CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON MENTAL HEALTH,
DEVELOPMENTAL DISABILITY,
ALCOHOLISM, SUBSTANCE ABUSE AND
DISABILITY SERVICES JOINTLY WITH
THE COMMITTEE ON FIRE AND CRIMINAL
JUSTICE SERVICES AND THE COMMITTEE
ON HEALTH

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June 12, 2014
Start: 1:10 p.m.
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HELD AT: 250 Broadway - Committee Room,
16th Floor

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CHAIRPERSON CROWLEY: Good afternoon. My name is Elizabeth Crowley. I chair the Fire and Criminal Justice Committee her at the City Council. Today's hearing is a joint oversight hearing with the Committee on Health, Chaired by my Colleague here, Corey Johnson, and the Committee on Mental Health chaired by Council Member Andrew Cohen. We will examine the level of violence and the provision of mental health and medical service within New York City jails. The committee will also hear Intro 292 sponsored by Council Members Dromm, King, and Lancman, which requires the Department of Corrections to post a monthly report on its website regarding punitive segregation statistics for the city jail. I want to thank my co-chairs and their staff for their work on this hearing. I'd like to also acknowledge that in addition to the two co-chairs, that we've been joined by Council Member Lancman and Public Advocate Letitia James.

Over the past several years, there has been an alarming increase in jail violence. After hearing May de Blasio's Executive Budget Plan for Fiscal Year 2015 and learning that the Department of Corrections has not [sic] asked for additional

resources for this next fiscal year, which begins in July. But rather, it believes that it will spend less money than it did this past fiscal year. I am not confident that the Administration understands the reality on Rikers Island, and that action and resources are needed now. Some have attributed the rise in violence to the staffing cuts the department has made over the past few years. And as a result, correction officers work ungodly amounts of overtime. In fact, the overtime spending is out of control. The department will spend over $140 million in overtime this fiscal year. And there is no plan in place to increase that amount of money, or increase staffing.

At the Executive Budget hearing, Commissioner Ponte also addressed the issue of jail violence, and said candidly it was clear to him that despite the efforts of the prior administration, the department is in deep trouble. I appreciate the Commissioner's candor, and his acknowledgement that over the past fours uses of force has increased by 59%. Slashings and stabbings have increased by 100%, and assaults on staff have increased by more than 30%. The numbers show a department crying out for

help. The city jails must be safe, safe for inmates, and safe for staff. Steps need to be taken to address inmates with serious mental health diagnoses. Some of them do not belong in a jail setting on Rikers Island. The administration must also address the housing of non-violent inmates with violent inmates. It just does not make any sense. Currently, the broken system of classification of 600 inmates who have been found guilty of committing infractions facing no disciplined housing. But with the general population where they are likely to re-attract or coerce or cause violent incidents.

At the Budget Hearing last month, Commissioner Platt had no plan of action to house these inmates, and this issue is of alarming concern. A comprehensive plan to reduce jail violence is needed. The plan needs to include additional training for correction officers and supervisors; increase coordination with the Department of Health; increase programming for inmates so that they're not idle; and have more access to chapels. The recent deaths of two mentally ill inmates, Bradley Ballard and Jerome Murdough, show the dire need for reforms at Rikers. And the release of Daniel St. Hubert from

the State Department of Corrections highlights the horrors that can occur when mentally ill inmates are released onto the general public without mental health treatment and oversight needed.

I now would like recognize Council Member Corey Johnson for his opening Statement.

CO-CHAIRPERSON JOHNSON: Thank you, Chair Crowley. Good afternoon everyone. My name is Corey Johnson. I'm the Chair of the Council's Committee on Health. I want to thank you for joining us at today's hearing on violence and the provision of mental health and medical services in New York City Jails. (coughs) Excuse me. As well as a hearing on Introduction No. 292 requiring the Department of Corrections to report punitive segregation violence statistics for city jails. I would like to thank my co-chairs Council Member Andrew Cohen, and especially Council Member Elizabeth Crowley, who has been a leader on improving the City's jail system. These are incredibly important matters before us, and deserving of serious scrutiny.

I am deeply disturbed by recent reports about rising rates of violence in prisons. The poor and inadequate treatment of inmates with mental

health problems, and what I believe is the woefully inadequate safety of healthcare workers at these facilities. As a preliminary matter, although today's hearing is specifically about violence in the city's jails and a good deal of my focus would be on the safety of healthcare workers, equally as important is the issue of whether inmates are receiving quality healthcare. I'd like to examine the adequacy of health and mental health services in the city's jails in a subsequent hearing. Whether inmates are getting proper and adequate treatment and how medical are in our jails figures into our overall health system is an important and big topic.

So we will be revisiting that. But violence and quality of access to care are related. We need to look at what needs to be done to improve the system to make it more humane for the inmates and workers who serve them. The healthcare works in our city's jails, the doctors, the nurses, dentists, and social workers perform a noble service. These are people who have already dedicated themselves to a helping profession, and have taken extra steps to work in one of the most challenging environments you could imagine. Their safety is paramount. Their

safety is important not just because they deserve it, that it is the right thing to do, but because we need to attract new candidates to these difficult jobs. But also, because it is vital to the health of the inmates they are serving.

The recent rise in violence against healthcare workers stunning. One inmate who was incarcerated on a charge of assaulting a woman allegedly beat a 24-year-old medical intern resulting in the intern sustaining a broken jaw, and numerous facial fractures. I've heard other reports from healthcare workers who we're going to hear from today that are very disturbing. For example, healthcare workers are sometimes left alone to escort uncuffed inmates down corridors, or are left out of sightlines of correction officers when treating an inmate. And the failure to give healthcare workers panic buttons would have clear protocols on how healthcare workers should alert correctional officers when they are, in fact, in danger. Some healthcare providers have stated that they believe recent reforms in punitive consequences have contributed to recent spikes in violence. I would like to hear from the Administration on that point, and whether they think

policy changes have caused the recent surge in violence.

As anyone who has studied this issue knows, the problem of violence, adequacy of health and corrections staffing, and healthcare for inmates are deeply interconnected. The availability of and timely access to mental care and mental health services can exacerbate the behavior of inmates, a likely contributing factor to the rise in violence against healthcare workers. Additionally, the limitations in staff size of corrections officers impacts their ability to properly coordinate the healthcare of inmates, which in turn may lead to more violence. We can't look at our correctional system in isolation of the impacts it has on society. Ensuring adequate health and mental health services isn't just vital to improving the correctional system itself, it's essentially about the safety of all New Yorkers.

We have seen the horrible consequences in the form of victims of a killing spree, that of Daniel St. Hubert that he recently went on. Although Mr. St. Hubert was incarcerated in state prison, this tragic event should give us all pause to think about

how crime, imprisonment, and recidivism are all marked by violence at every step. A mentally ill inmate who is not properly screened at intake, and is not provided with consistent behavioral health services and medication can have their symptoms worsen potentially leading to violence against themselves or others, and an extended time in a correctional facility. Without services, once released, this person is then subject to the same flare-up of symptoms that potential aggression that may lead them right back to the doors of Rikers. We need to ensure the consistency and quality of services at every step to try to stop this cycle of violence.

The point to underscore here is that none of these issues, the safety of corrections officers, healthcare workers, and the health and wellbeing of detainees is more important than the other. So as you look at reform of this system, we need to think about all potential consequences. As many of you know, with the arrival of our new Commissioner, Mr. Ponte, the new Commissioner of the Department of Corrections, Mary de Blasio is breathing life into these issues. And I hope we end up with a package of

reforms that rethinks the system from top to bottom, and from pre-detention to post-release.

It will allow the creation of this new task force and the serious attention being paid to how we address the treatment of inmates with mental health issues, we have to take pains to make sure all voices are heard. Too often, what we think is a model where groundbreaking reforms are made, but too little attention is paid to how those will play out on the ground level by frontline workers. I urge the Administration to solicit the viewpoints of healthcare workers, corrections officers, and inmates themselves. We're going to hear from a wide variety of experts today, people who have helped shine a light on these problems, and understand what policies need to be put in place. This is the beginning of what I hope is fruitful conversation about positive steps that our city can take in this arena. The goal is to have system that works across the board, and I truly believe you only get there if you take all viewpoints into account.

