pain, yelling for help, and sometimes crawling on the floor of his cell. A use of force expert for plaintiffs in *Coleman v. Brown* who watched the video stated that Padilla "was not lucid or coherent enough to be able to follow the officer's orders to back up to the cell and 'cuff up'. He turned in circles near the cell door but did not get the concept that relief might come if he could back up to the cell door and then manage to place his hands through the cuff port in the door."[119]

His complaint alleges that Padilla believed the extraction team was "there to harvest his organs or turn him into a cyborg." According to an incident report subsequently filed by a captain who authorized the cell extraction and observed it, during the extraction Padilla was "very confused and disoriented" and was "observed in a mental state where he could not follow the simpliest [sic] instruction."[120]

When the use of spray did not succeed in making Padilla agree to cuff up, a supervising officer decided the team should enter Padilla's cell and physically extract him. [121] As shown on the video, an extraction team entered his cell, used the full-length shield to pin him down, and then put arm and leg restraints on him while he continued to scream and resist. He was placed on a gurney, naked, with his genitals exposed, and taken to a restraint bed where he was fully immobilized. On the video, as Padilla is being wheeled into the room and put in restraints, he can be heard making statements such as "Why is this happening," "I didn't do nothing wrong ... I don't want to decapitate nobody ... Why is my skin falling off?" and "I don't want to be executed." His complaint alleges that Padilla was "scared that Defendants were going to cut off his limbs with a chainsaw, put a fake heart in his chest, or do experiments on him. It seemed to him that everything he feared from his hallucinations was coming true."

Padilla was involuntarily medicated by injection and kept immobilized in restraints for about three days. The complaint alleges that he was not allowed out of restraints to use the bathroom; he urinated on himself, the bed, and the floor. The psychiatrist treating him testified that Padilla's "combativeness when psychotic" warranted great caution before removing the restraints, and he thought Padilla should remain restrained until he agreed to take his medications orally, was likely to take medications voluntarily in the future, and had a "demonstrated ability to acknowledge and state the reason he's restrained." According to the complaint, after Padilla had been restrained for 72 hours, another psychiatrist ordered him released from the restraints. The complaint in his case states that he was subsequently transferred to an inpatient mental health hospital within Salinas Valley State Prison. He was released from prison on February 14, 2013.[122]

III. Approaches to Use of Force

> [U]se of force incidents with the mentally ill can exacerbate and worsen their mental health illness. [A]voidance of use of force needs to be a primary value of the organization when you're dealing with mentally ill inmates.
>
> —Eldon Vail, former Secretary, Washington State Department of Corrections.[123]

Justin Monroy, a 22-year-old with paranoid schizophrenia and bipolar disorderwho lived with his parents, sister, and three younger brothers in Michigan, was arrested after he threatened his sister with a knife in an argument over cigarettes and was held at the Jackson County Jail. According to information Monroy and his family provided to the press, Monroy's mental health deteriorated in jail where he did not receive his medication. According to the *Detroit Free Press*, after he kicked, punched, and banged his head against a cell door, officers sprayed Monroy with a chemical agent. Still concerned that Monroy might continue to hurt himself, officers reportedly also shocked him with an electric stun device and shackled him in a restraint chair with ankle chains. According to a psychiatric evaluation, Monroy believed government agents were out to kill him. He was subsequently transferred to a psychiatric hospital.[124]

There are no national statistics on the prevalence of staff use of force against inmates in general, or inmates with mental disabilities in particular, in the more than 5,100 jails and prisons in the United States.[125] Experts we consulted for this report said that force is used disproportionately against prisoners with mental illness.[126] This disproportion is reflected in the statistics we have been able to gather[127]:

1. In Colorado, 3 percent of the prison population was diagnosed with mental illness but those inmates were the targets of force in 36 percent of the use of force incidents. Cell extractions involving pepper spray occurred at a rate of 44.4 per 1,000 inmates with mental illness compared to 3.8 per 1,000 other inmates.[128]
2. In South Carolina, inmates diagnosed with mental illness were subjected to use of force at a rate two-and-a-half times that of other inmates.[129]
3. In 12 California prisons, use of force incidents against inmates with mental illness were reported at a rate more than double their representation in the prison population. In four of the 12 facilities, force against prisoners with mental illness constituted 87-94 percent of use of force incidents, even though those prisoners constituted only 30-55 percent of the population of the four facilities.[130]
4. In Washington state prisons, out of a total of 636 reported uses of force in calendar year 2013, 101 involved offenders in the mental health unit.[131]
5. In Los Angeles County jails, roughly a third of the use of force cases in 2011 involved inmates with mental health histories, although they constituted 15 percent of the jail population.[132]

Prison and Jail Policy and Practice

The use of force is inherent in the idea of involuntary confinement and is a fact of life in prisons and jails across the country.[133]Custody staff are permitted by law and policy to use force to protect themselves or others, prevent crimes and escapes, maintain safety and security, and enforce lawful orders.[134]

Agency policies establish the types of force staff may use, when force may be used, and rules for reporting on and investigating incidents in which force is used. Even with "excellent policy, training, equipment, practices and procedures, and the best of intentions, a use-of-force situation may produce serious injury or death."[135] When any one of those components is lacking—as is common in many facilities—unnecessary and excessive force causing injury or death becomes far more likely.

Staff reliance on force to manage or control inmates is diminished in agencies which are well managed, emphasize respect for inmates, provide them decent conditions of confinement, and provide mental health services to inmates who need them. Bernard Warner, Secretary of the Washington Department of Corrections, told Human Rights Watch, "If you have a well-run prison with good programming and mental health treatment, there will be less use of force."[136] According to Major Ron Freeman of the Ada County Jail in Idaho, "We teach inmate behavioral management instead of physical containment. We set expectations, use incentives and disincentives and hold inmates accountable to get the behavior we want. Force begets force. Officers are safer here if there is less force; the facility is calmer and less tense."[137] Staff who are trained and expected to defuse potentially volatile situations will also have less need to resort to force.

US court rulings, human rights standards, and corrections experts agree that staff should use force only when necessary, should use only the minimum amount of force necessary, and should use force only for so long as is necessary to attain a legitimate objective. The legitimacy and legality of the use of force depends on such

factors as the reason for the force, the relationship between that reason and the amount of force used, and efforts made to avoid force or to temper its severity. Even if force is required initially, staff may not continue to use it once a prisoner is subdued or secured, is no longer resisting, or has complied with staff orders. Force should never be used as punishment or reprisal against a prisoner or solely for the purpose of causing physical or psychological pain.[138]

The immediate use of force is unnecessary if the officers "could have waited without risking harm before using force."[139] Force is also not a necessary response to "every inmate who fails to follow a prison rule or order [absent] an immediate necessity to incapacitate, immobilize or neutralize threatening behavior."[140] When there is a recalcitrant or disruptive inmate who does not pose an imminent threat, sometimes the best option is to do nothing. "We're not here to punish. If an inmate is kicking and banging on his cell door and not hurting himself, we just let him stay there unless [he is] seriously disrupting the rest of the unit for a long time."[141] A "cooling off" period may succeed in obviating the need for force to be used at all.

When some level of force is warranted, the force should not be disproportionate to the risk of harm posed by the prisoner. For example, if an unarmed prisoner is sitting passively on a bed in a securely locked cell and refuses to return a food tray, the use of an electronic stun device to force him to return the tray would be disproportionately harsh. Because it would exceed what is needed to resolve the situation, it could not be considered necessary.[142]

While the exact language varies somewhat, good policies for the use of force echoing the principles outlined above are reflected in recent settlements of lawsuits bringing claims against corrections facilities and personnel for unconstitutional and abusive use of force. One such settlement, for example, requires the Los Angeles Sheriff's Department, which runs the Los Angeles County jails, to establish policies under which force:

(a) must be used as a last resort;

(b) must be the minimal amount of force that is necessary and objectively reasonable to overcome the resistance;

(c) must be terminated as soon as possible consistent with maintaining control of the situation and must be de-escalated if resistance decreases; "force may not be used as discipline or corporal punishment."[143]

The injunction to avoid unnecessary force is also spelled out in a settlement of litigation over the rampant misuse of force in Orleans Parish Prison in New Orleans. The sheriff of New Orleans is required to adopt policies that prohibit, for example:

> (1)Use of force as a response to verbal insults or prisoner threats where there is no immediate threat to the safety or security of the institution, prisoners, staff or visitors; (2) Use of force as a response to prisoners' failure to follow instructions where there is no immediate threat to the safety or security of the institution, prisoners, staff or visitors.[144]

Special Policies for Inmates with Mental Disabilities

Careful adherence to the principle of necessity would preclude the use of force in many instances in which it is currently used against prisoners whose behavior is symptomatic of mental health problems. But it also helps if use of force policies expressly require special steps, such as having mental health staff talk to the prisoner, before force can be used on such prisoners.[145]

Recent settlements and court orders in lawsuits alleging excessive use of force against inmates with mental illness require prisons and jails to adopt policies ensuring that mental health staff or other staff skilled in defusing volatile situations are called in to intervene with the inmate before force is authorized in non-emergency situations. Thus, for example, the settlement agreement in a case brought on behalf of Pennsylvania prison inmates with mental illness provides in relevant part:

> If an inmate with [mental illness] presents a non-emergency security threat, a [mental health professional], a person who is appropriately trained in Crisis Intervention, or a member of the Hostage Negotiation Team will be notified and that person will attempt to de-escalate the situation so that use of force is not necessary and/or to reduce the level of force required.[146]

As experts we consulted emphasized, to be effective at preventing the need for force, de-escalation or crisis interventions cannot be brief pro forma visits to the inmate's cell front. Mental health staff or other negotiators must be given the time and have the determination to connect with the individual to determine what is prompting his distress, what he is seeking, and how the situation can be resolved without violence. Correctional mental health expert Dr. Terry Kupers, for example, believes such interventions ideally should be without time limits, but should last at a minimum 30 minutes before force is initiated.[147]

The best use of force policies take into account the possibility that because of mental illness an inmate may not understand or be able to comply with an order.The case of Jermaine Padilla, featured in Chapter II above, illustrates how an inmate who is experiencing psychosis may not be able to comply with orders. A psychiatrist who testified for plaintiffs in the California case of *Coleman v. Brown* described how a cell extraction and the use of chemical agents (e.g. pepper spray) may be perceived by and affect individuals with mental disorders:

> [T]he 'cell extraction teams' (consisting of approximately five to seven custody officers) gear up in head-to-toe protective gear and gas masks or helmets, rendering them a bizarre and frightening team of figures as experienced by the inmate-patient. They then approach the inmate-patient's cell with various weapons at the ready including a range of sizes of OC canisters, expandable batons, and full-body shields. The officers proceed by speaking or shouting at the patient through a closed door and a helmet or mask, and deploying OC spray, grenades, and/or Barricade Removal Devices ("cell-busters") into the cells. For a psychiatric patient who may already be responding to delusions or internal stimuli such as voices, or who has impaired reality testing, or paranoia or anxiety about people picking on, physically hurting, sexually assaulting, poisoning, or attacking him or her, [forced cell extractions with pepper spray] can ... appear to be his delusions come-to-life...[148]

Because of the *Coleman v. Brown* litigation, the California Department of Corrections and Rehabilitation recently adopted use of force policies to reduce the pepper

spraying of inmates with mental illness. Absent an emergency or special authorization by senior facility officials, the policy prohibits the use of chemical agents against inmates in specialized mental health housing or against inmates who "do not possess the ability to understand orders, have difficulty complying with orders due to mental health issues, or are at increased risk of decompensation resulting from such use of force. For inmates who do not possess the ability to understand orders, the Warden ... may only authorize the use of chemical agents where serious circumstances exist calling for extreme measures to protect staff or inmates."[149]

Putting Policies into Practice

Good policies by themselves are not enough.[150] Training, supervision, and accountability mechanisms are crucial to ensuring staff refrain from misusing force. Sheriff Gary Raney in Ada County, Idaho, told Human Rights Watch:

> Agencies focus too much on finding the words to write in policy and hope that makes things better.... I've seen many jails that have good policies—that are ignored. When other jail administrators come here, they look for the policy and training, but I always tell them that while policy is important, it's not a significant factor of our success. Training is—so long as it is reinforced by effective supervision. That's the real key—policy, training and supervision—but I'll take supervision every time over the other two.[151]

Use of force training for correctional officers in the academy as well as in-service training often fail to give correctional officers the knowledge and skills to make sound judgments as to when force is necessary in any given situation and, if so, how much force should be used. It typically prioritizes physical containment over inmate management through non-forceful means, including verbal negotiation and de-escalation strategies, being responsive to inmate concerns, and the judicious use of cooling off periods. The training does not give officers the skills "to anticipate, stabilize and diffuse situations that might give rise to conflict..."[152]

Training and then supervision after training can help custody staff understand that force alone cannot keep a facility safe and secure, that unnecessary and excessive force creates the need for more force. Supervisors must constantly impress upon front-line staff the message that inmate violence and misconduct decline and facilities are safer when staff establish rapport with prisoners, are respectful to them, and are responsive to their legitimate questions and concerns.

Deputy-on-inmate violence, including needless and malicious force against inmates with mental disabilities, persisted for years in the Los Angeles County jails. According to a class action complaint, deputies were able to engage in such abuse because the sheriff and the jail's senior leadership turned a blind eye to evidence of it, tolerated a code of silence by front-line staff as well as supervisors, and failed to ensure accountability through timely and thorough investigations and discipline.[153] The settlement of the lawsuit and new leadership may lead to improved conditions in the jails, but the lawsuit put a spotlight on serious problems that the new jail leadership needs to act vigorously and effectively to address.[154] The role of leadership in staff violence at the jails was succinctly summarized by the Citizens Commission on Jail Violence in Los Angeles County:

> Over the years, some deputies have viewed force as a way to signal their authority over inmates and to establish "who is running the jails," rather than as a last resort in response to problematic inmate behavior. These deputies have adopted a confrontational approach in their interactions with inmates, thereby heightening disrespect among deputies and inmates and increasing tension in the jails. Management, in turn, has sent the wrong message by failing to address excessive force and a deputy culture resistant to supervision.

> [W]idespread use of excessive force is both indicative of, and often precipitated by, a problematic organizational culture.... [A] lasting transformation of the culture in custody will not be easy. It will require capable and committed supervisors; strong and clear communication of policies and Core Values; timely and strict enforcement action evidencing zero tolerance for misconduct and dishonesty; and engaged and visible leadership in regard to these issues at the highest level of the department."[155]

Mental Health Training for Staff

The front-line custodial staff who manage prisoners on a daily basis have a difficult job. Often working in insufficient numbers, they are asked to maintain control over prisoners in tense, overcrowded, and often physically unpleasant facilities. Before being hired, custody staff are rarely screened to determine whether they have the maturity and temperament needed to manage prisoners calmly and professionally, including prisoners who engage in erratic or disruptive behavior because of mental health problems.[156] Although "many officers do their best to provide compassionate supervision.... it is also unfortunately true that a few officers behave with a style, and sometimes an intent, that can only be described as harmful to the emotional well-being of any inmate and toxic to inmates with serious mental illness."[157]

Custody staff commonly receive little or no training in managing inmates with mental disabilities.[158] They are not given information on the nature of different mental health problems and the symptoms that may episodically or chronically result from them. Even officers who work on units with high proportions of, or dedicated to the confinement of, inmates diagnosed with mental illness may have scant understanding of what the inmates are living with and how it may affect their conduct. They do not understand that, for example, prisoners who are "hearing voices, [are] manic or severely depressed... may lack the capacity to regulate their behavior with the same speed and responsiveness as someone who is not suffering such distress."[159] They are not given the training that would help them distinguish between erratic behavior that is symptomatic of mental illness and genuine aggression.[160] Custodial staff are also rarely trained in verbal de-escalation and crisis intervention techniques that can be useful when confronting an agitated or violent prisoner whose mental condition is deteriorating and who is experiencing an increase in symptoms and a loss of function.[161] The importance of such training is increasingly recognized. Thus, for example, in a recent agreement with the Department of Justice, officials for Muscogee County, Georgia, agreed to provide correctional staff with "Crisis Intervention Team training that includes training on (i) understanding and recognizing psychiatric signs and symptoms to identify inmates who have or may have [serious mental illness], (2) using de-escalation techniques to calm and reassure inmates who have or may have [serious mental illness] before resorting to use of force, discipline, or isolation, and (3) making appropriate referrals of such inmates to mental health staff."[162]

Absent such training, correctional officers may act on the same misconceptions, fears, and biases about mental illness common among members of the general public

and which fuel discriminatory and hostile reactions. They may be hostile or disrespectful to inmates with mental health problems. They may believe "crazy" people are scary and dangerous.[163] They may not understand that their own conduct and attitudes about the prisoners' mental health conditions can influence how those prisoners behave. Lack of training, ignorance, and a correctional culture predicated on command and control all increase the likelihood that force will be the default response to disruption or disobedience by inmates with mental disabilities.[164]

Collaboration between Custody Staff and Mental Health Staff

Mental health training for correctional officers helps them better understand the contributions mental health staff can make to a safer facility and to overcome stereotypes that often impede effective responses to inmates with mental disabilities.[165] It is not uncommon for custody staff to view mental health staff with distrust, failing to understand that mental health staff can make their jobs easier. This view is reinforced when, as is usually the case, matters of safety and security are deemed the sole prerogative of custody staff, and mental health staff do not play a direct role in the daily operation and supervision of living units in which prisoners with mental disabilities are housed. Too often, mental health staff members "are treated as visitors in the units, not as co-workers who belong and share the work load of managing inmate behavior."[166]

In facilities in which mental health and corrections staff establish strong working relationships based on mutual respect, they can cooperate to minimize the use of force on inmates with mental health problems.[167] Indeed, the prevalence and extent of the use of force against inmates with mental disabilities may be inversely related to the extent to which custody and mental health staff work as partners in managing inmates. Officials with the Washington State Department of Corrections and the Ada County Sheriff's Office (which runs the county jail in Boise, Idaho), told Human Rights watch that their policies require mental health consultation wherever possible prior to the use of force on prisoners with mental health problems, and that, importantly, the institutional culture in their facilities has evolved into one in which mental health staff are respected and relied upon by custody staff—and vice versa, with a resulting diminution in the use of force.[168]

IV. Types of Force Used and their Harms for Prisoners with Mental Disabilities

Custody staff have a range of options for bringing disruptive or dangerous prisoners under control and getting them to comply with orders. Absent an imminent serious danger, the first option is to "do nothing," i.e., to talk to the inmate and try to defuse the situation, including by just letting time pass. When staff do use force, agency policies specify what types of physical force and weaponry may be used. As the permitted force against an inmate escalates in severity, so does the likelihood of pain and injury—both physical and psychological.

Force is undertaken with and without weaponry, but the use by corrections staff of weaponry, such as chemical agents (e.g., pepper spray) and electronic stun devices such as Tasers and stun shields, appears to be growing.[169] Full body restraints such as special restraint chairs or four- or five-point restraints on a bed are used to fully immobilize inmates. Use of deadly force, such as firearms, is rare in correctional settings and is not discussed in this report.

In this chapter we describe certain commonly use types of force and the physical as well as psychological impact they can have on inmates with mental disabilities. Absent litigation, it is rare for use of force policies to restrict the use of types of force according to an inmate's mental status.[170]

Physical Force & Cell Extractions

Officers sometimes use just their hands and bodies to control an inmate. Physical force can be either "soft" or "hard." Soft technique includes applying pressure to specific points, takedowns, joint locks, or simply grabbing on to the person. Hard technique entails striking, punching, and kicking.[171] The injury that may occur depends on the nature of the force, how long it lasts, and how many people participate in inflicting it. Punches, kicks, or blows to the head, neck, face, or groin carry a high risk of injury.[172] Staff may couple physical force with other forms of force such as non-lethal weapons and restraint chairs.

When an inmate in a cell does not agree to leave the cell voluntarily, staff may decide to forcibly extract him. The decision to forcibly extract an inmate might follow a prisoner's refusal to agree to a routine effort to move him to a new cell or it might be a response to misconduct, such as when an individual will not stop making a loud ruckus in his cell and staff decide he should be brought to the mental health unit.

Forced extractions are typically undertaken by a special tactical team resembling a SWAT team—team members are suited up in Kevlar vests, knee pads, helmets with visors and carry a range of weapons, such as batons, chemical spray, and electronic stun devices.[173] Chemical spray and Tasers may be used prior to the extraction in an effort to inflict enough pain to convince the individual to let himself be handcuffed and removed from the cell. The weapons may also be used once the officers enter the cell if the inmate continues to resist. With or without weaponry, forced cell extractions can be violent, as the team of officers grapples with the inmate and tries to place restraints on his arms and legs.

When the prisoner in his cell in not threatening imminent harm himself, that is, when there is no emergency, a forced extraction can often be avoided by talking for a while with the individual, or by giving him time to cool down. As one correctional mental health expert told us, when the inmate has a mental illness, "If you have a therapeutic, clinically informed approach, you often do not need a forced extraction."[174] Too often, however, extractions are initiated without meaningful efforts to avoid them. Worse, if staff are so inclined, a cell extraction easily can be used to physically punish an uncooperative prisoner.[175]

> When a confrontation with an inmate in his cell reaches a certain point and tempers have risen, there will be staff in some jails and prisons who do not want to see the situation resolved without force. Even when good faith efforts have been made to avoid a cell extraction, but unsuccessfully, staff may still use more force during the extraction than is necessary just to teach the inmate a lesson.[176]

Harm from Physical Force

Physical force used during cell extractions has resulted in serious injury and death for inmates with mental disabilities.[177] In many such cases physical force was

accompanied by the use of chemical spray and/or electronic stun devices.

Gregory Maurice Kitchen died in the Dallas County Jail in January 2010 while he was in pretrial detention. His estate filed a lawsuit alleging excessive force to extract Kitchen from his cell resulted in his asphyxiation and death.[178]

According to the court, the evidence before it showed Kitchen had been observed digging through other detainees' property, mumbling, walking backwards, and avoiding eye contact and had been placed in the facility's West Tower for psychiatric evaluation. During interviews with mental health staff, he urinated on himself, cried, stated he could hear his mother's voice, and admitted to suicidal thoughts. Just before midnight on January 21, 2010, staff observed Kitchen hitting his head on the cell door and walls, and Kitchen was sent to a nursing station for evaluation. He then broke free from the guards, started screaming, and grabbed a nurse. Officers subdued him and placed him in a restraint chair for five hours, after which he was transferred to another cell. The next afternoon, while officers were attending to another inmate, Kitchen began to scream obscenities, and cry out for his mother, and he resumed banging his head against the bars. One of the officers told him to have a seat and stop banging his head. Kitchen showed the officers his middle finger and urinated on the floor. At this point, several officers talked to him for seven to eight minutes, during which he was not causing any harm to himself. No one called medical or mental health staff. An officer then entered Kitchen's cell and a physical altercation ensued. It ended, ultimately, when a group of officers used pepper spray on Kitchen, took him out of the cell, and placed him in cuffs and leg irons.

What happened next was disputed by the parties. Four inmates provided affidavits asserting that officers kicked, choked, and stomped on Kitchen and applied pepper spray even after he had been restrained and was not resisting. Jail authorities denied staff these accounts or that engaged in malicious or excessive force.

Shortly after being restrained, Kitchen stopped breathing and died. According to the autopsy, which the court quotes, the death was a homicide caused by "complications of physical restraint including mechanical asphyxia due to neck restraint during struggle and the fact that one officer was kneeling on the decedent's back during restraint." Other factors included "physiological stress, morbid obesity and cardiomegaly, and exposure to oleoresin capsicum" (the chemical in pepper spray).[179]

The court of appeals noted that the record contained evidence creating a genuine dispute as to "the need for application of force, the relationship between that need and the amount of force used, the threat reasonably perceived by the responsible officials, and any efforts made to temper the severity of a forceful response." A reasonable jury could believe, it noted, that the officers may have engaged in the actions described by the inmate witnesses, and may conclude they did so to cause harm or because of an unreasonable perception that Kitchen still posed a threat after he had been restrained and subdued. The case is apparently still pending.

Charles Agee was a 47-year-old state prisoner at Alabama's William A. Donaldson Correctional Facility when he died in a prison infirmary.[180] Agee's estate brought a lawsuit against the Alabama Department of Corrections alleging excessive force, among other claims, and the account below is drawn from the court's order on the defendants' motion for summary judgment.

Agee had been diagnosed in 1995 with acute paranoid schizophrenic disorder and was housed in a residential treatment unit at Donaldson with other inmates with diagnoses of mental illness. He sometimes had periods of severe psychosis marked by agitation, belligerence, auditory and visual hallucinations, and delusions. He had a long disciplinary history in prison, including incidents of violence.

According to the court order, after lunch on January 21, 2005, a prison officer instructed Agee and other inmates in his cell block to return to their cells or join in a group counseling session. Agee wanted to return to his cell but he also wanted to take with him a chair on which he had marked his name. A scuffle ensued. According to the testimony related to the use of force on Agee that day, Agee swung the chair at an officer, and the officer immediately sprayed Agee in the face with Freeze+P, a chemical agent. The officer lost his footing and fell, and two other officers quickly came to his assistance.

One of the officers hit Agee several times with a baton, although there is conflicting evidence as to whether he hit Agee with it on the knees or his head and shoulders. The officer who sprayed Agee got up from the floor and allegedly punched Agee at least twice in the abdomen with his fist. Agee was then subdued and handcuffed. Another officer placed his knee on Agee's back to gain control. Some of the testimony presented to the court indicates that once Agee was on the ground and cuffed, the officers then "repeatedly hit, kicked, or stomped" on him. All three officers denied doing so.

Agee was taken to the infirmary. The court pointed out in its ruling that although Agee was conscious and able to walk out of the cell block area, by the time he arrived at the infirmary he was being carried by the officers, was barely conscious, and bloody drool was coming out of his mouth. At the infirmary, Agee began vomiting, appeared to have a seizure and became unresponsive. Infirmary staff were unable to resuscitate him. The autopsy concluded Agee died of internal bleeding because broken ribs had lacerated his spleen.

What caused Agee's injuries was disputed. The first officer who sprayed and punched Agee denied that he inflicted any injuries that could have led to Agee's death while they were in the cell block. The officer who placed his knee on Agee's back testified he neither placed his knee in a position to break Agee's ribs nor did he apply enough pressure to do so. Although a nurse and an administrative assistant heard loud noises and/or a scuffle as officers brought Agee from the hallway into the infirmary, the officers who transported Agee to the infirmary denied beating him. The court refused to grant summary judgment for the officers, because the question of who applied the force that led to Agee's death was a material issue of fact that would have to be resolved by a jury.[181]

The use of violent physical force against persons with mental disabilities can also cause psychiatric harm.

> What is little recognized is that if someone has mental illness, the trauma from a use of force can aggravate the pre-existing condition. It can trigger a psychotic episode or increase hallucinations. For a person with a pre-existing condition their symptoms can be exacerbated. For someone who is depressed, it can cause more depression; if bipolar, more depression or mania; schizophrenia, more hallucinations and delusions.[182]

The actual impact of the use of force on a given individual will differ depending on that individual's history and diagnosis.[183] But, "since many inmates have already

experienced trauma in their lives, they are already particularly vulnerable to the psychological impact of another trauma."[184] Even if a cell extraction is done well, for example, "it can deepen paranoia and distrust and aggravate symptoms."[185]

Chemical Agents

Proponents of chemical agents and electronic stun devices (described in the section below) say these weapons minimize injuries to inmates and staff because they make it less likely that direct physical force will be used and they enable staff to undertake a more graduated response to disruptive or dangerous situations. However, the very nature of these weapons makes it easy for staff to use them unnecessarily and punitively. A single officer can use them quickly and easily without risk to himself even when there is no immediate need for force, such as in response to verbal insolence or other minor misconduct that poses no physical threat.[186]

Although they can be highly effective at inflicting pain, neither chemical sprays nor electronic stun devices guarantee a prisoner will become compliant. Psychosis may render a prisoner incapable of understanding that compliance with an order is the fastest way to avoid the pain of pepper spray or electric shocks. In fact, the infliction of pain may strengthen paranoid delusions. One California inmate, for example, thought officers who ordered him to cuff up wanted to harvest his organs, and he resisted even when being deluged with pepper spray. Some individuals continue being combative despite repeated electric shocks.

Chemical agents are widely used in correctional agencies.[187] According to a former commissioner of New York City Department of Corrections, "The least force, indeed no force, is always preferable but when force is necessary to regain or to maintain order, utilization of a chemical agent yields the optimal outcome under the circumstances—order without injury."[188]

Oleoresin capsicum (OC) is the chemical agent most frequently sprayed on prisoners.[189] It is commonly referred to as pepper spray, because its active agent is extracted from hot peppers. OC can be dispersed in different ways—personal size aerosol cans, pepper balls, crowd size canisters, grenades—and the effectiveness and the rapidity of onset of its effect varies according to the delivery method. While the manufacturers typically provide instructions on the safe and effective use of their products, custody staff do not always adhere to them.[190]

Exposure to chemical agents is painful.[191] Jerry Williams, a North Carolina prisoner with mental disabilities described the experience as follows: *"[Y]ou feel blind. You ain't going to be able to see no more. And it burns real bad. Burns like you're on fire."*[192] Pepper spray:

> inflames the tissues. It burns the eyes, the throat, the skin. It frequently causes temporary blindness as the eyes dilate. It makes breathing difficult because of that, and sometimes people will panic... Depending on how much you are hit with, it lasts at least 30 to 45 minutes, sometimes as much as four hours. In some people it causes headaches. It makes the skin—people describe it as it feels like your skin is burning off. The eyes feel like they're bubbling and burning. Some people cough convulsively. It brings them to their knees.[193]

An advertisement by the manufacturer of a new form of pepper spray leaves no doubt as to its intended effect:"Two years of research has produced an OC aerosol which delivers immediate effectiveness ... [It] inflames the mucous membranes and upper respiratory tract, resulting in an intense burning sensation and a dramatic cough reaction. Unlike stream delivery products, OC Vapor affects the respiratory tract and any exposed skin, diminishing a person's ability to continue violent actions. Onset is immediate and extreme. Regardless of whether exposure is in an open area or in a confined space, the targets immediately focus on their own discomfort."[194]

Many use of force experts agree with Eldon Vail, former secretary of corrections in Washington state, that the use of chemical agents against prisoners with mental health problems should be avoided whenever possible.[195] But absent clear policies and diligent supervision, chemical sprays against those inmates can become the routine first response to perceived problems. For example, in Arizona isolation units confining many inmates diagnosed with mental illness, pepper spray was:

> routinely deployed with little or no apparent justification on inmates for such reasons as failing to return his food tray, covering his light fixture with a blanket, refusing to relinquish a blanket s/he had placed over her head, refusing to surrender a suicide smock, tampering with his colostomy bag, refusing to come out from under his bunk, refusing to take court ordered medication and tearing his suicide mattress. In none of these cases was the inmate or the spraying officer at risk of imminent or serious harm. Rather ... officers seemingly sprayed inmates—solely because they refused to obey the officers' command.[196]

In litigation successfully challenging the constitutionality of the treatment of inmates with mental illness in South Carolina prisons, plaintiff's use of force expert Steve J. Martin testified that prison staff used chemical sprays against individuals with mental health problems who masturbated while locked in their cells; verbally threatened officers while locked securely in a cell; complained about not receiving an evening meal; used profane language; kept banging on the cell door and let the sink overflow; and refused to sit on the cell stool.[197]Indeed, officers used crowd-control canisters of chemical spray against inmates with mental health problems, including, for example, an asthmatic inmate who refused to return his inhaler; an inmate who urinated inside a holding cell; and an inmate who had been placed on crisis intervention status and refused to surrender his boxer shorts.

Martin concluded on the basis of his examination of use of force practices, that South Carolina prison staff:

> routinely deploy chemical agents on mentally ill inmates in the absence of any objective and immediate enforcement necessity to incapacitate, neutralize or immobilize the subject inmates; routinely apply levels of force disproportionate to the levels of resistance presented by mentally ill inmates; routinely deploy dangerous and unnecessary quantities of chemical agents on mentally ill inmates who are locked securely in their cells, are not armed, and not barricaded; routinely fail to consider alternative measures to use of force and very often immediately resort to the use of chemical agents notwithstanding time and opportunity to consider/attempt alternative measures.[198]

The logic of pepper spray is that the pain it causes and the desire to avoid more such pain lead inmates to comply with orders. But this logic may not work with

prisoners with mental illness. "It's like a shot across the bow—cuff up or we'll do more or worse. But it is an impaired logic. With a psychotic prisoner it doesn't register. He does not get the causal relationship between gas and the next step in extraction, or why the gas."[199]

For example, when a prisoner diagnosed with schizophrenia housed in administrative segregation at California's Kern Valley State prison became increasingly paranoid, delusional, and persisted in playing with his feces, he was extracted from his cell so that he could be transferred to a mental health crisis bed. During the cell extraction the inmate was pepper sprayed several times in less than six minutes. During the spraying he yelled, "You're trying to kill me" and "don't treat me like a dog" and he called several times for medical staff. A victim of sexual abuse during childhood, the inmate became increasingly anxious that staff were going to rape him anally. Correctional officers used a device with a long metal tube to send OC gas into the cell and the inmate apparently feared the tube would be inserted in his anus, which caused him to resist even more vigorously officer orders to cuff up.[200]

Staff sometimes keep spraying even after the initial application of chemical does not have the desired effect.[201] An internal memorandum by a manufacturer of OC spray cautioned that persons who are mentally disturbed and/or extremely agitated are less likely to react to the pain of pepper spray and may not become immediately compliant with officers' commands. The memo states that law enforcement officers who mistakenly rely on OC to incapacitate someone might be inclined to administer repeated doses when the first dose does not have the desired effect. The memo concludes "[t]his obviously would be an overexposure, which may cause added health risks" and "raises the concern of excessive use of force."[202]

Incidents of repeated doses abound. For example, a naked prisoner in California on the mental health caseload was yelling that he was "the Creator" and threatening to kill himself. Custody staff decided that they need to remove him from his cell. In an effort to get the inmate to agree to be handcuffed, they sprayed him with pepper spray approximately 40 times, and entered his cell to handcuff the inmate and remove him. Plaintiff's corrections expert Eldon Vail testified during litigation that the "volume of spray used in this incident astounds me... [it] is excessive to the point of abuse."[203] As plaintiffs' expert in Arizona litigation, Vail testified that the use of pepper spray on prisoners who are disconnected from reality because of psychosis can feed into the inmates' delusions and hallucinations and exacerbate their condition. It yields only psychological harm and physical pain, "akin to corporal punishment."[204]

In a Florida case involving the repeated use of chemical agents against prisoners diagnosed with mental illness, an appellate court concluded "when the [Department of Corrections] fails to account for an inmate's decompensation, with the result that he is gassed when he cannot control his actions due to his mental illness, then the force no longer has a necessary penological purpose and becomes brutality."[205]

Following recent litigation, several corrections agencies have developed or are developing new policies restricting the use of chemical agents against prisoners with mental disabilities. The Arizona Department of Corrections, for example, has agreed to establish new policies that chemical agents can be used against prisoners with serious mental illness held in certain prison complexes:

> only in case of imminent threat.... If the inmate has not responded to staff for an extended period of time, and it appears that the inmate does not present an imminent physical threat, additional consideration and evaluation should occur before the use of chemical agents is authorized.... If it is determined the inmate does not have the ability to understand orders, chemical agents shall not be used without authorization from the Warden, or if the Warden is unavailable, the administrative duty officer.... If it is determined an inmate has the ability to understand orders but has difficulty complying due to mental health issues, or when a mental health clinician believes the inmate's mental health issues are such that the controlled use of force could lead to a substantial risk of decompensation, a mental health clinician shall propose reasonable strategies to employ in an effort to gain compliance...[206]

In California, new prison regulations adopted pursuant to a recent court order, prohibits the use of chemical agents on inmates who do not possess the ability to understand orders, have difficulty complying with orders, or are at increased risk of decompensation resulting from use of force unless there is an emergency or the warden or other designated senior officials authorize their use because "serious circumstances exist calling for extreme measures to protect staff or inmates."[207] The policy also bans the use of chemical agents in controlled use of force situations within mental health treatment facilities absent high level authorization.

RAMIREZ V. FERGUSON

Larry Ramirez was a 32-year-old welder diagnosed with schizophrenia, bipolar disorder with psychotic features, and panic disorder. Ramirez was brought into the Benton County Detention Center in Arkansas on July 7, 2007 after an arrest for fraudulent use of a credit card, public intoxication, resisting arrest, and possession of a controlled substance. He filed a lawsuit alleging jail deputies used excessive force against him on his first day of detention, and a judge ruled in his favor after trial.[208]

As summarized by the court, the jail's use of force policy provided that staff should only use the force and restraint necessary to control an inmate who displays violent or threatening behavior. If verbal persuasion and warnings are not effective, a deputy should call for back up and if necessary, attempt to use physical holds to control the inmate. With regard to the use of pepper spray, the policy prohibited its use on an inmate who has not demonstrated an intention to use violence or force. The court found that these policies were not followed with regard to Ramirez.

According to the court, jail deputies pepper sprayed Ramirez twice, including once after they had restrained him. The first spraying occurred after Ramirez had been taken to the holding cell. The deputy who sprayed Ramirez testified that, "Ramirez wasn't aggressive as in trying to fight us. [He] wasn't swinging, wasn't using force. He just was not complying with us." After he refused orders to stop banging his cell door and go to the back of the cell, the deputy sprayed him. The court noted, did not credit the deputy's testimony that he believed Ramirez posed a physical threat to him and that he could not use control holds or call for back-up to subdue Ramirez as required by jail policy. The court found that the deputy pepper sprayed Ramirez for non-compliance with orders, which constituted unjustified and excessive force.

About one hour after the first pepper spray incident, the deputy re-entered the cell with two other deputies. The court credited Ramirez' testimony that the deputies "entered his cell and, without giving him any commands, forcefully took him to the ground, restrained his arms and legs behind his back, sprayed him with OC spray again, and lifted him by his restraints and dropped him two or three times." Photographs taken after the incident showed bruising, abrasions and blood on Ramirez' head and face, and swollen eyes. The medical observation form states that Ramirez was in obvious pain. The court ruled this force was excessive and not reasonable to quiet someone from banging a door. According to the court, Ramirez could not identify which deputies lifted and dropped him from

his shackles or sprayed him the second time, although he did hear all three laughing and commenting "you're not so tough now." The court nonetheless held all three liable for the use of unnecessary and excessive force, because even if an officer does not participate in such force, he has a duty to prevent it.

The court found that the three deputies "acted willfully and maliciously in using excessive force" against Ramirez. The Court stated that it "respects the fact that jail deputies have a difficult job and must make split-second decisions in situations where their safety or the security of the jail is at risk. However, that is not what occurred here. What occurred here was an abuse of the deputies power over an inmate." The court awarded Ramirez $5,500 in compensatory damages for pain and suffering and $15,000 in punitive damages ($5,000 per deputy) "to punish the three deputies and to deter them, as well as other deputies, from abusive conduct in the future."

Harm from Chemical Agents

"With inmates [who] are not able to adequately process information and who are already in an agitated state, the use of and then repeated use of pepper spray would only exacerbate [their symptoms]."***[209]***

In most cases, chemical agents cause acute but temporary pain. Individuals with asthma or chronic obstructive pulmonary disease, however, are more sensitive to the irritation effects of pepper spray.[210]The chemical agentschloroacetophenone (CN) and chlorobenzalmalononitrile (CS) also cause tearing and respiratory effects, but do not cause the temporary blindness and inflammation that pepper spray causes.

Repeated applications of any of the chemical sprays without appropriate decontamination can cause second degree burns, as evident in the case of Jeremiah Thomas, discussed below. There can be even more serious consequences. If an inmate is exposed to chemical agents and then placed on his stomach, it can aggravate the risk of positional asphyxia and death.[211] When used on someone taking antipsychotic medication or illegal drugs such as cocaine, pepper spray may be the precipitating agent that contributes to death.[212]

According to mental health experts, the use of pepper spray can have severe mental health consequences for prisoners who are already psychologically vulnerable because of mental illness. Pepper spray can leave someone temporarily unable to breathe, which can be a terrifying experience for anyone. But the impact can be even more terrifying and traumatic for someone whose experience is colored by mental illness.