As we look toward the future, my colleagues and I have a lot of questions. I would like to focus on how training of corrections and

health staff should be improved and better coordinated, what policy changes, and changes to the physical plan of DOC facilities need to be made in order to improve the safety of healthcare workers. Whether there should be greater oversight by DOHMH of Corizon the independent contractor charged with providing health services in our city jails. And how can we get these agencies and inmates to work together more so that we can reduce violence while increasing positive health outcomes for inmates. Finally, I believe that the bill before us today, of which I am a co-sponsor would be critical in helping the Council and public get a handle on the quality of our jail system, and how the system is performing in terms of the treatment of inmates. I also question whether the public needs more data to better assess DOHMH and Corizon's performance.

Lastly, I want to acknowledge my colleagues on the Health Committee who are joining us. We are joined by Council Member Espinal who is on the committee. We've also been joined by Council Member Vallone, and Council Member Koo, and a colleague, Council Member Lancman and Public Advocate James. I want to thank my Legislative Director Louis

Cholden-Brown; Health Committee Counsel Dan Hafiz [sp?]; Policy Analyst for the Health Committee Crystal Pond; Finance Analyst for the Health Committee Crilhien Francisco, as well as the staff of the committees on Fire and Criminal Justice Services and Mental Health for all their hard work in making this hearing happen today. Thank you very much, Chair.

CHAIRPERSON CROWLEY: All right. I'd like to recognize Council Member Cohen for his opening statement.

CO-CHAIRPERSON COHEN: Chair, good afternoon. Thank you. I'm Council Member Andrew Cohen Chair of the Council's Committee on Mental Health, Developmental Disability, Alcoholism, Drug Abuse and Disability Services. I am pleased to be holding this joint hearing today with Council Member Crowley, Chair of the Fire and Criminal Justice Committee, and Council Member Johnson Chair of the Health Committee, as well as our Public Advocate. Today, I look forward to discuss -- Today, I look -- today we are here to discuss violence and the creation of mental health and medical services in New York City jails. I'm sure everyone here has read the

recent news article about violence in city jails and the increase in the percentage of mentally ill inmates. The City's Independent Budget Office just released a report stating that 37% of the roughly 12,000 inmates in New York City jails have a mental health diagnosis.

Now, a mental health diagnosis alone does not result in violence. In fact, the vast majority of people with mental illness are not violent, and far more likely to be the victim of a violent crime. However, studies have shown that when people with severe mental illness have a co-occurring substance abuse disorder, their risk for violence increases. Unfortunately, research has also shown that in national jail populations the majority of the people meeting the criteria for serious mental illness also have a co-occurring substance abuse disorder. Therefore, today I am hoping to learn more about how inmates are assessed for mental health disorder and substance abuse disorders, and how those suffering from those disorders are treated, and what we can do better.

I'd like to learn more about how such inmates are prepared for release from the Department

of Corrections' custody, and provided with follow-up services. I look forward to an ongoing dialogue, and I also want to thank the staff for helping me prepared for today's committee.

[Pause]

CHAIRPERSON CROWLEY: We were also briefly joined by Council Member Cabrera, which will be back soon. We'd like to hear from the Administration. We'd also like first to remind the Administration sometimes the Administration can go wrong, and we're a committee here, three different committees with a lot of questions today. And more severe testimony probably could be answered with questions. But the attention span of the people in the room is usually better to cut the opening statement to only a few minutes, and open up quickly for questions. So it's 1:25 now. We would ask the Administration to try to stay within 20 minutes of testimony. And I'm not sure if the Department of Corrections will speak first or the Department of Health, but then of the 20 minutes if they could divide it, ten and ten, something like that.

COMMISSIONER PONTE: Good afternoon, Chairpersons Crowley, Johnson, Cohen, and members of

the Committee on Fire and Criminal Justice Services and Mental Health and New Mental Health. I am Joe Ponte, Commissioner of the New York City Department of Corrections. Beside me is Deputy Commissioner Berliner, who is in charge of planning of programs for the agency. And we also have the Chief of the Department William Clemons sitting out here in front. Thank you for the opportunity to testify today. I am pleased to be here in the company of my colleague Dr. Bassett of the Department of Health and Mental Hygiene. As you know, New York City is one of the only jurisdictions in the United States that lodges responsibility for jail security and health services in two separate agencies. This approach provides independent oversight of the Correctional Healthcare Program, but it also requires an extra level of interagency coordination. Our joint appearance today is evidence our agencies share commitment to work together to address the serious issues on today's agenda, which is violence and the provision of mental health and mental services in New York City jails.

Just ten days ago before the Committee on Fire and Criminal Justice Service, I presented my initial assessment of the Department of Corrections

after two months on the job. I described how assaults on staff, assaults on other inmates, and splashing and stabbing incidents as well as uses of force by staff have also substantially increased over the past several years. These long-term trends years in the making are clearly unacceptable, and reversing them is my top priority. But as a correction professional with over 40 years experience, I must assure you that the process will not be quick, nor will it be easy. A key component will be recognizing that the Department of Corrections job is changing. Over the past decade, our average daily population declined from 13,000 in fiscal year 2004 to as low as 10,008 in recent months. The character of our inmate population has shifted.

One of the most significant developments is the increasing rate of mental illness in our jails. in fiscal year 2007, 24% of inmate population had a diagnosed mental illness. Today, that is nearly 40%. I do not mean to equate mental illness with violent behavior, but I do want to stress that any comprehensive strategic plan to reduce violence in jails must include significant reforms in the way we manage and treat inmates with mental illness. The

task force on behavioral health and the criminal justice system that Mayor de Blasio announced earlier this month will be a great help in this regard. It will be developing strategies to keep mentally ill people from entering the criminal justice system when they do not have to. And also improve in-custody and post-release treatment for those who come into our custody.

Dr. Bassett and I are both part of the task force, and I'm sure she would agree that we are looking forward to participating in its deliberations, and acting on its recommendations. In the meantime, however, we are already collaborating to make facilities safer for staff, and inmates alike, and to ensure that quality care is delivered to those in need. The need for better staff training and steady assignments is paramount, and the current class of recruited officers in DOC Academy will be receiving an additional eight hours of mental health training that we've developed jointly in addition to the established 38.5 hours. The new training includes an overview of mental illness, and substance use disorders; introduces the participants to risk factors and warning signs of mental health problems;

and builds understanding of how mental illness may impact security staff efforts.

It has also become apparent to us to that the security of Mental Health staff need to be able to share more information about the behaviors likely to be exhibited by the inmates in a particular unit. DOC is now providing officers and clinical staff with information about relevant behavioral information with housing area officers. Clinical staff has also been sharing information. DOC staff cannot know an inmate's diagnosis or medication details, for example. However, working together, DOC and DOHMH are determining the level of detail that is both necessary and appropriate to keep housing areas safe, while still respecting inmate's medical privacy.

In recent months, much of the discussion on inmate mental health needs has focused on punitive segregation even though this accounts for less than six percent of our total inmate population. As you know, punitive segregation is a corrections practice common throughout the United States in which inmates who misbehave especially in ways that jeopardize the safety of inmates and staff are temporarily removed from the general population and confined to their

cell most of the day. Over the past year and a half, significant changes have been made in how the jail based disciplinary process responds to inmates with mental illnesses. DOC and DOHMH's longstanding housing response to inmates with mental illness who have been found guilty of an infraction goes to the Mental Health Assessment Unit for Infracted Inmates. Inmates commonly refer to this as MHAUII. While well intended, its creation in the late 1990s, the unit failed to provide adequate care, and routinely saw some of the Department's highest rate of uses of force.

In December 2013, the last MHAUII units were closed permanently after punitive segregation underwent some reform, and inmates were transferred to alternative housing units generally developed by DOC, DOHMH. The Clinical Alternative to Punitive Segregation or CAPS, and restricted housing units, which go by the acronym RHU, are the new units that have been developed. The Clinical Alternative to punitive segregation provides a hospital style clinical-driven treatment focused environment for seriously mentally ill inmates who have misbehaved, that is completely non-punitive. Inmates in CAPS are

not confined to their cells. They're not expected to participate in multiple treatment orientated activities throughout the day. CAPS, which to our knowledge is the only jail-based unit of its kind in the nation is an unqualified success. Rates of use of force and inmate of force and inmate violence are extremely low compared to the former MHAUII or even the current mental operation housing. The non-treatment segregation housing the department uses for inmates with mental illness wants mental illness to warrant special attention. This suggests that more treatment and more activity can reduce violence, and this behavior amount all inmates with serious mental illness. We are working with DOHMH to determine whether the CATS model, which is very expensive, has a broader application in mental application housing areas for those inmates who have not infracted. Restricted housing units previous -- Restricted housing units have punitive segregation with a progressive approach that includes a self-paced behavioral treatment program. RHUs offer inmates an opportunity to earn additional time out of their cells each day for good behavior and clinical engagement. The program is built around a step

system. When inmates behave and participate, they progress through the steps and earn incentives including additional out-of-cell time. Rule violations usually result in a step backward, and a lost of earned incentives rather than a new infraction with additional segregation time.

Since bringing the RHUs to scale in December of 2013, DOC and DOHMH jointly relocated the units from facilities in which they were open to an alternative site that is more conducive to programming, and better management of the inmates. We have subsequently seen a steep decline in the number of splashing incidents, and sizeable reductions in the uses of force. We also know there have been -- the inmates have participated in programming much more than they had in the prior units. The early or the early incarnations of the RHUs. So the RHUs have been evolving over time, and we think they're better today than they were when we first established them.

We are working with DOHMH to refine our RHU model and make it even more program focused, building on successes that we have already had. These programs, which once again apply to only a

small fraction of our total inmate population, have demonstrated the principles that can be applied to reduce violence in the general population leading ultimately to the reduction in the use of punitive segregation as a disciplinary tool. The first is that steady staff committed to the mission of the unit makes a big difference. Consistency and familiar staff provided the structure that the inmates seem to need. It also allows staff to anticipate and head off problems before force becomes necessary.

The next principle is that training is crucial. While officers and captains are not permitted to know the diagnostics of an inmate or treatment information about the inmates in custody, they are certainly able to learn behaviors, triggers, and warning signs. For decades, our mental health training has focused on policy and not on skill building, the necessary piece to manage the current needs of our jail population. New Training in the CAPS and RHU settings that include behavior recognition, trigger identification and avoidance techniques in addition to modern de-escalation approaches has shown tangible benefits.

The third principle is that punitive segregation time is not the only appropriate method to respond to misbehavior. It is one of many tools that DOC should be able to use to manage violence in our jails. The RHUs demonstrate the value of alternative inmate management techniques, such as incentives like extended lockout time for good behavior. It is important to understand, however, that these units were quickly implemented as the MHAUII was discontinued, and management of these units has been continuously readjusted in the face of unacceptably high levels of violence. And there is more to learn. Just last night, an officer who works daily with the mentally ill population is specially trained in the setting, and was following proper procedure was assaulted as he uncuffed an inmate who had been progressing well through this program, and was about to participate in group therapy.

Staff safety must continue to be our highest priority. Moreover, while incentives in informal and immediate sanctions such as the loss of outdoor rank and locking an inmate in through the lockout hours, could be used to discourage misbehavior, they are largely prohibited by the Board

of Corrections Standards. We hope to work with the Board, which is engaged in rulemaking to open up these options. DOC is focusing on issues of punitive segregation, and its effectiveness within jail systems in order to develop a thoughtful and effective approach going forward. One that can provide the possibility of separation of violent inmates from the population for the appropriate period of time while continuing to observe basic standards of care that comport with science.

The Council has asked about our general approach to violence reduction. What I have described is intended for staff working directly with the mentally ill. However, it represents the underlying strategic approach to general issues of violence reduction. We need to better understand the risks, and the needs of an increasing complex inmate population. We must make our officers confident that they have the skills and tools necessary to control their housing areas, and the inmates within them to prevent incidents and avoid uses of force. We must also provide constructive activities for the inmates from increased recreation to programming in housing areas, and elsewhere in the jails. By reducing idle

time and engaging inmates in productive activities, we can make significant gains in reducing violence. This can only be done through systematic cultural changes. The longstanding trend toward increased violence cannot be resolved with memos and staff meetings or even a new program. System change, particularly in an organization the size and scope of ours, must be carefully planned and implemented, and will include upgraded facilities, training staff, and recreating a culture. These significant changes will take time, but there are steps that we are taking now to make the jail safe. The first is communication. The new exchange of information between DOC and DOHMH staff will make everyone working in these housing areas more aware of the potential dangers and help prevent violence.

The second is training. Department wide training reform will take time to undertake, but the process is beginning. And the next recruit class will receive new mental health training. Training reform includes a greater focus on field training. Again, our staff, who go through the Training Academy, are placed in these housing units. And the old concept of having field-training officers to help

and guide our officers on-site no longer exists in any of our facilities.

Training reforms -- we will need field training staff to develop officer skills so they have the confidence to apply what they've learned in the classroom to real everyday situations. The third is the immediate responses to misbehavior. We hope to work with the DOC to make these tools available. I believe one way we can make everyone from the City Council to the taxpayers of New York City to the inmates in our custody confident that the work is ongoing and taking effect is that to be transparent about it. We will continue to update you on our strategic plan and implementation, especially regarding violence reduction initiatives, and treatment for the mentally ill. And to work with the labor unions, oversight bodies, and advocacy organizations that have a vested interest with an outcomes of this important work. Thank you for the opportunity to testify today, and obviously we're available for questions. Thank you.

Madam Chair, should I proceed?

CHAIRPERSON CROWLEY: Yes.

DR. MARY BASSETT: Good afternoon, Chairpersons Crowley, Cohen, Johnson, Members of the Committee and our Public Advocate Letitia James. I'm Dr. Mary Bassett, Commissioner of the New York City Department of Health and Mental Hygiene. I'm joined also by Dr. Amanda Parsons of Healthcare Access and Improvement. She's our Deputy Commissioner with the Department, as well as Dr. Homer Venters, who is the Department's Assistant Commissioner for Correctional Health Services. I am grateful for the opportunity to testify today on the topic of violence and the prevention of mental health and medical services in New York City jails. This is an important and complicated issue for both our department and for our city, and I thank you for focusing on it. I am mindful of your comments at the outset of our testimony, but I hope that my testimony will answer many of your questions, and I...

CHAIRPERSON CROWLEY: [interposing] I'm sorry, but I don't want to cut your testimony down. The Commissioner's testimony, written testimony, was a bit shorter than yours, the DOC Commissioner, and he took about 20 minutes.

DR. MARY BASSETT: I'll do my best.

CHAIRPERSON CROWLEY: If you could --

DR. MARY BASSETT: I'll do my best. I realize that we also started a bit late. So this is a very important topic, and I am eager to share some for that information with you, and I will do my best to get to my testimony. So what I'm going to do is provide an overview of the role of the Health Department and the New York City jails. And I can point out at the outset that Commissioner Ponte and I have already met on several occasions. I've had the opportunity to visit the Rikers complex, and I'm going to now today discuss some of the activities in which Commissioner Ponte and I with our respective agencies are currently collaborating, as well as some of the new initiatives in reducing violence. It has no place in any healthcare setting.

The Department is charged under city charter with providing health and mental health services in the city's correctional facilities. As you know, the city has 12 jail facilities. Each of them have at least one clinic. We have about 11,000 people in these jails daily. Most stay for only a short period of time. Over 90% of inmates are male. Nearly all are African-American or Latino, and many

come from the poorest neighborhoods in the city. The inmates enter the jail system already with a high burden of disease.

The mission of the Department's Bureau of Correctional Health Services is to provide the best possible medical assessment and treatment during an inmate's detention, and appropriate health related discharge planning services. These services are critical both for the patient's safety and health while they are in jail, and they're also important for safeguarding the health of the community to which they will return. Each month, the Department provides over 63,000 healthcare visits in the jails, most of which occur at Rikers. These include 5,300 comprehensive intake exams; 40,000 medical and dental visits, 2,300 specialty clinic visits, and 20,000 mental health visits. All inmates receive a full medial intake examination within the first 24 hours of entering custody. This intake exam allows us to screen patients, and guess our subsequent referral to arrange services. Our screenings include a comprehensive health assess, screening for sexually transmitted diseases, and an initial mental health assessment. Approximately 46% of inmates report that

they have active substance abuse use when they are first seen, but we believe that the actual prevalence of substance abuse use may be much higher. We seek to actively identify and assist individuals with a history of substance use in order to provide them with care when they are detailed so that they can return to their communities linked with appropriate assistance.

We are the only large correctional system to provided Methadone treatment. We've provided these services since 1987. They include both detoxification and Methadone maintenance, and we treat about 17,000 patients annually, and discharge patients to community searches. Further expansion of addiction services would be useful. In addition to these services, the Department offers special programs. A Road Not Taken is a substance use treatment program about which I would be glad to tell you more in question and answer. We are also a national leader in the adoption and use of a prevention oriented electronic health record, which allows our health workers to better coordinate the care of their patients. These patient health records

can be shared with community providers as well through a regional health information organization.