Psychiatrist Dr. Edward Kaufman says that pepper spray can have immediate as well as long term consequences:

[I]n the short term there is a real escalation of fear and anxiety. And in the longer term there is ... a destruction of trust in the mental health staff. And in many of the cases there occur prolonged psychotic episodes, when the inmate recovers, there are recurrent psychotic episodes. Some inmates have almost a posttraumatic stress disorder in which they become very frightened of even seeing custody [staff]. They have dreams and nightmares about custody.... And then with each succeeding psychosis there is potentially brain damage and definitely vulnerability to future psychotic episodes.[213]

In 1998, the Florida Department of Corrections Office of Health Services alerted prison officials that pepper spray should not be used on inmates with serious mental illness or who were in mental health patient units.[214] But custody staff nonetheless sprayed such prisoners when they created minor disturbances such as when they kicked their cell doors and yelled. During litigation challenging the constitutionality of this use of chemical agents, mental health professionals testified that chemical sprays could exacerbate the very conditions that mental health staff were trying to treat, leading to a vicious cycle of behavior that required further intervention with chemical agents to address the inmates' rapidly destabilizing behavior. According to one of plaintiffs' experts, gassing the inmates "makes them more paranoid, frightened and fearful, and it makes them less trusting and more angry which is detrimental to the mental health services attempting to be provided to them."[215] Another of plaintiffs' experts testified that it could also cause "intense physical and psychological pain" and give the inmates a "fear of dying ... and intense helplessness."[216]

It is unclear whether mental health staff are typically aware of, much less communicate with custody staff about, the potential psychiatric injury from pepper spray. Even in facilities in which mental health staff collaborate with custody staff to avoid the use of force, our research does not indicate that they are attentive to the possibility of trauma from cell extractions in which pepper spray is used. Unless the inmate has a physical condition such as asthma, medical staff routinely "clear" inmates for cell extractions, i.e., they indicate there is no medical reason to preclude the use of force. This assessment apparently looks only at physical, and not psychological, concerns.

NICK CHRISTIE

Nick Christie died two days after repeatedly being pepper sprayed and placed in a restraint chair with a spit mask in a Florida jail. His wife filed a lawsuit alleging he died from excessive force, among other claims.[217] The account below of the last days of his life is taken from the court order responding to defendants' motion for summary judgement.

In March, 2009, the 62-year-old left his home in Ohio to visit his brother in Florida. Christie had chronic obstructive pulmonary disease, morbid obesity, and asthma. He had stopped taking his antidepressant and antianxiety medication and his mental health was on a downward spiral. On March 25, he was arrested for public intoxication, briefly detained and released. On March 27 he was again arrested again, this time at an Arby's restaurant where he was trying to give money to passers-by. He was held at the Lee County Jail in Fort Meyers, Florida, where he was placed in the unit for detainees with mental health concerns.

According to the court, while detained Christie was apparently "loud and belligerent" and confused (for example, he asked for his keys so he could return home) but there was little evidence that he was physically violent with staff. Nevertheless, over the course of about 36 hours at the jail, Christie was sprayed more than 12 times with pepper spray (OC spray) and was decontaminated only once. He was held naked in a restraint chair for more than five hours, was sprayed with OC while restrained, was not decontaminated after the spraying, and had a spit mask placed over his nose and mouth while in the restraint chair and after being sprayed. Apart from evidence that Christie was sprayed once because he was yelling, the court's opinion does not provide explanations for why Christie was sprayed on the other occasions. The court's opinion noted, however, that plaintiff's evidence suggested "deputies in the Jail were using pepper spray nearly indiscriminately to enforce the rules of the Jail."

On March 29, Christie's health deteriorated. He was taken to the hospital and he died there two days later. The emergency room physician who examined Christie testified that he was "entirely covered" in pepper spray. The coroner determined Christie died due to OC poisoning.

Plaintiff's claims against the Sheriff centered on the lack of policies with regard to pepper-spraying. As the court pointed out, when Christie was incarcerated at the jail, there was clear legal precedent that pepper spraying a detainee unable to conform his behavior in response to the spraying violates the detainee's constitutional rights. Nevertheless, the jail did not have any policy regarding whether, and if so, when, detainees with mental illness could be sprayed. As the court stated:

> The Jail had no mechanism to determine whether an inmate's mental health rendered him incapable of following a corrections officer's commands, and thus should not be pepper-sprayed for refusing to follow those commands. Rather, the Jail's policy was that inmates who yelled or banged on their cells were pepper-sprayed—spray first, ask questions later. And there is no dispute that the unit on which Christie was housed...was regarded by staff as the unit in which mentally ill inmates were held, so that staff knew or should have known that inmates in that unit were likely suffering from sort of mental health issue.[218]

The jail also lacked policies regarding the number of times an inmate could be sprayed with pepper spray, whether an inmate held in a restraint chair could be pepper sprayed, or requiring immediate decontamination after pepper-spraying.

In a motion for summary judgment the moving party has the burden of establishing there are no contested issues of material fact and that the party is entitled to judgment as a matter of law. In reviewing motions for summary judgment, courts interpret facts in the light most favorable to the non-moving party. In this case, considering the defendants' motions, the court found that "the absence of any policy regarding whether the use of pepper spray is appropriate on an individual who is fully restrained" should have put the Sheriff on notice that a detainee's constitutional rights might be violated. It also observed, "[E]ven assuming that Christie continued to yell or that he spat in the direction of an officer after he was restrained does not necessarily justify the pepper spraying that occurred. Rather, there is at least a question of fact as to whether there was any penological justification for the custom of allowing the use of pepper spray on restrained individuals." The court also ruled that there was a genuine issue of fact as to whether some of the defendant jail staff were deliberately indifferent to Christie's physical and mental needs. The "corrections defendants had to be aware of the serious side effects multiple pepper-sprayings posed to even healthy inmates. At least one employee testified that on Sunday morning the air in the unit was so permeated with pepper spray that everyone in the unit was having difficulty breathing, 'even the nurses.'" With regard to the officers who participated in or ratified the pepper-spraying of Christie, the court ruled there was evidence from which a jury could conclude that the Corrections Defendants were not attempting to maintain or restore discipline but rather were simply attempting to harm Christie.[219]

JEREMIAH THOMAS

> Being sprayed with a chemical agent would "eat me up on the inside...it burn me real bad and it harmed me."[220]

Jeremiah Thomas was one of several plaintiffs with mental health problems who joined a lawsuit against Florida State Prison for repeatedly spraying inmates with chemical agents when they caused disturbances in their cells in the close management (solitary confinement) wings of the prison.[221] A federal district court ruled that Thomas and another plaintiff were sprayed with chemical agents in non-emergency situations at times when they were unable to conform their behavior to prison standards due to their mental illness, a practice which amounted to unconstitutionally cruel and unusual punishment.[222]

Thomas was serving a 30-year sentence for second degree murder and other charges. He had diagnoses of schizoaffective disorder, bi-polar type, and antisocial personality disorder with severe borderline features. According to the court, during 15 years of incarceration, Thomas would be periodically non-compliant with his medications and would subsequently decompensate. His symptoms included auditory hallucinations, impaired thought processes and paranoid delusions, and his behavior while incarcerated included acute agitation, banging on his cell door, eating his feces, pouring urine on his hands, exhibitionistic masturbation, urinating on his mattress, attempting to cut his penis, and repeated suicide attempts. He was frequently sprayed with different chemicals, including OC, CN and CS gas, despite the fact that custody staff observed this had no effect on his compliance with staff orders to stop.

In a 21-day period between July 20 and August 3, 2000, Thomas was sprayed with chemical agents eight times for simply yelling in his cell or banging on his cell door.He was then sprayed six times in seven days between September 20 and September 26, 2000. He consistently refused to take showers to decontaminate after being sprayed. After the September 26 incident, Thomas was taken to the prison infirmary where "medical staff reported he had first to third degree burns on his back, abdomen, arms, elbows, and buttocks." The severity of his burns prompted medical staff to consider sending him to a special burn treatment facility.[223] Thomas was then transferred to Union Correctional Institution (UCI), a prison providing inpatient psychiatric care, where he remained for three years. According to a psychiatrist who treated Thomas at UCI, it took her six months to stabilize him. Department policy prohibited the use of chemical agents at UCI.

Thomas was returned to FSP in June 2003. He resumed kicking his cell door and cursing staff, and custody staff resumed spraying him, according to the district court's decision. Thomas' mental health again deteriorated and in July 2003, he was sent back to the UCI inpatient unit where he remained until his death from natural causes.

The use of pepper spray was not permitted at UCI. The trial court noted testimony from senior department officials that facilities such as UCI that provide inpatient treatment have greater resources which permit closer supervision and monitoring of inmates. It pointed out that when there are disturbances such as an inmate banging on a cell door or yelling, the first response is with "mental health intervention instead of with security measures." According to the court, the department has recognized that, "it is possible that the symptoms of their mental illness have exacerbated to the extent that they cannot control their actions or that their reactions or particular situations are disproportionately magnified due to the exacerbation of their mental illness symptoms, and not due to recalcitrance." The court also referred to the testimony of a psychiatrist who worked at UCI that "mental health and security staff work together as a team" and that inmates could usually be counseled into cooperating when mental health staff intervene.[224]

Electronic Stun Devices

Officers in some prisons and jails are equipped with weapons that administer electric shocks—referred to variously as stun guns, electroshock guns, or conducted emergency devices, among other terms.[225] The most commonly used stun weapons are Tasers, made by Taser International. Because of the pain from the shocks and their dangerousness, it is generally agreed that if electronic stun devices are used at all, it should only be when necessary to control dangerous or violent subjects when other tactics have been or would be ineffective.[226]

Officers can administer electric shocks to prisoners in one of two ways—either by placing the weapon directly against the body of the person in so-called drive-stun mode—or by sending dart-like projectiles which administer a shock to a person located at a distance. The "drive-stun" or contact mode of applying shocks does not cause muscular incapacitation. It is used to inflict pain on inmates to convince them to comply with orders in order to avoid further pain. When the darts are used, the electrical charge "overrides the subject's central nervous system, causing uncontrollable contraction of the muscle tissue and instant collapse."[227] That collapse then enables staff to restrain the inmate.

It is easy for staff who routinely carry stun devices to deploy them unnecessarily.[228] Indeed, "by their very nature, [these weapons] lend themselves to misuse."[229] Officers have stunned inmates with mental disabilities who are not acting aggressively or posing an imminent threat of danger. They have used them to make inmates comply with verbal commands even absent a threat, and they have used them punitively.[230] For example:

> According to newspaper accounts, Marie Franks, a 58-year-old woman with bi-polar disorder, was jailed in Muscateen, Iowa, in September, 2013 after she made multiple non-emergency calls to 911 and resisted arrest.[231]She was not taking her prescription medications while incarcerated and her mental health deteriorated.[232] On October 7, according to a news story, jail staff wanted Franks to change her jumpsuit. A videotape of the incident was obtained by the *Des Moines Register* and can be viewed on its website.[233] As shown in the video, when a group of several officers enter Franks' cell, she begins screaming and shouting profanities, which she continues to do for most of the next 20 minutes. She resists being handcuffed, and she resists having her jumpsuit changed. But the video does not show she posed a direct threat to the officers or assaulted them. Nevertheless, as shown in the video, over an eight-minute period, an officer shocked her with a Taser once while the officers were trying to cuff her, and two or three times after she was cuffed.[234] An unidentified guard can be heard to say at the end of the video, "Good job, everybody. I tell you what, that is one psychotic woman."[235]

> According to report by Jim Mustian in the *Ledger Enquirer*, James C. Williams, who had a history of mental health problems, was arrested on drug and obstruction of justice charges and held in the Muscogee County Jail in Georgia.[236] While in his cell, he reportedly masturbated in front of officers distributing the laundry. A sergeant ordered him to put on his shirt and exit the cell. A video filmed by jail staff shows that Williams put on his shirt and then begin to walk in the corridors.[237] A sergeant ordered him to stop, but he kept walking and then refused to cooperate in being handcuffed. The video does not show Williams acting aggressively. According to Mustian's report, the sergeant used a Taser on him 11 times. On the video one can hear the sound of the Taser being fired and Williams yelling in pain.

Experts who reviewed the footage and related documents at the request of the *Ledger Enquirer* differed as to the reasonableness of the use of the Taser.[238] The newspaper reported that the use of the Taser on Williams and another inmate prompted a reworking of the jail's use of force policy. The new policy reportedly clarifies that Tasers should not be used as punishment or to "gain compliance from inmates that are non-compliant by passively resisting verbal commands."[239]

Harm from Stun Devices

Electronic stun devices can have serious and even lethal consequences.[240] The company that makes Tasers recognizes their use may increase the risk of death or serious injury because of physiologic and/or metabolic effects such as: "changes in blood chemistry, blood pressure, respiration, heart rate and rhythm, and adrenaline and stress hormones, among others.... Some individuals may be particularly susceptible to the effects.... Repeated shocks can have cumulative effects and increases the risks of injury."[241]

According to Amnesty International, by 2012 more than 500 people in the United States had died after being shocked with Tasers either during their arrest or while in jail.[242] A study for the federal National Institute of Justice concluded individuals who are mentally ill, drug-intoxicated, or have serious underlying medical conditions are at higher risk than other people for serious complications and even death from being stunned. The study also found that death is more likely when there has been continuous or repeated discharge of the stun device.[243]

SHREVE V. FRANKLIN COUNTY

In 2010, the Department of Justice (DOJ) intervened in a civil rights case filed by inmates at the Franklin County Jail in Ohio alleging jail staff had engaged in a pervasive pattern of unnecessary and excessive use of Tasers. The Justice Department's Complaint in Intervention alleged that the Franklin County Sheriff's Office engaged in an unconstitutional pattern and practice of using Tasers in an abusive manner, failed to adequately investigate their use, and failed to adequately train corrections deputies in their use. In February 2011, these claims were resolved by a court-enforceable settlement agreement. [244]

The policy of the Franklin Country Jail at the time authorized the use of Tasers "to gain control of a violent or dangerous inmate...when attempts to subdue the inmate by conventional tactics have been or are likely to be ineffective or there is a reasonable expectation that it will be unsafe for deputies to approach within contact range of the inmate." Nevertheless, the DOJ claimed, jail deputies frequently and gratuitously used Tasers to inflict pain, fear, corporal punishment, and humiliation, and they used Tasers on individuals even when sufficient numbers of deputies were present to easily physically control an individual, while individuals were in mechanical restraints, and even when they were fully immobilized in restraint chairs. They used Tasers on people whose only offenses were minor rule violations that did not pose any threat to anyone, people who showed verbal or passive resistance to being stripped or otherwise showed lack of cooperation during the booking process, and people who used profanity or made derogatory remarks to deputies. However, staff officials who reviewed use of force reports and videotapes routinely found such uses of Tasers to be "justified."

In one case described in the DOJ's complaint, deputies used a Taser on an inmate who was fully immobilized in a four point restraint chair. "In another cases, deputies came to a cell ostensibly to assist a mentally ill inmate who was banging his head against his bed. Instead of entering the cell to remove the inmate, a team of deputies stood around outside the cell while a sergeant repeatedly tased this inmate a total of fourteen times because he would not slide out of the cell by himself."

The class action complaint provides numerous other examples. In one incident, deputies came to the cell of an inmate with mental health problems to move him to another location. When deputies opened the cell door the inmate was holding a mat in front of him and speaking unintelligibly. According to the class action complaint, a deputy used a Taser on this inmate "for not standing up and tased him again for moving his arms and legs, stating, 'I'm tired of playing with you.'" When the inmate tried to crawl under the bed, the officer continued to use a Taser on him. The inmate was finally pulled out of the cell, still clutching his mat. He was put in leg irons and allegedly had a Taser used on him again when he would not let go of the mat. [245]

In the settlement agreement, the sheriff agreed, inter alia, to limit the use of conducted energy devices:

> Absent exigent and exceptional circumstances, [conducted energy devices] shall not be deployed against any person who is not reasonably perceived to pose a threat to the safety of the deputy or others and is not resisting by use of physical force or by displaying Active Aggression against the deputy or others, or who questions a deputy's commands in a non-violent manner, or who remains in a limp or prone position. When such exigent and exceptional circumstances exist, [interpersonal communication skills] and alternative forms of force or control techniques shall be considered first and rejected only if there is an objectively reasonable basis that alternative forms of force or control techniques would be unsafe.

The Agreement also specifically provides additional protection of persons with mental disabilities.

[The jail] [s]hall prohibit the deployment of the CED, except when there is an objectively reasonable threat to an individual's safety, a display of active aggression, or an attempt to flee or escape, against the following.... subjects who have a mental or physical impairment or are intoxicated due to drugs or alcohol such that it is reasonably perceived to be impossible or impracticable to comply with an order. A deputy shall consider any known or apparent mental or physical impairment or intoxication due to drugs or alcohol in determining whether there is an objectively reasonable basis to deploy the CED.

Full Body Restraints

When an inmate is out of control and unable or unwilling to stop acutely dangerous behavior, correctional policies typically permit custody staff to temporarily immobilize his arms, legs, and sometimes head in special chairs or outfitted beds.[246] Such full body restraints should only be used in extreme and exigent circumstances and as a last resort when other types of control are ineffective.[247]

Custody staff have used full body restraints for prisoners with mental health problems in non-emergency situations without attempting less restrictive means of control. They have used them for their own convenience to manage inmates who may be annoying or engaging in misconduct, but who are not a grave danger to themselves or others. Even when custody staff have used restraints because of an imminent threat of serious self-harm, they have continued to apply the restraints after they are no longer necessary.[248] In South Carolina, for example, a court concluded that staff used restraints unnecessarily and excessively.[249] The court noted, among other misuses of restraints, that staff routinely left inmates in restraints for specified increments of time, regardless of whether such immobilization continued to be necessary.[250]

Plaintiffs' use of force expert testified that South Carolina prison staff, "routinely utilize the restraint chair as a means of imposing summary and corporal punishment on mentally ill inmates who are not engaged in active or combative resistance, and in the absence of an objective and immediate need to fully immobilize the subject inmates."[251] According to Martin, custody staff placed inmates in restraints as deliberate punishment for prior misconduct and as a warning not to engage in it again. He testified that staff continued restraints after they were no longer necessary. For example, they returned inmates to restraint chairs for additional periods of time after the inmates had been released from restraints for a meal or a hygiene break and were calm and compliant. [252]

When a prisoner with mental disabilities is acting in ways that are extremely dangerous to themselves or others, mental health staff should if possible be involved in any decision as to whether full body restraint is necessary as an emergency measure. [253] If restraints have already been authorized by custody staff, the restraints should not be continued unless a licensed mental health practitioner, preferably a physician, has assessed the situation and decided whether the restraints are still necessary or whether the prisoner should be released and, for example, transferred to a mental health setting. Although prisoners are often held restrained in ordinary cells or other security settings, mental health experts maintain that if prisoners with mental health conditions require emergency restraint, it should be "in the prison or jail infirmary, which generally have 24-hour coverage by mental health staff who can provide health care assessments and treatment for inmates." [254]

Some correctional mental health experts argue that the use of restraints for mental health purposes in correctional facilities should be limited to the stabilization of unsafe situations until the inmate can be transferred to a psychiatric hospital.

> Jails and prisons are inherently nontherapeutic environments and are not adequate settings for managing mental health emergencies, such as those that require the use of restraints. Correctional conditions often contribute to the onset, and impede the resolution, of the underlying mental health crisis. Attempts to contain mental health emergencies in a correctional setting with an expanded use of restraints can compromise clinical care, overlook the root cause of many crises, impair the role of mental health professionals by blurring the distinction between mental health and security staff, and can lead to a deterioration in the standards of care.[255]

Use of Restraints at Pennsylvania State Correctional Institution, Cresson, Pennsylvania

A Department of Justice (DOJ) investigation into the use of isolation for prisoners with mental illness at the Pennsylvania State Correctional Institution at Cresson ("Cresson") revealed—among many other problems—the excessive and punitive use of full-body restraints on those prisoners. [256] According to the DOJ, officers used full-body restraints on them not only to prevent imminent harm, but also to discipline or punish prisoners by using the restraints to cause discomfort or pain. Prisoners were kept in restraints for an average of 10.5 hours. When restrained, "the prisoners typically

were held in one fixed position in a windowless cement cell, were sometimes required to urinate while still in restraints, and wore only light smocks that left most of their bodies bare and exposed to the cold." Mental health staff were not consulted about the use of restraints nor did they monitor restrained inmates. The DOJ also identified instances in which officers used additional force such as electronic stun devices against inmates who were already fully immobilized.

Quoted below from the DOJ's findings letter are two examples that illustrate the misuse of restraints at Cresson:

> On July 21, 2010, prisoner KK, who had an extensive history of self-injury and was diagnosed with a depressive disorder, ran headfirst into his cell door.... Officers found KK unresponsive and lying on his back. After a brief medical evaluation, officers placed him into a restraint chair and deploying [sic] an EBID [an electronic stun device] twice during the placement. While restraining him in the restraint chair, officers "exercised" KK—a process during which one limb at a time is removed from restraints. When KK's left leg was exercised, he began kicking. Officers responded by twice applying a handheld EBID. Later, during another exercise, a handheld EBID was applied again when he had only one limb removed. A third time, during exercise, officers applied a handheld EBID four times and deployed pepper spray on his face twice while he had only one limb removed. It appears KK's total time in the restraint chair neared 24 straight hours.

> Prisoner CC had been diagnosed with schizophrenia, had a history of psychiatric hospitalization starting at age eight, and had a low IQ. During periods of confinement in isolation he would decompensate; be transferred to inpatient mental health treatment units and then once stabilized be returned to isolation where the cycle would begin again. He ingested objects such as sandwich bags and spoons. He cut his wrists and tied a sheet around his neck. Cresson staff dismissed his serious acts of self-injury as "behavioral issue[s]" and malingering. On five occasions, between February and March 2011, he was placed in a restraint chair for periods lasting between 7 and 15 hours. On July 4, 2011, he was placed into a restraint chair for more than 19 hours after banging his head against the wall.

The Department of Justice described such uses of force as:

> cruel and unnecessary. Instead of increasing compliance with prison rules, Cresson's use of excessive force on prisoners with serious mental illness without any meaningful mental health supervision or intervention has the effect of further traumatizing the prisoners, intensifying their psychotic episodes, and exacerbating their mental illness.

After its investigation at Cresson, the Department of Justice initiated a system-wide investigation into the use of solitary confinement in Pennsylvania Department of Corrections facilities, an investigation that also found unnecessary and excessive use of full-body restraints for prisoners with serious mental illness in other facilities. [257] It concluded that across the state "corrections officers routinely use full-body restraints for far longer than is needed to avoid harm. Instead, they often appear interested in using the restraints as a means to discipline prisoners by causing discomfort or pain." [258] It proposed as a remedial measure that the Pennsylvania Department of Corrections ensure that: "The restraint chair, and other uses of force, are not used as punishment or as a substitute for mental health interventions and are instead used only in instances where a prisoner poses a physical threat." [259]

Harm from Full-body Restraints

Custody staff may fail to follow proper procedures to care for an inmate while restrained, increasing the likelihood of injury and prolonging physical as well as psychological pain. They may fail to give the restrained inmate sufficient feeding and hydration, or not provide bathroom opportunities, leaving the inmate to defecate and urinate on himself.[260] They may not move inmates' arms and legs periodically, which is necessary to avoid the formation of potentially deadly blood-clots.[261] Inmates who have experienced the restraint chair for several hours or more complain of limbs going numb, swelling limbs, and varying degrees of pain and extreme discomfort.[262]

As with other types of force, full body restraints can produce unique harm for persons with mental disabilities. Prolonged use of restraints on inmates with certain clinical conditions, including some paranoid conditions, anxiety syndromes, and post-traumatic stress disorder, can be extremely difficult for them to tolerate.[263] The Department of Justice concluded that subjecting prisoners with mental illness to harsh treatment such as prolonged restraint "in response to behaviors derivative of their illness does nothing but accelerate their mental deterioration and intensify their mental torment and anguish."[264]

When proper procedures are not followed, full-body restraints can be lethal, with death resulting from cardiac difficulties, aspiration (breathing in of vomit), pulmonary embolisms, and positional asphyxia (death by respiratory obstruction).[265] The danger of injury and death is even more acute when staff also use pepper spray or electric stun devices on the inmate immediately preceding the restraint or while he or she is in the restraint. In addition to the case of Nick Christie, presented above, the lethal danger of these restraints is revealed in the following cases.

Daniel Linsinbigler was 19 years old when he died in the Clay County Jail in Florida. His estate filed a lawsuit alleging the death was the result of excessive force.[266] Linsinbigler was incarcerated on March 2, 2013 after a misdemeanor arrest for trespassing and indecent exposure. According to news accounts, the police said he had entered two apartments naked and without permission and, "yelling bible scriptures and proclaiming he was Jesus."[267] He was kept on suicide watch in the jail. After he had been detained for a week, Linsinbigler asked staff to give him a pencil. According to the account an inmate housed in the cell next to Linsinbigler gave investigators with the Clay County Sheriff's office, the staff refused to give Linsinbigler a pencil. Instead they teased and mocked him about his religious beliefs.[268] Linsinbigler reportedly grew agitated and kicked and punched his door. The next morning when Linsinbigler began yelling again and throwing himself against his cell, a nurse recommended he be removed from his cell because she feared he would injure himself. Officers entered the cell around 8:30 a.m., subdued him with pepper spray, strapped him into a restraint chair, and then placed a spit hood over his head. According to an audio recording of statements by the officer who sprayed Linsinbigler, he realized Linsinbigler had mental health problems.[269] The officer was ordered to spray him, but he did not want to. As can be heard on the audio recording, he states: "I didn't need to. I'm a big guy, controlling this guy was not going to be an issue for me at all. He was a fragile guy as it was."

> Three inmates claim to have heard Linsinbigler complaining that he could not breathe and pleading for help. The officers said they did not hear any such requests for help and that they monitored him every 15 minutes as required by jail policy. Nevertheless, sometime shortly after 9:00 a.m., Linsinbigler was discovered without a pulse and not

breathing. He was taken to a hospital where he was declared dead. According to the complaint filed by his estate, the state medical examiner identified the cause of his death as asphyxiation.[270]

Timothy Souder died at age 21 in the Southern Michigan Correctional Facility at Jackson, Michigan, while serving a sentence for resisting arrest and destroying police property.[271] He had a history including bipolar disorder, depression, hyperactivity, and suicide attempts. In 2006 he was transferred from general population to administrative segregation for disobeying orders, and his continued disobedience led to his being placed on August 2, 2006 in "top of the bed restraints," what the court called " a euphemism for chaining an inmate's hands and feet to a concrete slab." Restrained prisoners were to be observed every 15 minutes and offered bathroom and water drinking breaks every two hours. An outpatient social worker determined that Souter was "floridly psychotic" and referred him for transfer to a prison psychiatric hospital, but the transfer never took place. Because the staff psychiatrist was on an extended leave, there was no on-site psychiatric coverage at the prison. According to the court, the "immediate consequence of the failure to transfer was that a psychotic man with apparent delusions and screaming incoherently was let in chains on a concrete bed over an extended period of time with no effective access to medical or psychiatric care and with custody staff telling him that he would be kept in four-point restraints until he was cooperative."[272] Souder was taking several psychotropic medications which increase the risks of dehydration and can interfere with temperature regulation. During the period Souter was restrained, conditions at the prison were hot and humid, with heat index reading around 100 degrees on two of the days. Although Souter's medical condition needed careful medical monitoring because of the heat, no such monitoring occurred.

The court found it "striking" that neither custody staff, who checked on Souter at regular intervals, nor psychological and nursing staff, who saw him in a state of decline, "took any action to summon emergency care," even though it was apparent that Souter was experiencing mental and physical deterioration. When he was released from the restraints on August 6, he was unable to stand and fell face first onto the floor. He died shortly thereafter of dehydration and arrhythmia.

V. Retaliatory and Gratuitous Use of Force

In early 2014, according to a mental health clinician who witnessed the incident, a homeless man, who the psychiatrist thought was psychotic, was held in pretrial detention in the mental health unit of an upstate New York jail. An officer had a sandwich and put it on top of the counter in the common area of the unit. The detainee, who apparently was hungry, picked up the sandwich. The officer responded by spraying him with a chemical agent. When the clinician asked the officer why he had sprayed the inmate, the officer said, "because he looked at me funny."[273]

Corporal Punishment

Use of force by correctional staff for purposes of punishment or retaliation—corporal punishment—is prohibited by constitutional jurisprudence, professional standards, and agency policies.[274] Despite this prohibition, it takes place across the country, including against inmates with mental disabilities. Sometimes corporal punishment consists of prolonged vicious beatings by one or more officers in which there is not even a pretense of necessity. Sometimes chemical agents and the restraint chair are used "as a means of imposing summary and corporal punishment on mentally ill inmates who are not engaged in active or combative resistance, and in the absence of an objective and immediate enforcement necessity to incapacitate, neutralize or immobilize" them.[275]

There is also "the more insidious pattern or practice of unlawful staff use of force that is cloaked with, or protected by, an air of legitimacy or facial validity. It is not uncommon for ostensibly lawful applications of physical force to mask the intentional infliction of punishment, retaliation or reprisal on prisoners."[276] The initial use of force may have been appropriate, but the force is continued long after it is no longer needed, such that it becomes punitive. The use of force must stop when the need for it to maintain or restore discipline no longer exists. Force should not be continued once the prisoner is incapacitated and no longer able to pose a threat to staff's ability to maintain order, resist orders, or engage in disruptive behavior. Using force at that point has no object other than to inflict pain.

Some custody staff have also deliberately used disproportionately severe force for the purpose of inflicting pain as punishment for misconduct. When "unnecessary or disproportionate force is applied for the primary purpose of inflicting punishment, retaliation or reprisal rather than control, [it constitutes] de facto corporal punishment.... Often, the subjects of such force are mentally ill offenders whose behavior as viewed by inadequately trained officers, is to be punished rather than treated."[277]

Officers often use force immediately after an incident of misconduct has ended. In a not uncommon example, an inmate securely locked in a cell throws urine or feces on an officer but then retreats to the back of his cell and makes no further threatening gestures. He has broken rules, but he does not pose an ongoing danger that requires him to be controlled. If the officer nonetheless responds immediately by spraying the inmate with pepper spray, he has engaged in retaliation or punishment, not a reasonable good faith effort to gain control. The disciplinary system exists to impose sanctions for rule breaking, but some officers nonetheless believe such conduct calls for the immediate infliction of pain.

Thorough reviews of use of force incidents and, where appropriate, full-fledged investigations by senior agency staff outside the facility chain of command are vital to determine whether the force was legitimate and proportionate or constituted corporal punishment. The facts must be reviewed to ascertain, for example, whether the staff manufactured or exaggerated the need to physically control a prisoner or legitimately initiated the force and then unnecessarily but deliberately escalated it—both examples of corporal punishment that remain hidden absent a closer look by senior staff who report directly to the head of the agency.

Court decisions and Department of Justice reports include a plethora of cases of punitive violence against inmates with mental health problems. We detail some illustrative cases below, and in the following chapter we describe agencies and facilities in which punitive force has become widespread and systemic.

Jerry Williams, a prison inmate in North Carolina, filed a lawsuit alleging unconstitutionally excessive use of force.[278] The 57 year-old Williams has been diagnosed with paranoid schizophrenia, and according to press accounts spent much of his adult life in state psychiatric hospitals and prisons. He received a 28-year sentence in 2002 following a lengthy record of convictions for trespassing, assault and burglary.[279] Since then, he has cycled between the solitary confinement unit of the Central Prison and an inpatient mental health ward. According to press accounts, his prison record lists 142 infractions over ten years, many for disobeying orders or throwing cups filled with bodily waste.[280] Williams' response to defendants' motion for summary judgment, alleges that some of the primary symptoms of his illness—agitation,

yelling, kicking and throwing things—have been responded to as "pure behavior problems that must be punished with the intentional infliction of pain."[281] For example, between June 5, 2008 and September 17, 2009, he was allegedly sprayed with pepper spray at least eight times for nonviolent conduct such as kicking on his cell door, profane language, and throwing liquids.

Williams contended that on September 17, 2009, his dinner tray did not include bread or a spoon. Williams kicked the door of his cell to complain and later, when a correctional officer returned to collect the food tray, refused to return it. Two officers subsequently returned to his cell and ordered him to return the tray. According to the court in its ruling on defendants' motion for summary judgment, the parties disputed what happened next. Williams claimed the tray slipped from his hands and fell through the food port to the floor outside his cell. One of the officers then deployed a single burst of pepper spray, and after he did so, Williams retaliated by throwing a cup of water at him. According to the officer, however, Williams threw the food tray out of the food port, picked up a cup of liquid as if to throw it at the officer, and refused an order to put it down. The officer then pepper sprayed Williams in an unsuccessful effort to deter him from throwing the liquid.

According to the court's recounting of the events, the officer subsequently ordered Williams to submit to handcuffs to be taken out of his cell but Williams refused. Officers then tried to forcibly remove Williams from his cell, efforts which included the repeated use of pepper spray, before they succeeded the second time. Defendants contended that Williams had jammed his cell door and used his mattress to prevent it from fully opening. They also claimed Williams attempted to assault them by throwing more liquid on them and by swinging a sock with a bar of soap in it at them. Williams denied hitting any of the officers. According to the officers, after they entered his cell Williams refused to submit to handcuffs; Williams said that he complied. After he was out of his cell, officers placed him in full restraints.

The parties' accounts of what happened next diverge markedly. According to the court, Williams alleged that after he was handcuffed, officers proceeded to beat him, stomp him, kick him and stand on his back, chest, head and neck and that one of the officers grabbed and twisted his hands, allegedly breaking three of his fingers. Defendant officers denied such a beating occurred.[282]

Robert Sweeper was booked into the Alvin S. Glenn Detention Center, the county jail in Richland County, South Carolina, on February 7, 2013. While detained in the jail, Sweeper was assaulted by staff, causing serious injuries. The US Attorney brought a criminal case against a jail officer, and Sweeper brought civil complaints against Richland County and against the jail's medical care providers.[283]

Sweeper was charged with trespassing after University of South Carolina campus police found him sleeping in a classroom building doorway on a cold night and took him to the jail. He was behaving erratically, was uncooperative, combative, and incoherent.[284] Staff recognized Sweeper had mental health problems and assigned him to suicide watch, but they did not send him to a hospital where he could receive psychiatric care. Over the following days he was disoriented, rambling, illogical, refused food, and showed poor hygiene.

On February 11, corrections officers were searching cells that housed inmates with mental illness and those on suicide watch to look for weapons or tools inmates could use to hurt themselves. According to the felony information filed by the US Attorney, Officer Robin Smith, "while acting under color of law, did willfully kick R.S. multiple times, causing bodily injury."[285] Smith pleaded guilty to a criminal civil rights violation. The plea agreement stated:

> On or about February 11, 2012, Defendant Robin Smith was employed as a corrections officer at the Alvin S. Glenn Detention Center ("ASGDC") in Richland County, South Carolina, in the District of South Carolina. At approximately 6:30 am, Defendant Smith entered the suicide watch cell assigned to Robert Sweeper, a pre-trial detainee. Sweeper was assigned to suicide watch because, while non-violent, he was mentally ill and generally incoherent. During the course of a routine search of Mr. Sweeper's cell, Defendant Smith twisted Sweeper's wrist and arm, and kicked Sweeper in the upper body. During the assault, Sweeper was lying on the floor of the cell with one hand cuffed. Mr. Sweeper was not combative and posed no threat to Defendant Smith. There was no legitimate law enforcement purpose for Defendant's level of use of force. As a result of Defendant Smith's unjustified and excessive use of force, Mr. Sweeper sustained bodily injury.[286]

According to the assistant US attorney who handled the case against Smith, "Smith lost his temper, and when you are a correctional officer you can't do that, and the system will not tolerate it."

Sweeper ended up with three broken ribs, a punctured lung, and two fractured vertebrae.[287] Four days passed before Sweeper was taken to a hospital, where he remained eight days.[288] Smith was sentenced to two years in prison. Six other guards were fired for not reporting the beating.[289]

Darren Rainey, a 50-year-old man with a diagnosis of schizophrenia, was housed in the inpatient mental health unit at Florida's Dade Correctional Institution while serving two years on a cocaine charge.[290] According to a lawsuit filed by his estate, Rainey's mental health problems sometimes led him to smear feces on himself and his cell, and he did so on the evening of June 23, 2012. Under normal procedures, the custody staff would have taken Rainey to the closest shower to be washed. Instead, it is alleged they took him to a more distant shower that was either altered or broken in such a way that correctional officers could set the temperature to scalding and Rainey could not shut the water off, control its temperature, or leave the shower until staff opened the door.[291] A related lawsuit brought by Disability Rights Florida alleged in its complaint that staff at this institution had previously placed another inmate with mental health problems in the scalding shower to punish him.[292]

Nearly two hours later, according to the Rainey complaint, when the officers went to retrieve Rainey, he was lying unresponsive on the floor of the shower. They called a nurse who discovered Rainey had no pulse and was not breathing. He had burns over 90 percent of his body, and his skin was hot/warm to the touch and slipped off when touched. Inmates told journalists that Rainey had angered corrections officers by defecating in his cell and refusing to clean up the mess. A psychotherapist who worked at the prison between 2008 and 2011 told the press that guards at the prison "taunted, tormented, abused, beat and tortured chronically mentally ill inmates on a regular basis."[293]

Two years after Rainey's death the police investigation remains pending and there is no report from the medical examiner. Settlement discussions are ongoing in consolidated lawsuits filed by Rainey's estate for damages and by Disability Rights Florida for injunctive relief.[294]

Paul Schlosserlll, age 27, an inmate at the Maine Correctional Center diagnosed with bipolar disorder and depression and serving a sentence for robbery, returned from a hospital in June 2012 where he had been treated for deep self-inflicted cuts on his arm. According to news stories, after returning to the prison, he removed the dressing from his cuts and reopened them, but refused to go to the medical unit to be treated. Officers placed him in a restraint chair with his ankles and waist strapped to the chair and took him to another cell where a nurse could take care of his arm.[295] As shown in a 17-minute video recorded by prison staff, Schlosser was quiet and compliant while the officers took the cuffs off of his wrists so they could fasten his arms to the chair until one of the officers pinned back his head. He then started to struggle and spit at one of the officers. A captain with the officers immediately then sprayed Schlosser in the face with a short blast of pepper spray.

The video shows that after Schlosser was pepper sprayed, he gagged, choked, and gasped for breath, and pleaded not to have his head restrained. The captain then ordered a spit guard put on Schlosser without decontaminating him first, which trapped the pepper spray against Schlosser's face. Schlosser kept saying he was unable to breathe, begged to have the spit guard removed, and promised not to spit again. As can be heard on the video, the captain's response was to keep repeating, "If you can talk you can breathe." The captain also berated Schlosser, saying, for example, "Why did you remove the dressing, why did you spit on an officer?" and asking if Schlosser was "done playing games." The captain also told Schlosser that if he refused to cooperate, "This will happen all over again... You're not going to win... we win every time." At the end of the video, following an order from the captain, officers remove the spit mask.

According to the news stories, a prison investigator who looked into the incident said, "[T]he situation went from a security situation to a punishment one." The captain reportedly told the investigator that the use of pepper spray was appropriate because Schlosser, who has hepatitis C, spit on one of the officers and was not being cooperative. The captain was fired but Corrections Commissioner Joseph Ponte reinstated him with a 30-day suspension because of his otherwise clean work record.

A Culture of Abuse

> Prisons don't have to be as dangerous and as violent as they are. The culture of our prisons virtually dictates the level of violence you will have in them. And if you change that culture, you will reduce the violence.
>
> —Donald Specter, Prison Law Office, Testimony to Commission on Safety and Abuse in America's Prisons[296]

In some correctional facilities, a culture of violence develops in which staff routinely, maliciously, and even savagely abuse inmates, including inmates with mental health problems, using force, fear, reprisal, and retaliation to control them. All levels of staff become complicit, actively or passively, in the widespread physical abuse. Force is used but not reported; if reported it is reported inaccurately with key facts omitted; staff who witness an incident say nothing; supervisors do not carefully scrutinize use of force reports, incidents are not referred for investigation or, if they are, the investigation is cursory. Impunity for abuse is the norm. As Steve J. Martin notes, where such practices exist they operate to say, in effect, "This is the way we do business here.... We use force on our own terms, not the terms of what the law requires or what sound corrections practice requires, but on our terms."[297]

New York City Department of Corrections: Rikers Island

> Andre Lane was locked in solitary confinement in a Rikers cellblock reserved for inmates with mental illnesses when he became angry at the guards for not giving him his dinner and splashed them with either water or urine. Correction officers handcuffed him to a gurney and transported him to a clinic examination room beyond the range of video cameras where, witnesses say, several guards beat him as members of the medical staff begged for them to stop. The next morning, the walls and cabinets of the examination room were still stained with Mr. Lane's blood.
>
> —Michael Winerip and Michael Schwirtz, "Rikers: Where Mental Illness Meets Brutality in Jail," *New York Times* [298]

Staff brutality has been pervasive for decades in New York City's main jail complex on Rikers Island. Rikers Island houses 10 facilities (nine operational currently), holding about 11,000 inmates daily, 85 percent of which are pretrial detainees.[299] Over a period of 25 years, five separate class action lawsuits were brought to end staff abuse. Each of the lawsuits was successful in obtaining changed policies and practices to end staff violence, including video monitoring, staff training, and unbiased and thorough investigations. But the injunctive relief was often limited to the particular facilities subject to the lawsuits, and the city failed to keep all the measures in place once the court orders expired.

A new system-wide class action lawsuit was filed in 2012 replete with harrowing allegations of staff violence against inmates. The complaint claims Rikers Island is "pervaded by a culture of routine and institutionalized staff violence against inmates, by a failure of accountability at every level, and by supervisors' deliberate and even calculated indifference to, and tolerance and encouragement of, the Constitutional violations that occur on their watch."[300]

On December 18, 2014, the United States intervened in that lawsuit, following release of a federal report that documented a "deep-seated culture of violence" at Rikers and highlighted the slow pace of negotiations to secure needed reforms.[301] The complaint by the United States alleges systemic use of unnecessary and excessive force against inmates to control them and to punish disobedience or disrespect. Even when some level of force is necessary, staff often use force that is disproportionate to the risk posed by inmates.