Although the oversight of Health Services and Discharge Planning in the city jails is the Department's responsibility, direct medical, mental health, dental care services are performed by a vendor -- vendor personnel from health services providers. These include Corizon Health, Inc., we call it Corizon, and the Damian Family Care Centers. We call that Damian. Hospital level services are provided by the New York City Hospitals Corporation. Corizon, the largest private for-profit correctional health services provided in the United States manages most of the day-to-day medical and mental health services, all of them actually on Rikers Island as well as two other jail facilities. And the Damian Family Care Center, which is a non-profit provider provides services as the Vernon C. Bain Correctional Services. We closely monitor both of these vendors through multiple lines of supervision. These include the credentialing of their physicians, their physician assistants, formulating all policies related to medical nursing, mental health, and substance use services, as well as ensuring

compliance with those policies through a rigorous quality assurance process that is based on reporting of 40 performance measures.

Identifying inmates with mental illness and helping them receive appropriate services is the core focus of our work. All arriving inmates of part of the intake assessment receive a behavioral health screen. And those that are determined to meet a more in-depth mental health evaluation receive one with 72 hours. Our data show that about 25% of the inmates are assessed to have some form of mental health diagnosis while in jail. A much smaller number, 4.5% of the total inmate population is designated as seriously mentally ill, and this includes psychotic illnesses such as schizophrenia. The remaining mental health diagnoses include such conditions as depression, anxiety, adjustment disorders. It's worth noting that the rates of diagnosis that both mental illness and serious mental illness in the jails are consistent with the rates of the United States population overall. However, at any given time in the correctional system, the overall burden of mental illness is about 38%. This larger proportion arises from the fact that mental health

diagnoses are associated with on average longer lengths of incarceration. So, because people with mental health diagnoses are less likely to exit the system, they are over-represented in the inmate population. We don't know exactly the reasons for this, and we look forward to exploring it more as well as many other issues with Commissioner Ponte and other members of the Mayor's Behavioral Health and Criminal Justice Task Force in the coming months.

The majority of patients assessed to have a serious mental illness are housed on mental observation units, which Commissioner Ponte touched upon earlier, which are designed to meet these patients' needs. The Department operates 19 mental observation units, which currently house about 645 patients. These patients are provided with a range of services ranging from outpatient level of care with talk therapy to inpatient level of care, coordination with social workers, psychologists, psychiatrists, and pharmacists. And we are currently engaged in the process of examining these mental observations in the housing areas with the goal of reforming their operations, and I will come back to this a bit later.

There are complexities that arise from the joint aims of maintaining security and promoting health and access to care. Our data show that mental health and violence in the jails are intertwined. Research conducted by the Department reveals that serious mental illness and placement in solitary confinement as punishment are predictive of acts of self-harm including lethal self-harm. Independent of other factors, placement in solitary confinement as punishment increases the risk of self-harm. And this risk is especially high among adolescent, whom we found to be seven times as likely to engage in self-harming behavior. Mental Observation Units are among the most violent settings on Rikers as was the recent closed MAHUII Unit, which housed mentally ill inmates who were placed in solitary confinement as punishment.

Research published by the Department shows that half of adolescents arrive in jail with a history of having been struck on the head and suffering altered consciousness. These factors are associated with traumatic brain injury. Others will sustain head injuries while in jail with injuries from inmate fights, and as a result of reported use

of force by correctional officers. And about 30% of violent interactions between correctional officers and inmates, there's evidence of a blow to the head. We're in ongoing discussions with the Department of Corrections to determine how we can create a more therapeutic setting as data show that standard practices in the correctional system including particularly solitary confinement as punishment and reliance on force can be linked to outcomes that we all seek to prevent, including the violence against self and others.

As you have already heard from Commissioner Ponte, as a result of this discussion the Department along with DOC, work to eliminate solitary confinement as punishment among seriously mentally ill -- among the seriously mentally ill, and open the clinical alternatives to punitive segregation or CAPS Units. There are three CAPS Unit, two for males, one for female inmates, and these offer better opportunities for inmates to engage with clinicians, receive mental health services. And our initial experience shows that these approaches improve health outcomes, and reduce inmate self-injury and consistently experience lower

rates of violence and self-harm. These are now less than half the rates on units where these patients have been housed previously. The CAPS Units report about 40 acts of self-harm per 100 patients compared to 260 acts of self-harm per 100 patients in the restricted housing units, which combine solitary confinement as punishment with some mental health services.

During a recent visit to Rikers, I met a patient in one of the CAPS Units who had spent nearly two years in solitary confinement as punishment for various infractions where he was involved in multiple violent encounters every month. When I saw him in the CAPS Unit, he had spent about six months without any violent encounters or any other problems. We have a total of 32 clinical staff in these units, and as you've heard from Commissioner Ponte, these units are more intensive, and more costly to operate. They are for the seriously -- but they do provide programming as well as enriched mental health services for the seriously mentally ill men and women who are housed there. In addition, we have worked to design new units for inmates with mental illness. These include six restricted housing units across the

jails, four for adult inmates, and one for adolescent male inmates, and one for female inmates. As Commissioner Ponte has mentioned, these units are a work in progress. They are evolving as we strive to balance punishment and appropriate treatment.

Finally, the Department provides discharge planning to eligible inmates with mental illness. These services, which are provided to about 20,000 individuals annually, include arranging for post-release medical and mental health care, applying for or re-activating Medicaid; applying for public assistance; providing a supply and prescription for medications; arranging for transportation; organizing post-release follow up. The success of healthcare delivery in our jails depends on the safety of correctional healthcare workers. It's difficult to overstate how distressing the recent increases in assaults are to the Administration, to the Department, and to me personally. Incidents of assaults against healthcare workers at Rikers spiked in December 2013, and have continued on average to occur at a higher rate in 2014 than in years past. We are working to better understand the factors that have contributed to this rise in violence. And our

most urgent priority is to work as we have begun to work with both DOC and Corizon to protect our healthcare workers. We are improving communication between healthcare workers and correctional staff. This ensures that healthcare and DOC staff communicate about high risk patients after every tour of duty. Allowing staff to identify behavioral shifts, and target resources and treatment to these patient. Second, healthcare staff and jail wardens are meeting to address jail specific safety concerns resulting in improvements to staff workflows, and additional security measures in the clinic. We have also revised our protocols so that high-risk patients receive services in clinic areas instead of in their housing units to ensure a safer setting for staff to administer care.

Further, the Department, the Department of Corrections and Corizon are addressing environmental issues in jail facilities, which involve moving units in areas with unsafe features such as narrow corridors to areas that have a more secure layout. We also have put an aggressive alert patient -- an aggressive patient alert function in our electronic health record. So that safety

precautions can be addressed prior to treating these high-risk patients, and focusing our attention on locations where assaults are most frequent, such as the mental health areas and high security settings. Although we don't believe staffing needs to be increased across the board, there are areas where we think additional staffing may improve safety, such as the mental observation units to better identify patients in crisis and provide them with the services in order to prevent a violent encounter.

The Department is also working closely with the DOC to reassess the treatment of mentally ill and seriously mentally ill inmates. Especially since a majority of recent assaults on staff and patient deaths have occurred in the mental observation units. As I had mentioned earlier, we are working together to redesign workflows in these units, improve staff safety, and patient health. And the goals of this redesign include giving staff more say in these units about how they are run, enhancing support to our social workers, instilling routine patient-centered communication between health and security staff that covers the basic elements of each patient's status. The Mental Observation Unit

redesign process is expected to take several months, and we look forward to sharing more information with you about these changes in the future.

Finally, I want to reiterate what Commissioner Ponte said earlier that he and I communicate regularly, not just about jail safety and inmate health issues, but also on the issues of broader reforms in the criminal justice system as we work together on the Mayor's Behavioral Health and Criminal Justice System Task Force. The Task Force chaired by Deputy Mayor Lilliam Barios-Paoli and the City's Director of the Office of Criminal Justice Elizabeth Glazer is charged with developing and implementing strategies to ensure the appropriate diversion of mentally ill people away from the criminal justice system. I look forward collaboration with Commissioner Ponte, and his agency as we move forward together to improve health and safety of staff and inmates in our city's jails. I thank you for the opportunity to testify, and my colleagues and I are happy to answer any questions.

CHAIRPERSON CROWLEY: Thank you for your testimony. We've been joined by Council Member Barron, Council Member Eugene. We were joined

earlier by Council Member Wills. Before I recognize the Public Advocate for her questions and comments, I'd like for the staff to know, for the committee here also to know that last year the Independent Office -- Budget Office put out a report saying how many mentally ill inmates are in the city jails. And how does that compare with the capacity of the City's psychiatric facilities, and it's nearly equal. There is no availability in our city for more psychiatric patients in our hospitals. Yet, we have almost the same amount of inmates with mental health diagnoses in our jails, and that's extremely troubling. Public Advocate James.

PUBLIC ADVOCATE JAMES: Thank you, Chair, and I want to thank all the Chairs. Just to give you some -- the Commissioner some perspective. Back in 2008 -- 9, excuse me, 8 when I was a City Council Member I was involved in the hearing involving the 18-year-old Christopher Robinson who was an adolescent and who died. And, in fact, I was involved in authoring the law, Local Law 29, which requires the Department of Corrections to report on certain jail security indicators regarding adolescents on a quarterly basis. So obviously, this

is an issue going back that I have -- going back for some time that I have been interested in. And obviously, the most -- the recent number of avoidable deaths, as I said behind the wall, is disturbing. And that is why I'm here today to see how we can address the issue. Let me just go on to say that we cannot continue to sustain overtime costs both behind the wall, by the Department of Corrections and outside the wall by NYPD.

The issue is really about safety, and I also believe that officers of the Department of Corrections are not adequately trained or, in fact, really not in a position to address inmates with histories of mental health. And so, really I want to get to the issue of those inmates who suffer from mental illness. And I particularly want to talk about a report, which was authored by, or commissioned by then Mayor Bloomberg. And what is really disturbing is that the report found that people with mental illnesses had almost doubled the length of stay in city jails. But what's really disturbing is that the majority of admissions to city jails are detainees who are basically unable to make bail at arraignments. And that the question and the

report recommended that the City needed to develop alternatives to detention to people with mental illness who can safely be released as opposed to being held in restrictive detention centers.

And so, my question really is: As a result of this report, have any of these recommendations been adopted? Have you thought about a diversion program working with OCA, Office of Court Administration? What can we do to working with defense counsel? As a former Legal Aid attorney, and someone who involved herself with identifying individuals with mental health illness in the criminal justice system when I was an attorney then. What can we do to identify those individuals, divert them from the criminal justice system, and get them the assistance that they need? And lastly, those individuals with serious mental health illness, what are we doing when they are discharged working with the community based mental health organizations to have a discharge plan for those individuals suffering from mental health?

And then, my other question is: The individuals who unfortunately died that was reported most recently, Mr. Ballard and Mr. Murdough. Why

were they not in the program that was mentioned earlier, and that is the CAPS Program? If those two issues can be addressed, that would be greatly appreciated. And if you can talk a little bit about the delivery of healthcare behind the wall, the contract with Corizon and what mental health services do they offer? How often do you monitor that contract, and their performance? My understanding is that some staff has come forward with regards to inadequate staffing levels. And the fact that there is minimal amount of time dealing with individuals who seek out healthcare services at these agencies, or at these companies, which are, for the most part, for-profit companies who are in contract with the City of New York for hundreds of millions of dollars.

[Pause]

DR. MARY BASSETT: Thank you for a whole series of very good questions. I hope I got all of them. If not, you'll remind me. The first question was about the observation that people with mental illness diagnoses are more likely to spend longer in the jail system than people who don't have these diagnoses. In fact, it is a twofold difference, and that is accurate, and it continues to be accurate. I

can't tell you all the reasons for that, but it certainly is true that people with mental health diagnosis are more likely to have longer stays on Rikers. You asked about the early --

PUBLIC ADVOCATE JAMES: [interposing] Stop. But could it be because of their -- because of their psychosis, they're not in a position to--

DR. MARY BASSETT: [interposing] I can speculate, if you'd like me to speculate, but I can't tell you that I've -- we've looked at the data to tell you.

PUBLIC ADVOCATE JAMES: [interposing] No I understand that.

DR. MARY BASSETT: [interposing] So it's maybe that they're more likely to get into trouble because they--

PUBLIC ADVOCATE JAMES: [interposing] How about this, how about this. What if they're not in a position perhaps to consult with counsel, and come up with a defense. And because of that situation, that is the cause for the delay. That's my opinion, and what do you think of that? And if there's anyone else who can jump in and confirm that hypothesis, that would be helpful.

DR. MARY BASSETT: So, okay, I will pass it to my colleague. I am unable to answer that.

PUBLIC ADVOCATE JAMES: Getting in trouble? I don't know what getting in trouble means. Getting in trouble would be -- it's a symptom of a mental health illness.

DR. HOMER VENTERS: So, what we think we know about this problem is that at almost every point in the criminal justice system people with mental illness have slowdowns. And one of them is almost assuredly an inability work with counsel as clearly or as concisely as somebody without mental illness. But it's really at every point that the work of the -- the work that went into the report that you talked about sort of gets at the point that from arraignment all the way through discharge, everything goes a little bit slower for people with mental illnesses. That probably spans the range of probable reasons from an inability to work as clearly with counsel to a lack relative to their amount of mentally ill counterparts, a lack of community support to expedite discharge processes. To sometimes the need for programming solutions to be in place in addition to

criminal justice adjudication. And so those are probably the primary reasons that things slow down.

PUBLIC ADVOCATE JAMES: Thank you.

DR. MARY BASSETT: It's worth noting I think that in the same report that you mentioned, that you're referencing that was produced during the previous administration shows the people with serious mental illness. They are people, who I mentioned have psychotic diagnoses like Schizophrenia had so much shorter stays than the classification of people with mental health diagnoses. So serious mental illness at 91 days; mental health diagnosis I believe was over 120 days. You also asked a question so you are happy with the conversation about the length of stay. You also asked the question--

CHAIRPERSON CROWLEY: [interposing] Sorry about that.

DR. MARY BASSETT: That's okay.

CHAIRPERSON CROWLEY: I think there's a point that has not been brought up in that an average inmate at Rikers Island is a recidivist, and that on average I've seen numbers such as eight times or nine times that they've been to Rikers Island. Now, we have to look at that as it relates to the mentally

ill population. Because what happens once they are discharged? And what type of oversight the Department of Mental Health has to make sure that these once inmates, but yes people with diagnosis are still under the care of a physician.

DR. MARY BASSETT: Right.

CHAIRPERSON CROWLEY: And if they're not under the care of physician, they're more likely to infract on the streets and get in trouble, and come back into the jail system. Obviously, otherwise, the numbers wouldn't be so great. So I mean there has to be an answer to that that we need to get to the heart of as well.

DR. MARY BASSETT: So should I-- You had a series of other questions. Should I continue with your questions, or should I move on to--

CHAIRPERSON CROWLEY: Length of stay is a really good question.

DR. MARY BASSETT: [interposing] Okay.

CHAIRPERSON CROWLEY: You say 91 days for the average inmate with a mental health diagnosis--

DR. MARY BASSETT: [interposing] No, that was the serious mental illness.

CHAIRPERSON CROWLEY: Serious but 120 days versus another inmate that doesn't have a diagnoses, and their stay is only about 50 or 55 days. So, I mean look, it's staying and it's coming back, and it's important to us.

DR. MARY BASSETT: [interposing] Yes.

CHAIRPERSON CROWLEY: It's a more important question today because it's DOH that is having to keep track--

DR. MARY BASSETT: [interposing] I'm happy to answer your question, Chair. I just was asking whether I had a series of questions from the Public Advocate.

CHAIRPERSON CROWLEY: [interposing] Well, we would like every question answered.

DR. MARY BASSETT: So I'm happy to answer every questions that I have. Although I -- I don't know how long the people in the room are willing to stay.

CHAIRPERSON CROWLEY: [interposing] Well, the questions, we'll stay here all afternoon to evening.

DR. MARY BASSETT: [interposing] But I just wondered what order I should go with. So on

discharge planning, as you know, we have a class of patients who are stipulated under court -- Under the Brad H. Stipulation, that we should, for whom we do our discharge planning. And we do discharge planning, active discharge planning for about 20,000 individuals each year. We are not in the position of mandating treatment. We can connect people to care. We can ensure that they have the resources to get care. We can work to get them re-enrolled in Medicaid, ensure that they have public assistance; work to connect them to community-based service providers. But we do not mandate that people get that care. There is court-mandated supervision of people. That's under the Kendra's Law, but the court's mandate treatment, not the Health Department.