The federal report focuses on the force used against youthful inmates (most of whom are pretrial detainees) held at Rikers. It identifies a "staggering" number of injuries: nearly 44 percent of the adolescent male population in custody as of October 2012 had been subjected to use of force by correctional staff. Many of the incidents involved adolescents with significant mental health problems who have limited impulse control. An unpublished internal study by the city's Department of Health and Mental Hygiene found that over an 11 month period in 2013, 129 inmates suffered serious injuries—fractures, wounds requiring stitches, head injuries in one case, even a perforated bowel—at the hands of corrections officers. According to the *New York Times*, which obtained a copy of the study, the report lays "bare the culture of

brutality [at Rikers] and makes clear that it is inmates with mental illnesses who absorb the overwhelming brunt of the violence."[302] Inmates with mental illness, who make up 40 percent of the jail population, suffered more than three-quarters of the injuries from staff use of force documented in the study.

According to the federal report, youth are in constant danger of physical harm even when they present no risk to the system or safety of the staff. Inmates are beaten and battered for minor infractions. Force is routinely used not so much to keep order but for the express purpose of "inflicting injuries and pain.... Inmates are beaten as a form of punishment, sometimes in apparent retribution for some perceived disrespectful conduct." The report includes, for example, a December 2012 incident in which two inmates with mental disabilities who were in the Mental Health Assessment Unit for Infracted Inmates (MAUII) facility were forcibly extracted from their cells, taken to the clinic at the George R. Vierno Center and beaten in front of medical staff. The New York City Department of Investigation (DOI) conducted an investigation and concluded that staff had assaulted both inmates "to punish and/or retaliate against the inmates for throwing urine on them and for their overall refusal to comply with earlier search procedures." The federal report provides the following lengthy description of the incident:

> Based on inmate statements and clinic staff accounts, a Captain and multiple officers took turns punching the inmates in the face and body while they were restrained. One clinician reported that she observed one inmate being punched in the head while handcuffed to a gurney for what she believed to be five minutes. Another clinician reported that she observed DOC staff striking the other inmate with closed fists while he screamed for them to stop hurting him. A physician reported that when he asked what was happening, correction officers falsely told him that the inmates were banging their heads against the wall. A Captain later approached a senior [mental health] official and stated, in substance, that it was good the clinical staff were present "so that they could witness and corroborate the inmates banging their own heads into the wall." The correction officers' reports did not refer to any use of force in the clinic, and each report concluded by stating: "The inmate was escorted to the clinic without further incident or force used." The involved Captain did not submit any use of force report at all. One inmate sustained a contusion to his left shoulder and tenderness to his ribcage, and the other inmate reported suffering several contusions and soreness to his ribs and chest. One of the inmates told our consultant that he was still spitting up blood due to the incident when interviewed more than a month later.[303]

In its complaint, the Department of Justice summarizes the failure of the top management of the New York City Department of Correction, which operates Rikers island, to take meaningful steps to correct the excessive violence against inmates by staff as well as inmate-on-inmate violence. It alleges officials have failed to meaningfully address an organizational culture that tolerated unnecessary and excessive force; to ensure the use of force is properly reported and investigated; to appropriately discipline correction officers who utilize unnecessary and excessive force, as well as those who supervise such officers; and to implement measures to ensure inmates are appropriately supervised by experienced, qualified, and well-trained staff.[304]

While the lawsuit continues, steps are being taken to improve conditions at Rikers, including steps to improve the jail's ability to care for inmates with mental illness. For example, Mayor Bill de Blasio has appropriated funds to create specialized therapeutic units that reward improvements in behavior.[305] On December 17, 2014, Mayor de Blasio and Joseph Ponte, Commissioner for New York City's Department of Correction, announced the end of punitive segregation for adolescents in New York City jails. "By ending the use of punitive segregation for adolescents, we are shifting away from a jail system that punishes its youngest inmates, to one that is focused on rehabilitation with the goal of helping put these young New Yorkers on the path to better outcomes," said Mayor de Blasio. "Commissioner Ponte is a proven change agent and today's announcement is one of a series of reforms under his leadership that will begin to stabilize the situation and unwind the decades of neglect that have led to unacceptable levels of violence on Rikers Island."[306]

Orleans Parish Prison

In 2012, prisoners at the Orleans Parish Prison (OPP), the city jail for New Orleans run by the New Orleans Sheriff's department, filed a class action lawsuit alleging unconstitutional jail conditions, including staff violence against inmates, inmate-on-inmate violence, and terrible medical and mental health care.[307] The Department of Justice joined the lawsuit after its investigations revealed OPP to be a "violent and dangerous institution, with shockingly high rates of serious prisoner-on-prisoner violence and officer misconduct.... The violence, sexual assaults, and pervasive atmosphere of fear are the direct result of such failures in jail management as adequate staffing, poor staff training, failed systems of accountability."[308] According to the Department of Justice, OPP also lacked appropriate mechanisms to identify prisoners with mental illness and too few treatment staff to address their urgent and chronic conditions.[309]

The complaint provided examples of detainees with mental disabilities alleged to have been physically abused by jail officers. For example, LaShawn Jones, one of the named plaintiffs, has been diagnosed with bipolar disorder and schizophrenia.[310] She was arrested and placed in OPP on March 21, 2012 after she refused to leave a mental health center (her family was informed later that the facility could not take care of her due to budget cuts). The complaint alleges that a deputy brought her to the psychiatric floor of one of the OPP facilities and said, "You wanna fucking fight me one on one? You want to fucking play with me?" The deputy then allegedly beat Jones, leaving her with lacerations, bruises, and a blackened and bloody eye. Defendants denied the allegation.[311]

Mark Walker, another named plaintiff in the lawsuit, has been diagnosed with bipolar disorder and is legally blind. He has allegedly been attacked multiple times by inmates and beaten by staff. According to the complaint:

> One night, Mark was packing up his items to move to another facility. When he grabbed his mat, the deputy said that Mark had hit him with it. The deputy took Mark, to the back of [the facility] and beat him, while he was handcuffed. A female deputy witnessed this incident and initially laughed while Mark endured the beating, but eventually, after the deputy continued to beat Mark for an extended period of time, she told him to stop.[312]

Defendants also denied this allegation.[313]

The parties entered into settlement negotiations. Before approving their proposed settlement and certifying the proposed class, the court reviewed the evidence in the record. It concluded the record showed brutal beatings of inmates by inmates and staff, stark and shocking deficiencies in mental health and medical care, and deplorable living conditions.[314] The court also said the evidence showed OPP had "deeply ingrained problems with respect to staff members' uncontrolled use of force

on inmates."[315] Existing use of force policy was routinely ignored. Staff members were not familiar with it, supervisors did not hold them accountable for failing to comply with it, and the jail lacked a system to track uses of force or staff misconduct.[316]

The detailed June 2013 consent decree, "seeks to overhaul decades of unsafe conditions, lack of basic medical and mental health care for inmates, underfunding, insufficient staffing, and the absence of a professional corrections experience."[317] Progress at fulfilling the requirements of consent decree has been slow. Budget and political disputes between the city and the sheriff's office, disagreements among the parties, a lack of experience in professional jail management in New Orleans, and poor coordination of compliance have hampered efforts to remedy the unconstitutional conditions.

Compliance with the consent decree is monitored by a court appointed monitor. The most recent report by the monitor, issued in August 2014, found that inmates and staff "continue to face grave harm."[318] The jail remains "dangerous, there is an overreliance on use force (sic) to control inmate behavior," and it is unclear if the full extent of incidents is reported. The monitor also found, "There have not been a sufficient number of corrections deputies hired, trained, and/or deployed to allow for sufficient staffing to properly supervise inmates. [N]o policies on use of force that comply with the language of the Consent Judgment have been completed and implemented, nor staff trained."[319] The monitor further concluded that use of force reports were not timely reviewed in many cases and the reports that supervisors signed off on "were often inadequate and/or incomplete, and contained boilerplate and conclusory language that does not allow the reader to make an evaluation of the level of resistance, the level of force used, and/or the appropriateness of the force." The use of force reports do not detail "what type of behavior prompted the use of force, de-escalation efforts, and the type of force used"[320] The monitor also found that inmates with mental health problems are still held "in deplorable conditions" and that "[m]ental health care is virtually non-existent."[321]

The monitor's report ends with the recognition that "years of neglect, lack of leadership, and inadequate funding" can only be remedied in the long term, but that, meanwhile, "the health and safety of more than 2,000 inmates are in peril today." Recognizing the need for leadership to solve the problems, the report calls on the sheriff and the city to "never lose track during debates and arguments about funding (or whatever issues arise) that there are Parish citizens incarcerated who require basic care and protection."[322]

VI. Applicable Constitutional and International Human Rights Law

> Prisoners retain the essence of human dignity inherent in all persons.
>
> —*Brown v. Plata* [323]

> All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.
>
> —International Covenant on Civil and Political Rights, Article 10(1) [324]

All prisoners have the right, under the US Constitution as well as international human rights law, to be treated with respect for their humanity. Unnecessary, gratuitous, or punitive force violates that right. It can constitute cruel and unusual punishment prohibited by the Eighth Amendment to the US Constitution, and "torture or other cruel, inhuman or degrading treatment or punishment" prohibited by international human rights treaties.

The Eighth Amendment

The Eighth Amendment of the US Constitution prohibits "cruel or unusual punishments," a prohibition the courts interpret to reflect evolving standards of decency.[325] In cases centered on allegations that officers used prohibited force against specific individuals, courts consider whether the use of force was undertaken "maliciously and sadistically for the very purpose of causing harm," rather than "in a good faith effort to maintain or restore discipline."[326] The key inquiry for a court is whether officers' actions are "objectively reasonable" from the perspective of a reasonable officer on the scene in uncertain, rapidly evolving circumstances. Factors the courts consider include the need for the application of force, the extent of the injury suffered by the inmate, and the relationship between that need and the amount of force used.[327] Officers may not use gratuitous force against a prisoner who is already subdued or restrained, and the court must decide whether any force was necessary and, if some force was justified, whether the amount of force used was reasonable.

The courts recognize that officers must make difficult judgments and therefore the "infliction of pain in the course of a prison security measure ... does not amount to cruel and unusual punishment simply because it may appear in retrospect that the degree of force authorized or applied for security purposes was unreasonable, and hence unnecessary in the strict sense."[328]

When courts confront claims that use of force policies and practices create unconstitutional conditions of confinement, they consider whether officials have engaged in the "unnecessary and wanton infliction of pain" and whether they have been "deliberately indifferent" to the unnecessary suffering they cause.[329]

The mental health status of the prisoners is taken into account in determining whether use of force policies and practices are constitutional. In a significant and recent case, *Coleman v. Brown*, a federal district court confronted allegations that pepper spray was used unnecessarily and excessively against prisoners who because of their mental illness either could not understand the orders being given them or could not comply. The court noted that a violation of the Eighth Amendment with respect to use of force "arises from policies and practices that permit use of force against seriously mentally ill prisoners without regard to (1) whether their behavior was caused by mental illness and (2) the substantial and known psychiatric harm and risks thereof caused by such application of force."[330] The court concluded that for pepper spray to be used consistent with the Eighth Amendment, prison policies must establish "clear and adequate constraints on the amount, if any, of pepper spray that may be used on mentally ill inmates generally and more particularly when such inmates are confined in a space such as a cell or a hold cage." In addition, policy must

establish "significant constraints, if not a total ban, on the use of pepper spray on mentally ill inmates who because of their mental illness are unable to comply with official directives."[331]

Human Rights Law

The touchstone of human rights is the dignity of all persons. Human rights treaties to which the United States is a party, including the International Covenant on Civil and Political Rights (ICCPR) and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture) codify some of the rights that derive from this dignity and which must be respected and protected by public officials.[332] Because people involuntarily confined are particularly vulnerable to violations of their rights, both the ICCPR and the Convention against Torture give special attention to their treatment.[333]Corrections officials must treat all prisoners with humanity and respect for their inherent dignity.[334] In addition, the treaties expressly forbid subjecting a prisoner to torture or to cruel, inhuman or degrading treatment or punishment.[335]

Torture and other prohibited cruel, inhuman, or degrading treatment are not subject to precise delineation but exist on a continuum of acts by public officials (or others acting at their direction or instigation) that inflict pain or suffering, be it physical or mental.[336] The prohibition against ill-treatment should be interpreted to provide the widest possible protection against physical or mental abuse.[337] Practices by prison staff that cause acute physical or mental suffering beyond that inherent in incarceration may be impermissible regardlessof their ostensible justification.[338]

This does not mean that prison officials are prohibited from ever using force that may be painful.[339] But to be consistent with human rights, the use of force must be subject to basic principles of necessity, proportionality and non-punitiveness.[340]

Necessity: Force, including measures of control and restraint, should only be used when it is necessary and is the least intrusive or restrictive option available to ensure the safety of inmates, staff or visitors, or the security of the facility.[341] Implicit in the concept of necessity is that force is only permissible as a last resort.[342] Prison authorities must prioritize non-violent means of carrying out their duties, and can only use force if those non-violent means prove ineffective or have no possibility of success.[343]

Proportionality: In the narrow circumstances when force may be appropriate, the use of force must be kept to a minimum to achieve a legitimate objective.[344] Prison authorities may not use force greater than is necessary nor for longer than necessary.[345] Whenever the use of force is unavoidable, officials shall "exercise restraint in such use and act in proportion to the seriousness of the offence and the legitimate objectives to be achieved.'"[346] They must also "minimize damage and injury, and respect and preserve human life."[347]

Prohibition on force as punishment: Prison officials may not use corporal punishment as punishment for rule breaking by prisoners.[348]To protect against the ill treatment of prisoners, even in the pursuit of legitimate goals of safety and security, prison officers should be trained in the techniques to restrain aggressive prisoners, without unnecessarily endangering either the life of the prisoner or the life of the officer.[349] Further, prison officials must be trained to recognize situations when these techniques are necessary. For example, non-lethal incapacitating weapons, such as pepper spray, should be deployed only after the officer carefully evaluates the risk of endangering uninvolved persons and should be carefully controlled.[350]In order to prevent abuses and ensure accountability, use of force incidents must be adequately recorded. Immediately after a use of force incident, the officer must report the incident to the director of the institution.[351]When an injury or death has been caused by the use of force, an independent authority such as a prosecutor must conduct an investigation.[352]

While standards regarding the use of force for reasons of safety and security are more likely to apply to the actions of custodial staff, mental health staff have responsibilities to safeguard their patients from use of force practices that constitute ill-treatment. According to the Standard Minimum Rules for the Protection of Prisoners, which are not legally binding but provide authoritative and internationally accepted guidance on good principle and practice in the treatment of prisoners and management of penal institutions, a facility's medical director shall report to the head of the facility "whenever he considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment."[353] The head of the facility is required either to act on the medical officer's concerns or to send his own report and the medical officer's to a higher authority.[354]

Rights of Persons with Mental Disabilities

The Convention on the Rights of Persons with Disabilities (CRPD), which the United States has signed, seeks to "promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities."[355] Announcing the decision to sign the convention, President Obama stated, "Disability rights aren't just civil rights to be enforced here at home; they're universal rights to be recognized and promoted around the world."[356] To promote equality and eliminate discrimination on the basis of disability, public officials must ensure reasonable accommodation for persons with disabilities.[357]

The UN Special Rapporteur on Torture has pointed out that persons with disabilities are often segregated from society in prisons as well as in other institutions. Inside these institutions, persons with disabilities "are frequently subjected to unspeakable indignities, neglect, severe forms of restraint and seclusion, as well as physical, mental and sexual violence."[358] Under the CRPD, states have the obligation to ensure that persons deprived of their liberty are entitled to provision of reasonable accommodation.[359] "This implies an obligation to make appropriate modifications in the procedures and physical facilities of detention centres ... to ensure that persons with disabilities enjoy the same rights and fundamental freedoms as others, when such adjustments do not impose a disproportionate or undue burden. The denial or lack of reasonable accommodations for persons with disabilities may create detention and living conditions that amount to ill-treatment and torture."[360]

In a September 2014 statement, the CRPD Committee, which monitors implementation of the treaty, explained: "The committee is of the view that persons with disabilities who are sentenced to imprisonment for committing a crime should be entitled to reasonable accommodation in order not to aggravate incarceration conditions based on disability."[361]

As elaborated by the UN Special Rapporteur on Torture, the CRPD affirms the right of persons with disabilities not to be subjected to torture or other cruel, inhuman or

degrading treatment by corrections agencies.[362] If pain is inflicted unnecessarily or punitively on prisoners for conduct that reflects mental disability or, even more egregiously, in situations in which the prisoner cannot understand or comply with staff orders because of mental disability, it could constitute a violation of the CRPD as well as a violation on the universal prohibitions on ill treatment contained in the ICCPR, discussed above.

Prison officials are not required to tolerate uncontrolled misconduct by prisoners with mental disabilities. But they are required to take steps to ensure persons with mental disabilities are not discriminated against with regard to the use of force. If US jails and prisons offered prisoners with mental disabilities adequate mental health treatment, less stressful and difficult conditions of confinement and access to productive and rehabilitative programs, and services, the putative need for force would undoubtedly be significantly reduced. Similarly, ensuring custody staff engage in de-escalation techniques and seek the intervention of mental health staff to help defuse volatile situations before resorting to force can also be considered reasonable accommodation to prevent the discriminatory use of unnecessary or punitive force against persons with mental illness.

It is important to note that conduct justified for "the good of" the inmate or for another benign or beneficial purpose, such as protecting facility safety and security, may still amount to cruel, inhuman, or degrading treatment or even torture: Officials also have a different albeit interrelated obligation to prevent discriminatory mistreatment of persons with mental disabilities whether inflicted deliberately or negligently and regardless of an ostensible good purpose. [363]

Non-Lethal Weapons and Restraints

Human rights treaty bodies and experts have noted the special potential for prohibited ill-treatment to arise from the use of chemical sprays, electronic stun devices, and restraints. For example, the UN Special Rapporteur on torture has observed the possibility that misuse of restraints, chemical sprays, and electronic shock devices, particularly applied in a "degrading or painful manner," may amount to torture.[364] The UN Special Rapporteur on torture has also noted that these types of force can be misused—sometimes due to a lack of proper training—or intentionally used to inflict torture and other forms of ill treatment.[365]The Committee against Torture has expressed concern about allegations of ill-treatment of vulnerable groups by US law enforcement officers.[366]

Electronic Stun Devices

Numerous human rights bodies have criticized the use of electronic stun devices in light of international standards on use of force. The Committee against Torture has expressed concerns that electrical discharge weapons can cause "severe pain constituting a form of torture," and has recommended that at least one state party relinquish their use because the impact on the prisoners' mental and physical state appears to violate international law.[367] Confirming that the use of these weapons "should be subject to principles of necessity and proportionality," the Committee has stated that extensive use of them by law-enforcement personnel raises "serious issues of compatibility" with the Convention against Torture.[368]The Human Rights Committee has expressed concern that electronic stun devices are being used against vulnerable people, including persons with mental disabilities.[369]

In 2006, the Human Rights Committee spoke directly to the use of stun devices in the United States and registered concern that they were being used in situations where such force is not necessary.[370] The Committee suggested that US policies on the use of these weapons use do not comply with the UN Basic Principles on the Use of Firearms by Law Enforcement Officials.[371] In 2014, the Committee again raised concerns about "excessive use of force by certain law enforcement officers, including the deadly use of tasers" and suggested that the United States remained non-compliant with the Basic Principles.[372]

The European Committee for the Prevention of Torture (the CPT) has addressed the proper use of electronic stun devices (which it calls electronic discharge weapons) so as to avoid their use in ways that constitute torture or other prohibited ill-treatment.[373] In its view, any use of these devices:

> [S]hould be subject to the principles of necessity, subsidiarity, proportionality, advance warning (where feasible) and precaution.... [Their use] should be limited to situations where there is a real and immediate threat to life or risk of serious injury. Recourse to such weapons for the sole purpose of securing compliance with an order is inadmissible. Furthermore, recourse to such weapons should only be authorised when other less coercive methods (negotiation and persuasion, manual control techniques, etc.) have failed or are impracticable and where it is the only possible alternative to the use of a method presenting a greater risk of injury or death.[374]

Applying these principles to the use of these weapons in prisons, the CPT has concluded that:

> Only very exceptional circumstances (e.g. a hostage-taking situation) might justify the resort to [electrical discharge weapons] in such a secure setting, and this subject to the strict condition that the weapons concerned are used only by specially trained staff. There should be no question of any form of EDW being standard issue for staff working in direct contact with persons held in prisons or any other place of deprivation of liberty.[375]

Restraints

Under the current Standard Minimum Rules for the Treatment of Prisoners, Rule 33, instruments of restraint, such as four-point restraints, may only be used "(a) as a precaution against escape during a transfer, (b) On medical grounds by direction of the medical officer; (c) by order of the director, if other methods of control fail, in order to prevent a prisoner from injuring himself or others or from damaging property; in such instances the director shall at once consult the medical officer and report to the higher administrative authority."[376] Restraints should not be applied for longer than strictly necessary.[377] At a recent meeting of experts convened to consider changes to the Standard Minimum Rules, consensus was reached that the provision permitting restraints on medical grounds by direction of the medical officer should be deleted.[378] The experts also agreed the following principles should apply when restraints are authorized:

> (a) Restraints are to be imposed only when no lesser form of control would be effective to address the risks posed by unrestricted movement; (b) The method of restraint shall be the least intrusive necessary that is reasonably available to control the prisoner's movement, based on the level and nature of the risks posed; (c) Restraints should only be imposed for the period required, and are to be removed as soon as possible once the risks posed by unrestricted movement are no longer present.

European human rights jurisprudence affirms that restraints may only be used to avoid self-harm or serious danger to others, may never be used for punishment, and that their use for periods of time beyond what is strictly necessary can constitute inhuman or degrading treatment or punishment. [379] For example, the European Human Rights Court found that placing an individual in a restraint bed constituted inhuman and degrading treatment when the prisoner was restrained because he had been banging on the door of a cell. [380]

According to the Committee for the Prevention of Torture, "In those rare cases when resort to instruments of physical restraint is required, the prisoner concerned should be kept under constant and adequate supervision. Further, instruments of restraint should be removed at the earliest possible opportunity; they should never be applied, or their application prolonged, as a punishment."[381]

Chemical Spray

The European Court of Human Rights has held that, in certain circumstances, the use of chemical spray on a prisoner can constitute inhuman and degrading treatment. [382] Stressing the dangers of chemical spray, the court has emphasized that it should be used only in exceptional circumstances and not in confined spaces. The court was unequivocal that chemical spray "should never be deployed against a prisoner who has been brought under control."[383]

Detailed Recommendations

To Federal, State and Local Officials

- Enact the Comprehensive Justice and Mental Health Act of 2015 in the U.S. Senate and House of Representatives (S. 993 in the Senate, HR 1854 in the House), and similar state and local legislation to increase collaboration among the criminal justice, juvenile justice, mental health treatment, and substance abuse systems. Such legislation should also support and authorize funding for programs and strategies to ensure appropriate interventions for persons with mental health problems at every stage of the criminal justice system, reduce their confinement in jails and prisons, and improve treatment and rehabilitation programs for the behind bars in and in the community.

To Federal, State, and Local Officials with Responsibilities over who is Jailed or Sent to Prison

- Reduce the number of individuals with mental disabilities who have committed l low-level non-violent offenses who are confined in jails or prisons, including by increasing access to criminal justice diversion programs, and by increasing the availability of low cost or free voluntary community-based mental health services. Reducing the number of individuals with mental health problems sent to jails and prison will diminish the number who are unnecessarily confined in environments that are not likely to respond appropriately to their mental health needs and will free up correctional resources to ensure appropriate mental health treatment for those men and women who must be incarcerated for reasons of public safety, whether pre-trial or following a criminal conviction.

To Federal, State, and Local Public Officials with Responsibilities for the Allocation of Resources for Jails and Prisons

- Ensure there are enough qualified mental health professionals and treatment resources in jails and prisons to provide appropriate mental health care to prisoners with mental disabilities. Mental health treatment can help individual prisoners and increases the likelihood they will be able to return successfully to their communities following release. It can also improve facility safety and security by reducing disruptions and rule violations by such prisoners and reducing the number of instances in which use of force against prisoners with mental disabilities is deemed necessary.

To Federal, State, and Local Public Officials Who Determine or Administer Policies Governing Use of Solitary Confinement

- End the prolonged solitary confinement of any prisoner.
- End solitary confinement for prisoners with mental disabilities. When such prisoners must be segregated from the general population as a disciplinary sanction or to protect institutional safety and security, they should receive at least 20 hours a week of out-of-cell time for structured and unstructured activities, including mental health programs.

To Federal, State, and Local Public Officials Involved in Hiring Heads of Corrections Agencies

- Select as heads of corrections agencies professionals who have the skills, experience, and determination to be effective leaders and who are committed to operating safe and secure facilities in which the wellbeing and dignity of all inmates are protected. Officials should also give correctional leaders the financial resources needed to pursue humane conditions of confinement, eliminate unnecessary or excessive use of force, and respond appropriately to the unique vulnerabilities and needs of prisoners with mental disabilities. Officials should pay close attention to prison and jail conditions through effective oversight mechanisms and hold accountable, including by removing them from their positions, those leaders who fail to protect the wellbeing and dignity of those held in their facilities.

To Federal, State, and Local Public Officials Who Determine, Administer or Oversee Use of Force Policies and Practices

- Ensure that use of force policies include the following provisions:
    - A clear statement of the agency's commitment to minimize the use of force, to authorize force in non-emergency situations only when no reasonable alternative is possible or all less restrictive measures have been tried and exhausted, and then to permit only the minimum force necessary to regain control of inmates or secure inmate compliance with an order.
    - An unequivocal prohibition on the use of force as punishment or as retaliation, and on the continued use of force after a prisoner has ceased to offer

resistance or is under control.

- Except in emergencies when immediate action is required to prevent serious injury or escapes, a requirement that staff make every reasonable effort to avoid the use of force, including through the use of "cooling off" periods and verbal persuasion and negotiation strategies to defuse and de-escalate volatile situations. If an inmate is in his cell and there is no emergency, policy should also establish a presumption that force not be used unless all less restrictive measures have been tried and exhausted and securing compliance with the order is imperative for prison safety and security.
- A prohibition on the use of chemical sprays, electronic stun devices, or forced cell extractions against inmates with mental disabilities unless:
    1. there is an emergency (i.e. imminent threat of serious injury or death to a person, serious damage to property, or an escape) or
    2. custody or mental health staff have taken the time needed to make a meaningful effort, using verbal persuasion and negotiation strategies and "cooling off" time, to try to talk the inmate into complying with orders; mental health staff have determined that the individual is not experiencing psychosis and is capable of understanding and conforming his behavior to the order; and custody and mental health staff have jointly decided that on balance the risks of physical or psychological harm to the inmate from the use of force are outweighed by the importance of ensuring compliance with an order or restoring control.

- Ensure enforcement of policies and careful review of use of force incidents:
    - Senior officials at corrections facilities should review every use of force incident, including video where available, to ascertain whether the use of force was appropriate, including whether the timing, reasons for, and nature of the force used were consistent with policy. The review should determine what precipitated the incident and consider whether there were reasonable steps staff could have taken to avoid the use of force and to provide reasonable accommodations for persons with mental disabilities. Any use of force that involved the use of chemical sprays or electronic stun devices or other weaponry or caused more than minor injuries to the prisoner should be sent to headquarters for further review. The purpose of that review should include identifying cases that warrant further investigation by an entity outside the facility chain of command that reports directly to the head of the agency. Such cases should include, at a minimum, those which result in serious injury, involve blows to the head of the inmate or the use of electronic stun devices or impact weapons, and failures to promptly, fully, and truthfully report on the incidents.
    - Officials at agency headquarters should randomly review individual use of force incidents to assess compliance with policies and to ensure the quality of investigations and reviews. Headquarters officials should undertake special in-depth analyses where the nature or prevalence of uses of force suggests the need for changed policies or practices, additional staff training, or changes in programming available to or conditions of confinement for inmates.
    - Staff who do not comply with use of force policies should be subject to appropriate disciplinary sanctions up to and including dismissal and referral for criminal prosecution where appropriate.
    - Staff should be required to fully and honestly answer questions concerning the use of force, the "code of silence" should not be not tolerated, and staff who fail to forthrightly answer questions regarding use of force should be sanctioned.
    - Headquarters officials should ensure the creation of and regularly review comprehensive data on the use of force in their facilities. The data should include identification of the specific reasons for the use of force, what alternatives to use of force were tried or considered, what type of force was used, whether the force was used against a person on the mental health caseload, the names of staff and inmates involved in the incident, and the nature of any injuries sustained by inmates or staff. Based on the data and trends, officials should look more closely at use of force practices in individual facilities, look more closely at individual staff or inmate records, and take appropriate action, including disciplinary action against individuals and revision of applicable policies or practices.
    - Senior mental health staff at each facility should review each use of force against inmates on the mental health caseload to determine what precipitated the incident, whether mental health staff undertook efforts to prevent the use of force, whether a proper determination was made that the prisoner was able to understand and comply with orders prior to the use of force, and to consider what mental health staff might have done differently to avoid the incident. The mental health review should be incorporated in the facility's use of force review and sent to agency headquarters. Senior mental health staff should also notify the senior officials at the facility and at agency headquarters if they believe either custody or mental health staff have violated agency use of force policies.
    - Custody and mental health staff at both the facility level and at headquarters should periodically meet to review use of force incidents involving inmates on the mental health caseload, and to assess whether changes in policies or practices would better meet needs of patients and the safety and security of the facility.

- Ensure appropriate staff are hired, trained, and retained:
    - Correctional officers should be screened before hiring to make sure they have the character and personality to work in a professional and respectful manner with all inmates, including those who may be disruptive or difficult because of mental disabilities. Performance reviews should include consideration of whether staff interact with inmates in a respectful manner, comply with use of force policies, and provide truthful, complete responses during use of force reviews and investigations. Individuals who violate use of force policies should be held accountable through appropriate sanctions.
    - Custody staff should receive training in the academy and on an ongoing basis on the signs and symptoms of mental health conditions. Custody staff on units designated for or with high proportions of inmates with mental disabilities should receive additional mental health training.
    - Custody and mental health staff should be trained in the use of verbal negotiation and de-escalation techniques, in how to manage assaultive behavior, and in other means of responding to disruptive or assaultive inmates without recourse to use of force. Trainings should include role playing and scenario-based exercises. In-service training should ensure that staff remain familiar and comfortable with techniques to avoid use of force and have the opportunity to learn new ones.
    - Custody staff should be given positive incentives and rewards, including recognition and merit awards, for avoiding unnecessary or excessive force.

- Increase transparency and promote better understanding of use of force patterns, practices, and trends:
    - Conduct periodic audits of use of force practices with the results reported to senior facility and headquarters officials, to executive and legislative officials

who oversee or have funding responsibility for prison or jail operations, and to the public. To ensure thorough and impartial review, the audits should be conducted by experienced professionals who are not employed by the correctional agency unless they are part of an inspector general's office.

- Compile summary data on incidents involving the use of force (with names and identifying information deleted to protect privacy interests); such data should be periodically made available to the public for free and without special request, for example, by posting it on the agency website. The data should provide information on the most recently concluded period as well as trends over time.

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[1] Hans Toch, "Humpty Dumpty in the Prison," *Correctional Mental Health Report*, vol. 16, no. 4 (November/December 2014), p. 51.

[2] Doris J. James and Lauren E. Glaze, Bureau of Justice Statistics, US Department of Justice, "Mental Health Problems of Prison and Jail Inmates," September 2006, http://www.bjs.gov/content/pub/pdf/mhppji.pdf (accessed February 9, 2015), p. 10.

[3] Michael Winerip and Michael Schwartz, "Rikers: Where Mental Illness Meets Brutality in Jail," *New York Times*, July 14, 2014, http://www.nytimes.com/2014/07/14/nyregion/rikers-study-finds-prisoners-injured-by-employees.html (accessed February 15, 2015).

[4] The United States Department of Justice, "Rights of Persons Confined to Jails and Prisons," http://www.justice.gov/crt/about/spl/corrections.php (accessed April 1, 2015).

[5]Liz Szabo, "Cost of not caring: Nowhere to go," *USA Today*, May 12, 2014, http://www.usatoday.com/longform/news/nation/2014/05/12/mental-health-system-crisis/7746535/ (accessed February 10, 2015).

[6] Human Rights Watch, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, October 22, 2003, http://www.hrw.org/reports/2003/usa1003/usa1003.pdf.

[7]E. Fuller Torrey et al., Treatment Advocacy Center, "More Mentally Ill Persons are in Jails and Prisons than Hospitals: A Survey of the States," May 2010, http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf (accessed February 10, 2015); Human Rights Watch, *Ill-Equipped*,http://www.hrw.org/reports/2003/usa1003/usa1003.pdf, pp.16-19.

[8]Ibid.

[9]National Institute of Mental Health, "Any Mental Illness (AMI) Among Adults," http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml (accessed February 10, 2015) (serious mental illness defined as a mental disorder with serious functional impairment which substantially interferes with and limits one or more major life activities). See also, National Alliance on Mental Illness (NAMI), "Mental Illness Facts and Numbers," http://www.nami.org/factsheets/mentalillness_factsheet.pdf (accessed February 15, 2015).

[10] Jeffrey L. Metzner et al., "Treatment in Jails and Prisons," in Robert M. Wittstein, ed., *Treatment of Offenders with Mental Disorders* (New York: The Guilford Press, 1998), p. 211. See also David Lovell et al., "Evaluating the Effectiveness of Residential Treatment for prisoners with Mental Illness," *Criminal Justice and Behavior*, vol. 28 (February 2011), p. 83-104 (reviews of clinical studies indicate 10-15 percent of inmates in state prisons have serious mental illness).

[11] Allen J. Beck et al., Bureau of Justice Statistics, US Department of Justice, "Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-2012," Table 14, May 2013, http://www.bjs.gov/content/pub/pdf/svpjri1112.pdf (accessed March 25, 2015), p. 24. Nearly 15 percent of state and federal prisoners and 26 percent of jail inmates had symptoms of serious psychological distress. Ibid., p. 25.

[12] Doris J. James and Lauren E. Glaze, Bureau of Justice Statistics, US Department of Justice,"Mental Health Problems of Prison and Jail Inmates," September 2006, http://www.bjs.gov/content/pub/pdf/mhppji.pdf (accessed February 9, 2015).

[13]National Commission on Correctional Health Care, "The Health Status of Soon-to-be Released Inmates, A Report to Congress," March 2002, https://www.ncjrs.gov/pdffiles1/nij/grants/189735.pdf (accessed March 11, 2015), vol. 1, p. 22.

[14]American Psychiatric Association, Psychiatric *Services in Jails and Prisons*, 2nd Ed. (Washington, DC: American Psychiatric Association, 2000), p. xix.

[15]The prevalence of mental illness within individual facilities or agencies will vary depending on a variety of factors, including the quality of the community mental health system, police practices, the degree of poverty in the community, and the availability of beds in mental health hospitals. Caution should be exercised in comparing prevalence across facilities or states: the accuracy of the prevalence data depends greatly on the thoroughness, frequency, and accuracy of mental health screening and diagnoses in individual facilities and agencies.

[16] Michael Winerip and Michael Schwartz, "Rikers: Where Mental Illness Meets Brutality in Jail," *New York Times*, July 14, 2014, http://www.nytimes.com/2014/07/14/nyregion/rikers-study-finds-prisoners-injured-by-employees.html (accessed February 15, 2015).

[17]Human Rights Watch telephone interview with Waseem Ahmed, M.D. and Medical Director, Dallas County Correctional Health Services, Dallas, Texas, April 27, 2014.

[18]Email from David Lovell, Board of State and Community Corrections, Sacramento, California, to Human Rights Watch, July 29, 2014, on file at Human Rights Watch.

[19] Iowa Department of Corrections, "Seriousness/Acuity of Mentally Ill Offenders in Prison, Data Download," July 2009, http://www.doc.state.ia.us/UploadedDocument/475 (accessed March 2, 1015).

[20]*T.R. et al. v. South Carolina Department of Corrections*, case no. 2005-40-2925, slip op. (S. Car. Court of Common Pleas, Jan. 8, 2014).

[21]*Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Order, filed April 10, 2014, p.4.

[22] See Human Rights Watch, *Ill-Equipped*, http://www.hrw.org/reports/2003/usa1003/usa1003.pdf, for a more detailed overview of the reasons for high rates of incarceration of persons living with mental illness. For discussion of diversion, see generally, Substance Abuse and Mental Health Services Administration GAINS Center for Behavioral Health and Justice Transformation, "Jail Diversion," http://gainscenter.samhsa.gov/topical_resources/jail.aspaccessed March 25, 2015); Bazelon Center for Mental Health Law, "Diversion from Incarceration and Re-entry," http://www.bazelon.org/Where-We-Stand/Access-to-Services/Diversion-from-Incarceration-and-Reentry-.aspxaccessed March 25, 2015).

[23]From 2009-2012, states cut $5 billion in mental health services and eliminated 4,500 public psychiatric hospital beds. Szabo, "Cost of not caring: nowhere to go," *USA Today*, http://www.usatoday.com/longform/news/nation/2014/05/12/mental-health-system-crisis/7746535/. Individual states have had dramatic cuts: for example, between 1987 and 2003, Michigan closed three quarters of its 16 state psychiatric hospitals. Jeff Gerritt, "Mentally ill get punishment instead of treatment," *Detroit Free Press*, February 5, 2012, http://archive.freep.com/article/20120205/OPINION02/202050442/PUNISHMENT-INSTEAD-OF-TREATMENT-Hundreds-of-Michigan-s-mentally-ill-inmates-languish-in-solitary-confinement-lost-in-a-prison-system-ill-equipped-to-treat-them (accessed March 11, 2015). Illinois closed 6 of its 12 community health centers in 2012. Adults without insurance can turn to one of the six remaining clinics, but may have to travel long distances and face high out of pocket costs. Even with private insurance, individuals may have to wait many weeks or months to see a psychiatrist. Bridget Kuehn, "Criminal Justice Becomes Front Line for Mental Health Care," *JAMA: The Journal of the American Medical Association*, vol. 311, no. 19 (2014), p. 1953.

[24]Nearly 40 percent of adults with severe mental illness such as schizophrenia or bipolar disorder received no treatment in the previous year. Data from 2012 National Survey on Drug Use and Health, cited in Johnson, "Mental Illness Cases Swamp Criminal Justice System," *USA Today*, http://www.usatoday.com/story/news/nation/2014/07/21/mental-illness-law-enforcement-cost-of-not-caring/9951239/.

[25] Individuals with mental health problems often have co-occurring substance abuse problems. See generally, Substance Abuse and Mental Health Services Administration, "Co-Occurring Disorders," http://www.samhsa.gov/co-occurringaccessed March 25, 2015).

[26] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Washington, DC: American Psychiatric Association, 2013), p. 20. The latest Diagnostic and Statistical Manual of Mental Disorders, commonly referred to as the DSM-5, presents diagnostic criteria for 28 categories of mental disorders, many of which have subcategories. Categories include neurodevelopmental disorders, schizophrenia spectrum and other psychotic disorders, bipolar and related disorders, depressive disorders, personality disorders, and neurocognitive disorders. Individuals can have symptoms that cross different categories and subcategories. According to the DSM-5, "The symptoms contained in the respective diagnostic criteria sets do not constitute comprehensive definitions of underlying disorders, which encompass cognitive, emotional, behavioral and physiological processes.... Rather, they are intended to summarize characteristic syndromes of signs and symptoms that point to an underlying disorder with a characteristic developmental history, biological and environmental risk factors, neuropsychological and physiological correlates, and typical clinical course." Ibid., p. 19. The DSM-5 is used by mental health professionals to diagnose, understand and treat mental health problems.

[27] "In terms of mental disabilities, impairment cannot be understood as a fixed structural or mechanical 'abnormality'... Innate or acquired genetic or biological factors associated with the origins of serious mental disabilities are ... 'vulnerability factors' – rending the individual susceptible to psychosocial and environmental factors within society." Jonathan Kenneth Burns, "Mental health and inequity: A human rights approach to inequality, discrimination, and mental disability," *Health and Human Rights Journal*, vol. 11, no. 2 (2009), p. 22. Burns provides extensive citations to research in the United States and elsewhere on the impact of social, economic and political factors on the prevalence of mental disability and access to mental health services.

[28] Doris J. James and Lauren E. Glaze, Bureau of Justice Statistics, US Department of Justice, "Mental Health Problems of Prison and Jail Inmates," September 2006, http://www.bjs.gov/content/pub/pdf/mhppji.pdf (accessed February 9, 2015), p. 4.

[29] From a clinical perspective, the need for treatment takes into consideration many factors, including the nature and severity of the symptoms, the person's distress and pain associated with the symptoms, impairments in life activities associated with the symptoms and the risks and benefits of different types of available treatments. DSM-5, p. 20.