PUBLIC ADVOCATE JAMES: Can I ask you a question? If they are a threat to themselves and/or to others, are you then mandated to get them assistance?

DR. MARY BASSETT: The court makes that determination.

PUBLIC ADVOCATE JAMES: So at any point in time you have the ability to go to court, and get

a court order to mandate that a certain inmate who is presenting certain problems get medicated?

DR. MARY BASSETT: No, let me turn to -- let me turn to the people who are actually doing this work to ask how the process of getting it court mandated works.

PUBLIC ADVOCATE JAMES: A court order.

DR. MARY BASSETT: Are we talking about-- are we talking about--? We're talking about a Rikers inmate--

PUBLIC ADVOCATE JAMES: [interposing] Yes.

DR. MARY BASSETT: --who you imagine that they might have been seen by a mental health provider, and we consider that they-- they're about to be discharged?

PUBLIC ADVOCATE JAMES: No.

DR. MARY BASSETT: And we consider that they are a risk to themselves and to others?

PUBLIC ADVOCATE JAMES: No, no. No, I know obviously with, you know, with privacy concerns you obviously cannot get the medical records of inmates. I got that. Or can you? Can you get the

medical records of inmates? Probably not because of privacy.

DR. AMANDA PARSONS: If patients give us consent, we can access medical records.

PUBLIC ADVOCATE JAMES: Okay.

CHAIRPERSON CROWLEY: A point of clarification also that is the Department of Health, not the Department of Corrections?

DR. MARY BASSETT: That is correct.

CHAIRPERSON CROWLEY: The Department of Corrections does not have access to health records?

PUBLIC ADVOCATE JAMES: [interposing] Right.

DR. MARY BASSETT: That is correct.

CHAIRPERSON CROWLEY: So the Department of Health--

DR. MARY BASSETT: [interposing] And we get access to health records of the patient's agreement and consent.

PUBLIC ADVOCATE JAMES: So if -- so if an inmate enters the Department of Corrections, can the Department of Corrections and the inmate presents symptoms, which suggest that they have a mental health history, right, and the individual is

unwilling -- is unwilling to take medication. At that point, in time, can the Department of Corrections go to court, get a court order so that this individual can get medicated? Yes or no.

DR. MARY BASSETT: So this is about people who are in the jail?

PUBLIC ADVOCATE JAMES: Correct.

DR. MARY BASSETT: You're asking about ensuring the people in jail--

PUBLIC ADVOCATE JAMES: [interposing] Yeah, yeah, yes, yes.

DR. MARY BASSETT: I don't know. Do you know anything about getting a court order.

COMMISSIONER PONTE: It can still be done.

DEPUTY COMMISSIONER BERLINER: Yes, we at the Department of Corrections can't do that. We wouldn't really necessarily know that they weren't taking their medication. That would be a transaction that they have with their healthcare provider. There are options, of course, for a hospitalization that point. Right, and the hospital at the point would get the forced order for medication.

PUBLIC ADVOCATE JAMES: Okay. So what I'm seeing is that the only option that is utilized for the more part by the Department of Corrections is some sort of segregation. And in the absence of consent, or in the absence of I guess hospitalization inmates are basically just penalized. Mental health inmates are penalized, and there's no-- As far as I can tell, and correct me if I'm wrong, what is the Department of Corrections doing to either divert inmates, or inmates with mental health histories from the Department of Corrections facility and/or get them assistance; get them adequately medicate?

COMMISSIONER PONTE: Let me try just a little bit on that one. You know, we don't take -- we don't ask for inmates to come to us. They are already adjudicated by a court. So they're here because the court says we need to incarcerate them. Once an inmate comes into the system, he comes into our intake area, he gets met by an officer. He goes through a search procedure. He is then looked at by Mental Health and medical staff. So at that point, it becomes their process. So we're not punishing them. It becomes a medical process as to where he lives if he's mentally ill. If he's seriously

mentally ill, there's Bellevue? Bellevue Hospital. So there's all kind of options available at that point right coming in the door.

PUBLIC ADVOCATE JAMES: So the two instances where it resulted in death, the Murdough case, and the other case that I just cited. What is it? I'm sorry. Mr. Ballard. What failed? What happened? Why did not those two individuals get assistance, medical assistance, particularly mental health services?

DR. MARY BASSETT: Both of these patients were in the Mental Observation Unit. So they had diagnoses of mental illness, and--

PUBLIC ADVOCATE JAMES: [interposing] But clearly, Commissioner, something failed.

DR. MARY BASSETT: I agree with you.

PUBLIC ADVOCATE JAMES: So what failed?

DR. MARY BASSETT: Something failed and, as you know, both of these cases are being litigated in the courts. I consider these tragic and unnecessary deaths, and ones in which multiple systems failed. We are looking at this carefully, both with our contractor, with the Department of

Corrections, and we are intent on identifying the sources of failure, and correcting them.

PUBLIC ADVOCATE JAMES: And lastly, I really want to thank the Chairs. DR. MARY BASSETT: [interposing] Can I-- ? Just one other thing I wanted to--

PUBLIC ADVOCATE JAMES: [interposing] Is anyone talking to the Department -- OCA, Office of Court Administration with regards to this? There seems to be a third leg in this, which is missing, and that is the -- the Office of Court Administration continue to refer -- to refer or remand individuals with mental health histories to the Department of Corrections.

DR. MARY BASSETT: One of the things that I wanted to tell you about under your question about what are we doing as a result of this previous steering committee that examined these issues. And a program that was established that has now been launched and is underway and should soon, by July I believe be expanded to all four boroughs. It's called the Court-Based Intervention Resource Team. And the intention of this program is to identify people with mental illness in the jails who can be

sort of fast tracked to early release. And to divert -- get people out of the jails, we need to have their mental health issues addressed that don't need to be in jail. So that's really part of a broader picture of diversion, which we all -- which we intend to look at as part of the newly established Task Force on Behavioral Health in the Criminal Justice System. I think that the case of Mr. Murdough, and I'm looking towards our General Counsel, I can say that a question can be asked: Where else could he have been other than in jail? And that's a question that we all have to be able to answer. The first question is how do people who are mentally end up in jail in the first place? And what are the opportunities for diversion before someone ends up in jail? And there are a number of points along the way. At arraignment; when people get to jail we have the search. Then there's the whole challenge of discharge planning, and availability of services in the community to which we want people to be connected. All of this will be addressed as we go forward with the task force.

PUBLIC ADVOCATE JAMES: [interposing] And that includes inmates who cannot make bail who are incarcerated because they cannot make it?

DR. MARY BASSETT: [interposing] That is correct. That is correct.

PUBLIC ADVOCATE JAMES: Thank you, Chairs.

CHAIRPERSON CROWLEY: Thank you, Public Advocate. So earlier, I referenced the Independent Budget -- Office of Budget -- Independent Office -- Independent Budget Office, and how they said there are X amount of people living on Rikers Island with mental health needs versus a number of patients in psychiatric facilities. It seems as if the people who are poor and indigent, and don't have the means for healthcare are going to Rikers Island. So if they can't put up the money for bail, and that you have a population there that should really be in a psychiatric facility. But our City does not have the expanded psychiatric facilities to house a population that you have on Rikers.

DR. MARY BASSETT: As you're -- I think that what you're pointing out is a graph that shows a number of people on Rikers Island with mental health

diagnoses versus available psychiatric beds. Many of the people, as I mentioned, on Rikers Island have mental health diagnoses for which I-- And I'm not a psychiatrist, but for which I as a physician wouldn't think that they needed to be institutionalized. In general, we like to try and take care of as many people in a community setting as we can. If we can get the appropriate supports, appropriate care. And the supports include more than access to medical care, both for their general health and their mental health needs. It includes issues of supportive housing, issues of job training, job placement. But it's better for many of the people with mental health diagnoses to be in communities and getting appropriate services. So I think in a way that's provocative graph, but it's an apples and oranges graph. I don't think that all the people with a mental health diagnosis on Rikers need to be in psychiatric hospitals. I also think that it's important for you to challenge us, to say to us, Well, do they belong on Rikers? And that is something that will be--

CHAIRPERSON CROWLEY: [interposing] Or whether they need to be not in a facility so as an

institution but certainly if they have mental health needs, they should be under the care of a physician.