[30] For a description of conditions under which such prisoners commonly live, see Human Rights Watch, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness,* October 22, 2003, http://www.hrw.org/reports/2003/usa1003/usa1003.pdf.

[31] Prison and jail inmates with mental health problems are between two and three times more likely to be injured in a fight with other prisoners. Doris J. James and Lauren E. Glaze, Bureau of Justice Statistics, US Department of Justice, "Mental Health Problems of Prison and Jail Inmates," Table 16, September 2006, http://www.bjs.gov/content/pub/pdf/mhppji.pdf (accessed February 9, 2015), p. 10. Individuals in prison with mental health problems are more likely to be victimized by other prisoners, and that victimization includes rape. Prisoners with mental illnesses were sexually abused at significantly higher rates than other inmates: in a recent survey, an estimated 6.3 percent of state and federal prisoners identified with serious psychological distress reported that they were sexually victimized by another inmate compared to 0.7 percent of prisoners with no indication of mental illness. Allen J. Beck et al., Bureau of Justice Statistics, US Department of Justice, "Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-2012," May 2013, http://www.bjs.gov/content/pub/pdf/svpjri1112.pdf (accessed March 25, 2015), p. 7.

[32]See, for example, the descriptions of conditions of the Orleans Parish Prison in *Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Order Approving Consent Judgment and Certifying Settlement Class, filed on June 6, 2013 (cells covered with crusted fecal matter, urine, old food, and prisoners plagued by deaths, suicides, rapes, stabbings, and severe beatings.); South Carolina prisons *in T.R. et al. v. South Carolina Department of Corrections*, case no. 2005-40-2925, slip op. (S. Car. Court of Common Pleas, Jan. 8, 2014(cold, filthy special management cells with trash, blood and feces scattered about; inmates without blanked or mattresses sleeping on cold steel or concrete slab.); East Mississippi Correctional Facility in *Dockery v. Epps*, United States District Court for the Southern District of Mississippi, case no. 3:13-cv-326, Class Action Complaint, filed on May 30, 2013 (floors and walls caked with dirt, excrement, blood;

broken toilets so inmates defecate in plastic buckets; broken ventilation systems, vermin infestations, dark cells because of non-existent or broken light bulbs).

[33]Cheryl D. Wills, M.D., "The Impact of Conditions of Confinement on the Mental Health of Female Inmates Remanded to Alabama Department of Corrections," prepared for *Laube v. Haley*, United States District Court for the Middle District of Alabama, case no. 02-T-957-N, on file at Human Rights Watch. On December 12, 2002, the court granted plaintiffs' motion for a preliminary injunction finding that inmates at the Julia Tutwiler Prison for Women were at a substantial risk of serious harm caused by the facility's "greatly overcrowded and significantly understaffed open dorms.... [T]he unsafe conditions are so severe and widespread today that they are essentially a time bomb ready to explode facility-wide at any unexpected moment in the near future." *Laube v. Haley*, 234 F. Supp. 2d 1227, 1252 (M.D. Ala. 2002).

[34]*Ruiz v. Johnson*, 37 F. Supp. 2d 855, 914 (S.D. Texas, 1999). The quote is as apt today as when written by Judge William Wayne Justice.

[35] Our description of Lopez' death is based on *Lopez v. Wasko*, United States District Court for the District of Colorado, case no. 1:14-cv-01705, Complaint, filed June 19, 2014; which in turn draws heavily from a six-hour video made by the Department of Corrections pursuant to policies requiring staff to film certain types of prison incidents. Plaintiff's law firm Killmer, Lane & Newman law firm edited the film to a 45 minute version available on YouTube at https://www.youtube.com/watch?v=LqdLDLiyiwQ (accessed March 11, 2015). We also talked with the attorney for the estate, Human Rights Watch telephone interview with David Lane, attorney for plaintiff, Denver, Colorado, February 3, 2015; and from Tom McGhee, "Colorado gives $3 million in case of inmate who died as guards laughed," *The Denver Post*, December 18, 2014, http://www.denverpost.com/news/ci_27162848/colorado-gives-3-million-case-inmate-who-died (accessed March 30, 2015).

[36] Under Colorado Department of Corrections regulations, special controls status is to be used only to house prisoners who have become violent or destructive to themselves or others. According to the complaint, the shift commander allegedly described Lopez as "psychologically intimidating" and justified the extraction because Lopez refused to acknowledge staff directives and just lay on the floor.

[37] Tom McGhee, *The Denver Post*, "Colorado gives $3 million in case of inmate who died while guards laughed," December 18, 2014, http://www.denverpost.com/news/ci_27162848/colorado-gives-3-million-case-inmate-who-died (accessed March 30, 2015). The fact of a settlement agreement is not an indication or admission by a defendant of guilt or liability.

[38] Associated Press, "$3M settlement reached in Colorado inmate's death," December 18, 2014, http://coloradosprings.com/3m-settlement-reached-in-colorado-inmates-death/article/1543323 (accessed March 30, 2015). Defendants' willingness to settle a case is not an admission of legal wrongdoing.

[39]Frederica W O'Connor, David Lovell, and Linda Brown, "Implementing Residential Treatment for Prison Inmates with Mental Illness," *Archives of Psychiatric Nursing*, vol. 16, no. 5 (October 2002), p. 232. See generally, Fred Cohen, *The Mentally Disordered Inmate and the Law*, vol. 1, 2nd edition, (Kingston, NJ: Civil. Research Institute, 2008), sections 2.3 and 4.5.

[40] The right to treatment is limited to serious conditions and the avoidance of deliberate indifference that results in the unnecessary and wanton infliction of pain. Although there is no explicit mention of a right to health care in the US constitution, the right of prisoners to receive medical and mental health treatment was established by the US Supreme Court in *Estelle v. Gamble*, 429 U.S. 97 (1976) and *Farmer v. Brennan*, 511 U.S. 825 (1994) as emerging from the Eighth Amendment's prohibition on cruel or unusual punishment. Although there is extensive jurisprudence on the meaning and application of the deliberate indifference standard, the courts have rarely addressed what constitutes a "serious" condition and no clear definition emerges from the cases. Email from Fred Cohen to Human Rights Watch, January 30, 2015. See generally, Fred Cohen, "Correctional Mental Health Law: Origins, Status, Future," *Criminal Law Bulletin*, vol. 49, no. 5 (2013); Human Rights Watch, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, http://www.hrw.org/reports/2003/10/21/ill-equipped-0, p. 209-213.

[41]*Brown v. Plata*, 131 S. Ct. 1910, 1923 (2011).

[42]The basic components of prison mental health services are well established. Prisons must have procedures for screening and identifying prisoners with mental health problems; a range of mental health treatment services, including appropriate medication and other therapeutic interventions; a sufficient number of mental health professionals to provide adequate services to all prisoners with serious mental disorders; adequate and confidential clinical records; protocols for identifying and treating suicidal prisoners; procedures to ensure timely access by prisoners to necessary mental health services; and different levels of care, e.g. emergency psychiatric services, acute inpatient wards with intermediate levels of care, and outpatient services. The minimally necessary components to pass constitutional muster were first articulated in *Ruiz v. Estelle*, 503 F. Supp. 1265 (S.D. Tex. 1980). Additional components have subsequently been identified as desirable for effective and comprehensive correctional mental health services. See Cohen, *The Mentally Disordered Inmate and the Law*, section 2.6, Components of a Treatment Program; National Commission on Correctional Health Care, *Standards of Mental Health Services in Correctional Facilities* (Chicago: NCCHC, 2008). Human Rights Watch, *Ill-Equipped*, http://www.hrw.org/reports/2003/10/21/ill-equipped-0, Chapter IX.

[43] For example, when the California prison system was at double capacity, the inability of medical and mental health staff to provide sufficient care to the prisoners yielded needless suffering and death, as evidenced by a suicide rate in California prisons 80 percent higher than the national prison average. The United States Supreme Court upheld lower court rulings that required a reduction in the prison population to remedy unconstitutionally deficient medical and mental health care. *Brown v. Plata*, 131 S. Ct. 1910 (E.D. Cal) 2011.

[44] According to a 2006 report based on a survey of inmates in a national sample of prisons and jails, among prisoners and inmates with mental health problems, only 34 percent of state prisoners, 24 percent of federal prisoners, and 17 percent of jail inmates received mental health treatment following admission. Doris J. James and Lauren E. Glaze, Bureau of Justice Statistics, Department of Justice, "Mental Health Problems of Prison and Jail Inmates," September 2006, http://www.bjs.gov/content/pub/pdf/mhppji.pdf (accessed February 9, 2015), p.9, table 14.

[45] The extent to which correctional mental health professionals provide mental health services that respect the dignity, autonomy, and rights of prisoners with mental disabilities, including their rights not to be subjected to involuntary medication or to prolonged seclusion and restraint for treatment purposes, is a critically important question, but one beyond the scope of this report, which focuses on unnecessary, excessive, and punitive use of force by correctional staff.

[46]*Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Expert Declaration of Edward Kaufman, M.D., filed March 14, 2013, p. 55.

[47] Cece Hill, "Inmate mental health care," *Corrections Compendium*, vol. 29, no. 5 (2004), p. 15-31.

[48] Jeffrey L. Metzner and Jamie Fellner, "Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics," *The Journal of the American Academy of Psychiatry and the Law*, vol. 38, no. 1 (201), http://www.hrw.org/news/2010/03/22/solitary-confinement-and-mental-illness-us-prisons (accessed February 11, 2015).

[49]*Dockery v. Epps*, United States District Court for the Southern District of Mississippi, case no. 3:13-cv-00326, Expert Report of Terry A. Kupers, M.D., on Eastern Mississippi Correctional Facility, filed September 25, 2014. See also the Class Action Complaint in that case, filed May 30, 2013.

[50]*T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed Jan. 8, 2014.

[51]Bruce C. Gage, M.D., "Expert Evaluation: Mental Health Care at the Orleans Parish Prison," March 3, 2013, p. 52, on file at Human Rights Watch. Decades of inadequate mental health care, among other problems, led to the filing of *Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Class Action for Declaratory and Injunctive Relief, filed April 2, 2012. The United States intervened in the case a few months later. In September 2013, the parties reached a settlement agreement. Ongoing monitoring pursuant to that agreement reveals progress implementing its term has been slow. An August 2014 monitors report revealed that mental health care remains "virtually non-existent." *Jones v. Gusman*, Monitors' Report No.2, filed August 26, 2014.

[52] Terry Kupers, M.D., *Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It* (San Francisco, California, Jossey-Bass Publishers: 1999), pp. 84-85. See also, Jeffrey L. Metzner, et al., "Treatment in Jails and Prisons," in *Treatment of Offenders with Mental Disorders*, ed. Robert M. Wittstein (New York: The Guilford press, 1998), p. 229. (Continuing education and training of prison mental health in addition to the use of part-time consultants can help prevent burnout.)

[53] Prisoners can, of course, be manipulative, feigning mental illness for numerous reasons— to gain a transfer, change housing assignments, seek attention, or to improve their legal situation. But manipulation is not inconsistent with mental illness. For example, behavior such as self-mutilation can be manipulative. But it can also—and simultaneously—be a symptom of a major psychiatric disorder or a self-reinforcing behavior that requires a psychiatric response. See Human Rights Watch, *Ill-Equipped*, p. 106-109.

[54]U.S.Department of Justice, "Investigation of the Pennsylvania Department of Corrections' Use of Solitary Confinement on Prisoners with Serious Mental Illness and/or Intellectual Disabilities," February 24, 2014, http://www.prisonpolicy.org/scans/DOJ_Findings_Letter_Issued_by_DOJ_2_24_2014.pdf (accessed February 9, 2015), p. 15.

[55]"[Such labeling] demonstrates gross inattention to the underlying reasons for engaging in or talking about self-harm, resulting in lack of appropriate treatment and intervention." It also ignores the fact that most prisoners who are unhappy with their housing do not engage in or threaten self-harm. Bruce C. Gage, M.D., "Expert Evaluation: Mental Health Care at the Orleans Parish Prison," March 3, 2013, p. 51, on file at Human Rights Watch.

[56] Promising programs for prisoners with personality disorders have been developed in some state correctional agencies, e.g. Massachusetts and Washington. Because the origins of personality disorders are rooted in life histories, e.g. childhood traumas and perhaps genetics, psychotropic medication developed to address brain chemistry and other organic problems that may play a role in mental illness has limited utility in addressing personality disorders.

[57] According to the DSM-5, a " personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment." DSM-5, p. 645. The DMS-5 identifies 10 specific personality disorders, with numerous subcategories. Anti-personality disorder is described as "a pattern of disregard for, and violation of, the rights of others," and borderline personality disorder is "a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity." DSM-5, p. 645.

[58] Mental health staff are likely make a diagnosis of a personality disorder, in the words of one doctor, if "an inmate does not appear to have bona fide depressive or psychotic illness at the moment he is being examined. This implies that the individual should be treated less like a patient and more like an antisocial person who needs greater control." Letter from Seymour L. Halleck, M.D. to Randall C. Berg, Florida Institute of Justice, Miami, Florida, "Evaluation of Conditions of Close Management," December 30, 2001, on file at Human Rights Watch

[59]Terry Kupers, "What to do with the Survivors? Coping with the Long-Term Effects of Isolated Confinement," *Criminal Justice and Behavior*, vol. 35, no. 8 (August 2008). http://www.nrcat.org/storage/documents/usp_kupers_what_do_with_survivors.pdf (accessed April 20, 2015), p. 1014. See also Jamie Fellner, "Afterwords: A Few Reflections," *Criminal Justice and Behavior*, vol. 35, no. 8, August 2008, 1079-1087.

[60] Human Rights Watch telephone interview with Steve Cambra, former warden, California Department of Corrections and Rehabilitation, Elk Grove, California, April 16, 2014.

[61] Human Rights Watch interview with Bruce Gage, M.D. Chief of Psychiatry, Washington State Department of Corrections, Olympia, Washington, July 14, 2014.

[62] A high percentage of prisoners diagnosed with mental illness also have co-occurring substance use disorders and those prisoners "may be more likely to have difficulty managing the stresses and expectations within corrections settings and incur disciplinary problems at higher rates than those without behavioral health issues. Some may have difficulty understanding directions or controlling impulses while in custody as well." Fred Osher et al., Council of State Governments Justice Center, "Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery," 2012, https://www.bja.gov/Publications/CSG_Behavioral_Framework.pdf (accessed March 11, 2015), p.7.

[63]Kupers, *Prison Madness*, p. 81; Martin Drapkin, *Management and Supervision of Jail Inmates with Mental Disorders* (New Jersey: Civic Research Institute, 2003), ch. 4.

[64] Schizophrenia is a complex disease which may include disordered thinking or speech, delusions (fixed, rigid beliefs that have no basis in reality), hallucinations (hearing or seeing things that are not real), inappropriate emotions, confusion, withdrawal, and inattention to any personal grooming. Among the subtypes of schizophrenia is "paranoid schizophrenia" with characteristics of delusions of persecution and extreme suspiciousness.

[65] Bipolar disorder (previously called manic-depressive disorder) is characterized by frequently dramatic mood swings from depression to mania. During manic phases some people may be psychotic and experience delusions or hallucinations. See Martin Drapkin, *Management and Supervision of Jail Inmates with Mental Disorders* (New Jersey: Civic Research Institute, 2003), ch. 4, for an overview of the nature of and correctional implications of various mental diseases and disorders.

[66] Michael Winerip and Michael Schwirtz, "For Mentally Ill Inmates at Rikers Island, A Cycle of Jail and Hospitals," *New York Times*, April 10, 2015, http://www.nytimes.com/2015/04/12/nyregion/for-mentally-ill-inmates-at-rikers-a-cycle-of-jail-and-hospitals.html?_r=0 (accessed April 22, 2015).

[67] Human Rights Watch telephone interview with Dr. Jeffrey Metzner, clinical professor of psychiatry, University of Colorado Health Sciences Center, Denver, Colorado April 2, 2003.

[68] Human Rights Watch interview with Steve J. Martin, New York, New York March 9, 2015.

[69]Frederica W O'Connor, David Lovell and Linda Brown, "Implementing residential treatment for prison prisoners with mental illness," *Archives of Psychiatric Nursing*, vol. 16, no. 5 (2002), p 232. See Human Rights Watch, *Ill-Equipped*, for references to other studies.

[70] Doris J. James and Lauren E. Glaze, Bureau of Justice Statistics, "Mental health Problems of Prison and Jail Inmates," September 2006, http://www.bjs.gov/content/pub/pdf/mhppji.pdf (accessed February 9, 2015), p. 10.

[71] Ibid. Among jail inmates, 8.2 percent with mental health problems were charged with assault compared to 2.4 percent of other inmates.

[72]Dora B. Schriro, commissioner, NYC Department of Correction, "Statement to the New York City Council, Committee on Fire and Criminal Justice Services," March 7, 2013, http://www.docstoc.com/docs/153297337/Statement-to-the-New-York-City-Council-Committee-on-NYC-gov# (accessed March 20, 2015), p. 11. Schriro did not define "acutely mentally ill."

[73]*Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Expert Declaration of Eldon Vail in Support of Motion for Enforcement of Court Orders and Affirmative Relief Related to Use of Force and Disciplinary Measures, filed May 29, 2013, para 47; and Expert Declaration of Eldon Vail, filed on March 14, 2013, para 78.

[74] The de facto purpose of the disciplinary hearing is to determine the appropriate sanction. Guilt is all but a foregone conclusion. Jamie Fellner, "A Corrections Quandary," *Harvard Civil Rights-Civil Liberties Law Review*, vol. 41 (2006), p. 391-412.

[75]Ibid. Prison officials—and mental health staff—are concerned that having mental health staff involved in the disciplinary process, even if solely regarding possible mitigation of the punishment, can encourage prisoners to feign illness as an excuse to soften the punishment and could also expose clinicians to retaliation from patients. Human Rights Watch, *Ill-Equipped*, p. 64.

[76]For refusing orders to cuff up, the California inmate described in the summary of this report was punished with a 30-day loss of privileges, including use of the dayroom, TV, radio, telephone calls, and family visits. The punishment deprived him "of virtually all of his opportunities for external stimuli, which further isolates him and increases his paranoia and anxiety, and contradicts every recommendation made by the clinician in the Mental Health Assessment." *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Supplemental Expert Declaration of Edward Kaufman, M.D., In Support of Plaintiffs' Motion for Enforcement of Court Orders and Affirmative Relief Related to Use of Force and Disciplinary Measures, filed September 23, 2013, p.8. In South Carolina, inmates may be found "guilty but not accountable" in disciplinary proceedings but this finding typically had scant effect on the sanctions imposed. *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed Jan. 8, 2014, p. 12.

[77]*Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Plaintiffs' Post-Trial Brief Regarding Use of Force and Disciplinary Practices and Provision of Inpatient Mental Health Treatment to Condemned Class Members, filed November 15, 2013, p. 10. In every single instance of a cell extraction of a class member for which defendants produced documentation, CDCR charged the prisoner with a rule violation and found the prisoner guilty. The court ordered the CDCR to implement a plan that had been agreed upon in 2011 that would ensure appropriate use of mental health assessments in the disciplinary process.

[78] Memorandum of Agreement Between the United States Department of Justice and the Consolidated Government of Columbus, Georgia Regarding the Muscogee County Jail, 2015, http://www.justice.gov/crt/about/spl/documents/muscogee_moa_1-16-15.pdf (accessed April 28, 2015), p. 6. "A person with serious mental illness is a person with a mental, behavioral, or emotional disorder of mood, thought, or anxiety; diagnosable currently or within the last year; that significantly impairs judgment, behavior, capacity to recognize reality, and the ability to cope with the demands of life in the general population facilities of the Jail."

[79] Ibid. p. 15.

[80] U.S. Department of Justice, "Investigation of the Pennsylvania Department of Corrections' Use of Solitary Confinement on Prisoners with Serious Mental Illness and/or Intellectual Disabilities," February 24, 2014, http://www.justice.gov/crt/about/spl/documents/pdoc_finding_2-24-14.pdf (accessed February 16, 2015), p. 12.

[81] When segregation is imposed as punishment after a disciplinary hearing, officials refer to it as disciplinary segregation. Prisoners can also be segregated from general population as housing or classification decision made administratively. Disciplinary segregation is imposed for a specified period of time, although it can be extended if the prisoner continues to engage in misconduct. Administrative segregation can be and often is indefinite.

[82] For example, in Indiana, 33 percent of prisoners with mental illness are in segregation. *Indiana Protection and Advocacy Services Commission v. Commissioner*, United States District Court for the Southern District of Indiana, case no. 1:08-cv-01317, Entry Following Bench Trial, filed on December 31, 2012, p. 16. In the Washington State Department of Corrections, 30.5 percent of prisoners in the intensive management units have a mental illness. Vera Institute of Justice, Segregation Reduction Project, Vera/DRW Project Update, "Washington State Department of Corrections," October 2012, on file at Human Rights Watch.

[83]U.S.Department of Justice, "Investigation of the Pennsylvania Department of Corrections' Use of Solitary Confinement on Prisoners with Serious Mental Illness and/or Intellectual Disabilities," February 24, 2014, http://www.justice.gov/crt/about/spl/documents/pdoc_finding_2-24-14.pdfp. 3. In a settlement agreement in a lawsuit filed by Disability Rights Network on behalf of Pennsylvania inmates with serious mental illness, the state agreed to stop housing those inmates in its segregated housing units. Inmates with serious mental illness who require restricted housing because they pose safety and security threats are to be housed in special secure treatment units in which they receive at least 20 hours a week of unstructured and therapeutic out of cell time. *Disability Rights Network of Pennsylvania v. Wetzel*, United States District Court for the Middle District of Pennsylvania, case no. 1:13-cv-00635 Settlement Agreement, p.46, January 5, 2015.

[84]*T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed Jan. 8, 2014, p.10-11. See Human Rights Watch, *Ill-Equipped*, p. 147-149, for other examples of disproportionate confinement of inmates with mental illness in solitary confinement.

[85]U.S.Department of Justice, "Investigation of the Pennsylvania Department of Corrections' Use of Solitary Confinement on Prisoners with Serious Mental Illness and/or Intellectual Disabilities," February 24, 2014, http://www.justice.gov/crt/about/spl/documents/pdoc_finding_2-24-14.pdf p. 3.

[86]*T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed Jan. 8, 2014,

[87] For a graphic description of especially harsh isolation units, see *Parsons v. Ryan*, United States District Court for the District of Arizona, case no. 12-cv-00601, Expert Report of Craig Haney, filed November 7, 2014

[88]Psychological effects can include anxiety, depression, anger, cognitive disturbances, perceptual distortions, obsessive thoughts, paranoia, and psychosis. Jeffrey L. Metzner and Jamie Fellner, "Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics," *The Journal of the American Academy of Psychiatry and the Law*, vol. 38, no. 1 (2010). Craig Haney, "Mental Health Issues in Long Term Solitary and 'Supermax' Confinement," *Crime & Delinquency*, vol. 49, no. 1 (2003), http://www.supermaxed.com/NewSupermaxMaterials/Haney-MentalHealthIssues.pdf (accessed March 11, 2015).

[89]*T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed Jan. 8, 2014, p.6 ("Prolonged segregation of inmates with

serious mental illness, particularly those in crisis, exposes them to a substantial risk of serious harm by limiting their access to mental health counselors and psychiatrists, disturbing their eating and sleeping cycles, disrupting the administration of medications, and deepening their mental illnesses. These conditions have contributed to the deaths of multiple inmates in segregation, while placing other inmates and staff at risk.") US Department of Justice, "Investigation of the Pennsylvania Department of Corrections' Use of Solitary Confinement on Prisoners with Serious Mental Illness and/or Intellectual Disabilities," February 24, 2014, http://www.justice.gov/crt/about/spl/documents/pdoc_finding_2-24-14.pdf (accessed February 25, 2015) (noting that the manner in which the department isolates prisoners with serious mental illness "exacerbates their mental illness and leads to serious psychological and physiological harms including severe mental deterioration, psychotic decompensation, and acts of self-harm. [M]ore than 70 percent of the documented suicides occurred in the solitary confinement units"). See generally, Jamie Fellner, "Correctional Psychiatry and Human Rights: An Unfulfilled Vision," Robert Trestman, Kenneth Appelbaum and Jeffrey Metzner, eds, *The Oxford Textbook of Correctional Psychiatry* (forthcoming 2015).

[90] Metzner and Fellner, "Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics," *The Journal of the American Academy of Psychiatry and the Law.*

[91]Maureen L. O'Keefe, et al., "One Year Longitudinal Study of the Psychological Effects of Administrative Segregation," submitted to the National Institute of Justice, October 31, 2010, https://www.ncjrs.gov/pdffiles1/nij/grants/232973.pdf (accessed February 9, 2015).

[92]United Nations Human Rights Committee, "Consideration of reports submitted by States parties under Article 40 of the Covenant: Concluding observations of the Human Rights Committee," UNHRC, UN Doc. CCPR/C/USA/CO/3, December 18, 2006; United Nations Committee Against Torture, "Consideration of reports submitted by States parties under Article 19 of the Convention, Conclusions and Recommendations of the Committee Against Torture, United States of America," UN Doc. CAT/C/USA/CO/2, 2006; United Nations General Assembly, "Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment," UN Doc. A/66/ 268, August 5, 2011.

[93]UNGA, "Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment," August 5, 2011, p. 21.

[94]*Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal 1995). According to the Department of Justice, isolating prisoners on the basis of their mental illness constitutes impermissible discrimination under the Americans with Disabilities Act "where it unjustifiably denies those prisoners access to services and programs provided to most other prisoners." US Department of Justice, "Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation," May 31, 2013 (internal citations omitted), http://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf (accessed March 13, 2015).

[95] The American Psychiatric Association issued the following position statement in 2012: "Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates. If an inmate with serious mental illness is placed in segregation, out of cell structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space and adequate unstructured out of cell time should be permitted. Correctional mental health authorities should work closely with administrative custody staff to maximize access to clinically indicated programming and recreation for these individuals." American Psychiatric Association, "Position Statement on Segregation of Prisoners with Mental Illness," December 2012, http://www.dhcs.ca.gov/services/MH/Documents/2013_04_AC_06c_APA_ps2012_PrizSeg.pdf (accessed March 12, 2015);

The Society for Correctional Physicians issued a similar position statement:Society of Correctional Physicians, "Restricted Housing of Mentally Ill Inmates, Position Statement," July 9, 2013, http://societyofcorrectionalphysicians.org/resources/position-statements/restricted-housing-of-mentally-ill-inmates (accessed February 6, 2015).

[96] Memorandum of Agreement Between the United States Department of Justice and the Consolidated Government of Columbus, Georgia Regarding the Muscogee County Jail, 2015, http://www.justice.gov/crt/about/spl/documents/muscogee_moa_1-16-15.pdf (accessed April 28, 2015), p. 13. A person with serious mental illness is defined in the agreement as " a person with a mental, behavioral , or emotional disorder of mood, thought, or anxiety; diagnosable currently or within the last year; that significantly impairs judgment, behavior, capacity to recognize reality, and the ability to cope with the demands of life in the general population facilities of the Jail."

[97] When lawsuits challenging the isolation of prisoners with mental illness are brought, courts almost always order correctional agencies to eliminate solitary confinement of such prisoners or to modify the length of time they are isolated in their cells and to increase their access to mental health services and programming.

[98] Elizabeth Simpson, North Carolina Prisoner Legal Services, Inc., "Reassessing Solitary Confinement II: the Human Rights, Fiscal, and Public Safety consequences," Hearing before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights, February 24, 2014, http://solitarywatch.com/wp-content/uploads/2014/02/Jerry-Williams-testimony-for-hearing-on-solitary-confinement.pdf (accessed April 22, 2015), p. 1.

[99] Human Rights Watch interview with Jeffrey L. Metzner, M.D, Denver, Colorado March 16, 2015.

[100]*Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Testimony of Steve Martin, Evidentiary Hearing, November 5, 2013, transcript, p. 1857-1858. The Department of Justice has described the cycle of isolation, misconduct and force this way: "[A] prisoner with serious mental illness is placed in isolation with inadequate mental health care, causing him to decompensate and behave negatively; staff respond by subjecting the prisoner to harsher living conditions, denying him stimuli, and/or using excessive force against him; the prisoner's mental health continues to deteriorate, and he begins to engage in self-injurious conduct (e.g., banging his head hard and repeatedly against a concrete wall, ingesting objects, or hurling himself against the metal furnishings of his room) or attempts to kill himself; staff eventually respond by placing him in [a mental health unit] where a limited amount of treatment is provided; as soon as the prisoner begins to stabilize, he is returned to isolation, and the prisoner's mental health again spirals downward." US Department of Justice, Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation, May 31, 2013 (internal citations omitted), http://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf (accessed February 8, 2015).

[101]*Disability Law Center, Inc. v. Massachusetts Department of Correction*, United States District Court for the Court of Massachusetts, case no. 1:07-cv-10463, Memorandum and Order, filed on April 12, 2012.

[102] Information in this section based on Human Rights Watch telephone interviews and email communications in 2014 and January 2015 with Joel Andrade, Program Manager and Director of Clinical Programs, Massachusetts Partnership for Correctional Health Care, Westborough, Massachusetts, and Leslie Walker, Executive Director, Prisoner Legal Services, Boston, Massachusetts.

[103] Arthur Laudman, Jerome Laudman's uncle, quoted in "Family: Corrections Treatment of Nephew Was Inhumane," WLTX News – CBS Affiliate, January 20, 2014, http://www.wltx.com/story/news/2014/02/12/1694012/ (accessed March 12, 2015).

[104] Unless otherwise noted, information about Jerome Laudman is drawn from *Laudman v. Padula*, United States District Court for the District of South Carolina, case no. 8:12-cv-02382, Amended Complaint, filed September 7, 2012. Relying primarily on the evidence in the complaint, the court granted defendants' motions for summary judgment as to some claims and denied them as to others,

Laudman v. Padula, Report and Recommendation, filed August 22, 2013. The court addressed defendant's asserted legal defenses to liability, e.g. that the statute of limitations had expired, Eleventh Amendment immunity from monetary damages, and whether defendants could be sued in their official or individual capacities. The circumstances leading to Laudman's death are also summarized in *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed January 8, 2014, a class action case that successfully challenged the deficient treatment of inmates with mental illness in South Carolina prison.

[105]*T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed Jan. 8, 2014.

[106]According to Drs. Jeffrey Metzner and Raymond Patterson, who inspected the unit as plaintiffs' experts in *T.R. v. South Carolina Department of Corrections*, the Supermax section of the SMU was especially inappropriate as housing for inmates with mental illness because the harsh conditions of confinement were likely to exacerbate their symptoms. Prisoners in the Supermax confronted scant time out of cell, limited access to showers, filthy and unhygienic cells, and extreme social isolation. Psychiatric staffing was inadequate, and mental health services consisted primarily of short, infrequent meetings at the inmates' cell fronts, *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed January 8, 2014.

[107]Lloyd R. Greer, Investigative Report, Office of Inspector General, South Carolina Department of Corrections, June 8, 2008, p. 5. (hereinafter "Greer Report"). Greer conducted an investigation into the circumstances surrounding Laudman's death. He reviewed prison and medical records and interviewed numerous prison security and medical staff as well as inmates. His report was originally filed in court under seal but the confidentiality order was subsequently lifted and the report was attached to the Plaintiffs' Opposition to Defendants' Motion for Summary Judgment, filed August 2, 2013.

[108] Greer Report, p. 4.

[109] Greer Report, p. 7.

[110] Greer Report, p. 13

[111] Greer Report, p. 12.

[112] According to the complaint, the death certificate reported the cause of death as "cardiac arrhythmia and cardiomegaly." The case was settled in 2015 for $1.2 million. Tim Smith, "State pays $1.2 million in lawsuit over mentally ill inmate who died," *Greenville Online*, January 9, 2015. http://www.greenvilleonline.com/story/news/politics/2015/01/09/state-pays-million-lawsuit-mentally-inmate-died/21525039/ (accessed February 11, 2015). The fact of a settlement agreement is not an indication or admission by a defendant of guilt or liability.

[113] Unless otherwise noted, information about Jermaine Padilla is drawn from *Padilla v. Beard*, United States District Court for the Eastern District of California, case no. 2:14-cv-01118, Amended Complaint, filed December 2, 2014. Evidence about Padilla was also presented in the class action case *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, including a video of the cell extraction of Padilla and the following expert reports: Supplemental Expert Declaration of Edward Kaufman, M.D., in support of plaintiffs' Motion for Enforcement of Court Orders and Affirmative Relief Related to Use of Force and Disciplinary Measures, filed September 23, 2013; Declaration of Eldon Vail, filed March 14, 2013; and Expert Declaration of Eldon Vail, filed March 14, 2013.

[114] In the mental health context, the term "decompensation" is a clinical term referring to a deterioration in the condition of a person with mental illness, e.g. a worsening of symptoms and a loss of ability to function. Email communication from Pablo Stewart, M.D., to Human Rights Watch, March 30, 2015.

[115] All quotes from the psychiatrist, Dr. Ernest Wagner and statements about his views and conduct with regard to Padilla are from the transcript of his examination and cross-examination during the court hearings are from the transcript of his examination during the court hearings in *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Evidentiary hearing, October 22, 2013.

[116]Under international human rights law, the forced administration of psychiatric medication to individuals with psychosocial disabilities may amount to torture or other prohibited ill treatment. See United Nations General Assembly, "Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Mendez," A/HRC/22/53, February 1, 2013, available at http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf (accessed March 17, 2015); United Nations General Assembly, "Torture and other cruel, inhuman or degrading treatment or punishment, Note by the Secretary-General," A/63/175, July 28, 2008, http://www.refworld.org/docid/48db99e82.html (accessed February 17, 2015). Assessing whether the forced medication of Padilla constitutes torture or prohibited ill treatment is, however, beyond the scope of this report.

[117]Following prison policies, prison staff made a video of Padilla's cell extraction which was introduced as evidence in *Coleman v. Brown*. Human Rights Watch obtained a copy of the video from the court hearing that case.

[118]*Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, including a video of the cell extraction of Padilla and the following expert reports: Supplemental Expert Declaration of Edward Kaufman, M.D., in support of plaintiffs' Motion for Enforcement of Court Orders and Affirmative Relief Related to Use of Force and Disciplinary Measures, filed September 23, 2013.

[119]*Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Expert Declaration of Eldon Vail, filed March 14, 2013, p. 19.

[120] Crime/Incident Report by Captain Jenna Castro, incident log number COR-HCO-12-07-0431, dated July 24, 2012, p. 2, on file at Human Rights Watch.

[121] Ibid, p.3. "After approximately 10 minutes when the controlled use of force was initiated I decided based on the circumstances (i.e., attached lanyard, inmate distance from the food port, mental state of the inmate, OC pepper spray not having the desired effect), the best option was to ...send the cell extraction team inside of the cell to subdue the inmate."

[122] Human Rights Watch telephone interview with Lori Rifkin, attorney for Padilla, February 4, 2015.

[123]*Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Deposition of Eldon Vail, filedOctober 2, 2013, p. 139

[124]Gerritt, "When jails must be mental clinics," *Detroit Free Press*. Gerritt interviewed Monroy and his family for the story. Human rights Watch was not able to talk with Monroy, but we did interview the reporter of the story, Jeff Gerrit, now a deputy editor with the Toledo Blade. Gerritt told us that to report the story, in addition to talking with Monroy and his family, he also talked with jail staff and read a copy of Monroy's psychiatric evaluation. He said that no complaints were made about the accuracy of his account after the story ran. Human Rights Watch telephone interview with Jeff Gerritt, Toledo, Ohio, April 30, 2015.

[125]Some agencies do not track uses of force; those that keep data rarely make it public. Moreover, where use of force data is kept, it is difficult to make comparisons among agencies because of different reporting criteria and reliability. According to correctional use of force expert Jeffrey Schwartz, "In badly run facilities where there is a significant amount of excessive force, any data that exists are also likely underestimates, because many uses of force in such facilities go unreported." Human Rights Watch email correspondence with Jeffrey A. Schwartz, February 23, 2015.

[126]For example, Steve J. Martin, an independent corrections consultant, has visited, investigated or monitored hundreds of facilities in 35 states. He told Human Rights Watch that everywhere he has looked at use of force data, force has been used disproportionately against prisoners with mental illness. Human Rights Watch telephone with Steve J. Martin, Austin, Texas, April 29, 2014.

[127] The data presented here should not be used to make comparisons among jurisdictions because different agencies use different definitions regarding what constitutes use of force and how prisoners are identified as having mental disorders. We offer the data simply to show that some agencies do have data that indicates prisoners with mental illness within their jurisdiction are subjected to force more frequently than other inmates. We found no data that indicates prisoners with mental illness are less likely to be subjected to use of force.

[128]Data based on number of cell extractions, forced cell entry, restraint chair, and four or five point restraints at San Carlos and Centennial, the Colorado prison facilities devoted primarily to custody of prisoners with mental illness, from March, 2013 through February 2014. There may also be prisoners with mental illness confined in other facilities. Data provided to Human Rights Watch by Colorado Department of Corrections, on file at Human Rights Watch.

[129]In some individual prisons the disparity was even higher. At Perry Correctional institution for example, 44 percent of the mentally ill were subjected to at least one use of force compared to 16 percent of those without mental illness. Incidents involving the use of force were measured from January 2008 through September 2011. *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed Jan. 8, 2014, p. 16.

[130]*Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Deposition of Eldon Vail, para. 9-11.

[131]Data provided to Human Rights Watch by Dan J. Pacholke, Deputy Secretary, Washington State Department of Corrections, June 25, 2014. Data was not available that indicated how many prisoners with mental illness who were not in the mental health unit had force used against them.

[132] Jack Leonard and Robert Faturechi, "L.A. County jailers more likely to use force on mentally ill inmates," *Los Angeles Times*, January 11, 2012, http://articles.latimes.com/2012/jan/11/local/la-me-sheriff-jails-20120111 (accessed March 12, 2015)

[133]In the corrections context, force "means offensive or defensive physical contact with a prisoner." American Bar Association, Standard 23-5.6(a), "Force does not include a firm hold, or use of hand or leg restraints, or fitting of a stun belt, on an unresisting prisoner," in American Bar Association, *ABA Standards of Criminal Justice (3rd ed.): Treatment of Prisoners*, June 2011, http://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/Treatment_of_Prisoners.authcheckdam.pdf (accessed March 12, 2015), p. 132.

[134]Constitutional and international legal standards governing use of force are discussed later in this report.

[135] Jeffrey A. Schwartz, "Come and Get Me! The Best and Worst in Cell Extractions," *American Jails*, July/August, 2009.

[136]Human Rights Watch interview with Bernard Warner, Secretary, Washington State Department of Corrections, Olympia, Washington, July 14, 2014.

[137] Human Rights Watch interview with Major Ron Freeman, Ada County Sheriff's Office, Boise, Idaho, July 17, 2014.

[138]For a good summary of the basic precepts governing the use of force, see *Shreve v. Franklin County*, United States District Court for the Southern District of Ohio, case no. 2:10-cv-00644, Report of Plaintiffs' Expert Steve J. Martin, filed July 23, 2010. The American Bar Association standard on the use of force provides that: "Correctional authorities should use force against a prisoner only: (b) (i) to protect and ensure the safety of staff, prisoners, and others; to prevent serious property damage; or to prevent escape;(ii) if correctional authorities reasonably believe the benefits of force outweigh the risks to prisoners and staff; and(iii) as a last alternative after other reasonable efforts to resolve the situation have failed. (c) In no case should correctional authorities use force against a prisoner:(i) to enforce an institutional rule or an order unless the disciplinary process is inadequate to address an immediate security need;(ii) to gratuitously inflict pain or suffering, punish past or present conduct, deter future conduct, intimidate, or gain information; or (iii) after the risk that justified the use of force has passed." American Bar Association, *ABA Standards of Criminal Justice (3rd ed.): Treatment of Prisoners*, June 2011, p. 132. The American Correctional Association's use of force policy calls on correctional authorities to seek to reduce or prevent the necessity of the use of force, to authorize force only when no reasonable alternative is possible, to permit only the minimum force necessary, and to prohibit the use of force as a retaliatory or disciplinary measure. American Correctional Association's (ACA) public correctional policy on use of force as published in Craig Hemmens and Eugene Atherton, *Use of Force: Current Practice and Policy*, American Correctional Association, (Upper Marlboro, MD: Graphic Communications, 1999), p. vi-vii. Specific standards governing the use of force in corrections are contained in the *Standards for Adult Correctional Institutions*, American Correctional Association, (Lanham, MD: American Correctional Association, 2003); and *Standards of Adult Local Detention Facilities* (4th ed), American Correctional Association, (Lanham, MD: American Correctional Association, 2004).

[139]*Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Order, filed April 10, 2014, p. 21 (quoting defendants' use of force expert Steve J. Martin).

[140]*T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed Jan. 8, 2014, p. 21.

[141] Human Rights Watch interview with Major Ron Freeman, Ada County Sheriff's Office, Boise, Idaho, July 17, 2014.

[142]Indeed, any use of force in this situation might be excessive. Staff could simply tell the inmate that he will not receive more food until he is willing to return the tray. California regulations previously authorized immediate use of force if an inmate refused to return a food tray. Under the new policy adopted in 2014, the inmate will be told he will not get another meal until he returns the food tray. After 24 hours, the manager will decide if force should be used to retrieve the tray. Also, if the goal is simply to retrieve the tray, and the tray can be retrieved without the use of a cell extraction team and force, staff may enter the cell, retrieve the tray and exit. *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Defendants' Plans and policies Submitted in Response to April 10, 2014 and May 13, 2014 orders, Policy 51020.12.5, filed August 1, 2014.

[143]*Rosas v. Baca*, United States District Court for the Central District of California, case no. 2:12-cv-00428, Implementation Plan, 2.2 and 2.6., filed December 17, 2014. The settlement also requires policies prohibiting striking inmates in the head or kicking them on the ground absent a situation of imminent danger of serious injury.

[144]*Lashawn Jones, et al., v. Martin Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859-LMA-ALC, filed December 12, 2012, p. 11.

[145]"When a prisoner has a history of mental illness or is exhibiting behaviors consistent with mental illness, the advice and intervention of a qualified mental health professional should be sought before taking action, or, if that is not possible, as soon as is feasible." American Bar Association, *ABA Standards of Criminal Justice (3rd ed.): Treatment of Prisoners*, June 2011, p. 132.

[146]*Disability Rights Network of Pennsylvania v. Wetzel*, United States District Court for the Middle District of Pennsylvania, case no. 1:13-cv-00635, Settlement Agreement, filed on January 5, 2015, p.46.

[147] Email to Human Rights Watch from Terry Kupers, M.D, Oakland, California, April 21, 2015.

[148]*Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Supplemental Expert Declaration of Edward Kaufman, M.D. in Support of Plaintiffs' Motion for Enforcement of Court Orders and Affirmative Relief Related to the Use of Force and Disciplinary measures, filed September 23, 2013, p. 5.

[149]*Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Defendants' Plans and Policies Submitted in Response to April 10, 2014 and May 13, 2014 Orders, Coleman v. Brown, filed August 1, 2014, p. 5.

[150]Thus, for example, the Arizona Department of Corrections policies instructed staff to employ chemical sprays to prevent suicide or serious self-inflicted injury only after attempts at verbal intervention failed. But in practice, custody staff routinely and immediately sprayed inmates who made even the slightest move towards self-harm without notifying or seeking intervention by mental health staff, *Parsons v. Ryan*, United States District Court for the District of Arizona, case no. 12-00601, Expert Report of Eldon Vail, filed November 8, 2013, p. 33.

[151] Email to Human Rights Watch from Sheriff Gary Raney, Ada County Sheriff's Office, Boise, Idaho, July 9, 2014.

[152] ABA Standard 23-5.6(b)(iii); The American Bar Association's Standards on the Treatment of Prisoners, reflect "constitutional and statutory law, a variety of relevant correctional policies and professional standards, the deep expertise of the many people who assisted with the drafting, and the extensive contributions and comments of dozens of additional experts and groups, they set out principles and functional parameters to guide the operation of American jails and prisons..." American Bar Association, *ABA Standards of Criminal Justice (3rd ed.): Treatment of Prisoners*, June 2011, p. 132.

[153]*Rosas v. Baca*, United States District Court for the Central District of California, case no. 00:12-CV-00428, Complaint for Injunctive Relief Class Action, filed January 18, 2012. The parties reached a settlement agreement three years later. *Rosas v. Baca*, United States District Court for the Central District of California, case no. 00:12-CV-00428, Preliminary Order Approving Parties Proposed Settlement, filed January 23, 2015. The fact of a settlement agreement is not an indication or admission by a defendant of guilt or liability.

[154] Editorial, "Can L.A. County Jails end the culture of violence against inmates," *Los Angeles Times*, December 16, 2014 http://www.latimes.com/opinion/editorials/la-ed-rosas-settlement-los-angeles-county-jails-20141217-story.html (accessed May 1, 2015).

[155] Citizen's Commission on Jail Violence, Report, September 28, 2012, http://ccjv.lacounty.gov/wp-content/uploads/2012/09/CCJV-Report.pdf (accessed February 11, 2015), p. 96.

[156] Human Rights Watch telephone interview with Eldon Vail, former Secretary, Washington State Department of Corrections and corrections consultant, Olympia, Washington, February 10, 2015. See Human Rights Watch, *Ill-Equipped*, p. 76-78.

[157] Kenneth L. Appelbaum, "Commentary: The Use of Restraint and Seclusion in Correctional Mental Health," *Journal of the American Academy of Psychiatry and the Law*, vol. 35, no. 4 (2007), p. 432.

[158] Although training for both prison and jail staff is inadequate, training for the latter is particularly deficient. During the hiring process, there is also typically less screening of jail staff than for prison staff to ascertain their ability to work with inmates who have mental health conditions. Email to Human Rights Watch from Fred Cohen, March 24, 2015.

[159]*Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Expert Declaration of Eldon Vail, filed March 14, 2013, p. 41.

[160] Peter Eliasberg, legal director of the ACLU of Southern California, which successfully sued the Los Angeles County jails for excessive use of force, has pointed out: "You have to be on guard that some [inmates] behave differently and they often do things that if they didn't have mental illness, it would be a real true sign of aggression. But if you're sensitive that this is an inmate with mental illness, you realize it's not a deliberate attempt to incite." Leonard and Faturechi, "L.A. County jailers more likely to use force on mentally ill inmates," *Los Angeles Times*.

[161]New policies and practices required after class action litigation by plaintiffs alleging g excessive force against mentally ill prisoners often include requirements for special mental health training for custody staff. See, e.g., *Disability Rights Network of Pennsylvania v. Wetzel*, United States District Court for the Middle District of Pennsylvania, case no. 1:13-cv-00635, Settlement Agreement, filed on January 5, 2015, (requiring staff to receive training in "Mental Health First Aid Training" and crisis intervention training); *Roses v. Baca*, United States District Court for the Central District of California, case no. 00:12-CV-00428, Implementation Plan, filed on December 17, 2014 (requiring "custody specific, scenario based, skill development training" for staff to enable them to identify and work with inmates who have a mental illness as well as such training in crisis intervention and conflict resolution. .)

[162] Memorandum of Agreement Between the United States Department of Justice and the Consolidated Government of Columbus, Georgia Regarding the Muscogee County Jail, 2015, http://www.justice.gov/crt/about/spl/documents/muscogee_moa_1-16-15.pdf (accessed April 28, 2015).

[163] Fear of persons with mental illness can combine with the adrenaline rush that can occur in a volatile situation to cause correctional officers to react more violently than necessary. David A. Rembert and Howard Henderson, "Correctional Officer Excessive Use of Force: Civil Liability under Section 1983," *The Prison Journal*, vol. 94, February 2014, p. 204.

[164]Human Rights Watch telephone interview with Lorna Rhodes, PhD, Orcas Island, Washington, June 26, 2014. Rhodes, an Emeritus Professor of Anthropology at the University of Washington, is author of *Total Confinement: Madness and Reason in the Maximum Security Prison* (2004).

[165]Correctional officers often believe mental health professionals coddle their patients, are duped by manipulative prisoners, and do not sufficiently appreciate security needs. They may see mental health treatment as a lot of "mumbo jumbo." On the other hand, mental health professionals may view correctional officers as averse to and unfit for anything but regimentation, control, and force. Working together can help dismantle such stereotypes, redounding to the benefit of the inmates and creating a safer prison.

[166]*Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Expert Declaration of Eldon Vail, filed March 14, 2013, p. 36.

[167] Since correctional officers typically have the most contact with prisoners on a day to day basis, they may notice unusual behavior or changes that suggest the need for attention by mental health

staff. Understanding the nature and symptoms of mental illness enhances the ability of officers to know when mental health staff should be called. If officers view acting out as deliberate volitional misbehavior, if they do not realize a prisoner who is mumbling to himself may be hallucinating, if they do not realize huddling in the corner of a cell and refusing to heat may be a sign of crippling depression, they will not call on mental health staff. Human Rights Watch, *Ill-Equipped*, p. 75.

[168] Human Rights Watch made a site visit to the Washington State Department of Corrections, July 14-15, 2014, and spoke with senior agency officials, including the secretary, at headquarters in Olympia as well as senior officials at the Monroe Correctional Complex in Monroe, Washington. Human Rights Watch also made a site visit to the Ada County Jail, Boise, Idaho, July 17, 2014 and spoke with senior officials there as well as custody and mental health staff.

[169] Chemical agents and stun devices are commonly called either "non-lethal" or "less-lethal" weapons. The federal Bureau of Prison's basic requirement for a "less-lethal weapon is that it must serve as an effective deterrent to an inmate by inducing a high degree of discomfort or pain, but remain a weapon that cannot cause an inmate's death under any conditions." Department of Justice, Office of the Inspector General, "Review of the Department of Justice's Use of Less-Lethal Weapons," May 2009, p. 56. See Appendix One of the report for photos and descriptions of many types of weaponry.

[170]Prisoners who are in inpatient units in correctional facilities may face a lower risk of pepper spray and Tasers than prisoners in general population, because the use of force standards in such units may be more restrictive. Thus, for example, some prison inpatient units do not permit chemical spraying except when necessary to subdue an inmate engaged in conduct likely to result in serious injury or death.

[171] National Institute of Justice, "The Use of Force Continuum," August 4, 2009, http://www.nij.gov/topics/law-enforcement/officer-safety/use-of-force/Pages/continuum.aspx (accessed February 10, 2015).

[172]According to the American Bar Association these types of force should not be used except in highly unusual circumstances in which a prisoner poses an imminent threat of serious bodily harm. American Bar Association, *ABA Standards of Criminal Justice (3rd ed.): Treatment of Prisoners*, June 2011, p. 132. Recent settlements of lawsuits restrict the use of such types of force. For example, part of the settlement of a lawsuit alleging widespread inmate abuse, the Los Angeles Sheriff's Department must develop use of force policies whereby "striking an inmate in the head or kicking an inmate who is on the ground, or kicking an inmate who is not on the ground anywhere above the knees is prohibited unless the inmate is assaultive and presents an imminent danger of serious injury..." See, e.g. *Rosas v. Baca*, United States District Court for the Central District of California, case no. 00:12-CV-00428, Implementation Plan, 2.6., filed on December 17, 2014.

[173]Human Rights Watch, *Cruel and Degrading: The Use of Dogs for Cell Extractions in U.S. Prisons*, October 2006, http://www.hrw.org/reports/2006/us1006/us1006webwcover.pdf.

[174]Human Rights Watch telephone interview Dr. Kenneth Appelbaum, M.D., Shrewsbury, Massachusetts, April 22, 2014. Dr. Appelbaum, a psychiatrist, is director of the Correctional Mental Health Policy and Research, and was previously the director of mental health at the UMass Medical School's mental health program in the Massachusetts Department of Correction.

[175]As use of force expert Steve J. Martin has observed, a cell extraction "can move from a proper tactical exercise to a punitive and retaliatory exercise." Erica Goode, "When Cell Door Opens, Tough Tactics and Risk," *New York Times*, July 28, 2014, http://www.nytimes.com/2014/07/29/us/when-cell-door-opens-tough-tactics-and-risk.html (accessed March 12, 2015).

[176] Email from Jeffrey Schwartz, corrections consultant, to Human Rights Watch, February 5, 2015.

[177] In one case, for example, the medical examiner listed the probable cause of death as a "beating" which left the prisoner with "[m]ultiple blunt traumatic injuries including contusions, abrasions and lacerations of face and scalp, fracture of mandible; patterned and unpatterned abrasions and contusions on anterior and posterior trunk, multiple serial rib fractures of right and left halves of rib-cage, fracture of sternum, right and left hemothoraces, and subcutaneous emphysema extending from lower face to scrotum; lacerations and hemorrhage of gut mesenteries and liver capsule; hemorrhage within and around right adrenal gland; abrasions of right and left legs from knee to ankle level and linear abrasions on right and left wrists." *Valdes v. Crosby*, 450 F.3d 1231, 1237 (11th Cir. 2006).

[178] Information on Gregory Maurice Kitchen and the incidents leading up to his death are taken from the summary of facts in *Kitchen v. Dallas County*, case no. 13-10545 (Fifth Cir.) July 17, 2014. The trial court granted defendants' motion for summary judgment as to all of plaintiff's claims, concluding the record before it, which concluded evidence presented by both plaintiff and the defendants contained insufficient evidence to create a genuine issue of material fact. On appeal, the court of appeals reversed the grant of summary judgment ruling that there were genuine issues of material fact as to whether officers had used excessive force. The appellate court noted that, with a "few critical exceptions," most of the facts were not in dispute. The case is still pending.

[179]Asphyxia—a condition of severely deficient supply of oxygen that can happen when someone is not able to breathe normally—is a risk anytime officers kneel, sit or stand on a prisoner's chest or back while attempting to restrain him or after the person is secured. It is particularly likely when prisoners have been placed in a prone position, with the arms behind the back, making it impossible for the respiratory muscles to work properly. The inability to breathe is aggravated and a fatal outcome likely, when the prisoner is overweight or obese and one or more officers then put weight on him. See generally, "Restraint Ties and Asphyxia, Part Two – Compressional Asphyxia," *AELE Monthly Law Journal*, vol. 101, January 2009.

[180] Information on the incidents of January 21, 2005 and the use of force against Charles Agee is taken from *Bogus v. Alabama Department of Corrections*, United States District Court for the Northern District of Alabama, case no. 7:06-cv-01667, Memorandum Opinion, filed August 21, 2009. Drawing on extensive testimony and exhibits submitted by plaintiff and the defendants, the court denied defendants' motion for summary judgment because certain material facts remained in dispute.

[181] The case was settled for an undisclosed sum shortly after the court's summary judgment ruling. The fact of a settlement agreement is not an indication or admission by a defendant of guilt or liability.

[182]Human Rights Watch telephone interview with Terry Kupers, M.D, psychiatrist and correctional mental health expert, Berkeley, California, April 18, 2014.

[183]Human Rights Watch telephone interview with Dr. Kenneth Appelbaum, M.D., psychiatrist, and former director of mental health at the UMass Medical School's mental health program in the Massachusetts Department of Correction.

[184]Human Rights Watch telephone interview, Pablo Stewart M.D., psychiatrist and consultant in correctional mental health care, San Francisco, California, April 21, 2014.

[185]Human Rights Watch telephone interview with Jeffrey Metzner, M.D., psychiatrist and correctional mental health expert, Denver, Colorado, March 24, 2014. See also, *Coleman v. Brown*, United States District Court for the Eastern District of California,case no. 2:90-cv-00520, Deposition of Ernest Wagner, M.D., filed on October 22, 2013, p. 681-682 (subjecting a flagrantly psychotic patient to a violent cell extraction can exacerbate symptoms of mental illness, and if the inmate was paranoid the extraction could "exacerbate paranoid ideation").

[186]See Human Rights Watch, *Red Onion State Prison: Super-Maximum Security Confinement in Virginia*, April 1999, http://www.hrw.org/reports/1999/redonion, for an early description of the misuse of

electronic stun devices.

[187] In California prisons, chemical agents are used in approximately half of use of force incidents. Office of the Inspector General, State of California, "Use-of-Force within the California Department of Corrections and Rehabilitation January-June 2012," October 2012, http://www.oig.ca.gov/media/reports/SAR/2012/Use-of-Force%20within%20CDCR%20January-June%202012.pdf (accessed April 28, 2015).

[188]Dr. Dora B. Schriro, Commissioner, NYC Department of Correction, "Statement to the New York City Council, Committee on Fire and Criminal Justice Services," March 7, 2013, http://www.docstoc.com/docs/153297337/Statement-to-the-New-York-City-Council-Committee-on-NYC-gov# (accessed March 20, 2015), p. 6-7.

[189] The other commonly used chemical agents are chloroacetophenone (CN) and chlorobenzalmalononitrile (CS). OC is putatively less toxic than CN and CS, though there has been a paucity of research on the acute or long-term effects of any of the compounds. See Hu H, Fine J, et al., "Tear gas—harassing agent or toxic chemical weapon?" *Journal of the American Medical Association*, vol. 262 (5), August 1989, p.660-3; Graham Chambers, ed., *Crowd Control Technologies*, OMEGA Foundation (European Parliament: Luxembourg 2000), p. xxi. http://www.europarl.europa.eu/RegData/etudes/etudes/stoa/2000/168394/DG-4-STOA_ET(2000)168394_EN(PAR02).pdf.

[190]For example, in South Carolina, "officers routinely gas inmates with OC spray in amounts that exceed manufacturer instructions and at closer distances than the manufacturer directs...[They also use] MK-9, crowd control fogger devices in large disbursements in individual closed cells, again contrary to manufacturer instructions and [agency] policy." *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, stip op, filed Jan. 8, 2014, p. 18.

[191]Office of Justice Programs, Department of Justice, "Oleoresin Capsicum: Pepper Spray as a Force Alternative," March 1994. https://www.ncjrs.gov/pdffiles1/nij/grants/181655.pdf (accessed April 3, 2015).

[192]Elizabeth Simpson, North Carolina Prisoner Legal Services, Inc., "Reassessing Solitary Confinement II: the Human Rights, Fiscal, and Public Safety consequences," Hearing before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights, February 24, 2014, http://solitarywatch.com/wp-content/uploads/2014/02/Jerry-Williams-testimony-for-hearing-on-solitary-confinement.pdf (accessed April 22, 2015), p. 5.

[193]*Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Deposition of Eldon Vail, October 2, 2013, p. 125. Manufacturer instructions and agency policies call for prompt decontamination with soap and cold water of anyone who has been subjected to pepper spray. Failure to provide proper decontamination procedures can prolong the pain from the agents and puts prisoners at risk of skin burns. Numerous cases we have reviewed involving allegations or findings of misuse of pepper spray also included complaints that the inmates were denied opportunity to decontaminate or that decontamination was deliberately delayed as "punishment."

[194] "OC Vapor," Defense Technology promotional pamphlet, 2014, https://www.safariland.com/on/demandware.static/Sites-tsg-Site/Sites-tsg-Library/default/v1412382183860/resources/def-tech-pdfs/MK-9SOCVaporFlier-Web.pdf (accessed February 16, 2015).

[195]*Parsons v. Ryan*, United States District Court for the District of Arizona, Expert Report of Eldon Vail, filed November 8, 2013.

[196]Ibid., p. 35 (internal citations omitted).

[197]Ibid., p. 13-15.

[198]*T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925,Report of Plaintiffs' Expert Steve J. Martin, filed March 11, 2011.

[199]Human Rights Watch telephone interview with Terry Kupers, M.D., Berkeley, California, April 18, 2014.

[200] The videotape of the cell extraction of the prisoner, referred to as "inmate B," was introduced as evidence in *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520. The incident is discussed by plaintiffs' experts, Testimony of Edward Kaufman, M.D., Evidentiary Hearings, October 2, 2013, transcript, p. 207-211; Expert Declaration of Eldon Vail, filed May 29, 2013, p.9.

[201] Agency policies that authorize the use of chemical sprays often fail to provide guidance as to the amount that should be used, whether there should be multiple applications and, if so, how much time should lapse between each application and how and when to decide that additional spraying would be futile. Agencies also often fail to measure how much spray has been used and to record how much spray is used in each incident.

[202]*Vandehey v. Vallario*, United States District Court for the District of Colorado, case no. 1:06-cv-01405, First Amended Class Action Complaint, filed August 1, 2006, p. 13 (citing corporate memorandum obtained published by the ACLU of California in the mid-1990s).

[203]*Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Expert Declaration of Eldon Vail, filed May 29, 2013, p.12. Vail also noted that correctional officers sometimes applied chemical spray repeatedly without giving it a chance to work before the next application.

[204]*Parsons v. Ryan*, United States District Court for the District of Arizona, Expert Report of Eldon Vail, p. 35.

[205]*Thomas v. Bryant*, 614 F.3d 1288, 1311 (11th Cir. 2010), (internal citations omitted).

[206]*Parsons v. Ryan*, United States District Court for the District of Arizona, case no. 12-cv-00601, Stipulation, filed on October 14, 2014, par.27 (a)-(d).

[207]*Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Defendants' Plans and Policies Submitted in Response to April 10, 2014 and May 13, 2014 Orders, filed August 1, 2014, p.5.

[208]Information and quotes about case of Larry Ramirez from *Ramirez v. Ferguson*, United States District Court for the Western District of Arkansas, case no. 08-cv-5038, Order, filed on March 29, 2011, following a bench trial..

[209]*Christie v. Scott*, United States District Court for the Middle District of Florida, case no. 2:10-cv-00420, Expert Report by Sally Johnson, M.D., filed on July 3, 2012.

[210]C. GregorySmith and Woodhall Stopford, "Health Hazards of pepper spray," *North Carolina Medical Journal*, vol. 60, no. 5, September/October 1999, p. 268-274. See also, Michael Cohen, "The Human Health Effects of Pepper Spray: A Review of the Literature and Commentary," *Journal of Correctional Health Care*, vol. 4, issue 1, spring 1997, p. 73.

[211]Positional asphyxia occurs when an individual's body position interferes with respiration, resulting in death. See *Parsons v. Ryan*, United States District Court for the District of Arizona, case no. 12-cv-00601, Supplemental Report of Eldon Vail, p.4, describing the apparently routine but dangerous practice in Arizona prisons of cuffing inmates behind their back after they have been pepper sprayed and placing them on a gurney face down for transportation to decontamination and placement in another cell.

[212]Cohen, "The Human Health Effects of Pepper Spray: A Review of the Literature and Commentary," *Journal of Correctional Health Care*, p. 77.

[213] *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Testimony of Edward Kaufman, M.D. (E.D. Cal.) Oct. 2, 2013, p. 177-178.

[214]*Thomas v. McDonough*, United States District Court for the Middle District of Florida, case no. 3:04-cv-917, Plaintiffs Omnibus Response in Opposition to Defendants' Motions for Summary Judgment, filed September 27, 2007, p.45.

[215] Ibid., p. 46 (quoting Dr. Donald Gibbs).

[216] Ibid., p. 39 (quoting Dr. Kathryn Burns).

[217] Information on Nick Christie taken from the court's Memorandum and Order, in *Christie ex rel. Estate of Christie v. Scott*923 F.Supp.2d 1308 (M.D. Fla), Jan. 9, 2013. Christie's widow brought a lawsuit alleging excessive force and deliberate indifference to Christie's serious medical and mental health needs against the contract provider for medical and mental health services at the jail, medical staff employees, the Sheriff and his employees who worked at the jail. *Christie v. Scott*, The United States District Court for the Middle District of Florida, case no. 2:10-cv-420, Motion for Summary Judgment, filed June 11, 2012. After reviewing the record, including evidence submitted by both plaintiff and defendants, the court granted in part and denied in part defendants' motions for summary judgment, with many of plaintiff's claims against the Sheriff and the officers who participated in the pepper-spraying surviving the defendants' motions.

[218]*Christie v. Scott*, 923 F. Supp. 2d at 1323.

[219] A month after the court's decision, the sheriff's office signed a $4 million dollar settlement with Christie's wife. Aisling Swift, "Widow receives $4M settlement in Lee jail pepper-spray death," *Naples Daily News*, July 2, 2013. The fact of a settlement agreement is not an indication or admission by a defendant of guilt or liability.

[220]*Thomas v. McDonough*, United States District Court for the Middle District of Florida, case no. 3:04-cv-917, Plaintiffs Omnibus Response in Opposition to Defendants' Motions for Summary Judgment, filed on September 27, 2007, p. 14.

[221]Unless otherwise noted, all information about Jeremiah Thomas comes from *Thomas v. McNeil*, United States District Court for the Middle District of Florida, case no. 3:04-cv-917- 2009, Findings of Fact and Conclusions of Law, filed January 9, 2009 (2009 WL 64616; 2009 US Dist. LEXIS 1208), aff'd. *Thomas v. Bryant*, 614 F. 3d 1288 (11th Cir. 2010). Plaintiffs sought an injunction to prevent the Florida Department of Corrections from spraying them while housed in close management at the Florida State prison without first conducting a mental health consultation to evaluate whether they possessed the mental faculties to understand and follow instructions. Plaintiffs' contended such decisions to spray them constituted cruel and unusual punishment in violation of the Eighth Amendment. The trial court made its findings based on its evaluation of the evidence in the record, including facts jointly stipulated to by the parties and the testimony and exhibits admitted at the bench trial. Where the evidence to support a relevant finding was in dispute, the court weighed the evidence to determine which facts were more "likely true than not."

[222] The case was not a class action. By the time of trial, four of the original ten plaintiffs had been dismissed from the suit. The district court entered judgment in favor of two of the remaining plaintiffs, ruling that the Florida prison policies as applied to them were unconstitutionally cruel. Thomas died in prison while the Department of Corrections' appeal of the district court's decision was pending.

[223]*Thomas v. McNeil*, United States District Court for the Middle District of Florida, case no. 3:04-cv-917- 2009, Findings of Fact and Conclusions of Law, filed January 9, 2009 (2009 WL 64616; 2009 US Dist. LEXIS 1208), p. 33

[224] Ibid., p. 16.

[225]Many police agencies also arm law enforcement officers with electronic shock devices. According to the National Institute of Justice, as of spring 2010, conducted energy devices (CEDs) have been procured by more than 12,000 law enforcement agencies in the United States. According to the New York Civil Liberties Union, in 2011, Tasers were in use by 16,000 law enforcement agencies. New York Civil Liberties Union, "Taking Tasers Seriously: The Need for Better Regulation of Stun Guns in New York," 2011, http://www.nyclu.org/files/publications/nyclu_TaserFinal.pdf, (accessed March 13, 2015), p. 1. The number of agencies equipping officers with these weapons has soared in recent years. According to a spokesperson for the Taser, 576,000 devices were used by more than 16,500 organizations, mostly in the United States in 2012, compared to only 500 or so agencies using them in 2000. Dan Hinkel, "Doubts surface as police sharply increase Taser use," *Chicago Tribune*, January 1, 2012, http://articles.chicagotribune.com/2012-01-01/news/ct-met-taser-use-increases-20120101_1_tasers-electroshock-weapons-doubts-surface (accessed March 13, 2015). We do not know of data that indicates how many Tasers have been purchased or issued to staff working in jails or prisons.

[226]For a description of the history and functioning of Tasers, see *Thomas v. Nugent*, on petition for writ of certiorari to the United State Court of Appeals for the Fifth Circuit, case no. 13-682, Brief of Former Law Enforcement, Prosecutors, Judges, Corrections Officials, and Experts on Police Accountability and Use of Force as Amici Curiae in support of the Petitioner, filed on February 21, 2014. (The case concerned the use of Tasers by the police to secure compliance by handcuffed non-threatening persons).

[227]Stanford Criminal Justice Center, "Use of Tasers by Law Enforcement Agencies: Guidelines and Recommendations," 2005, http://www.law.stanford.edu/academic/programs/criminaljustice (accessed February 16, 2015), p. 4.

[228]We have not found documentation of patterns of electronic stun device use in correctional agencies. More attention has been paid to how police use—and misuse—them. The New York Civil Liberties Union found, for example, that New York police frequently used them even in the absence of active aggression or risk of physical injury, shocking people when they were merely passively or verbally noncompliant with a police order. New York Civil Liberties Union, "Taking Tasers Seriously: The Need for Better Regulation of Stun Guns in New York."

[229]Council of Europe, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, "CPT Standards," CPT/Inf/E (2002) 1 - Rev. 2011, March 8, 2011, p. 100.

[230]For multiple examples of the unnecessary and punitive use of electric stun devices, see *Rosas v. Baca*, United States District Court for the Central District of California, case no. 00:12-CV-00428, Complaint for Injunctive Relief Class Action, filed on January 28, 2012.

[231] See Jason Clayworth, "Tasered woman: I'd hate to see anyone else go through this," *Des Moines Register*, November 23, 2013, http://archive.desmoinesregister.com/article/20131124/NEWS01/311230057/Tasered-woman-d-hate-see-anyone-else-go-through-this (accessed February 27, 2015); and Jason Clayworth, "Register Investigation: Muscatine County Democrats call for probe of Taser use in jail," *Des Moines Register*, January 24, 20014, http://archive.desmoinesregister.com/article/20140125/NEWS14/301250059/Register-Investigation-Muscatine-County-Democrats-call-probe-Taser-use-jail (accessed February 15, 2015). Human Rights Watch was not able to contact Franks or her father, with whom she lived at the time. The newspaper accounts are based on the reporters' interviews with Franks, her father, county officials and a records review.

[232] There was some disagreement as to whether the jail failed to provide Franks with her medications or she refused to take them. Jason Clayworth, "Tasered woman: I'd hate to see anyone else go through this," *Des Moines Register*, November 23, 2013, http://archive.desmoinesregister.com/article/20131124/NEWS01/311230057/Tasered-woman-d-hate-see-anyone-else-go-through-this (accessed February 27, 2015).

[233] Ibid.

[234] The news accounts all say Franks had a Taser used on her four times. On the video, however, an officer states he had used a Taser on her three times.

[235] Disability Rights Iowa filed a lawsuit against the Muscatine County Sheriff's Department, *Disability Rights Iowa v. David White*, United States District Court for the Southern District of Iowa, case no. 4:14-cv-00092, Complaint for Injunctive and Declaratory Relief, filed March 12, 2014; the Parties settled, and the case was dismissed, Dismissal With Prejudice, filed July 1, 2014. The fact of a settlement agreement is not an indication or admission by a defendant of guilt or liability. The *Des Moines Register* reported that under the settlement, the sheriff's department agreed, among other things, to prohibit the use of Tasers under the following new provisions: "Use of Tasers on pregnant women, individuals with mental or physical impairments and inmates impaired by drugs or alcohol will be prohibited unless they individuals threaten officials' safety, act aggressively or attempt to flee or escape; in addition, Sheriff's staff must seek a mental health consultation before using a Taser or other 'electronic control device' on a person with a mental illness." Jason Noble, "Muscatine County to revise Taser policy," *Des Moines Register*, July 21, 2014, http://www.desmoinesregister.com/story/news/investigations/2014/07/07/muscatine-county-revise-taser-policy/12279619/ (accessed February 16, 2015).

[236] Information on James C. Williams comes from Jim Mustian, "Muscogee County Jail officials changed guidelines after questionable tasings," *Ledger Enquirer*, June 9, 2012, http://www.tmcnet.com/usubmit/2012/06/09/6359353.htm (accessed May 5, 2015). Mustian said his article is based on interviews and his review of internal documents.

[237] A video of the incident is posted on https://www.youtube.com/watch?v=JCD1fH2aPW4 (accessed March 23, 2015).

[238] Mustian, "Muscogee County Jail officials changed guidelines after questionable tasings," *Ledger Enquirer*. One former police officer and criminology professor who reviewed the video thought Williams was not engaged in active resistance. He is quoted in the article as saying, "He's just being a pain in the neck." He also stated, "Let's assume it was OK to tase him the first time. He goes to the floor eventually. At that point, that's where physical control and restraint – handcuffs – should have been applied in my opinion." Another police practices consultant said, "The number of uses of the Taser was just astounding" and that some of the later stuns appeared to be "gratuitous." But another expert, a police department sergeant, said the tasings were not out of line given the "number of warnings" the sergeant gave Williams. He said, "Sometimes the only thing – because of the size of the person and how violent they can get—that's allowing you to keep the status quo in the situation is to keep applying the Taser, because that's how nasty these fights get."

[239] Mustian, "Muscogee County Jail officials changed guidelines after questionable tasings," *Ledger Enquirer*.

[240]US Department of Justice, Office of the Inspector General, "Review of the Department of Justice's Use of Less-Lethal Weapons," May 2009, http://www.justice.gov/oig/reports/plus/e0903/final.pdf (accessed February 17, 2015). The report reviews studies on the effect of Tasers. The New York Civil Liberties Union reported that more than a dozen New Yorkers have died after Taser shocks. New York Civil Liberties Union, "Taking Tasers Seriously: The Need for Better Regulation of Stun Guns in New York."

[241]Taser International, Product Warnings for Law Enforcement, https://www.taser.com/images/resources-and-legal/product-warnings/downloads/law-enforcement-warnings.pdf (accessed February 17, 2015).

[242] Amnesty International, "Amnesty International Urges Stricter Limits on Police Taser Use as U.S. Death Toll reaches 500," press release, February 15, 2012, http://www.amnestyusa.org/news/press-releases/amnesty-international-urges-stricter-limits-on-police-taser-use-as-us-death-toll-reaches-500 (accessed February 17, 2015). Amnesty does not indicate the number of cases in which medical examiners concluded the shock devices contributed to or caused the fatalities. In a 2008 report, Amnesty said examiners had done so in 50 out of 334 deaths following use of stun devices. Amnesty International, "'Less than lethal'? The use of stun weapons in US law enforcement," 2008, http://www.amnesty.org/en/news-and-updates/report/tasers-potentially-lethal-and-easy-abuse-20081216 (accessed February 16, 2015).

[243]National Institute of Justice, "Study of Deaths Following Electro-Muscular Disruption," May 2011, https://www.ncjrs.gov/pdffiles1/nij/233432.pdf, (accessed February 17, 2015). National Institute of Justice, "In-Custody Death Study: The Impact of Use of Conducted Energy Devices," http://www.nij.gov/topics/technology/less-lethal/pages/incustody-deaths.aspx (accessed February 17, 2015), p. 3. The study looked at the police use of stun devices in the field, not in correctional settings

[244]Information in this section from *Shreve v. Franklin County*, United States District Court for the Southern District of Ohio, case no. 2:10-cv-644, United States' Complaint in Intervention Pursuant to 42 U.S.C. §14141, filed on November 3, 2010; Agreement between the United States of America and the Sheriff of Franklin county Ohio, http://www.justice.gov/crt/about/spl/documents/franklin_settle_2-4-11.pdf. See also *Shreve v. Franklin County*, United States District Court for the Southern District of Ohio, case no.2:10-cv-644, Individual and Class Action Complaint, filed on July 16, 2010.

[245]*Shreve v. Franklin County*, United States District Court for the Southern District of Ohio, case no.2:10-cv-644, Individual and Class Action Complaint, filed on July 16, 2010. p.12.

[246] Correctional agencies add ankle, wrist and sometimes chest straps to turn beds into vehicles for immobilization. Restraint chairs are specifically designed by their manufacturers for use in restraining an inmate, although sometimes agencies will restrain prisoners in an ordinary chair. While restraint chairs have the advantage of mobility, permitting the restraint to occur in different settings, such chairs are often used in housing units where "the environment is not supportive and staff are not trained or experienced with the use of restraint... Proper procedures are less likely to be followed in such circumstances, which increases the likelihood of an adverse outcome." Jeffrey L. Metzner et al., "Resources Document on the Use of Restraint and Seclusion in Correctional Mental Health Care,"

Journal of the American Academy of Psychiatry and the Law, vol. 35:4, 2007. p. 420. When custody staff have placed an inmate in restraints for security reasons, medical staff should review the inmate's health record for contraindications or need for accommodations, monitor the inmate's health at designated intervals and if the inmate's health is or becomes at risk, communicate immediately with custody staff. National Commission on Correctional Health Care, "Standards for Health Services in Prisons," Standard P-1-01, National Commission on Correctional Health Care, 2014.

[247]*Standards for Adult Correctional Institutions (4th ed.)*, American Correctional Association, (Lanham, MD: American Correctional Association, 2003). According to the US Department of Justice, "Because of the dangers associated with using full-body restraints, professional standards have been developed to delineate the scope of their use. These standards require staff to only use full-body restraints in exigent circumstances, and only for the briefest time necessary to ensure the safety of the subject prisoner or those around him. As with all uses of force, staff have an obligation to explore alternatives to the use of full-body restraints as a means for controlling a prisoner's behaviors. Those alternatives include engaging in de-escalation techniques, giving the prisoner medicine, and/or providing additional mental health treatment." US Department of Justice, "Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation," May 31, 2013, http://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf (accessed March 13, 2015). (internal citations omitted).

[248] "Sometimes a prisoner's ability to control his behavior can be ascertained by observation while he is restrained. In others, staff must assess the prisoner's behavior, every time they observe or interact with the restrained prisoners, looking for clues about his impulse control and emotional status." Metzner et al., "Resources Document on the Use of Restraint and Seclusion in Correctional Mental Health Care, *Journal of the American Academy of Psychiatry and the Law*, pp. 420, 424.

[249]*T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, Order, filed Jan. 8, 2014, p. 18.

[250] Ibid.

[251]*T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925,Report of Plaintiffs' Expert Steve J. Martin, filed March 11, 2011, p. 10.

[252] Ibid., p. 28. In one incident described by Martin, an inmate was placed in a restraint chair in the nude to prevent self-harm and was allowed out after four hours for an evening meal. He was thereafter returned to the chair, released again after four hours for a hygiene break and then again returned to the chair. Even though he was compliant each time he was released from the chair, he was kept there for a total of twelve hours.

[253] Email communication with Human Rights Watch on January 30, 2015 from Terry Kupers, M.D.; Human Rights Watch telephone interview with Jeffrey Metzner,M.D. Denver, Colorado, February 9, 2015. Professional standards permit mental health staff to authorize restraints "as an emergency measure to prevent imminent harm when other means of control are not effective or appropriate." Metzner et al., "Resources Document on the Use of Restraint and Seclusion in Correctional Mental Health Care," *Journal of the American Academy of Psychiatry and the Law*, p. 417.

[254] Metzner et al., "Resources Document on the Use of Restraint and Seclusion in Correctional Mental Health Care," *Journal of the American Academy of Psychiatry and the Law*, p. 419.

[255] Kenneth L. Appelbaum, M.D., "Commentary: The Use of Restraint and Seclusion in Correctional Mental Health," *Journal of the American Academy of Psychiatry and the Law*, vol. 35, No.4 (2007) p. 431.

[256] US Department of Justice, "Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation," May 31, 2013 (internal citations omitted), http://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf (accessed March 13, 2015).

[257] US Department of Justice, "Investigation of the Pennsylvania Department of Corrections' Use of Solitary Confinement on Prisoners with Serious Mental Illness and/or Intellectual Disabilities," February 24, 2014, http://www.prisonpolicy.org/scans/DOJ_Findings_Letter_Issued_by_DOJ_2_24_2014.pdf (accessed February 9, 2015), p. 15.

[258] Ibid. p. 11.

[259] Ibid., p. 24

[260] While a prisoner is in restraints, adequate nutrition, hydration, and toileting are necessary, and a health care official should perform frequent periodic assessments every 15 minutes, including a range of motion checks and complete in-person evaluations. US Department of Justice, "Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation," May 31, 2013, (internal citations omitted).

[261]Michael Valent, a Utah prisoner with schizophrenia, died in 1997 when blood clots formed in his legs broke loose and lodged in his lungs after he had spent 16 hours strapped in a restraint chair.

[262]*T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925,Report of Plaintiffs' Expert Steve J. Martin, filed March 11, 2011, p. 27

[263] Metzner et al., "Resources Document on the Use of Restraint and Seclusion in Correctional Mental Health Care," *Journal of the American Academy of Psychiatry and the* Law, p. 421.

[264]US Department of Justice, "Investigation of the State Correctional Institution at Cresson and Notice of

Expanded Investigation," May 31, 2013, p. 19.

[265] A recent review of deaths at county jails around the country found more than three dozen restraint chair deaths since the late 1990s. Anne Schindler, "Controversial restraint chair linked to jail deaths," *First Coast News*, May 7, 2014,

http://www.firstcoastnews.com/story/news/crime/2014/05/07/restraint-chair-jail-deaths-controversial/8769607/90s (accessed March 15, 2015). Deborah Dorfman, Sara Fawk and Bob Fleischner, "Restraint Chairs and People with Disabilities," Center for Public Representation, Northampton Mass, May 2012. See Amnesty International, "United States of America: The restraint chair. How many more deaths?" February 2002, http://www.refworld.org/pdfid/3c8c81f36.pdf (accessed March 13, 2015); see also Sue Burrell, "Moving Away from Hardware: The JDAI Standards on Fixed Restraint," Youth Law Center, prepared for the Annie E. Casey Foundation Juvenile Detention Alternative Initiative, February 2009, http://ylc.org/wp/wp-content/uploads/MovingAwayFromHardware-Final.pdf (accessed March 13, 2015); William P. Angrick, II, "Investigation of Restraint Device Use in Iowa's County Jails," Iowa Citizens' Aide/Ombudsman, February 2009,

https://www.legis.iowa.gov/docs/publications/CI/9966.pdf (accessed March 13, 2015).

[266]*Curtis v. Beseler*, The United States District Court for the Middle District of Florida, case no 3:13-cv-01352, Complaint and Demand for Jury Trial, filed on November 11, 2013.

[267] Unless otherwise noted, information on Daniel Linsinbigler is from Anne Schindler, "Strapped In: Local teen dies in police custody," *First Coast News*, June 16, 2014, http://www.firstcoastnews.com/story/news/local/orange- park/2014/05/07/restraint-chair-death-daniel-linsinbigler/8768079/ (accessed March 13, 2015).