DR. MARY BASSETT: [interposing] Well, they -- people -- let me reiterate what I said in my testimony that on day one, or within the first 24 hours all incoming inmates have an intake assessment, which includes a behavioral health screening. Anyone for whom we have concerns--

CHAIRPERSON CROWLEY: [interposing] Oh, okay, we heard that. We read it.

DR. MARY BASSETT: --within 17 hours has a full mental health diagnosis.

CHAIRPERSON CROWLEY: [interposing] It was in the testimony. We know that. Just get into the harder questions.

DR. MARY BASSETT: And then we do treatment.

CHAIRPERSON CROWLEY: [interposing] Right. I understand that.

DR. MARY BASSETT: So we don't just identify the problems.

CHAIRPERSON CROWLEY: [interposing] What I'm trying to get at--

DR. MARY BASSETT: People get treatment.

CHAIRPERSON CROWLEY: --is the violence that is out of control. There is a population that doesn't necessarily-- Is there a population -- in order to have a greater staff to inmate ratio so that there could be better care and control on Rikers Island, should there be a percentage of the inmates taken out of a jail setting, and put in a hospital type setting. You said of the roughly four to five thousands inmates that have mental health diagnosis, approximately one-third of them have a significant serious mental health diagnosis.

DR. MARY BASSETT: We do have connections with the hospital system, as I noted with the Health and Hospitals Corporation and Bellevue Hospital. Patients who have mental health conditions, which we cannot manage safely for them or for the population will be referred to the hospital system for care.

CHAIRPERSON CROWLEY: This next question is for the Commissioner of the Department of Corrections. What is the ratio on any given day and DC, which is the jail that houses adolescents, or GNDC [sp?] , which is the jail for adults, what is the staff to inmate ratio in those jails? And what is it in those particular jails compared to the

overall staff to inmate ratio on any given day? And this is a question that's getting at the heart of the control because as I mentioned in my statement earlier, the violence is spiraling out of control. I don't expect you to be able to bring that number down significantly in one day. But it has spiraled out of control in a short amount of time. So it is my hope that we can put a timetable together, and bring that number into a reasonable area where we reduce significantly the incidents of violence?

COMMISSIONER PONTE: I don't have the numbers for the staff ratios for all the individual facilities, but we can get those. The staffing plan for any facility could and will be looked at as a factor of responding to the issues that are occurring at that facility.

CHAIRPERSON CROWLEY: For four and a half years, for as long as I've been chairing this committee, year after year I've been asking for a table of organization for staffing levels. I mean, the Department has no idea how many officers are needed for each individual jail. If you did know--

COMMISSIONER PONTE: [interposing] Yes, we do.

CHAIRPERSON CROWLEY: --you would have a better handle on ratio.

COMMISSIONER PONTE: Yes we do. I don't have the ratios off the top of my head, but I can produce a staffing plan at least for our facilities.

CHAIRPERSON CROWLEY: Well, when we spoke at the Budget hearing last month, or about ten days ago, I asked about the overall Executive Budget, and it's important today because we're looking at a budget that starts next month--

COMMISSIONER PONTE: [interposing] Correct.

CHAIRPERSON CROWLEY: --in only a few weeks. Your Executive Budget is significantly less than what we're expected to spend this fiscal year, although there is no staff changing. There's no staffing -- increased staffing that would possibly bring down the overtime budget. But your overtime budget for this year, I understand half was in the previous administration. But I've already seen numbers from April and May as it relates to the overtime that is happening within the jails. It angers me because I believe that the Department is being run to the ground. Our officers are tired.

They're working an ungodly amount of overtime. Correctional officers are working without a day off, and there is a standard that the Board of Corrections reports saying that anything more than 32 hours or 33 hours per month is too much. But you have officers in the city that are working over 72 hours a month in overtime. They're tired. They're run down. When violence occurs, I mean how could they be as ready to stop it as an officer that just works a regular 40-hour shift?

So in that question is: What are we doing to cute down the overtime? Why is it that we're anticipating spending a significantly amount less in overtime if we're already in mind to spend a hell of a lot on overtime? And why are we not staffing up if there is so much violence happening in these jails. And this is something if you implemented it in the short-term, if you were able to hire more officers, you would be able to bring down the level of crime. If you just look at how many more officers we had five, six years ago, you would see that there was less violence happening. I understand your population is changing, but the officers don't know who is mentally ill or not, and

they're not allowed to. But they're the ones on the front line. They're keeping the order and control in the jails, and how can they do it with less? And then be expected to spend so much time every week working beyond their regular shift?

COMMISSIONER PONTE: I'm not sure what the actual question is. I agree with your assessment. I agree that those are all critical --

CHAIRPERSON CROWLEY: [interposing] I thing an answer would be I have to go back to the Mayor and say, I need more money to hire more correction officers. Or how are the staffing ratios going to change. Because I believe when looking at statistics and number don't lie, violence has gone up significantly year after year, and you look at staffing ratios, and you could see that there is a greater number of inmates to each officer year after year. And with that, you have an increase in violence with no plan right now to address it.

COMMISSIONER PONTE: Again, I arrived here on April 7th. The budget was substantially completed by then. It would be irresponsible for me as an executive of the City Government to offer you a conceptual response to this issue. As you painted

out very clearly, it would be irresponsible to say I need 100 people, 200 people or ask the Mayor for anything. I mean there's been four years of records by others before me to do all of that you said, reduce the violence, improve on the overtime. That hasn't worked--

CHAIRPERSON CROWLEY: [interposing] But year after year I asked Commissioner Shiro to hire more correctional officers, and year after year, there were fewer in the budget. Year after year I asked her to go to Mayor Bloomberg, and I was hoping for change in this Administration. But the budget we're looking at in July has no greater amount of officers or increase in staffing that would have anything to do with reducing the ratio. And I was hoping that we would have change. We're six months into the Administration. I want to give you a shot, Commissioner. I understand you've only been the Commissioner for two months, but I feel it's my responsibility and it's the Committee's responsible to have the proper oversight. I understand you have long-term plans of building better facilities, and I support that wholeheartedly. Unfortunately, the

capital process in the City of New York takes years. We need quick fixes. We need action now.

COMMISSIONER PONTE: I agree.

CHAIRPERSON CROWLEY: And then lastly, I'm going to have one question, and then I'm going to turn it over to my colleagues who have plenty of questions. You have nearly 600 or more inmates that have been found guilty of infractions and they have mental health diagnoses. But they're in general population because there's nowhere to put them. And there is no segregated area away from general population. And it is often those inmates in that population that infract again, and continue to cause violence. And earlier you spoke about CAPS and RHU, which I support and the committee we worked diligently with the previous commissioners who that have done that. But there is no real plan for expanding that. Right now, you have only about a hundred beds in a facility with a waiting list of 600 plus. And if there were some way of treating the 600 that have infracted and are more likely to continue to infract instead of keeping them with the general population, you would be able to get at the heart of the violence and where it exists. So what's the plan

of action to bring down that waiting list, and to help bring order?

COMMISSIONER PONTE: I think as mentioned before, a lot of the inmates are not in programs. So the programs, or the intense programs that are available in RHUs and MOU units are working and they're pretty effective. The availability of that same level of programming, both clinically and at any program is just not available to the general population. So as we look at RHUs--

CHAIRPERSON CROWLEY: I'm sorry, I don't want to interrupt, but Commissioner, you're so untimely. Everybody knows that those programs are not available to the general population.

COMMISSIONER PONTE: [interposing] Correct.

CHAIRPERSON CROWLEY: Those programs are not available to the 600. Those programs are very expensive. Those programs are good. You have statistics showing that they work. Why can't you give those programs to all 12,000 inmates? Why can't they use their time at Rikers Island to conduct it, you know, whether you're violent or non-violent, or if you have a mental health diagnosis or you don't

have a mental health diagnosis, you're spending on average 50+ days on Rikers Island. And those 50 days instead of staring at the walls, one could be participating in programs. Those programs cost money, but those programs give you results. But right now you have 600 people who have infracted who are staring at the walls, who are starting fights with other people as well as people in the general population. And there's no way of preventing them from continuing to get into fights because those programs are limited.

COMMISSIONER PONTE: That's correct.

CHAIRPERSON CROWLEY: So can we agree that you have -- it would be a good idea to expand those programs?