[268] An audio of inmate Linus Farr describing officers taunting Linsinbigler is available at http:/download.gannet.edgesuite.net/wtlv/mp3/farr_taunting.mp3 (accessed March 30, 2015). This audio was embedded in Anne Schindler, "Strapped In: Local teen dies in police custody," *First Coast News*, June 16, 2014. The audio was made while Farr was speaking with the Sheriff's internal affairs investigators.

[269] Audio recording of Deputy Rodney Houldson, http://download.gannett.edgesuite.net/wtlv/mp3/houldson_pepperspray.mp3 (accessed March 30, 2015). This audio is embedded in Anne Schindler, "Strapped In: Local teen dies in police custody," *First Coast News*, June 16, 2014, http://www.firstcoastnews.com/story/news/local/orange-park/2014/05/07/restraint-chair-death-daniel-linsinbigler/8768079/ (accessed March 13, 2015). The audio was made while Houldson was speaking with the Sheriff's internal affairs investigators.

[270]*Curtis v. Beseler*, The United States District Court for the Middle District of Florida, case no 3:13-cv-01352, Complaint and Demand for Jury Trial, filed on November 11, 2013. The case settled for $2.2 million. Susan Cooper Eastman, "Clay County Puts A Price Tag on Daniel Linsinbigler's Life: $2.2 million," *Folio Weekly*, November 17, 2014, http://folioweekly.com/CLAY-COUNTY-PUTS-A-PRICE-TAG-ON-DANIEL-LINSINBIGLERS-LIFE-22-MILLION,11511 (accessed March 31, 2015). The fact of a settlement agreement is not an indication or admission by a defendant of guilt or liability.

[271] Information about Timothy Souder taken from *Hadix v. Caruso*, case 4:92-cv-00110, Opinion, filed November 13, 2006. Plaintiffs in Hadix, a class action case filed in 1980 regarding unconstitutional conditions in Michigan prisons, including inadequate mental health care. In 2001, the court granted defendants' request to terminate enforcement of the mental health provision of the consent decree in the case. The death of Souder along with other deaths attributable to deficient mental health care prompted a motion in 2006 by the Hadix plaintiffs to reopen the terminated provisions and for a preliminary injunction pertaining to mental healthcare. The court granted the motion and, among other things, ordered the Michigan Department of Corrections to stop using any form of punitive mechanical restraints in the facilities covered by Hadix. In that opinion, the court discussed the facts surrounding the death of Souter (identified as T.S.). Souder's estate filed a lawsuit, *Souder v. Burt*, United States District Court for the Eastern District of Michigan, 2:06-cv-14353, on October 3, 2006. The case was settled for $3,250,000 on June 18, 2008.

[272] Hadix v. Caruso, 461 F. Supp. 2nd 574, W.D. Mich (2006).

[273]Human Rights Watch telephone interview with a forensic psychiatrist [name withheld on request], New York, April 29, 2014.

[274] Retaliation can take forms other than brutality such as writing false disciplinary reports, trashing mail, denying meals or commissary access, or transferring prisoners to less desirable cells or work details. See, e.g., David A. Rembert and Howard Henderson, "Correctional Officer Excessive Use of Force: Civil Liability under Section 1983," *The Prison Journal*, vol. 94, no. 2, February 2014, p. 207.

[275]*T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925,Report of Plaintiffs' Expert Steve J. Martin, filed March 11, 2011, p. 10.

[276] Steve J. Martin, "Staff Use of Force in U.S. Confinement Settings: Lawful Control Tactics Versus Corporal Punishment," *Social Justice*, vol. 33, no. 4, 2006, p. 183.

[277] Martin, "Staff Use of Force in U.S. Confinement Settings: Lawful Control Tactics Versus Corporal Punishment, *Social Justice*, p. 183.

[278] Unless otherwise noted, information on Williams is drawn primarily from *Williams v. Wellman*, United States District Court for the Eastern District of North Carolina, case no 5:12-ct-03055, Order on Motion for Summary Judgment, filed July 17, 2014 (granting defendants' motions for summary judgement on grounds of qualified immunity based on evidence submitted by plaintiffs and defendants).

[279] Michael Biesecker, "Suit: Mentally Ill NC Inmate Often Pepper Sprayed," Associated Press, October 27, 2013, http://hamptonroads.com/2013/10/suit-nc-inmate-was-repeatedly-pepper-sprayed (accessed March 13, 2015).

[280] Ibid.

[281]*Williams v. Wellman*, United States District Court for the Eastern District of North Carolina, case no 5:12-ct-03055, Plaintiff's Response in Opposition to Defendants' Motion for Summary Judgment, filed on October 17, 2013, p. 1.

[282] The trial court, construing disputed issues of fact in the light most favorable to plaintiff, granted the defendants' motion for summary judgment. It ruled that even assuming the officer pepper sprayed Williams in his cell solely to cause him harm, Williams had failed to show that any injury from a single burst of pepper spray was more than *de minimis* or that even he had suffered harm from the use of pepper spray during the effort to extract him from his cell. The court also ruled that even if Williams did sustain fractures to three of his fingers during the alleged beating, such injuries were also *de minimis*. At the time in the Fourth Circuit, absent extraordinary circumstances, a plaintiff with *de minimis* injuries could not prevail on an excessive force claim even if the injuries were caused by officers using force maliciously and sadistically. In 2010, the Supreme Court ruled that the proper focus in an excessive force case was on the nature of and reason for the force not the extent of the injury caused. *Wilkins v. Gaddy*, 130 S. Ct. 1175 (2010).

[283] Information on Sweeper is compiled from the felony information filed by the US Attorney, *United States v. Smith*, United States District Court for the District of South Carolina, case no. 3:13-995; the complaint Sweeper filed against the jail's medical contractor and staff, alleging unconstitutionally deficient medical care, *Sweeper v. Correct Care Solutions*, United States District court for the District of South Carolina, case no. 2:14-cv-1950, Complaint, filed May 9, 2014; John Monk, "Richland County pays 750,000 to settle inmate beating suit," *The State*, July 16, 2014, http://www.thestate.com/news/local/crime/article13868816.html (accessed March 13, 2015); and Noelle Phillips, "Former Jail Guard Sentenced to 2 years in Beating of Homeless Columbia man," *The State*, April 9, 2014 http://www.thestate.com/news/local/crime/article13846913.html (accessed March 30, 2105); John Monk, "Former Richland County jail guard to be sentenced Wednesday for beating mentally-ill homeless prisoner," *The State*, April 8, 2014, http://www.thestate.com/news/local/crime/article13846580.html#storylink=cpy (accessed May 5, 2015)

[284] Monk, "Former Richland County jail guard to be sentenced Wednesday for beating mentally-ill homeless prisoner," *The State*.

[285]*United States v. Smith*, United States District Court for the District of South Carolina, case no. 3:13-995, Information, filed November 12, 2013.

[286]*United States v. Smith*, United States District Court for the District of South Carolina, case no. 3:13-995 Amended Plea Agreement, filed April 7, 2014.

[287] Monk, "Richland County pays 750,000 to settle inmate beating suit," *The State*.

[288] The delay before Sweeper was taken to a hospital may have aggravated his injuries. The pre-sentencing report noted that "While the victim required a great deal of medical care as a result of his significant injuries, the government conceded the evidence collected during the investigation does not conclusively prove the full array of injuries Sweeper sustained resulted directly from the specific assault by acts committed by Smith. Indeed, the Government represented Smith's acts started a chain of events, in combination with other concurrent causes, which proximately resulted in Sweeper's deteriorated health and required hospitalization." *United States v. Smith*, United States District Court for the District of South Carolina, case no. 3:13-995, Sentencing Memorandum, filed December 18, 2013.

[289] Richland County agreed to pay $750,000 to settle Sweeper's lawsuit. John Monk, "Richland County pays $750,000 to settle inmate beating suit," *The State*, July 16, 2014, http://www.thestate.com/news/local/crime/article13868816.html (accessed March 13, 2015). The fact of a settlement agreement is not an indication or admission by a defendant of guilt or liability. In January 2015, Sweeper's case against the medical care provider was dismissed pursuant to plaintiff's stipulation.

[290] Unless otherwise noted, information on Darren Rainey is taken from the lawsuit seeking damages that were filed by Rainey's estate, *Chapman v. Florida Department of Corrections*, United States District Court for the Southern District of Florida, case no. 1:144-cv-23323, Amended Complaint, filed on December 18, 2014. This case was consolidated with a civil rights lawsuit filed seeking injunctive relief by Disability Rights Florida claiming that Florida prison staff at the Dade Correctional Institution subjected other inmates, all with serious mental illnesses, to scalding showers in retaliation for behaviors that correctional officers did not like, *Disability Rights Florida v. Jones*, United States District Court for the Southern District of Florida, case no. 1-14-cv-23323, Amended Complaint, filed on January 23, 2015.

[291]Julie K. Brown, "Staff at a Miami-Dade prison tormented, abused mentally ill inmates, former worker says," *Miami Herald*, May 20, 2014, http://www.miamiherald.com/news/local/community/miami-dade/article1964709.html (accessed February 16, 2015).

[292]See *Disability Rights Florida v. Jones*, United States District Court for the Southern District of Florida, case no. 1-14-cv-23323, Amended Complaint, filed on January 23, 2015, p. 11.

[293] Julie K. Brown, "Behind Bars, a brutal and unexplained death," *Miami Herald*, May 18, 2014, http://www.miamiherald.com/news/local/community/miami-dade/article1964620.html (accessed March 13, 2015).

[294] Human Rights Watch telephone interview with Peter Sleasman, attorney, Florida, February 17, 2015.

[295] Information on Paul Schlosser comes from David Hench, "Prison captain fired, but later reinstated, after pepper spraying inmate," *Portland Press Herald*, March 16, 2013, http://www.pressherald.com/2013/03/16/prison-captain-fired-but-later-reinstated-after-pepper-spraying-inmate__2013-03-17/ (accessed March 2015); David Hench, "Maine prisoner files claim over pepper-spray incident," *Portland Press Herald*, December, 2013, http://www.pressherald.com/2013/12/05/maine_inmate_may_file_lawsuit_over_restraint__pepper-spraying/ (accessed March 13, 2015); and 17-minute video of the pepper spraying recorded by prison staff which can be seen at https://www.youtube.com/watch?v=0MN4ngibpHs (accessed March 31, 2015).

[296] "Confronting Confinement: A Report of the Commission on Safety and Abuse in America's Prisons," Vera Institute, June 8, 2006, http://www.vera.org/sites/default/files/resources/downloads/Confronting_Confinement.pdf (accessed March 13, 2015).

[297] Human Rights Watch interview with Steve J. Martin, New York, New York March 9, 2015.

[298]Michael Winerip and Michael Schwirtz, "Rikers: Where Mental Illness Meets Brutality in Jail," *New York Times*, July 14, 2014, http://www.nytimes.com/2014/07/14/nyregion/rikers-study-finds-prisoners-injured-by-employees.html?_r=0 (accessed March 13, 2015).

[299] Editorial, "What is Happening at Rikers Island," *New York Times*, December 15, 2015, http://www.nytimes.com/2014/12/16/nyregion/what-is-happening-at-rikers-island.html (accessed April 22, 2015).

[300]*Nunez v. City of New York*, United States District Court for the Southern District of New York, case no. 11-cv-5845, Amended Complaint, filed on May 24, 2012, p. 2-3.

[301]*Nunez v. City of New York*, United States District Court for the Southern District of New York, case no. 11-cv-5845, United States' Motion to Intervene Pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.SC. § 1997, United States' Proposed Complaint-In-Intervention, filed on December 18, 2014; U.S. Department of Justice, "CRIPA Investigation of the New York City Department of Correction Jails on Rikers Island," August 4, 2014, http://www.justice.gov/usao/nys/pressreleases/August14/RikersReportPR/SDNY%20Rikers%20Report.pdf (accessed February 17, 2015).

[302]Winerip and Schwirtz, "Rikers: Where Mental Illness Meets Brutality in Jail," *New York Times*.

[303] U.S. Department of Justice, "CRIPA Investigation of the New York City Department of Correction Jails on Rikers Island," August 4, 2014, http://www.justice.gov/usao/nys/pressreleases/August14/RikersReportPR/SDNY%20Rikers%20Report.pdf (accessed March 17, 2015), p. 15. The complaint in *Nunez v. City of New York* provides numerous and sickening examples of staff force against inmates, but does not specify which of the inmates has a serious mental illness.

[304]*Nunez v. City of New York*, United States District Court for the Southern District of New York, case no. 1:11-cv-05845, United States' Proposed Complaint-In-Intervention, filed December 18, 2014, p.2. See also U.S. Department of Justice, "CRIPA Investigation of the New York City Department of Correction Jails on Rikers Island," August 4, 2014, p. 44.

[305] Michael Winerip and Michael Schwirtz, "For Mentally Ill Inmates at Rikers Island, A Cycle of Jail and Hospitals," *New York Times*, April 10, 2015, http://www.nytimes.com/2015/04/12/nyregion/for-mentally-ill-inmates-at-rikers-a-cycle-of-jail-and-hospitals.html?_r=0 (accessed April 22, 2015).

[306] New York City Press Release, "De Blasio Administration Ends use of Punitive Segregation for Adolescent Inmates on Rikers Island," December 17, 2014, http://www1.nyc.gov/office-of-the-mayor/news/566-14/de-blasio-administration-ends-use-punitive-segregation-adolescent-inmates-rikers-island#/0 (accessed April 22, 2015).

[307]*Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Complaint, filed April 2, 2012.

[308]Civil Rights Division,U.S. Department of Justice, "Update to Letter of Findings, United States' Civil Rights Investigation of the Orleans Parish Prison System," April 23, 2012, http://www.justice.gov/crt/about/spl/documents/parish_update_4-23-12.pdf (accessed April 29, 2015), p. 2. It also concluded that the Orleans Parish Prison (OPP) had done little to prevent or correct the "pattern or practice of unnecessary and inappropriate uses of force by OPP correctional officers" that the DOJ had identified in Civil Rights Division, U.S. Department of Justice, "Orleans Parish Prison System, New Orleans, Louisiana," September 11, 2009, http://www.justice.gov/crt/about/spl/documents/parish_findlet.pdf (accessed February 17, 2015).

[309] Civil Rights Division, U.S. Department of Justice, "Update to Letter of Findings, United States' Civil Rights Investigation of the Orleans Parish Prison System," April 23, 2012, http://www.justice.gov/crt/about/spl/documents/parish_update_4-23-12.pdf (accessed February 17, 2015), p. 3.

[310]*Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Complaint, filed April 2, 2012, p. 18.

[311]*Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Answer and Defenses, filed May 17, 2012.

[312]*Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Complaint, filed April 2, 2012, p. 31.

[313]*Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Answer and Defenses, filed May 17, 2012.

[314]*Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Order Approving Consent Judgment and Certifying Settlement Class, filed June 6, 2013 (noting that the facilities are in a "state of disrepair, many toilets, sinks and showers are not functional, sewage seeps into cells.... Mental health units smell strongly of feces, urine, and rotting organic matter. Several inmates had floors and walls smeared with feces").

[315]*Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Order Approving Consent Judgment and Certifying Settlement Class, filed June 6, 2013, p. 38.

[316]Ibid.

[317]*Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Monitors' report No.2, filed August 26, 2014, p. 1.

[318]Ibid.

[319] Ibid., p. 29. According to Katie M. Schwartzmann, lead counsel for plaintiffs in the lawsuit and co-director of the MacArthur Justice Center's office in New Orleans, "The lack of progress outlined in the monitor's second report to the court reflects the grave and deadly continuing crisis facing the men, women and youth in Orleans Parish Prison. Medical care, mental health care and violence have continued to worsen, jeopardizing the lives of everyone who is held at the jail, as well as the staff." MacArthur Justice Center, "Orleans Parish Prison Lawsuit: Lack of Progress in Improving Conditions at Orleans Parish Prison 'Inexcusable,'" August 27, 2014, http://neworleans.macarthurjusticecenter.org/Projects/Motion-Granted-to-Enroll-MacArthur-Justice-Center-in-Orleans-Parish-Prison-Lawsuit.html (accessed March 17, 2015).

[320] Ibid., p. 36.

[321] Ibid., p. 6.

[322] Ibid., p. 128.

[323]*Brown v. Plata*, 131 S. Ct. 1910, 1928 (2011).

[324] International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, ratified by the United States on June 8, 1992, art. 10(1).

[325]U.S. Const., 8th Amendment. The Fourteenth Amendment's substantive due process protections have been similarly interpreted to protect pre-trial detainees, affording them somewhat greater protections because legally they are merely being held, not punished. *Bell v. Wolfish*, 441 U.S. 520, 545, n.16 (1979) ("Due process requires that a pretrial detainee not be punished. A sentenced inmate, on the other hand, may be punished, although that punishment may not be 'cruel and unusual' under the Eighth Amendment."); see also *Whitley v. Albers*, 475 U.S. 312, 327 (1986) (indicating that Fourteenth Amendment standards for use of force are at least as stringent as Eighth Amendment standards, and may not require intentional conduct like the Eighth Amendment does).

[326]*Whitley v. Albers*, 475 U.S. 312, 320-21 (1986) (quoting *Johnson v. Glick*, 481 F.2d 1028, 1033 (2d. Cir. 1973)); see also *Hudson v. McMillian*, 503 U.S. 1, 7 (1992).

[327]*Hudson v. McMillian*, 403 U.S. 1, 7 (1992); *Johnson v. Glick*, 481 F.2d 1028, 1033 (2d Cir. 1973).

[328]*Whitley v. Albers*, 475 U.S. 312, 319 (1986).

[329]E.g., *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. civ. S-90-520, Order, April 10, 2014. The two different approaches are often blended or muddled in practice. Human Rights Watch telephone interview with Fred Cohen, Tucson, Arizona, January 28, 2015.

[330]*Coleman v. Brown*, United States District Court for the Eastern District of California, case no. S-90-520, Order, April 10, 2014. Precedent firmly established that the use of pepper spray was subject to restrictions under the Eighth Amendment. In *Williams v. Benjamin*, 77 F. 3d 756, 763 (4th Cir 1996), cited by the Coleman court, the court ruled "it is a violation of the Eighth Amendment for prison officials to use mace, tear gas or other chemical agents in quantities greater than necessary..." because of their inherently dangerous characteristics.

[331]*Coleman v. Brown*, p. 14.

[332] ICCPR, adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, ratified by the United States on June 8, 1992; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture), adopted December 10, 1984, G.A. res. 39/46, annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984), entered into force June 26, 1987, ratified by the United States on October 21, 1994. See generally, Jamie Fellner, "Correctional Psychiatry and Human Rights: An Unfulfilled Vision," in Robert Trestman, Kenneth Appelbaum, and Jeffrey Metzner, eds., *The Oxford Textbook of Correctional Psychiatry* (Oxford: Oxford University Press, March 2015).

[333] See generally, Jamie Fellner, "Correctional Psychiatry and Human Rights: An Unfulfilled Vision," in Robert Trestman, Kenneth Appelbaum, and Jeffrey Metzner, eds., *The Oxford Textbook of Correctional Psychiatry* (Oxford: Oxford University Press, forthcoming 2015).

[334] International Covenant on Civil and Political Rights (ICCPR) Article 10 (states that "[a]ll persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person." Paragraph 3 of article 10 continues, "[t]he penitentiary system shall comprise treatment of prisoners the essential aim of which shall be their reformation and social rehabilitation." Ibid.

The obligation to respect the dignity of prisoners is also contained in UN documents developed to provide more detailed guidance to officials on how to apply treaty provisions with regard to prisoners and other persons subject to the authority of law enforcement officials. See, e.g., Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, G.A. res. 43/173, annex, 43 U.N. GAOR Supp. (no. 49) at 298, U.N. Doc. A/43/49 (1988), prin. 1 ("All persons under any form of detention or imprisonment shall be treated in a humane manner and with respect for the inherent dignity of the human person"); Basic Principles for the Treatment of Prisoners, adopted December 14, 1990, G.A. Res. 45/111, annex, 45 U.N. GAOR Supp. (No. 49A) at 200, U.N. Doc. A/45/49 (1990), prin. 1 ("All prisoners shall be treated with the respect due to their inherent dignity and value as human beings"); and Code of Conduct for Law Enforcement Officials, G.A. res. 34/169, annex, 34 U.N. GAOR Supp. (No. 46) at 186, U.N. Doc. A/34/46 (1979) (Code of Conduct for Law Enforcement Officials), art. 2 ("[i]n the performance of their duty, law enforcement officials shall respect and protect human dignity and maintain and uphold the human rights of all persons").

[335]ICCPR, art. 7, states "[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."The Convention against Torture, in Article 2, prohibits torture, and requires parties to take effective measures to prevent it in any territory under their jurisdiction. This prohibition is absolute and non-derogable. Article 16 of the Convention against Torture requires parties to prevent "other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture." Because it is often difficult to distinguish between cruel, inhuman, or degrading treatment or punishment and torture, the Committee against Torture, the body of human rights experts that monitors implementation of the Convention against Torture by State parties considers Article 16's prohibition to be as absolute and non-deroagable as the prohibition in Article 2. See UN Committee against Torture, General Comment No. 2. Implementation of article 2 by States Parties, U.N. Doc. CAT/C/GC/2/CRP. 1/Rev.4 (2007), para. 3.

[336] For a thorough analysis of current international law on what constitutes torture and other ill-treatment, see Nigel Rodley and Matt Pollard, *The Treatment of Prisoners under International Law* (3rd ed.), (Oxford: Oxford University Press, 2009), chapter 3.

[337]To qualify as torture, severe suffering must be intentionally inflicted for a specific purpose such as punishment. Treatment can constitute prohibited "cruel, inhuman, or degrading treatment," however, without such a specific purpose and without the same degree of pain.

[338] Insufficient, inappropriate, or untimely mental health treatment can also constitute cruel, inhuman, or degrading treatment. Such treatment can be deliberate or the result of negligence, oversight, or ignorance. As the European Committee for the Prevention of Torture has noted, inadequate health care can "lead rapidly to situations falling within the scope of the term 'inhuman and degrading treatment,'" Council of Europe, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, "CPT Standards," CPT/Inf/E (2002) 1 - Rev. 2011, March 8, 2011, p. 100. The touchstone is the suffering endured by the prisoner and whether staff conduct caused or aggravated that suffering. For example, if prisoners' mental health deteriorates and they endure serious suffering due to insufficient clinical staff to treat them, their right to be free of cruel or inhuman treatment may have been violated, regardless of the reason for the staff shortage.

[339] The U.N. Open-ended Intergovernmental Expert Group on the Standard Minimum Rules for the Treatment of Prisoners. "Second Report of Essex Expert Group on the Review of the Standard Minimum Rules For The Treatment Of Prisoners," U.N. Doc. CCPCJ/EG/6/2014/NGO.7 (Mar. 20, 2014), para. 42; observed that "international law recognizes certain legitimate reasons for using force or restraints such as to protect prisoners or staff, to prevent escape, to prevent harm and suicide and in self-defense."

[340]Various documents developed within the United Nations provide authoritative guidance on how governments may use force without engaging in torture or other cruel, inhuman or degrading treatment or punishment. See, e.g.

United Nations Standard Minimum Rules for the Treatment of Prisoners (Standard Minimum Rules), adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolution 663 C (XXIV) of July 31, 1957, and 2076 (LXII) of May 13, 1977.; Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, adopted by the General Assembly in 1988; G.A. res. 43/173, annex, 43 U.N. GAOR Supp. (no. 49) at 298, U.N. Doc. A/43/49 (1988); Basic Principles for the Treatment of Prisoners, G.A. res. 45/111, annex, 45 U.N. GAOR Supp. (no. 49A) at 200, U.N. Doc. A/45/49 (1990). Additionally there are documents directing the conduct of law enforcement officials (including prison officials) directly, such as the Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Havana, 27 August to 7 September 1990, U.N. Doc. A/CONF.144/28/Rev.1 at 112 (1990) (Basic Principles on the Use of Force and Firearms by Law Enforcement), and the Code of Conduct for Law Enforcement Officials, G.A. res. 34/169, annex, 34 U.N. GAOR Supp. (No. 46) at 186, U.N. Doc. A/34/46 (1979).

[341] According to the U.N. Open-ended Intergovernmental Expert Group on the Standard Minimum Rules for the Treatment of Prisoners: ""international law only permits the use of force and restraints in very narrow and exceptional circumstances, in line with the principles of legality, necessity and proportionality and when all other methods have been exhausted and no alternatives remain." U.N. Open-ended Intergovernmental Expert Group on the Standard Minimum Rules for the Treatment of Prisoners. "Second Report of Essex Expert Group on the Review of the Standard Minimum Rules for The Treatment Of Prisoners," March 20, 2014. These principles are also delineated by other international authorities and in authoritative documents: Principle XXIII, which states Inter-American Commission on Human Rights, "Principles and Best Practices on the Protection of Persons Deprived of their Liberty in the Americas," approved by the Commission during its 131st regular period of sessions, March 3-14, 2008. ("[t]he personnel of places of deprivation of liberty shall not use force and other coercive means, save exceptionally and proportionally, in serious, urgent and necessary cases as a last resort after having previously exhausted all other options, and for the time and to the extent strictly necessary in order to ensure security, internal order, the protection of the fundamental rights of persons deprived of liberty, the personnel, or the visitors."); Code of Conduct for Law Enforcement Officials, art. 3, ("[l]aw enforcement officials may use force only when strictly necessary);" Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, para. 15 "([l]aw enforcement officials, in their relations with persons in custody or detention, shall not use force, except when strictly necessary for the maintenance of security and order within the institution, or when personal safety is threatened). See also, Report of the U.N. Special Rapporteur Theo van Boven on torture and other cruel, inhuman or degrading treatment or punishment, "Civil and political rights, including the questions of torture and detention," Commission on Human Rights, U.N. Doc. E/CN.4/2004/56 (Dec. 23, 2003). ("use of physical force which is not genuinely justified by the conduct of the detainee may amount to torture or another form of ill-treatment.")

[342] "Workshop 2: Survey of United Nations and other best practices in the treatment of prisoners in the criminal justice system," Twelfth United Nations Congress on Crime Prevention and Criminal Justice, Salvador, Brazil, April 12-19, 2010, U.N. Doc. A/CONF.213/13 (January 28, 2010), para. 46. ("The use of force must be the last resort in controlling detainees or prisoner if good order breaks down.")

[343]Basic Principles on the Use of Force and Firearms by Law Enforcement, para. 4. states, "Law enforcement officials, in carrying out their duty, shall, as far as possible, apply non-violent means before resorting to the use of force and firearms. They may use force and firearms only if other means remain ineffective or without any promise of achieving the intended result."

[344]Basic Principles on the Use of Force and Firearms by Law Enforcement, para. 5 states, "[w]henever the lawful use of force and firearms is unavoidable, law enforcement officials shall: (a) Exercise restraint in such use and act in proportion to the seriousness of the offence and the legitimate objective to be achieved."

[345]Standard Minimum Rules, Rule 54(1) states, "Officers who have recourse to force must use no more than is strictly necessary." Code of Conduct for Law Enforcement Officials, art. 3 states, "Law enforcement officials may use force only when strictly necessary and to the extent required for the performance of their duty." With regard to instruments of restraint, the Standard Minimum Rules, Rule 34 states, "Such instruments must not be applied for any longer time than is strictly necessary." U.N. Open-ended Intergovernmental Expert Group on the Standard Minimum Rules for the Treatment of Prisoners. "Second Report of Essex Expert Group on the Review of the Standard Minimum Rules for the Treatment of Prisoners," March 20, 2014.

[346] Basic Principles on the Use of Force and Firearms, 5(a).

[347] Basic Principles on the Use of Force and Firearms, 5(b).

[348]Standard Minimum Rules, Rule 31. ("Corporal punishment, punishment by placing in a dark cell, and all cruel, inhuman or degrading punishments shall be completely prohibited as punishments for disciplinary offences.") Corporal punishment may constitute cruel, inhuman and degrading punishment. Nigel Rodley and Matt Pollard, *The Treatment of Prisoners under International Law* (3rd ed.), (Oxford: Oxford University Press, 2009), p.436. See chapter 10 in Rodley and Pollard's book for an extensive discussion of international jurisprudence on corporal punishment.

[349] Standard Minimum Rules, Rule 54(2). The European Prison Rules provide that "staff who deal directly with prisoners shall be trained in techniques that enable the minimal use of force in the restraint of prisoners who are aggressive. "Council of Europe: Committee of Ministers, Recommendation Rec(2006)2 of the Committee of Ministers to Member States on the European Prison Rules, January 11, 2006, Rule 66. (European Prison Rules). They also provide that staff who work with specific groups of prisoners, such as mentally ill prisoners, shall be given specific training for their specialized work. Ibid., Rule 81.3.

[350] Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, Principle 3,

[351]Standard Minimum Rules, Rule 54.

[352]Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, Principles 6, 22.

[353] Standard Minimum Rules, 25(2). See also the European Prison Rules, 43.3; "The medical practitioner shall report to the director whenever it is considered that a prisoner's physical or mental health is being put seriously at risk by continued imprisonment or by any condition of imprisonment, including conditions of solitary confinement."

[354] Standard Minimum Rules, Rule 26(2). The director is required to "take into consideration the reports and advice that the medical officer submits according to rules 25(2) and 26 and, in case he concurs with the recommendations made, shall take immediate steps to give effect to those recommendations; if they are not within his competence or if he does not concur with them, he shall immediately submit his own report and the advice of the medical officer to higher authority."

[355]United Nations General Assembly, Convention on the Rights of Persons with Disabilities (CPRD), adopted January 24, 2007, A/RES/61/106, entered into force May 3, 2008, signed by the United States on July 30, 2009, http://www.unhcr.org/refworld/docid/45f973632.html (accessed September 17, 2009). The United States has not yet ratified the constitution, but as a signatory, may not take actions inconsistent with it. According to the convention, "persons with disabilities include those who have long-term physical, mental intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others." The principles reflected in and measures required under the convention are similar to those contained in domestic legislation protecting persons with disabilities from discrimination. Ibid., art. 1, the goals and requirements of the convention are similar to those established under section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794(a), and by Title II of the Americans with Disabilities Act, (ADA) 42 U.S C. § 12131.

[355] "Remarks by the President on the Signing of the Convention on the Rights of Persons with Disabilities Proclamation," White House Press Release, July 24, 2009, https://www.whitehouse.gov/the-press-office/remarks-president-rights-persons-with-disabilities-proclamation-signing (accessed April 29, 2015).

[356] Ibid.

[357] "In order to promote equality and eliminate discrimination, States parties shall take all appropriate steps to ensure that reasonable accommodation is provided." CPRD, art. 5(3).

[358]United Nations General Assembly, "Torture and other cruel, inhuman or degrading treatment or punishment, Note by the Secretary-General," A/63/175, July 28, 2008, available at http://www.refworld.org/docid/48db99e82.html (accessed February 17, 2015).

[359]CPRD, art. 14(2): "States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation."

[360] United Nations General Assembly, "Torture and other cruel, inhuman or degrading treatment or punishment, Note by the Secretary-General," A/63/175, July 28, 2008, http://www.refworld.org/docid/48db99e82.html (accessed February 17, 2015)), p.12.

[361] Committee on the Rights of the Persons with Disabilities, "Statement on article 14 of the Convention on the Rights of Persons with Disabilities," September 2014, http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=15183&LangID=E#sthash.La0fXcOB.dpuf (accessed April 23, 2015).

[362] Persons with disabilities are entitled to freedom from torture or cruel, inhuman, or degrading treatment or punishment. Officials must take effective measures to "prevent persons with disabilities, on an equal basis with others" from being subjected to such treatment or punishment. CPRD, art. 15(2).

[363] The Special Rapporteur on torture has noted that that prohibited torture or other ill-treatment of persons with mental disabilities can occur even in health care settings. Authorities have sought to defend certain cruel practices in health care facilities on the grounds of efficiency, behavior modification, or medical necessity, but such good intentions may not be sufficient. Indeed, in some cases of impermissible abuse "the explicit or implicit aim of inflicting punishment, or the objective of intimidation, often exist alongside ostensibly therapeutic ones." United Nations General Assembly, "Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Mendez," A/HRC/22/53, February 1, 2013, http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf (accessed March 17, 2015), p. 6.

[364]Report of the Special Rapporteur Theo van Boven on torture and other cruel, inhuman or degrading treatment or punishment, civil and political rights, including the question of torture and detention, "Study on the situation of trade in and production of equipment which is specifically designed to inflict torture or other cruel, inhuman or degrading treatment, its origin, destination and forms," Commission on Human Rights, U.N. Doc. E/CN.4/2003/69 (January 13, 2003).

[365]Ibid.

[366] "The Committee is concerned about reports of brutality and use of excessive force by the State party's law-enforcement personnel, and the numerous allegations of their ill-treatment of vulnerable groups...which have not been adequately investigated." U.N. Committee Against Torture, "Consideration of Reports Submitted By States Parties Under Article 19 of the Convention, Conclusions and Recommendations of the Committee Against Torture," U.N. Doc. CAT/C/USA/CO/2 (2006), para. 27.

[367]"The State party should consider relinquishing the use of electric 'TaserX26' weapons, the impact of which on the physical and mental state of targeted persons would appear to violate articles 1 and 16 of the Convention," United Nations Committee against Torture, "Consideration of Reports Submitted By States Parties Under Article 19 of the Convention, Conclusions and recommendations of the Committee against Torture, Portugal," CAT/C/PRT/CO/4, February 19, 2008, http://www1.umn.edu/humanrts/cat/general_comments/portugal2008.html(accessed March 17, 2015), para. 14.

[368]"The Committee is of the view that the use of electrical discharge weapons should be subject to the principles of necessity and proportionality..." United Nations Committee against Torture, "Concluding observations on the fifth periodic report of the United Kingdom, adopted by the Committee at its fiftieth session," CAT/C/GBR/CO/R/5, May 2013, para. 26; Discussing practices in U.S. prisons: "The Committee remains concerned about the extensive use by the State party's law-enforcement personnel of electroshock devices, which have caused several deaths. The Committee is concerned that this practice raises serious issues of compatibility with article 16 of the Convention," UN Committee against Torture, "Consideration of Reports Submitted By States Parties Under Article 19 of the Convention, Conclusions and Recommendations of the Committee Against Torture," CAT/C/USA/CO/2, July 25, 2006, para. 35.

[369] "The Committee is concerned in particular by the use of so-called less lethal restraint devices, such as electro-muscular disruption devices (EMDs), in situations where lethal or other serious force would not otherwise have been used. It is concerned about information according to which police have used tasers against unruly schoolchildren; mentally disabled ...without in most cases the responsible officers being found to have violated their departments' policies," U.N. Human Rights Committee, "Committee observations of the Human Rights Committee: United States of America," U.N. Doc. CCPR/C/USA/CO/3 (2006), para. 30. The recommendation continues: "The State party should ensure that EMDs and other restraint devices are only used in situations where greater or lethal force would otherwise have been justified, and in particular that they are never used against vulnerable persons."

[370]"The Committee is concerned in particular by the use of so-called less lethal restraint devices, such as electro-muscular disruption devices (EMDs), in situations where lethal or other serious force would not otherwise have been used" and "[t]he State party should ensure that EMDs and other restraint devices are only used in situations where greater or lethal force would otherwise have been justified..." United Nations Human Rights Committee, "Consideration of Reports Submitted by States Parties under Article 40 of the Covenant, Concluding observations of the Human Rights Committee: United States of America," CCPR/C/USA/CO/3, December 18, 2006.

[371]Ibid., "The State party should bring its policies into line with the United Nations Basic Principles on the Use of Force and Firearms by Law Enforcement Officials."

[372]"The Committee is concerned about ... reports of excessive use of force by certain law enforcement officers including the deadly use of tasers.... The State Party should (a) step up its efforts to prevent the excessive use of force by law enforcement officers by ensuring compliance with the 1990 UN Basic Principles on the Use of Force and Firearms by Law Enforcement Officers; ... and (c) improve reporting of excessive use of force violations and ensure that reported cases of excessive use of force are effectively investigated, alleged perpetrators are prosecuted and, if convicted, punished with appropriate sanctions, that investigations are re-opened when new evidence becomes available, and that victims or their families are provided with adequate compensation," United Nations Human Rights Committee, "Concluding observations on the fourth report of the United States of America," CCPR/C/USA/CO/4, April 23, 2014, para. 11.

[373]The CPT was set up under the 1987 Council of Europe Convention of the same name (hereinafter "the Convention") with a mandate of examining the conditions under which persons are deprived of their liberty with a view to strengthening their protection from torture and from inhuman or degrading treatment or punishment. It is one of the most informed and authoritative analysts of conditions of confinement and their compliance with human rights standards.

[374] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), "CPT Standards," CPT/Inf/E (2002) 1 - Rev. 2015, Strasbourg, January 2015, http://www.cpt.coe.int/en/documents/eng-standards.pdf (accessed March 17, 2015), paras. 69-70.

[375]Ibid., para. 71.

[376]Standard Minimum Rules, Rule 33.

[377]Standard Minimum Rules, Rule 34.

[378] Report of the open-ended intergovernmental Expert Group on the Standard Minimum Rules for the Treatment of Prisoners at its Fourth Meeting, United Nations Office of Drugs and Crime, http://www.unodc.org/unodc/en/justice-and-prison-reform/expert-group-meetings-8.html (accessed April 3, 2015). The recommended revisions will be considered at the 13th UN Congress on Crime Prevention and Criminal Justice (Doha, 12-19 April 2015) and may be adopted at the 24th session of the Commission on Crime Prevention and Criminal Justice (Vienna, 18-22 May 2015).

[379]European Court of Human Rights, *Tali v. Estonia*, Judgment of February 13, 2014, no. 66393/10, http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-140785 (accessed April 2, 2015). Paragraphs 81-82 of the judgment read in relevant part as follows: "The Court reiterates, however, that means of restraint should never be used as a means of punishment, but rather in order to avoid self-harm or serious danger to other individuals or to prison.... In the present case, the Court considers that it has not been convincingly shown that after the end of the confrontation with the prison officers the applicant—who had been locked in a single-occupancy disciplinary cell—posed a threat to himself or others that would have justified applying such a measure. Furthermore, the period for which he was strapped to the restraint bed was by no means negligible and the applicant's prolonged immobilization must have caused him distress and physical discomfort. In view of the above and considering the cumulative effect of the measures used in respect of the applicant on 4 July 2009, the Court finds that the applicant was subjected to inhuman and degrading treatment in violation of Article 3 of the Convention."

[380]European Court of Human Rights, *Julin v. Estonia*, Judgment of May 29, 2012, nos. 16563/08, 40841/08, 8192/10 and 18656/10, http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-110949 (accessed April 2, 2015). Paragraph 127 of the judgment reads in relevant part as follows: "Even assuming that his banging on the door of the cell had severely disturbed peace and order in the prison, the Court doubts that confinement in the restraint bed can have been the least intrusive measure available in this context. There is no indication that before the applicant's placement in the restraint bed, or in the course of the application of this measure, alternatives such as confinement to a high-security cell were considered."

[381]CPT Standards, para. 53.

[382] ECHR, *Tali v. Estonia*, para. 78 and 82. Paragraph 78 of the judgment emphasize that "pepper spray is a potentially dangerous substance and should not be used in confined spaces; even when

used in open spaces, there should be clearly defined safeguards in place.... Having regard to these potentially serious effects of the use of pepper spray in a confined space on the one hand and the alternative equipment at the disposal of the prison guards, such as flak jackets, helmets and shields on the other, the Court finds that the circumstances did not justify the use of pepper spray."

[383]Ibid.

FOR THE RECORD

DOCTORS COUNCIL
a national affiliate of SEIU

A United Voice for Doctors, Our Patients, & the Communities We Serve

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Testimony of Frank Proscia, M.D., President of Doctors Council SEIU

Before the Committee on Fire and Criminal Justice Services; the Committee on Public Safety; the Committee on Courts and Legal Services; and the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

May 12, 2015

Good Afternoon Committee Chairs and Council Members. My name is Dr. Frank Proscia and I am the President of Doctors Council SEIU which represents thousands of doctors in the Metropolitan area, including in every HHC facility, the New York City Department of Health and Mental Hygiene, New York City School Health Program, and New York City jails including Rikers and Vernon C. Baines Correctional Barge. Thank you for the opportunity to testify today.

As we know, individuals with behavioral health issues comprise an increasingly larger percentage of the total number incarcerated at Rikers. In recent months, the Council and the Administration have introduced various measures and funding streams to address mental health issues in the criminal justice system and Doctors Council SEIU applauds those efforts.

Our doctors working at Rikers Island are keenly aware of the mental health issues on the island. Put simply, even with new programs and housing units in place, detainees with behavioral health issues at Rikers are underserved because of significant shortcomings in medical staffing. For example, there are currently 13 full time vacancies for psychiatrists on Rikers Island out of 50 full time positions – that's a 26% shortage. In recent years, 6 full time psychiatrist positions have been cut by Corizon. Today, there is only one overnight psychiatrist available for the whole

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island.

What does this mean in practice? Our psychiatrists have reported they are unable to spend significant amounts of time with patients. Also, detainees with behavioral health issues sometimes act out in clinical settings, especially with long wait times, becoming agitated and making the visit more challenging for the detainee and the clinician.

Access to mental health services and general medical care is critical. It is unacceptable that in some cases, only 50 percent of detainees in need of care are actually seen in the clinics.

Doctors Council has spoken frequently about the workplace safety issues that can arise from these dynamics. DOC, DOHMH, and Corizon all have a role to play in establishing better protocols for the transport of detainees and the physical plant conditions that can ensure workplace safety in clinics.

Just as important as staffing is the inclusion of front-line doctors in decision-making in assessing new programs and protocols prior to putting them in place by DOC. Doctors at Rikers very much want to be part of conversations about how better to handle detainees with behavioral health issues.

We were pleased to see a bill introduced last week by Council Member Gibson, Intro 0770, a proposal requiring that the DOC establish a crisis intervention program. Our doctors are ready, willing and able to weigh in on protocols to improve across agency responses to crises. We recommend that the doctors at Rikers Island, especially the psychiatrists, be included in the course of planning and training of others for the crisis intervention teams.

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Our doctors have echoed the call for expansion of certain services such as drug treatment and detox programs. Furthermore, access to any mental health programs, services or housing units ought to be considered with translation services in mind. For many detainees, English is their second language.

Doctors Council commends the culture of change that has made alternative housing programs like CAPS possible. We also applaud the administration's funding proposal to provide psychiatric assessments and after-school therapeutic arts programming for all youth under 21 and substance abuse programming for 16-21 year olds. We recommend more of the same in the adult population.

Culture may be the most challenging aspect of reform at Rikers. Our doctors are absolutely committed to everyone's safety, and realize the necessary balance of restrictive techniques in a correctional setting along with appropriate medical follow-up, psychiatric counseling and medication management. A culture change though difficult is necessary and possible.

Lastly, an important piece of this discussion should be around continuity of care. We all know the disturbing statistics about prisoner reentry among individuals with mental health issues. We believe discharge services can be better coordinated with HHC directly without subcontracting for outpatient psychiatry. In-jail teams should be trained to connect detainees with local HHC facilities and offer information about enrollment into Metro Health Plus which is HHC's insurance program.

Thank you for the opportunity to testify today.

QUEENS LAW ASSOCIATES

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Good afternoon. My name is Lori Zeno. I am the Deputy Director of Queens Law Associates. Thank you Council Member Lancman for inviting me to speak today.

My organization, Queens Law Associates, is a public defender office, located in Queens County that represents more than 25,000 people annually in criminal and family court, and provides advice and representation on immigration matters. QLA is constantly working to provide quality comprehensive legal services.

We welcome this administration's commitment to reforming the criminal justice system. The much needed reforms outlined in the Mayor's Action Plan will benefit our most vulnerable population: those in need of mental health and behavioral services rather than incarceration. These reforms are a clear acknowledgement that the old criminal justice system did not work!

This proposed $130 million dollar investment has the potential to reduce unnecessary arrests and incarceration, re-direct criminal justice resources to where they will have the greatest public safety impact, and finally make our City's criminal justice system more fair. In the long term, this plan will benefit many people.

While this Action Plan is comprehensive some concerns remain. First, the projected timeline of the rollout of a number of these reforms will take too long. By that I mean, what about all of the people who need services right now? I believe there are immediate steps that can be taken to make programs accessible and more affordable to people in need of services.

Ten- thousand people are in jail today. Almost 40% of that 10,000 (I'm talking about 4,000 people) are facing behavioral health issues on some level. Of those 4,000 people, only 7% (less than 300 people) face serious mental illness that means that the overwhelming majority with low level mental health issues are not currently getting the services they need.

Second, this plan relies heavily on court-involved individuals having access to and qualification for Medicaid, which they do not. Consequently, finding a program that will take such a program is nearly impossible. Treatment courts and certain diversion programs cannot accept clients without Medicaid, private insurance, or the ability to self-pay. These requirements exclude a vast number of people. Applying for Medicaid is a lengthy and complicated process. If at the time of arrest, a person does not have active Medicaid benefits, it often delays a disposition of a criminal case. Even if a client does have Medicaid, without a co-existing disorder such as mental health or substance abuse, Medicaid will not cover certain types of programs. The types of programs that I

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am referring to are the types of programs that are actually offered as disposition in courts by district attorneys and judges such as: anger management, batterer's intervention program, or parenting skills classes.

Intake fees for some programs are as high as $75 and each additional session can cost up to $50. The sliding scale fee schedules only lower costs slightly and require significant documentation that oftentimes our clients do not have. Participation durations can range from 6, 12, 24, or 52 weeks depending on the program type and plea negotiated. This is an immediate and urgent problem; these issues cannot go unaddressed.

Moreover, I am concerned that this action plan is not address the needs of the diverse population of Queens County that has many foreign-born residents. People that are undocumented have extremely limited treatment options. Treatment costs are high and self-payment is out of reach for these individuals. One possible solution to this problem is to offer scholarships or free services so that all individuals can benefit from these reforms.

Treatment prevents recidivism, leads to favorable dispositions, and favorable plea-bargaining. The benefit to resolving criminal matters quickly, and with treatment alternatives, is found not only in cost savings; it extends to offenders and their families, reuniting families allowing families to remain intact when possible. Treatment and diversion reduces the collateral consequences of incarceration such as loss of housing, income, and employment.

There are many ways to modify the action plan. For example, designate funds to public defender offices for client scholarships for co-pay fees at necessary programs. Assign grants to existing programs appropriated for lowering intake and session fees for indigent participants.

The Action Plan is correct in addressing the need for more diversion possibilities at arraignments. While early diversion is admirable and innovative, we must ensure that due process and confidently rights are protected. Court-involved individuals must have a clear understanding of their confidentiality rights and make a knowing and voluntary waiver of those rights before speaking with any court representative. An explanation of these rights and the effect of the waiver on their criminal case must be explained by an attorney. We also caution that this added screening may delay the arrest to arraignment time if not effectively managed.

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Turning now to the funding aspect of the Action Plan, of the $130 million invested into this Action Plan, $40 million is from District Attorney's asset forfeiture fund. While we agree that redirecting these funds to help reform the criminal justice system is a great idea we note that the forfeiture procedure itself needs some scrutiny and perhaps reform. Some measures must be taken to ensure that only funds that appropriately qualify for forfeiture are taken from court-involved individuals before they are included in this fund.

Finally, going forward I hope that this Action Plan will expand to include provisions for the sealing and expunging of criminal convictions. As you know, a criminal record, and associated collateral consequences is a tremendous barrier to stability and an obstacle to entering and remaining in the workplace.

Thank you again for allowing me to comment on the proposed reforms to our criminal justice system. I am excited to be here, and excited to be a part of this tremendously important process.

Thank you.

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Summary:

- Not every indigent client qualifies for Medicaid
- Medicaid does not cover all behavioral and educational programs our clients need
- Indigent clients cannot afford a $75 program intake fee and additional $50 per session fee
- The sliding scale currently in place does not lower costs enough to make it affordable
- As a result, plea negotiations are delayed and at times halted, clogging court calendars
- NYC residents are not receiving necessary services to better their lives because they cannot afford it
- Short-term solution: designate funds to public defender offices for client scholarships for co-pay fees at necessary programs
- Assign grants to existing programs appropriated for lowering intake and session fees for indigent participants
- In the long term, find ways to create free programs that are accessible to all NYC residents
- We cannot expect to help the most vulnerable populations get better while still charging them fees; access to programs must be free

Last year in New York City, 312,193 people were arrested.[1] Of those arrests, 60,558 occurred in Queens County.[2] Queens Law Associates represents approximately 25,000 people charged with crimes in Queens County each year. **Currently there is a major cost barrier preventing indigent clients from participating in services needed not only to better their lives but also to resolve their criminal cases.** Our clients need affordable access to mental health treatment, alcohol and substance abuse counseling and behavioral and educational programs such as: anger management, batterers' intervention, and parenting skills.

[1] http://www.criminaljustice.ny.gov/crimnet/ojsa/arrests/NewYorkCity.pdf
[2] http://www.criminaljustice.ny.gov/crimnet/ojsa/arrests/Queens.pdf

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In 2014, 25.5% of all drug felony arrests in Queens County resulted in a conditional discharge.[3] Generally speaking clients either participated in a program, engaged in community service, paid fines, agreed to forfeiture of funds, or had another condition attached to their conditional discharge. In 2014, 18.3% of all misdemeanor arrests in Queens County concluded with a conditional discharge.[4] **In Queens County, some charges are commonly resolved with dispositions involving programs such as: drinking and driving, domestic violence, petit larceny, endangering the welfare of a child, sexual offenses, and various drug related charges.**

It is true that New York City has made great progress toward improving public safety and reducing the jail population. As of February 27, 2015, the population at Riker's Island was 9,822 this is the first time the population has been below 10,000 since 1984. **NYC criminal justice policy has begun to focus on broad-based, systemic intervention and diversion.** The variety of treatment programs utilized by the NYC court system demonstrates that the criminal justice system is increasingly receptive to the benefits of safely diverting individuals charged with crimes out of costly incarceration and addressing the behavioral health conditions underlying criminal behavior. **Allowing people to participate in programs may actually help address the issue that lead to the initial criminal behavior and prevent or reduce recidivism.**

Instead of incarceration, the justice system has begun relying on programs to supply appropriate services, supervision, and accountability to certain populations. NYC Treatment courts that enter into conditional pleas with clients while programs monitor treatment compliance during the pendency of the plea are the perfect example. **Clients remain at liberty while getting the services and treatment they need to be a functioning and contributing member of society**. The client is able to maintain contact with their family, who oftentimes can be an added support system. This court connects clients with resources and services they need to get their life on track creating a sustainable life treatment plan for them. **The problem is that unless a client can qualify for Medicaid, has private insurance, or can self-pay, they cannot participate i treatment.** Immediately, this eliminates anyone who is undocumented from participating in this opportunity. Additionally, it is a long process getting someone approved for Medicaid so if someone is incarcerated, they may not be a candidate for this court unless benefits are already in place at the time of arrest.

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[3] http://www.criminaljustice.ny.gov/crimnet/ojsa/dispos/queens.pdf
[4] http://www.criminaljustice.ny.gov/crimnet/ojsa/dispos/queens.pdf

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Furthermore, even if a client has Medicaid in place oftentimes it does not cover all the services they need. For example, anger management is a common program our clients need. In 2014, EACH DAY, NYPD officers responded to over 770 domestic incident reports.[5] It is evident that NYC residents can benefit from the healthy relationship advice that an anger management program has to offer. **Some of these programs have intake fees ranging from $50 to $75 and then each additional session is anywhere from $25 (if granted a sliding scale) to $50.** The Queens County District Attorney's Office usually requires a client to engage in 6 to 12 sessions depending on the severity of the case. Batterers' intervention program has a similar price point, only that program has durations of either 24 or 52 weeks depending on the plea entered. Parenting skills classes also have similar costs associated with participation. Almost all the programs our clients need have associated costs.

The risk associated with agreeing to engage in a program that you cannot afford is hazardous. You can be sentenced to jail as an alternative for failure to complete the program. Oftentimes, this does happen. Additionally, completing a program is a condition of being allowed back into your residence and having visitation with your family. **If you do not complete the program, the court will not modify the order of protection to a limited order from a full order of protection.** If you took a conditional plea to a misdemeanor, that charge may remain on your criminal record instead of the promised reduced violation (which is not a crime) if you completed the program. If you pled guilty to a felony that felony will now stay on your record instead of the promised reduction to a misdemeanor upon successful completion of the program. This can affect client's employment status, public benefits, financial aid, immigration status, voting rights, housing rights (NYCHA), driver's license, security license, Taxi and Limousine Commission license, other specialized work licenses, union memberships. etc. **Criminal convictions and the collateral consequences that follow are devastating and the impacts last a lifetime.**

It is proposed that New York City Council address the cost barrier to treatment using one of several methods. In the short term, designate funds to public defender offices for client scholarships for co-pay fees at necessary programs. Assign grants to existing programs appropriated for lowering intake and session fees for indigent participants. In the long term, look forward and find ways to create free programs accessible to all NYC residents. We cannot expect to help the most vulnerable populations get better while still charging them fees: access to programs must be free!

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[5] http://www.nyc.gov/html/prob/downloads/pdf/mou_grants_to_encourage_03192015.pdf

CJA | NEW YORK CITY CRIMINAL JUSTICE AGENCY

Jerome E. McElroy
Executive Director

AN OUTLINE OF CJA OPERATIONS

CJA is a non-profit agency serving as the City's pretrial agency, under contract to the Mayor's Office of Criminal Justice. It has been doing so since its incorporation in 1977, although it traces its roots to the original pretrial program, The Manhattan Bail Project in 1961.

Interviewing - CJA interviews virtually all arrested defendants held for arraignment (on-line cases) in the Criminal Court and prepares a report to assist the judge in making the release/bail decision in continued cases. The report includes a statistically-based assessment of the risk that the defendant might fail to appear if released. When the risk appears low, the report specifically recommends Release-on-Recognizance. In 2014, the agency's staff conducted approximately 270,700 such interviews.

Appearance Notification – For all cases continued past arraignment, and for DAT arraignments, the agency provides phone and text reminders of the next court appearance for the purpose of reducing failure-to-appear (FTA). For those without phones, the agency sends a letter.

Bail Expediting (BEX) – In cases in which bail set at $2,500 or less in the Bronx, and $3,500 or less in Manhattan, Brooklyn, and Queens, agency staff re-interview the defendant immediately after the arraignment to identify a person or persons who might serve as a bail surety for the defendant. If the defendant identifies such a person, staff reach out to inform him or her of the arrest and the bail amount. If the potential surety expresses a willingness to post the bail, and to do so within the next two hours, he or she will be instructed on how to do it, and the Department of Corrections will hold the defendant for a couple of hours before transporting him or her to a correctional facility.

Failure-to-Appear Units (FTA) – With the implementation of these units in the Bronx and Manhattan this fiscal year, all of the large boroughs are now covered. Each day agency staff members review the calendars from the Criminal Court and the Criminal Parts of the Supreme Court to identify all cases in which a warrant was issued for the defendant's failure to appear. Staff members then attempt to notify the defendant (through live phone calls, letters, and soon-to-be introduced text messages) of the missed appearance, the issuance of the warrant and the importance of his returning to court as soon as possible. Among the on-line cases, 51% of the cases in Brooklyn, and 52% of the cases in Queens, returned to court and had the warrant vacated. Given the newness of the program in the Bronx and Manhattan, comparable figures are not yet available.

Supervised Release Programs – In August of 2009, the agency, with the assistance and support of the then Criminal Justice Coordinator's Office, designed and implemented a program offering supervised release as an alternative to detention for use by the courts in non-violent felony cases. Potential cases are further screened to eliminate those with more than one

prior felony conviction and/or more than six prior misdemeanor convictions, and those with an extensive warrant history. To dramatically reduce the likelihood of the program being used in cases in which the imposition of bail is unlikely, those cases in which this is a first arrest and the CJA report had recommended ROR, are excluded from consideration. When a case appears to be potentially eligible, the program's court representative confirms with the defense attorney if bail is likely to be set and seeks the attorney's permission to pursue the case further. If that is given the court representative will interview the defendant to explain the nature of the program, determine his willingness to participate in it, and verify his residence, phone numbers and contacts in the community. The defense attorney is informed of his client's eligibility and may then propose the supervised release program as part of his bail application.

When the court places the defendant in the program, a program contract is signed and made part of the court papers. The client is then required to report to the program office and meet with his or her social worker/case manager. Two in-person sessions and one phone contact per week will be required at the initial stage of participation. The case manager, who is a social worker, will conduct an extensive assessment designed to identify substance abuse problems and/or mental health conditions for which referrals to appropriate service agencies will be offered. A letter summarizing the client's status in the program is sent to the court for all scheduled appearances until the case is disposed, and an off-calendar letter will be delivered when there is serious misconduct, such as re-arrest and detention while under supervision, or loss of contact with the client.

The Queens program began in August of 2009 and has served 1,807 clients since that date. Approximately 86% have completed the program successfully, while approximately 4% have had their supervision revoked for failing to appear, and another 7% had it revoked for a new arrest and detention.

Given the success of the Queens program, the City invited the agency to extend it to Manhattan in April 2013. Over the last two years, 776 clients have participated in the program, with approximately 81% completing it successfully, while 5% had their supervision revoked for failing to appear and another 8% for a new arrest and detention.

In both programs, the overall percentage of clients with a docketed re-arrest is 24%. However, the majority (nearly three quarters of the rearrested clients in Queens and two thirds of those rearrested in Manhattan) were charged with quality-of- life misdemeanor and lesser offenses.

BROOKLYN DEFENDER SERVICES

FOR THE RECORD

TESTIMONY OF:

Lisa Schreibersdorf – Executive Director

BROOKLYN DEFENDER SERVICES

PRESENTED BEFORE

The New York City Council Committees on

Courts & Legal Services

Fire & Criminal Justice Services

Public Safety

Mental Health

Developmental Disability, Alcoholism, Drug Abuse and Disability Services

"Oversight: Behavioral Health and the Criminal Justice System: Examining New York City's Action Plan."

May 12, 2015

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My name is Lisa Schreibersdorf. I am the Executive Director of Brooklyn Defender Services (BDS). BDS provides innovative, multi-disciplinary, and client-centered criminal, family and immigration defense, civil legal services, social work support and advocacy to more than 45,000 indigent Brooklyn residents every year. We recently represented our 400,000th client. I thank the Committees for holding this important hearing today to discuss the Mayor's Action Plan for Behavioral Health and the Criminal Justice System.

As interest in reforming our justice system grows among policymakers, BDS offers the wisdom and expertise of our staff and the stories of our clients. We can provide the facts and real experiences necessary to inform smart changes to make our laws more fair, effective, and humane. As a comprehensive indigent legal service organization, we are committed to helping enact systemic reforms that will improve outcomes for our clients before, during and after contact with the criminal, family, civil or immigration court systems.

Within BDS, we have a number of specialized units – for adolescent clients, clients with a serious mental illness, immigrant clients, veterans and victims of human trafficking. We find that nearly all of our units have routine experience with clients managing behavioral health symptoms, as this is a population that is uniquely vulnerable to arrest and typically receives worse outcomes at every step of the criminal legal process, when compared to other clients. BDS utilizes a model that includes two dedicated specialized attorneys to work with individuals with mental illness, as well as over 150 attorneys who assist clients throughout our criminal, family and immigration defense practice areas. Our team of licensed social workers and legal assistants 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. 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 assaults and other violent felonies. (More than two-thirds of arrests overall in New York City are for misdemeanors.) In addition to our work in the criminal court system, our Family Defense Practice represents about 2,000 families at all times, of which half are at risk of losing their children because of challenges associated with managing a mental illness.

We have an intimate perspective into the tragic nexus between unmet mental health needs and involvement in the criminal justice system. We agree generally with the recommendations of the Action Plan, and thank the administration for outlaying $130 million and additional resources to jump-start the process of finding solutions for what has been a far-too-long ignored reality; as Mayor Bill de Blasio put it: "Many people who cycle through the system could be better served – and public safety improved – if their underlying conditions were addressed effectively." On any given day at least 38 percent of the jail population in New York City has a diagnosed mental illness, with about one-third of that number managing serious mental illness such as schizophrenia or bipolar disorder. The need has become higher in jails, as our city and state have divested from community mental health care alternatives. Broken Windows policing vacuums up far too many people into the system.

The Action Plan recommends that people who may be in need of behavioral health services:

1) Do not enter the criminal justice system

2) If they do enter, are treated outside a jail setting
3) If they are in jail, receive treatment that is therapeutic rather than punitive in approach
4) And that upon release, they are connected to effective services

We support this basic outline; we also support many of the more specific recommendations, such as additional training for police officers, the concept of drop-off and respite centers for short-stay services, the expansion of supervised release and universal screenings for physical and mental health concerns by the Department of Health and Mental Hygiene pre-arraignment. We remain wary of many risk assessments, which are not immune to racial biases and run the risk of further entrenching the racial disproportionalities endemic to the criminal justice system. We believe that the Action Plan would benefit from a Racial Impact Statement, so that stakeholders could get a clearer understanding of how any policy changes might impact different demographic groups.

Prior to Arrest

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," or 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 by the Mayor to fund a CIT pilot program in Manhattan, and hope the program will be implemented broadly in the near future. There is a strong need for such a program in other boroughs, particularly in the communities from which our clients come. If people are identified as having a mental illness, calling in community-based services, not the legal system, is the best first option whenever possible. The impact of incarceration on public health cannot be overstated; being locked up negatively effects family and community ties, employment, housing options, treatment access, and the experience of incarceration often leads to new trauma.

We recently attended a presentation by the Mayor's Office of Criminal Justice on CIT's and were disappointed to learn that the CIT program being imagined for NYC is being designed solely by the NYPD with support from MOCJ. Where are the mental health service providers in this process; where are the mental health service consumers?

From Arrest to Arraignment

Generally, 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 of the 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 health care 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 seven months ago with no response. In October 2014, a client of ours, Jasmine Lawrence, 22, died in police custody because of a failure to provide 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. Ms. Livingston was told by officers at Central Booking that they would intentionally delay her arraignment, and 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 Committees review local police department 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 regardless of whether they have been arrested. A complete screening by DOHMH prior to arraignment in every arrest would make a dramatic difference in the care and assessment that our clients receive between arrest and arraignment. Unfortunately, case processing times often trump best practices in this regard.

Issues such as homelessness, substance abuse, and serious mental health issues can leave this demographic more likely to have bail set and thus be incarcerated due to poverty. It is very common for clients who have been identified as suffering from serious mental illness at arraignment who are charged with low-level, non-violent offenses to be detained and sent to City jails. The 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.

Diversion and Alternatives to Incarceration

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. BDS has seen some positive results with the alternatives available through the mental health court and Crisis Intervention Teams. Under the current paradigm, mental health court provides dramatically improved criminal justice outcomes for many of our clients, but in order for our clients to be accepted into the program they must be 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 many opportunities for placement because clients previously accepted into a program subsequently become too symptomatic due to their extended stays in jail.

The following story comes from a BDS attorney:

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 DOC to the forensic psychiatric center for evaluation took 6 weeks. 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.

Inside the Jails

People held in correctional facilities are the only demographic in the U.S. with a constitutionally mandated right to health care. However, the health care currently provided in jails and prisons is deplorable. The fact is that correctional facilities were never intended to function as health care providers, yet they currently house overwhelmingly large populations of individuals with serious mental illness and other complicated health needs. Treating and stabilizing serious mental illness, in particular, is a delicate medical process that is deeply compromised by jail and correctional environments, which frequently trigger and exacerbate many common symptoms. Confinement is not therapeutic. Jails and Prisons 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 acute health needs suffer tremendously as a result. Psychotropic medication has become the default treatment method for mental illness in correctional facilities. However, medication management without the supplement of supportive mental health services (i.e. individual or group therapies, case management services, supportive housing) that exist in the community is not medically sufficient care. This is a phenomenon experienced across the country, but it is especially true here in the New York City jails, including Rikers Island. In the absence of adequate care and support, and in extremely harsh environments like prisons and jails, people with mental illness often fall into a devastating cycle decompensation, rules infractions, and punitive segregation.

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 DOC. 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 bathe 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 community—our neighborhoods—less able to manage their illness on their own, further disconnected from family and 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 taxpayers.

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 in Rikers, but not every incarcerated person has this kind of support. 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, and long delays or lapses in filling orders for glasses or hearing aids. 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.

You might have read about the 2013 case of Bradley Ballard, who died after being left alone in punitive segregation for seven days without medicine for his diabetes or mental illness. A 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 [New York City Department of Correction (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 was less than forthright in its explanation of its patient's death. Quannell Offley died just weeks after Ballard in the same jail facility.

You might also be familiar with the case of Jerome Murdough, a homeless, mentally ill U.S. Marine Corps Veteran, who died in DOC 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. 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 presumed innocence and the condition of the individual.

Contrary to the reports 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. Corizon, Inc., the for-profit company tasked with fulfilling the City's correctional health contract, must go.

There are inherent problems with the provision of 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 procedure 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 for 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 of punitive segregation. 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 clients are determined by his peers or corrections officers to be vulnerable and 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.

It is clear that the amount of money being spent to essentially exacerbate the problems of sick, poor New Yorkers should be re-directed into community treatment options to address the health needs of these very same people. While the health care provided in correctional facilities is in dire need of substantial improvement, New York's prisons and jails will never be appropriate settings for comprehensive care. The current practice of utilizing them as mental health "treatment" facilities, at an astronomical price, is particularly egregious and counterproductive. It has never been morally justifiable. Furthermore, New York's county and municipal governments must end the incarceration of people who have committed nothing more than nuisance offenses. 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, yet those are the factors considered in bail hearings. I urge the Council to prioritize the reduction of the number of people in correctional custody at every level and invest in community-based high-quality mental health care, housing, education and targeted preventative, diversion and reentry services.

Segregated Confinement of Individuals with Mental Illness

According to the American Psychiatric Association, prolonged isolation "may produce harmful psychological effects," including "anxiety, anger, cognitive disturbance, perceptual distortion, obsessive thoughts, paranoia, and psychosis. For persons with serious mental illness, these effects may exacerbate underlying psychiatric conditions, such as schizophrenia, bipolar disorder, and major depressive disorder."[1] In Madrid v. Gomez, the U.S. District Court found that "placing [people with mental illness or developmental disabilities] in the SHU is the mental equivalent of putting an asthmatic in a place with little air to breathe."[2]

According to a September 5, 2013 report to the BOC by Dr. James Gilligan and Dr. Bandy Lee, experts in the field of mental health in prisons, "the proportion of mentally ill inmates in the New York City jail population is larger than ever before and growing."[3] Indeed, Rikers Island is the

[1] James H. Scully, Jr., M.D., Testimony Before the U.S. Senate Subcommittee on the Constitution, Civil Rights, and Human Rights (The Am. Psychiatric 2012).
[2] Madrid v. Gomez, 889 F. Supp. 1146 (N.D. Cal. 1995)
[3] James Gilligan, M.D. and Bandy Lee, M.D., Report to the New York City Board of Correction (New York City Bd. of Corr. 2013).

largest provider of mental health services in the state, though its infrastructure and personnel are entirely ill-equipped and unqualified to work with this population. According to the New York City Department of Health and Mental Hygiene (DOHMH), about 25 percent of the City jail intakes present with some kind of mental illness, including about 5 percent who present with serious mental illness such as schizophrenia. (This tracks, generally, the overall population.) Our experience leads us to believe that the incidence of mental illness is actually much greater than DOHMH's data, 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.

Those of our clients who have a mental illness almost always fare poorly in jail. Many of them end up in solitary confinement as a punishment for actions and behaviors related to their mental illness—mostly for disobeying orders, not acts of violence. In our City jails, there is a punitive segregation unit reserved for those with mental illness who infract called the Restricted Housing Unit (RHU). It did not surprise us, then, to read in the Gilligan and Lee report that, as the mentally ill population in the City jail system grew, the total number of inmates in punitive segregation grew, too—increasing 61.5% between 2007 June 2013.[4] Once isolated and deprived in this way, individuals with mental illness rapidly deteriorate. Indeed, Gilligan and Lee note, "From a medical/psychiatric standpoint, no one should be placed in prolonged solitary confinement, as it is inherently pathogenic—it is a form of causing mental illness."[5]

In 2008, New York State enacted the SHU Exclusion Law, which mandates that people with a "serious mental illness" (SMI) who face disciplinary confinement that could exceed 30 days be diverted to a Residential Mental Health Treatment Unit. The law represented an important acknowledgement of the dangers of extreme isolation, and spared many people the compounding misery of enduring serious mental illness in the Box. However, it left behind the vast majority of SHU residents, including many with debilitating mental illnesses not designated SMI. Furthermore, the statutory definition of SMI allows ample space for correctional health staff to underdiagnose, and data suggests this to be occurring. Crucially, A.1346A establishes a more inclusive standard and a more comprehensive exclusion, but advocates and legislators will have to monitor DOCCS and local corrections agencies to ensure that the subject populations are actually protected as the law intends.

Experiences of BDS's Clients and Staff

Mr. S

Mr. S is a young man who suffers from schizoaffective disorder and a learning disorder. During his incarceration, Mr. S was the victim of stabbing and burning attacks when he resisted pressure to join gangs. After staff failed to de-escalate conflicts with Mr. S over issues like lost property, he was issued infractions for disobeying orders, and he was eventually placed in the RHU—a punitive segregation unit for people with mental illness. The isolation endured by Mr. S contributed to his decompensation, and he began to experience more regular auditory and visual

[4] Ibid.
[5] Ibid.

hallucinations. Mr. S became increasingly depressed and hopeless while in the RHU. At one point, he shared his sense of hopelessness with staff, and in response, he was placed on suicide watch in an empty cell, with nothing more than a smock. After coming off of suicide watch, Mr. S was denied all out-of-cell time and access to privileges he had earned through program compliance for the next three weeks. In short, staff's response to a perceived suicidal statement was to categorically isolate Mr. S in his cell, 24 hours a day for a month. Mr. S discharged to the community directly from isolation.

Mr. F

Mr. F is a young man who suffers from paranoid schizophrenia. While incarcerated, Mr. F decompensated and began experiencing confrontations with custody staff, many of whom, lacking adequate training to de-escalate incidents involving individuals in his mental state, approached Mr. F aggressively. Mr. F received infractions during his incarceration and spent several months in the RHU at the George R. Vierno Center (GVRC) on Rikers Island. This isolation caused Mr. F to decompensate further, losing the few privileges he came to earn in the unit and lengthening his stay in the RHU. Eventually, Mr. F's condition worsened and he was transferred into another isolation unit, which housed mentally ill individuals deemed violent—12 Main at GRVC. In this unit, 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. He reported to our staff a feeling of being trapped. 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 move forward through the system. This case begs the question, what is the purpose of pre-trial detention if not to ensure people make it to court? One segregation unit was depopulated recently after people isolated there smeared feces on the doors and walls of their cells and others lit cell fires.

Historical Perspective

In a way, it is frustrating to have to explain the ills of segregated confinement, given the tremendous amount of research on its cruelty and inefficacy that already exists—dating back several centuries to the birth of the very concept of correctional facilities. As NYCLU's 2012 report on extreme isolation in New York, "Boxed In," notes, Alexis de Tocqueville and Gustave de Beaumont toured Auburn state prison in the early 1820's and found its use of extreme isolation to be ruinous and counterproductive. "[I]n order to reform them," they wrote, "[the prisoners] had been submitted to complete isolation; but this absolute solitude, if nothing interrupt it, is beyond the strength of man…it does not reform, it kills." That prison closed its solitary cells two years after opening them. Of the 26 who were pardoned after serving in solitary, 14 soon returned to prison on new offenses. Perhaps more timely, as New York City tries to heal its rift as a "Tale of Two Cities," is Charles Dickens' reaction to Pennsylvania's Eastern Penitentiary after touring the facility in 1842. He found the extreme isolation system there to be "worse than any torture of the body…[I]t wears the mind into a morbid state, which renders it unfit for the rough contact and busy action of the world."[6]

[6] Scarlet Kim, Talyor Pendergrass and Helen Zelon, Boxed In. (NYCLU 2012).

The City should stop placing anybody in solitary confinement until the conditions of this confinement are such that they no longer risk permanent physical and psychological damage to people and until such time as the validity of using solitary confinement to positively impact future behavior in jail is established by concrete evidence.

Special Note on Developmental and Cognitive Disabilities

People with Developmental Disabilities and Intellectual Disabilities are one of the most vulnerable populations in jail and prison settings. They are frequently the targets of violence, sexual violence, extortion, and abuse from staff and other incarcerated people. However, in New York City, when these individuals enter the criminal justice system there is no meaningful mechanism to keep them safe, provide accommodations, or direct them to necessary services.

Neither the Department of Correction, nor the Department of Health and Mental Hygiene includes the identification of Developmental and Intellectual Disabilities as part of their intake screening process. Very often individuals with such needs 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 there is no meaningful screening process, it is typically up to our office to identify for the Departments our clients who need accommodations for their cognitive deficits. Of course, lawyers are not often clinically trained to identify such conditions, and an arraignment interview is not the proper setting to do so. Therefore, we can only assume many of our clients with developmental disabilities pass through the system and are victimized not only by other individuals but by the system at large.

Currently people with developmental and intellectual impairments 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 while 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.

While we emphasize that the vast majority of people held in city jails are there unnecessarily – people with severe developmental and intellectual disabilities are a particularly egregious case. Once incarcerated, the lethargy of institutions charged with placing individuals into services in the community or to restore them to competence can leave people incarcerated for weeks and months for no good reason.

We would like to share the experiences of our clients which illustrate an all-too-common set of outcomes for individuals with cognitive impairments in the criminal justice system.

> *Mr. Spaulding suffers from moderate to severe mental retardation as well as mental illness. Despite multiple requests to the Department of Correction for Protective Custody, Mr. Spaulding bounced between several mental observation and general*

population settings. He was the victim of several beatings including a slashing attack to his stomach. Our office continued to request safe housing for Mr. Spaulding, but he continued to be victimized – he was again severely beaten, this time necessitating surgery to his face, and leaving his arm in a sling for several months. When Mr. Spaulding returned to population after hospitalization, his disability caused him to have trouble with jail rules – he did not understand why he was required to be strip searched and refused the traumatizing practice. In response, he was placed in solitary confinement in a contraband watch cell where he remained for several days, and where he was denied a counsel visit. In order to have him removed from these harmful conditions, our office provided DOHMH records regarding his intellectual disability. A five minute conversation with Mr. Spaulding is enough to raise serious red flags about his cognitive abilities. A meaningful intake screening process could have prevented repeated brutalization, months of pain in the hospital, and the suffering he endured in solitary confinement.

Mr. Williams suffers from a severe intellectual impairment and was charged with a misdemeanor. Mr. Williams was 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 have Mr. Williams released from jail, only to refer him for outpatient services at the very same facility at which he had received services in the past. Because his charge was a misdemeanor, it was dismissed upon his placement in OPWDD. Effectively, Mr. Williams was incarcerated for two months on no charges, during which time he was assaulted in his housing unit, suffering blows to his head and eye. Mr. Williams was determined to be safe to live in the community by OPWDD, yet our criminal justice system found him so dangerous he was forced to live in a jail that could not keep him safe.

The Urgent Need for Fewer Arrests

The surest way to ease the burdens on the criminal justice system is to reduce the size of the population in the City's custody. Serious crime 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. While it is rare that a misdemeanor, on the first instance, will lead to jail time, as low-level charges and summonses pile up – disproportionately in communities of color – people become vulnerable to detention on low-level charges. Fare-evasion, a misdemeanor, is one of the top charges leading to jail time in New York City, today; overall, misdemeanors account for more than 50 percent of jail admissions. Meanwhile, arrest, independent of long-term incarceration, can have severe collateral consequences to family structure, health, employment and education. According to the Vera Institute of Justice, arrest and incarceration are one of the major contributors to poor public health in certain communities. Due in part to racially discriminatory policing practices, these negative impacts fall heaviest on communities of color. 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.

Issues such as homelessness and substance abuse, which frequently co-occur with serious mental health symptoms can leave specific demographics vulnerable to having bail set at arraignments at a level that is impossible for our clients to reach. Thus many people are incarcerated due solely to their poverty, despite the clear language in the State's bail statute explaining that bail can be levied solely for the purpose of securing return to court. Our clients charged with low-level crimes, who have also been identified as having a mental health need, are frequently detained in City jails. There is a great body of evidence that would suggest that this practice, rather than one aimed at addressing the underlying needs of this population, serves little public safety purpose and rather "kicks the can down the road" leaving an unaddressed issue to resurface a few weeks later.

Thank you sincerely for providing us with the opportunity to share our experiences with the Council. Of course we remain available to answer questions or provide technical assistance should the need arise.

Lisa Schreibersdorf

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Center for Court Innovation Testimony

New York City Council

Behavioral Health and the Criminal Justice System: Examining New York City's Action Plan

May 12th, 2015

Good Afternoon Chair Lancman, Chair Crowley, Chair Gibson, Chair Cohen and esteemed members of the Council. My name is Carol Fisler, and I am the Director of the Mental Health Court and Alternative-to-Detention Programs at the Center for Court Innovation. Thank you for the opportunity to speak here today.

Through the Center's work involving mental illness and the criminal justice system, we believe we have placed ourselves in a unique position to provide insight into issues affecting the courts and correctional systems. National studies indicate that close to 20 percent of people booked into state prisons and local jails meet criteria for serious mental illness – more than triple the rate of mental illness in the general population. In New York City, as the population at Rikers Island dropped by 15 percent from 2010 to 2014, the number of inmates with recognized mental health problems increased by 15 percent, raising the percentage of inmates with mental health problems at Rikers from 29 percent in 2010 to 38 percent in 2014.

In the past decade, justice reformers have made great strides in developing new approaches to the complicated issue of mental illness within the criminal justice system, and the Center for Court Innovation is proud to be on the forefront of this problem-solving effort. In 2002, the Center opened one of the nation's first felony mental health courts, the Brooklyn Mental Health Court. Research has shown that the Brooklyn Mental Health Court, which links offenders to long-term, court-monitored mental health treatment, has reduced re-arrests, psychiatric hospitalizations, homelessness and substance abuse among participants. The Center has also provided training and technical assistance to the mental health courts in other boroughs. During 2014, the Center worked with partner agencies to launch Court-based Intervention Response Team (CIRT) projects in Brooklyn and the Bronx. The CIRT programs work in close partnership with the

at the top of the national treatment court charts. Both locally and nationally, there are a wide range of criminal justice and mental health collaborations at every stage of the criminal justice system, including jail diversion programs, forensic assertive community treatment teams, and specialized probation and parole programs. In recent years, a body of research on these interventions has begun to develop, showing positive, but also somewhat surprising, results, which I'd like to highlight:

- Compared to defendants in traditional courts, mental health court participants have lower rates of re-offending, longer times in the community before committing new offenses, and fewer days of incarceration. These positive effects can endure for a year or more after exiting mental health court.
- Mental health court participants also show greater engagement in community-based services.
- The seriousness of a defendant's charges or of the most serious prior offense is not associated with higher rates of re-offending. In fact, a couple of studies (including one of the Brooklyn Mental Health Court) show lower rates of re-offending among mental health court participants charged with violent felonies compared to those facing property or drug charges. This research finding is consistent with the experience of treatment court planning teams in New York City, which is that is it easier to get consensus around a project design for felony offenders than for misdemeanor offenders, for whom it is often preferable to serve a short amount of time in jail than to commit to a longer period of court-monitored treatment.
- National research indicates that, for mental health court participants, there is little or no correlation between history of psychiatric hospitalization, symptom severity at the time of court enrollment or six-months post-enrollment, insight into mental illness, the type of treatment received, or adherence to a medication regimen and reductions in recidivism.
- The national research indicates, instead, that the factors mostly strongly predictive of re-offending are the same as those seen in the general criminal justice population, such as attitudes and values, associations with justice-involved peers, lack of success in education and employment, and substance abuse. These findings have led policy experts to recommend that we focus on criminogenic risks and needs as well as behavioral health needs when we design alternatives to detention and incarceration, and several of

Innovation shows that defense concerns that judges might set higher bail or impose a more severe sentence if they know a person is mentally ill are legitimate. New initiatives to expand mental health screening at arraignment should include careful controls on the release of mental health information to judges and prosecutors and should be accompanied by training that seeks to reduce continuing stigma around mental illness.

The importance of reducing the use of bail on individuals with mental health issues is revealed through an analysis of the Rikers Island population conducted by the Council of State Governments Justice Center which found that people with mental health needs, compared to those without, stayed in jail almost twice as long, were less likely to make bail and, if they did make bail, took almost five times as long to do so. We believe that well-crafted supervised release programs can be at least as effective – and quite likely more effective – as bail in securing defendants' appearances in court without compromising public safety. Brooklyn Justice Initiatives, one of the newer programs of the Center for Court Innovation, is working to reduce the use of bail and unnecessarily long jail stays of individuals charged with misdemeanors by replacing detention with vigorous monitoring and links to voluntary services. Participants are recruited from the pool of non-felony defendants in Kings County who have bail set at arraignment and are unable to pay. Upon referral to Brooklyn Justice Initiatives, each participant undergoes a screening process and is connected to a program case manager. All participants can be referred to voluntary programming offered by a network of community based service providers including job training, drug treatment, and mental health counseling. The program offers on-going supervision and case management for eligible defendants until a disposition is reached. For defendants with mental health needs, the Brooklyn CIRT program is being coordinated with BJI, to positive effect.

We are excited about the progress that has been made in creating alternatives to detention and incarceration for people with mental illnesses in New York City over the last decade and are optimistic that the action steps proposed in the Mayor's Task Force Report will expand these opportunities.

Right Now We Have A Crisis In New York City.

Rikers Island Is In Turmoil.

There is a defiant attitude in the inmate population and aggressiveness in their behavior.

They feel empowered to act belligerently because they know that the correctional staff has less ability to sanction them.
They cannot be put in Administrative Segregation for long periods of time.

The way to stop this behavior is to distract the attention of the inmates away from what they can do in the jails to what they have to do when they get out of jail.

They all go back.
How well will they be equipped to cope with life and to face the challenges waiting for them out in 'the world'.

Programs are security.

Wardens know this to be true.

Effective programs provide more control over the behavior of inmates than any locked gate.

The Substance Abuse Intervention Division (SAID) program during the 1990's demonstrated the level of control that is possible.
So much so that 1500 beds were funded in 1999 for SAID program expansion on Rikers Island.
The Mayor and the City Council provided the funding.

The 1990's on Rikers Island was chaotic and violent.

It is incredible that there is no such program for the inmates on Rikers Island today.

We know what to do, we've done it before, why don't we do it again?

First, re-establish the SAID program to provide substance abuse and life skills counseling to the inmates on Rikers Island.

Second install the Values Re-Entry program for cognitive self change for inmates who are about to be released back to the streets of New York City.

These two aggressive responses to the turmoil, confusion and violence that has our jails nearly out of control, will restore order and enhance public safety when these same inmates are released back to the streets.

Remedial corrective action is a practical solution to the current crisis.

Yesterday, today and tomorrow, prisoners being released from Rikers Island will return to the streets and spaces of New York City.

We refer to this process of releasing prisoners as 'reentry'.

A lot is at stake every time reentry takes place, not only for the prisoner being released but for all of us.
We all have a stake in every reentry event, and what happens on Rikers Island is important to the process.

What we expect from our Criminal Justice System and from the Department of Correction, is a more civilized person than the person who went to jail.

We expect the Department of Correction to correct something.

There needs to be some specific program activity that prisoners are involved, in that reconditions their thinking away from committing crimes to joining with their communities to make everyone's living conditions better.

The Values Re-Entry program is designed for Cognitive Self Change.

Is there a reentry program to recondition their thinking on Rikers Island?
Is there a reentry and reintegration program made available to Rikers prisoners to enable Cognitive Self Change to occur?

Why not?

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Mental Health Care for Inmates on Rikers Island.

Inmates held in the custody of the NYC Department of Correction are systematically abused by the nature of Mental Health service delivery under contracts awarded to the lowest bidder for health services.

The health care contracts awarded by the City require as many cost saving measures as possible by the contractor, in order to maximize profits.
This necessitates a minimalist approach to service delivery.
Medical treatment that is less than optimum is built into both the quality and the extent of mental health care for inmates.

The contractor spends as little time and money as possible on service delivery, as this is how profits are generated.
Mentally ill inmates require more attention than this formula provides for.

One solution is to have the Health and Hospitals Corporation or a Hospital based facility responsible for providing direct care to all mentally impaired prisoners in the system.

Mental Health care for prisoners is a treatment specialty that has yet to be developed. It needs to be recognized, that mental health issues are associated with incarceration.
The various disorders, dysfunctions and illnesses that occur in a prisoner population are not the same as with patients that are not incarcerated.

Psychopathic criminal disorders must be identified.

More study is indicated to determine the diagnosis and treatment for a given disorder when the patient is incarcerated.

The DSM-V is not written for diagnosing incarcerated mental patients.

Only a City agency or a Hospital can dedicate the resources required to develop the necessary initiatives to create a protocol specific to the treatment and care of prisoners presenting mental health issues.

In addition, the staffing and accommodations needed at Rikers Island need review, as the housing units and Correction Officer training have never been specific to the mental health population.

Officers and supervisors need in depth training to understand and manage mental health challenged prisoners and need to be trained to respond properly and timely to any health care emergencies that might arise.

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Correctional "Aging Out" Programs

The single most prevalent cause for criminal offenders to quit committing crimes has proven to be what is called "aging out".
'Maturing out' is another way of expressing the process of desisting from criminal behavior.

Eventually almost all offenders change from anti-social thinking and behavior to pro-social behaviors.

Offenders who at some point re-evaluate the values and beliefs that support their criminal behavior, will begin to question whether those values and beliefs are working for them or not.
The revaluation process, occurring at some point in his criminal career is the most effective path to change.

Correctional programs that encourage the offender to take a hard look at his values will trigger a desire for joining with family and community.
Offender reentry, is a process that correctional systems should use to prepare offenders for successful community reintegration.

Correctional programs that reach into offender sentimentality are effective measures to motivate change from his criminogenic thinking.

Many reminders of places once enjoyed and people who give meaning to his life, provide visions of a world that could be.

Aging out means he will want something different and a better life.
If he wants something different, he will do something different.

THE VALUES RE-ENTRY PROGRAM

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Women in Corrections

More and more women are attracted to careers as Correctional Officers.

Salaries and benefits, particularly with the NYC Department of Correction exceed any other job opportunity with comparable levels of qualification. Female officers are a large percentage of the uniformed staff at Rikers Island, including supervisory positions.

Power and control issues apply differently to female officers, who lack the physical ability to assert their authority through threats of violence often used by their male counterparts, who have the physical size and strength to make those threats meaningful.

New methods and new technology is needed in Correctional environments that will enable females to carry out the physical equivalence of power and control over much stronger male prisoners.
Technology such as pepper spray and taser devices have shown themselves to be either ineffective or too dangerous to be employed when physical confrontations occur.

Cell extractions, which involve the physical subduing and forced movement of physically powerful prisoners, as well as mentally impaired but violent prisoners, are examples of routine duties that challenge the ability of correctional personnel, both male and female, but particularly in the case of women who may be called upon to execute these procedures.

There are many other demanding situations when physical confrontations occur with prisoners who attempt to not only resist control by officers, but will attempt to overpower correctional staff with fists, feet and weapons. Women are vulnerable in these situations both from a physical standpoint and from a temperamental attitude standpoint.
They are often not mentally prepared for physical altercations with larger, stronger male prisoners.

This has got to be addressed by the availability of new technology and new methodologies that will allow less physically capable female officers to assert power and control over prisoners.

Every physical act of resistance by prisoners should be considered an attempt to escape.
Officers do not carry weapons inside of jail and prison facilities.
They need tools that provide them with the ability to enforce rules and regulations and give them the power to force prisoners to obey their orders or follow their instructions.

The pharmaceutical industry needs to develop drugs that will incapacitate violent and resistant prisoners by sedating them.
Devices that enable officers to subdue prisoners with constraining garments and lasso-type objects need to be developed and made available.

Cells need to be redesigned to allow remote releasing of substances that incapacitate violent, determined, prisoners who refuse to leave their cells when court orders are being executed.

Patience is an effective weapon that allows authorities to 'out wait' offenders who are recalcitrant in some situations, and should be included in the repertoire of methodology.

Diets could be modified with court approval, to control predictably violent prisoners.

Research into tools and methods that will enable female correctional staff to carry out the difficult job of controlling prisoners in our jails and prisons without endangering themselves is indicated.

Administrative segregation is a necessary measure to separate some prisoners from other prisoners.

What is not necessary is total isolation, otherwise known as solitary confinement, which has been proven to be detrimental to the physical and mental health of offenders.

Cells can be designed to create segregation while at the same time providing limited visual contact with other human beings.

Offenders responsible for assaultive behavior that includes throwing objects, might indicate installing of partitions that can be attached to cell bars to defeat targeting of staff members, while still permitting visual contact between prisoners and staff.

Solid doors with food tray slots should be eliminated.
Cell doors are enough.

While segregation of offenders within jails and prisons is sometimes a necessary control measure, total isolation of an offender in a walled-in cell is unnecessary.

Pharmaceutical research is needed to find new ways to deal with violent prisoners, such as sedation, making use of physical force only minimally necessary.

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Once upon a time not too long ago, people convicted of some crimes were sentenced by courts to years of "hard labor".

Constitutional protections of the 8th amendment put a HALT to that practice.

Is it fair to say that locking human beings inside steel boxes might also come under the protection of the constitution or society's sense of humanity?

Will future generations of Americans wonder what today's corrections professionals were thinking of when they held prisoners in steel boxes and then released them back to their communities?

The courts never sentenced people to solitary confinement, corrections professionals decide to resort to the use of solid steel cages with food slots to totally isolate people from contact with other human beings.
What theory of socialization supports this practice?

These same prisoners are eventually going back to the streets and public spaces they came from.
Is solitary confinement the way to prepare them to behave better than they did before?

These are all questions about the intelligence and the humanity of American society and the Criminal Justice System.
One more question:

Isn't it time to bring solitary confinement to a HALT?

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Behavior modification should be the mission of corrections systems

Behavior modification can be accomplished through thinking modification.

Thinking controls behavior.
Thinking is cognitive and is influenced by education, information, understanding, beliefs and values.

Corrections systems should start by providing pro-social thinking skills.
Offenders held by corrections agencies should be exposed to a culture of civil behavior by all persons in an institution.
Manners and courtesies, polite decorum and personal grooming should be a requirement, just as it is in a community.

Prison meals should be the high points of each day.

Institutions should improve the preparation and flavoring of meals to match restaurant quality.

This could be a privilege earned by housing units exhibiting civil behavior and institutional cooperation.
Other housing units should get meals that are "standard" institutional quality, in a "Peter pays for Paul" rule.

A merit system that allows offenders to earn lower classifications would encourage offenders to improve their behaviors all the way to minimum security facilities, parole or even conditional release.

People who commit criminal offenses against other people and their property can only do so if their sense of humanity becomes numb or is ignored, when they first think of the behavior and when they actually perpetrate the crime.

Humanity is the moral value that is the crucial part of the belief system that controls a person's behavior towards other people, providing the basis of civilization and the ability of people to live together in peace.

If a person has a consciousness of humane treatment towards people, it will intervene when tempting circumstances present themselves that would otherwise lead his thinking to commit criminal actions.

Criminogenic thinking leads to criminal behaviors.

For most people it isn't a matter of their being immune to temptations, but it is the consciousness of treating others as they would like to be treated themselves, that prevents them from abusing or violating other people and their possessions.

That consciousness is what we call 'humanity'.

Criminal offenders are ex-communicated from the rest of society because of their actions that violate the rules of society, regarding how people treat other people and their property.

The time that they are removed from their community is the time that correctional interventions can be implemented for those offenders who might change from a lifestyle of being imprisoned.

Interventions that strengthen and reinforce their sense of humanity should be the correctional experience of criminal offenders.

Solitary confinement of any human being separates that person from contact with other human beings and at the same time, further reduces the humanity of an offender who is already deficient in a sense of humanity.

Does this make sense?
Is this what correcting anti-social behavior should consist of?

Confining an offender to a steel box with no visual or sense-contact with other human beings, is inhumane, thoughtless and the exact opposite of a treatment for criminogenic thinking.

Locking people in a steel box doesn't make sense in a civilized society.

Our prisons are a part of our society and are a reflection of the kind of society we claim to be.

Stop caging human beings in steel boxes.

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Why are offenders being released from Rikers Island without a Discharge Plan?

Why is there no pre-release program to help them "do the right thing"?
A pre-release program for cognitive self-change that will start them in a positive direction when released?

When will the NYC Department Of Correction provide programs that correct anti-social thinking?

When will Public Safety be the priority instead of Punishment and Control?

Punitive treatment and Fear doesn't prepare an offender for Re-Entry.

Public Safety depends heavily on what happens while an inmate is in custody.

The problem needs a positive solution.

The Values Re-Entry Program, a Cognitive Self-Change program for offenders is a positive solution.

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What is missing for inmates on Rikers, is contact with normal human beings who come to the jails every day to talk to and interact with the inmates.

Humanity.

It is well known that most of the inmates held on Rikers Island have substance abuse issues.
How is it that there is no system-wide substance abuse program in place?

The counselors who staffed the SAID program were not wise men and women, they were simply ordinary people who were willing to interact with inmates as human beings, not as numbers.
It made a difference to the inmates.

Not having this daily contact means that the inmate population has no other references to humanity than other inmates who are compelled to behave like criminals, following the convict code of 'jailing'.
The result is what you have on Rikers today.
Defiant, violent disrespectful behaviors.
They are disrespectful because they are being disrespected as human beings.

If you expect inmates to interact civilly with people in their communities when they are released, they have to have daily practice in the jail before they are released.

Treat them like animals, they will act like animals.

Programs

One of the measures of effective programming is the level of compliance and general behavior control.

How can programming change the behavior of offenders who are in the habit of criminal behavior?
Can programming change the level of violence between inmates and between inmates and staff?

Wardens have long recognized that effective programs enhance security. Distractions such as table games, playing cards and television are effective measures to make prison time more bearable.

Reading is also a way to involve offender thinking in new directions, particularly reading about life after jail.

An important part of Reentry programs is that the offender is given a sense of 'Hope'.
He can put together a set of goals that reward him with satisfying feelings about his future life.

When the offender is involved with his own life issues and feels concern about his future after release from custody, he is open to questions about what has not worked.

The Values Program is about dreams and goals to reach those dreams.

The offender focuses on his valuables, listing the people and things he wants in his future, and creates an imaginary life for himself, realizing the real value of things he already has, but has neglected.

The Values Program presents a set of personal rules, that are attached to important values.

Criminogenic thinking and Criminal behaviors are a dual addiction problem.. There is a strong, appealing lifestyle that goes with criminal actions. The fast life style is an addiction.

All addictive influences need to be considered in an effective program that is going to prepare the prisoner for citizenship.

EFFECTIVE OFFENDER PROGRAMS ENHANCE SECURITY AND REDUCE INMATE ON INMATE AND INMATE ON STAFF VIOLENCE IN THE FACILITY.

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The Values Re-Entry Program encourages offenders to stop thinking of criminal activity through a process of Cognitive Self Change.

If we change their thinking, we can change their behavior.

The reentry program needs to start while the offender is still locked up. Programs are effective when the offender feels the pain of being in prison.

The Values Re-Entry and Reintegration Program is a pre-release program that encourages offenders to think about the people and things that are on the outside of his prison's walls, but are on the inside of his heart.
The people who are inside of his heart are the key to his cognitive self change process.

We use Recidivism as the measure of program success, instead of the goal of convincing offenders to quit criminal thinking and actions and begin new lives as productive citizens.
Encouraging Desistance is the real solution to ending the cycles of prison to community and back to prison.

It's time we focused on the root cause of criminal behavior which is criminogenic thinking, instead of focusing on the statistics of criminal behavior.

If we can change their thinking, we can change their behavior.

The Values Re-Entry Program enables offenders to reevaluate their lives and become motivated to change to a better way to live.

The values Re-Entry Program for offenders is a guidebook that assists the offender in his change process.

It is a manual for change that prepares inmates for release from custody and reentry back to where they came from.

The reentry process should include reintegration to the neighborhoods and communities the offender's lived in, with a new way of thinking that changes their behavior.

If you can change their thinking from criminal thinking, you can change their behavior from criminal behavior.
Thinking controls behavior.

Where values come in is what causes one person to be a law abiding citizen and what causes another person with the same background, to become a criminal offender.
Their values are different.

The person in custody is a criminal offender.
He is going to be released, but can he be released with a change in his thinking?
Can he change the values that guide him through life?
Can he become a law abiding citizen with a positive, progressive mindset?

The answer is, yes he can.

Values are the principles that guide a person in a positive, progressive direction through life.
Values are taught from infancy through a person's formative years and on through adulthood.
The problems some people have is that they were taught them, but they never learned them.
They made up their own values instead.

We call these people 'criminals' because they do not follow the same rules, the same values as the rest of us; they live a life of committing crimes.

The Values Re-Entry Program provides the criminal offender with the basis for changing his concepts of life by changing the values he chooses to live by.

The Program is not for every offender, it only works for the offender who feels that he has had enough of the bumps and grinds of fast living, imprisonment, and trying to start all over again with nothing.

It works for the offender who is "aging out" or "maturing out" from his life-style that always ends up in a prison cell, eating prison food and having a number instead of a name.
The offender who has reached the point of being "sick and tired of being sick and tired".
The offender who wants help.

Help is written into the pages of the book of the Values Re-Entry manual and reading the messages in those pages will take the offender through the process of his release, reentry and his rejoining his important and valuable people.

He can find love.

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May 12, 2015 City Council Hearing
Testimony of Carla Rabinowitz

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My name is Carla Rabinowitz and I am a community organizer at Community Access, a 40 year old non profit that empowers mental health recipients by providing quality housing, internationally replicated employment training program and other recovery services, like we provide in the advocacy department of Community Access.

I am also project coordinator of CCIT NYC, Communities for Crisis Intervention Teams. The main goal of CCIT NYC is to encourage the police to implement a new model of police training where police can identify mental health symptoms in someone in crisis and respond in a way that de-escalates the crisis, and recognizes that the person in crisis is mentally ill not a criminal.

Fortunately, the Mayor shared our vision and will be creating 2 assessment centers where police can drop off people in crisis and will train 5,500 of the city's 35,000 officers on identifying mental health symptoms in those in crisis and de-escalating the situation.

What is a CIT?

A CIT (Crisis Intervention Team model) is a method of policing that provides officers with the tools they need to respond to incidents involving people in emotional distress. CITS ensure safe and respectful interactions between mental health recipients and law enforcement.

CITS require coordination between public health system and police department and mental health community. Police need a place to quickly drop off people in crisis and return to other police calls. This is why the Mayor's assessment centers are so important. Otherwise police could sit for hours in an emergency room with a person in crisis. Mental health recipients and provider staff need to know they can trust police when they call for help.

Why are CITs so needed in NYC?

NYPD responds to between 100,000 to 150,000 calls of those in mental health crisis a year, they call these calls EDPs(Emotionally Disturbed People calls). And today the NYPD officers receive little to no training on how to handle these calls.

So what happens? A family member or a housing agency calls for an ambulance if a person is in crisis. Police officers show up and go into their routine training model of "Command and Control", proving police are in control. Police may start shouting commands or say to the mental health recipient do you want to do this the easy way or the hard way.

Right away the encounter escalates, and the mental health recipient who is in crisis at the time becomes more upset. Sometimes all that happens is a long wait at a hospital or city jail, some times these encounters take a turn for the worse.

Some of the injuries and deaths of people in crisis include:
April 2015 Felix David was killed by police at a housing site for the mentally ill.
August 2014- Unidentified patient badly beaten by officers in Brooklyn
February 2014- Sahar Khoshakhlagh, 38, shot as a bystander to an edp incident gone wrong in Times Square.
January 2014- Suzanne Lafont, 59 and husband Karl Peltomaa, 50, injured and arrested from their home. Police stated they treated the professors so roughly because police thought Karl was an edp.
Nov 2013- Rexford Dasrath, 22, shot 5 times outside his home wielding a dinner knife his family claimed was to make sandwiches.
September 2012- Mohamed Bah, 28 shot to death in his home
August 2012- Darrius Kennedy, 31, shot to death in Times Square.
March 2012 Shereese Francis,30, died in police custody when police chased her around her home and suffocated her, as she was screaming for police to help.

Not only are there human costs from cities that lack CIT training of police, there are also financial costs.

NYC has set aside $674 million to cover claimants against NYC and expect to pay $782 in 2016.

Police misconduct, injury and civil rights allegations against NYPD make up more than 1/3 of all claims against the city.

Just one of those shootings could cost a city up to millions of dollars for one lawsuit.

What are the benefits of a CIT:

1. Less time for officers in between crisis calls, Chicago reduced this down time from 8 hours to 30 minutes.
2. Fewer injuries to police and mental health recipients. San Antonio which has trained 92 % of officers has not seen one use of force case since 2008. Houston which trained 50% of its 5,200 officers also reported drop in cases of force.
3. Improved perception of police by mental health recipients and staff at mental health agencies. Many times families or mental health provider staff are the ones who have to call police. We need to know we can trust how police will treat the people we are helping to care for.
4. Law enforcement's better view of mental health recipients and better confidence working with mental health recipients.
5. More positive media relations for NYPD and Mayor
6. Lends prestige to the City. Before the Mayor's announcement of police training, NYC was the only 1 of the 7 largest cities in the USA without a CIT type training of police.

Some Cities like Houston and Los Angeles have social workers riding along with police.

Houston has a social worker co-responder model but does more. Houston also trains all officers in the traditional CIT 40 hour training. And Houston has a telephone line for officers who are not trained in CIT to call in and get advice when the officer is handling an edp call.

All in all CITS are a win-win for police, mental health community and the general public.

I am so excited that Mayor de Blasio and Commissioner Bratton have embraced better training of police and more interactions with the mental health community leaders.

Crisis Intervention Teams in NYC

August 6, 2014

Review of 5 Models:

Chicago, Houston, San Antonio, LA, and San Diego

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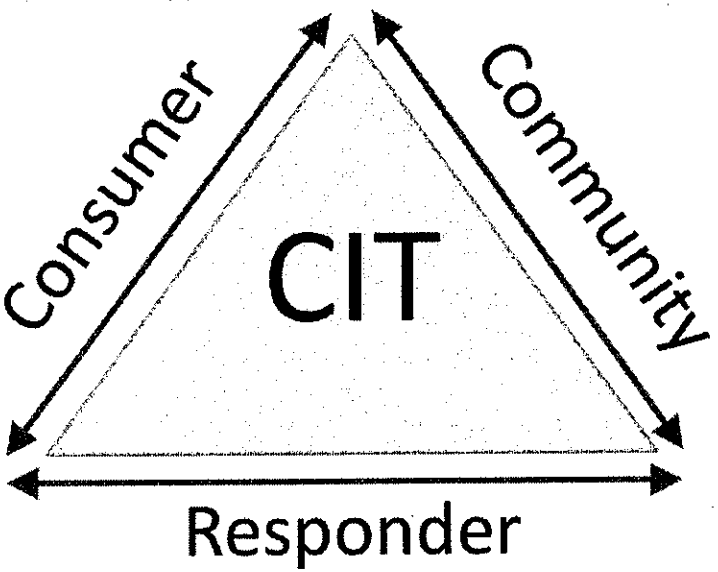
What is CIT?



A CIT (Crisis Intervention Team) is a method of policing that provides officers with the tools they need to respond to incidents involving people in emotional distress.[1]

CITs ensure safe and respectful interactions between mental health consumers and law enforcement.[2]

Coordination between consumers, community members, public health services, and responders is essential to the success of CIT.

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Why CIT in NYC now?

- Cities have been employing CIT as early as 1988 in Memphis, TN.[3]
- CIT programs have been created in over 2,700 communities to date, indicating it's a valuable method for community policing.[1]
- Police are the first to respond to someone experiencing an emotional health crisis. Lack of training and limited understanding of mental health puts consumers, bystanders, and police officers in danger. These situations can result in death, serious injury, and multi-million dollar lawsuits.[4]

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Why CIT in NYC now?

- Programs currently in place
  - NYC Emergency Service Unit (ESU): Responds to extreme emergency and high risk situations outside the duties of regularly trained police officers.
  - Bowery Residents' Committee (BRC) Pilot Project: Intervenes with homeless individuals on the subway.

- The problem
  - The ESU comprises less than 1% of city police officers (300 out of 34,000). Other cities such as Houston have as much as 50% of their police force trained in crisis intervention.
  - None of the deaths injuries published in the media involved the homeless or occurred on the subway.

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Consequences of No CIT

- Growing cost of claims against NYC:
  - In this year's budget, the city set aside $674 million to cover claimants and anticipates to pay $782 million in 2018.[5]

- Police misconduct, injury and civil rights allegations against the NYPD made up more than one-third of all claims against the city over the past year.
  - Misconduct claims alone rose 22% in NYC while they decreased in other cities.[6]
  - Police report 83 police shootings in 2012, half of which involve people with mental illness.[7]
  - Just one of these cases could cost the city millions: The family of Mohamad Bah (a consumer shot by the NYPD) is seeking $70 million from the city.[8]

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Consequences of No CIT

DEATHS

Nov 2007	**David Kostovsk**, 29, was shot in Brooklyn while armed with a broken bottle[9]
Nov 2007	**Khiel Copin**, 18, was shot 20 times by 5 officers while holding a hair brush mistaken for a gun[10]
Sept 2008	**Iman Morales**, 35, died after a taser shot caused him to fall from the ledge of his 3rd floor apartment in Bed-Stuy[11]
Mar 2012	**Shereese Francis**, 30, died in police custody at her home[12]
Aug 2012	**Darius Kennedy**, 31, was shot in Times Square while armed with a knife[13]
Sept 2012	**Mohamed Bah**, 28, was shot in his home wielding a knife[8]
Nov 2013	**Rexford Dasrath**, 22, was shot 5 times outside his home home wielding a steak knife[14]

INJURIES

Jan 2008	**Dustin Grose**, 28, was badly beaten at his home while unarmed[22]
Jan 2014	**Suzanne LaFont**, 59,and husband **Karl Anders Peltomaa**, 50, were injured at their home as a result of a mishandled medical emergency call[15]
Feb 2014	**Sahar Khoshakhlagh**, 38, was shot in Times Square by a stray bullet intended for an unarmed EDP[16]
Aug 2014	Unidentified patient was badly beaten by officers in Brooklyn[21]

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Benefits of CIT

- Less down time for officers: In Chicago, CIT reduced turnaround time from up to 8 hours to 15 minutes.[17]
- Fewer casualties to officers, consumers, and bystanders and less time off for injured officers[18]
- Fewer lawsuits
- Fewer unnecessary arrests + decreased jail time
  - 40% of Riker's Island inmates have MI, all of whom got to prison through police contact.[19]
  - Yearly cost per inmate is approximately $160,000.[20]
  - Chicago: average custody time decreased from 74 days to 3 hours.[17]
- Diversion of consumers away from hospitals
- Improved perceptions and attitudes
  - More positive media relations for the NYPD and the Mayor
  - Lends prestige to City. NYC is the only 1 of the seven largest US cities without a CIT program.
  - Law enforcement's improved perceptions of consumers + increased confidence in working with them.
  - Improved community perceptions of law enforcement

More consumers engaged in ongoing treatment

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Chicago at a Glance

CIT Began	2004
Population	2.8 million
Police Force	12,000
# CIT Officers	2,300 (19.2%)
Hours of Training	40
Method of Deployment	Officers' time cards indicate whether they are CIT trained. 911 dispatcher sends trained officer after identifying EDP call.
EDP Calls/Year	19,846
Drop-offs/Year	3,300
Drop-off Locations	Hospitals, separate rooms and entrances for EDP Free standing triage unit w/ separate nursing staff (30 ft from main hospital)
Other	Hospital staff must accept EDPs brought in by the police.

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The Chicago Model

- Chicago's pilot program began in 2004 in 2 districts with the most single resident occupancy (SRO) facilities housing individuals with serious and persistent mental illness. CITs expanded city wide in 2006.

- Chicago conducts about 14 classes of 25 officers each year in standard comprehensive Crisis Intervention Team training. The number of training classes varies each year. These trainings follow the Memphis model of CIT.

- Funding derives from an Illinois State Law Enforcement Agency, the Illinois Law Enforcement Training and Standards Board, and the City of Chicago.

- Chicago PD receives between $80,000 to $120,000 per year from this law enforcement agency.

The Chicago Model

Cost per Training

$200	Outside MH professional presenters per hour
$15	Consumer and family presenters per hour
$500	Annual luncheon for 50 officers ($1,000 in NYC)
$1700	Training materials (not including cost of copies)
$4200	Outside trained CIT police instructors
Unknown	Travel expenses
$8500	**Total**

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The Chicago Model

- Chicago's CIT training targets officers with at least 2 years of experience

- Training is voluntary
  - Officers volunteer to apply for the CIT training
  - Applicants then go through a screening process in order to be accepted into the training class.

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The Chicago Model

Each Training Includes:

1 hour	Intro, History, & Overview
3 hours	Mental Illness: Signs & Symptoms
1 hour	Developmental Disabilities
2 hours	Substance Abuse & Co-Occurring Disorders
4 hours	Risk Assessment & Crisis Intervention Skills
3 hours	Family Perspectives & Consumer Panel
2 hours	Child & Adolescent Disorders
1 hour	Geriatric Issues
1 hour	Department Procedures
1 hour	Psychiatric Medications
2 hours	Legal Issues
4 hours	Community Resource Panel
3 hours	Crisis Intervention Role Play & Hearing Voices Simulation
4 hours	Crisis Intervention Role Play & Virtual Hallucinations Machine
1 hour	Summary & Evaluation
1 hour	Written Examination
1 hour	Superintendent's Ceremony

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Houston at a Glance

CIT Began	1999
Population	2.2 million
Police Force	5,200
# CIT Officers	2,600 (50% of all officers on staff)
Hours of Training	40
Method of Deployment	Police and social workers ride together in the same cars. Team can be called by a dispatcher, other officers, or based on something they observe.
EDP Calls/Year	29,272
Drop-offs/Year	7,076
Drop-off Location	Psychiatric Assessment Center
Other	Houston police standard for picking someone up is imminent and serious risk of harm to self or others, regardless of whether or not a crime was committed.

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The Houston Model

Houston's approach to CIT is 4-fold

1. **Co-Responder Teams** (CIRT)
   - 10 pairs of social workers and police (soon to be expanded to 13) ride together in the same cars,
   - 24/7 coverage.
   - Total cost: $600K/year funded by County mental health department.
   - The social workers are overseen by a county mental health supervisor.

3. **Training** for all officers:
   - 40 hour initial + 8 advanced training hours each year after.
   - Developed training model using material from other cities and Houston PD's internal psychiatrists.

2. **Resources** for Non-CIT trained officers:
   - a telephone line (triage line) manned by CIT trained officers and social workers.
   - Calls to a psychiatrist at the drop-off assessment center.

4. **Protocol**
   - Houston's police can pick up an EDP without a crime being committed if the person poses an imminent and substantial risk of harm to self or others, regardless of whether a crime is committed.
     - Offering to sell body and being out at all hours of night
     - Standing in traffic
     - Wearing a winter coat in 100 degree temperature and hallucinating verbally
     - Eating dead pigeons

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The Houston Model

- The Neuro Psychiatric Center (Est. 1999)
  - Houston has a self-standing assessment center for EDPs not going to prison, both walk-ins and drop-offs.
  - 60 beds, open 24/7.
- The center is funded 80% by the county and 20% by the state.
- For psychiatric concerns only:
  - They will perform immediate triage when necessary e.g. injuries from a fall; and will dispense physical medications such as for High blood pressure.
  - For other physical concerns, they go to another building on the main hospital campus.
- Care on-site
  - Nurses, social workers and licensed mental health professionals.
  - 3-4 on call psychiatrists, at least 1 is available at all times.
  - Peers also work at the assessment center.
- Goal is to move people out in 24 hours. Average stay is 2-3 days.

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San Antonio at a Glance

CIT Began	**2003**
Population of City	**1.4 Million**
Police Force	**2,300**
# of CIT Officers	**2,100. 92% of staff**
Hours of Training	**40 hours cadets and officers**
Drop Offs per year	**600 to 800**
Drop Off Locations	**Varies**

San Antonio has role plays every day in week long training and over 4 hours of interaction with mental health recipients and families in that week of training.

San Antonio has not used force in a EDP related case since 2008.

San Antonio CIT is cost free.

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San Antonio at a Glance

- San Antonio started a Mental Health Unit in 2008. They have 6 officers and 1 supervisor in that unit.
- San Antonio trains all officers and cadets in 40 hours of training.
- San Antonio got the basis of its training from Houston. De-escalation, identifying MH crisis, recognizing symptoms, reflective listening, responding to suicidal behavior, etc.
- San Antonio conducts a role play every day and devotes more than 4 hours to mental health recipient, family member interaction.
- San Antonio training is paid for by stakeholders, hospitals supply meals at trainings and space for trainings, etc.

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San Antonio at a Glance

- San Antonio drops off those in crisis to a variety of locations.
- San Antonio police can drop people off at hospitals, free standing mental health clinics with 120 beds, or Crisis Stabilization Centers where people can be held for 48 hours, 16 beds.
- Police officers are the ones to decide where the EDP gets dropped off based on urgency of care.

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San Antonio at a Glance

- San Antonio police also escort people in crisis when called in by their 10 mobile crisis units, called Mobile Crisis Outreach Team.
- Mobile Crisis Outreach Teams are made up of doctors, social workers and police if needed.
- There is a 24 hour mobile crisis line for families and others to call in.
- The response time depends on the urgency of call. Emergency calls must get a 1 hour response. Urgent calls get an 8 hour response time. Routine calls are responded to within 2 days.

Los Angeles at a Glance

CIT Began	1993
Population	3.8 million (City)
Police Force	10,000
Other	Police and social workers co-respond, but ride in separate cars. There is a separate team to respond to EDPs that frequently utilize 911 services.

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The LA Model

- SMART (System-wide Mental Assessment Response Team)

- 1993: A dozen social workers rode with police.
  - The total cost was less than $1 million dollars.
  - Funding originated from the County's Mental health budget.

- 2014: About 100 police and social workers ride along together (70 police and 30 social workers).
  - The personnel budget is $5 to $6 million that includes police officer and social work staff.
  - The county mental health budget is $1.7 billion.

- Los Angeles also has a triage station at the police department manned by social workers or trained CIT police officers.
  - Untrained officers call in to this triage station when dealing with a mental health crisis.
  - This phone line is to be used only when other CIT officers are unavailable.

The LA Model

- LAPD recoups some of the cost by billing Medicaid for crisis calls and follow up care.

- CAMP (Case Assessment Management Program)
  - Manages follow up care.
  - LAPD works with 20 cases per week of those in crisis.
  - CAMP officers link those people in crisis to services, reducing arrests and encounters with police.

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San Diego at a Glance

CIT Began	1996
Population	1.33 million (City), 3.17 million (County)
Police Force	1,500 (City), 10,000 (County)
# CIT Officers	25-40% county-wide
Hours of Training	24
Method of Deployment	Co-responder unit of 23 clinicians that ride along with police.
Drop-off Locations	Hospital
Other	San Diego allows CIT police from the county to respond to calls from the city and vice versa.

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The San Diego Model

- CIT in San Diego is funded 100% by the county

- $2.7 million per year
  - 23 licensed clinicians to co-respond with police
  - Police liaison
  - Program director

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Conclusions

- CIT has been proven effective in major cities: Chicago, Houston, LA, San Antonio, and San Diego.
- There are vast monetary and societal benefits.
- CITs reduce injuries to police, bystanders, and those with mental illness that police must respond to.

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Final Recommendations

- 40 hour training
  - Increased depth and breadth of knowledge of mental illness.
  - Effective crisis de-escalation.

- Co-response model
  - A pilot project with peers or social workers riding with police in one precinct in each borough.

- Directing people to alternate care
  - Increased transport to assessment centers/respite centers and ongoing treatment facilities.
  - Decreased number of people in prison with mental illness.

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THE COUNCIL
THE CITY OF NEW YORK

Fire & Criminal Justice

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: 5/12/15

(PLEASE PRINT)

Name: Barry Campbell

Address: 29-76 North

I represent: Fortune Society

Address:

Mental Health and Criminal Justice Collaboration The Mayor's Action Plan

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☒ in favor ☐ in opposition

Date: 5/12/15

(PLEASE PRINT)

Name: Lynn Kaplan

Address: 50 Broadway NY NY 10004

I represent: Lifenet

Address:

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: 5/12/15

(PLEASE PRINT)

Name: ANDREW STA. ANA DAY-ONE

Address: 11 PARK PLACE SUITE 701, NY NY, 10013

I represent: DAY ONE

Address: ~~RESIDENCE~~ 11 PARK PLACE, 7TH FLOOR, SUITE 701, NY NY 10013

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THE CITY OF NEW YORK

Appearance Card

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Date: _____

(PLEASE PRINT)

Name: Jamin Sewell

Address: 90 Broad Street, NY, NY 10004

I represent: The Coalition of Behavioral Health Agencies

Address: Same

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: May 12, 2015

(PLEASE PRINT)

Name: Dr. Frank Proscia, Doctors Council

Address: 50 Bway

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: May 12, 2015

(PLEASE PRINT)

Name: SANDRA MITCHELL

Address: 3605 Kingsbridge Ave # 4L, Bronx

I represent: Community Access & National Action Network / 106-108 West 145th St

Address: NYC 10039

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THE CITY OF NEW YORK

Appearance Card 3 of 3

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 5/12/15

(PLEASE PRINT)

Name: SARAH KERR

Address: 199 WATER ST.

I represent: LEGAL AID SOCIETY

Address: 199 WATER ST.

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THE CITY OF NEW YORK

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Trish Marsik

Address: 1 Centre St.

I represent: The Mayor's Office of Criminal Justice

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card 2 of 3

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 5/12/15 1 of 3

(PLEASE PRINT)

Name: Regina Schaefer

Address: 199 Water Street

I represent: Legal Aid Society

Address: 199 Water Street NY NY 10038

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THE CITY OF NEW YORK

Appearance Card | 1 of 3

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 5-12

(PLEASE PRINT)

Name: WILLIAM GIBNEY

Address: THE LEGAL AID SOCIETY 199 WATER ST NY NY

I represent: LAS

Address: 199 WATER ST

PANEL

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: JEROME E MCELROY

Address: _____

I represent: NYC CRIMINAL JUSTICE AGENCY

Address: 52 DUANE ST - NY 10007

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: 5/12/15

(PLEASE PRINT)

Name: Cheryl Roberts

Address: _____

I represent: Greenburger Center

Address: _____

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: 05/12/15

(PLEASE PRINT)

Name: Dinah Luck

Address: MFY Legal Services, ~~299 Bro~~ 299 Broadway

I represent: _____

Address: _____

THE COUNCIL Fire 3
THE CITY OF NEW YORK criminal Justice

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 5/12/15

(PLEASE PRINT)

Name: Paul Lopotto 5/12/15

Address: [illegible]

I represent: NYC Independent Budget Office

Address: [illegible]

THE COUNCIL Fire & criminal
THE CITY OF NEW YORK Justice

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 5/12/15

(PLEASE PRINT)

Name: Nashla Rivas Salas

Address: _____

I represent: NYC Independent Budget Office

Address: _____

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all 4 committees

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

~~in favor~~ ~~in opposition~~ BOTH

Date: MAY 12, 2015

(PLEASE PRINT)

Name: MARY BETH ANDERSON

Address: 40 Rector St. NY NY 10006

I represent: Urban Justice Center Mental ~~Health~~ Health Project

Address: 40 Rector NY, NY 10006

THE COUNCIL Mental Health
THE CITY OF NEW YORK Public Safety

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 5/12/15

(PLEASE PRINT)

Name: Natis C. Rushfield

Address: 1750 Davidson Ave Apt 6A Bronx NY 10453

I represent: Community Access

Address:

THE COUNCIL Burns
THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: 5/12

(PLEASE PRINT)

Name: JUSTINE OLDERMAN

Address: 360 E. 161 Bx NY

I represent: THE BRONX DEFENDERS

Address: _____

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Mayor's plan
Behavioral Health
&
Criminal Justice

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THE CITY OF NEW YORK

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☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Carla Rabinowitz

Address: Community Access, 3 Washington Sq, 9th flr, NY, NY

I represent: Community Access, CCITNYC

Address:

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: 5/12/15

(PLEASE PRINT)

Name: John Volpe

Address:

I represent: DOHMH.

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☑ in favor ☐ in opposition

Date: 5.12.15

(PLEASE PRINT)

Name: Douglas Knight

Address: 125-01 Queens Blvd. Kew Gardens, NY 11415

I represent: Queens District Attorney Richard A. Brown

Address: Same as Above.

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 5/12/15

(PLEASE PRINT)

Name: Yulisan Liriano

Address: 3440 79th St 2b Jkn. NY 11372

I represent: Justice Committee

Address: 100 E 22nd St. Rm 103 10010

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: 5/12/15

(PLEASE PRINT)

Name: RANDOLPH MCLAUGHLIN, ESQ

Address: 1250 Broadway, 27th Fl, NY NY

I represent: HEAL Bah

Address: C/O 1250 Broadway

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: 5/6/15

(PLEASE PRINT)

Name: HEAL BAH

Address: C/O Randolph McLaughlin, 1250 Broadway 27th Fl NY NY

I represent: _____

Address: _____

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: 5/12/15

(PLEASE PRINT)

Name: Homer Venters

Address: 42-09 28th Street, LIC

I represent: NYC DOHMH

Address: same as above

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: May 12, 2015

(PLEASE PRINT)

Name: Erik Berliner

Address: Deputy Commissioner Health Affairs

I represent: Dept. of Correction

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: May 12th, 2015

(PLEASE PRINT)

Name: Michael Forte

Address: 33 Beaver Street - 18th Floor

I represent: NYC Department of Probation

Address: 33 Beaver Street - 18th Floor

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THE CITY OF NEW YORK

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Date: 5/12/15

(PLEASE PRINT)

Name: Dep. Comm. Susan Herman

Address: Dep. Comm., Collaborative Policing

I represent: NYPD

Address: 1 Police Plaza NYC

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 5/12/15

(PLEASE PRINT)

Name: Inspector Terrence Riley

Address: NYPD Training Bureau

I represent: 1 Police Plaza NYC

Address: _____

COURTS AND LEGAL SERVICES

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 5/12/

(PLEASE PRINT)

Name: LORI ZENO

Address: QUEENS LAW ASSOCIATES

I represent: 118-21 QUEENS BLVD.

Address: FOREST HILLS NY 11375

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: RICHARD MASCIE

Address: 415 OCEAN PKWY BROOKLYN NY

I represent: _____

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 5/12/15

(PLEASE PRINT)

Name: Carol Fisler

Address: 520 Eighth Ave NY NY

I represent: Center for Court Innovation

Address: _____

Please complete this card and return to the Sergeant-at-Arms