COMMISSIONER PONTE: It would be a great idea not just those programs, but other evidence-based programming as shown to be very good at reducing violence in jails and prisons across the country. And they all cost money, and we have staff training and lots of lead time for implementation.

CHAIRPERSON CROWLEY: Thank you.

CO-CHAIRPERSON JOHNSON: Thank you, Commissioners. I'm going to try to be as quick as

possible because I know we have a lot of questions from colleagues. I just want to say that I think the frustration that you're hearing has to do with there seems to be -- and I know we're just six months into a new administration -- but there seems to be real systemic change that is necessary. I know this task force is going to hopefully look into that. I know that it's difficult for government to think big sometimes, and to think in transformational terms. But this mill of sorts of the mentally ill being housed in prisons not getting effective treatment to take care of themselves. Being let out, reoffending, and going back into prison. I know that these things cost money, but my hope is that we can start to have a conversation and come up with a real concrete plan on what we're going to do, and that it happen sooner than later. There are temporary measures, which we know can stem some of the immediate violence that are occurring -- that's occurring. But I think that we have to make sure that this task force is getting all perspectives. As I said in my opening statement, are inmates going to be part of this task force? I don't think so. They are, okay. Because I want to make sure all viewpoints are part of it so that this

actually is done in a real way and not -- We fast track some of these things. So that six months or a year from now we're not sitting in the same committee room asking the same questions, looking at similar statistics with potentially small decreases or even some increases.

So a few quick questions. Commissioner Ponte, you stated that violent inmates are flagged for healthcare staff. What is the protocol when a healthcare worker sees a violent patient?

COMMISSIONER PONTE: I believe your question is about what the protocol is within the facility?

CO-CHAIRPERSON JOHNSON: Yes, so someone sees a violent patient, a healthcare worker, what then happens?

COMMISSIONER PONTE: Somebody anticipates the violence?

CO-CHAIRPERSON JOHNSON: Yes.

DR. MARY BASSETT: [off mic] So the idea there is that you have a forewarning of a person who is a potentially aggressive patient, and that a plan will be made to ensure that correction officers are available at the time the patient is seen. And that

the location is a safe and secure one. And as I mentioned, it's better for these patients to be seen in a medical room, than not on the housing units.

CO-CHAIRPERSON JOHNSON: So they --?

DR. MARY BASSETT: So I should further point out that the -- we have correction officers and, in fact, we depend on them, and present in our health clinics. And the challenge there is to ensure -- because they are rather large. You know, they're not huge, but they're multi-room facilities. So that's -- we need to ensure that there's enough communication so that if a potential aggressive patient is identified, and that the corrections officer is available at that time, and not distracted doing other things at the time that the person is seen. We also really hope that our healthcare workers, and with support from the corrections officers, can work to de-escalate the encounter so that it doesn't result in a use of force. Which in our opinion really serves to escalate a climate of violence and not contain it.

CO-CHAIRPERSON JOHNSON: I understand the Department of Corrections' reporting on the number of

assaults on staff does not include assaults on healthcare staff. Is that correct?

[Pause]

DEPUTY COMMISSIONER BERLINER: The (coughs) excise me. The number that we report as assaults on staff are assaults on the uniformed corrections staff. The assaults on healthcare workers are captured in a different metric, which is the metric we call the criminal act on DOC property, which would include assaults on any civilian employee of the Department or of another comparable--

CO-CHAIRPERSON JOHNSON: [interposing] But they're not in a standalone group because they're all metric. Are they?

DEPUTY COMMISSIONER BERLINER: No, there is no capturing --

CO-CHAIRPERSON JOHNSON: Why not?

DEPUTY COMMISSIONER BERLINER: Because up until the last two years, they represented a single digit number so it was being captured in a statistics that captured assaults on say a maintenance worker at DOC or a clinical staff person, or even an assault on an officer by a non-inmate.

CO-CHAIRPERSON JOHNSON: So it's my opinion that this should be a separate metric, a separate reported number that is captured to understand what is going on so that we have an accurate and true picture about the number of violent incidents that occur against doctors, nurses, mental health professionals. Do you have that number?

DR. MARY BASSETT: Yeah, I do. Yes.

CO-CHAIRPERSON JOHNSON: You track it?

DR. MARY BASSETT: Yes.

CO-CHAIRPERSON JOHNSON: Is it -- is that data made public anywhere? Is it reported -- ?

DR. MARY BASSETT: Now, that I don't know. I'm going to tell you the number.

DR. AMANDA PARSONS: We brought it to the Board.

DR. MARY BASSETT: We brought it to the Board of Corrections. And if you want me to tell you some numbers now--

CO-CHAIRPERSON JOHNSON: Yes.

DR. MARY BASSETT: --I think that will make the data public. In 2013, there were 32 assaults or attempted assaults. And so far this

year, there have been 25. So that does increase that.

CO-CHAIRPERSON JOHNSON: [interposing] So there's a significant rise?

DR. MARY BASSETT: An increase. About two-thirds of these assaults are what are known as splashing, and I don't know if the committee is familiar with that term. But it means splashing the worker either a corrections officer or a healthcare worker with a liquid, sometimes blood or sometimes urine. And so that's an assault, and accounted for as an assault, and about a third of them are physical assaults.

CO-CHAIRPERSON JOHNSON: But what do you attribute the increase to come from? We're talking about this increase. What do you attribute to the increase in violence? So you think it happens -- does it have -- does punitive segregation play a role in this increase?

DR. MARY BASSETT: I can tell you that the figures that I observe that we've talked about an alternative to solitary confinement for seriously mentally ill individuals. I think the Public Advocate asked me a question about an area that I'm

not sure that I got to because Chair Crowley had a lot of other questions. But the -- this program called the Clinical Alternative to Punitive Segregation has seen a great de-escalation in violence. And both violent encounters with the staff, and also with self-harm. So we do know a strategy that works. Our challenge is to identify the elements of those strategies that could feasibly be extended to other settings. One of them seems an obvious one, and is part of our response to these attacks on health workers, which is better communication between our staffs. In the CAPS Unit both correction staff, and health staff are all present there. They have a lot of interaction with the inmates and they can observe when an inmate seems to be sort of due compensating. The behavior of somebody prior to a violent episode is sometimes a better predictor than even their past record. So now we have by mutual agreement a sign-out effectively at the end of every shift where both the correction staff, and the house staff exchange information on patients identified as high risk and report to each other any changes that they've noted in behavior.

CO-CHAIRPERSON JOHNSON: [interposing] Do you think there are other contributing factors?

DR. MARY BASSETT: Well, I think that the-- the, um. I'm going to let Dr. Parsons, who is trying to tell me something. But I think just to clarify the question, I think that you are referring to what contributes to violence in the jails. Are you asking what contributes to the violence in jail?

CO-CHAIRPERSON JOHNSON: Specifically around healthcare, healthcare workers' violence.

DR. MARY BASSETT: Okay.

DR. AMANDA PARSONS: So in an analysis of the splashing, it looked like about 89% of the people who were doing the splashing had a mental health diagnosis, and 92% of those were occurring in punitive site center. So based on that snapshot, it does appear that punitive site--

CO-CHAIRPERSON JOHNSON: [interposing] Plays into that.

DR. AMANDA PARSONS: --plays into at least the splashings. Through some interviews with the people who actually committed the splashings when asked to explain why they did, a number of reasons were elicited. A general theme was people were angry

over a lack of -- of the person's lack of services. They felt like they weren't getting the access that they wanted in the timeframe that they wanted. They were things like the phones, and showers, and like, et cetera.

CO-CHAIRPERSON JOHNSON: [interposing] Okay.

DR. AMANDA PARSONS: They were angry sometimes with issues with the medical and mental health treatment, and felt like this was a way to make that known to us.

CO-CHAIRPERSON JOHNSON: [interposing] Okay.

DR. AMANDA PARSONS: And lastly, some of the just wanted to get out of their confinement setting, and that was what our interviews turned up.

CO-CHAIRPERSON JOHNSON: Thank you. Commissioner, final question and then I'm going to go back to the Chair, and then I will take -- Hear a bit from Chair Cohen, and then I will wait for the second round to come back to some of these, but I want to give time to everyone else. This is for Commissioner Ponte. You stated in your testimony that you will work with the Board of Corrections to make tools

available for immediate response to misbehavior. You said that towards the end of your testimony. Can you elaborate a bit on that, what you mean in that regard? What types of tools are you looking for?

COMMISSIONER PONTE: For the officers to take immediate response to inmate behavior like walking an inmate in, taking away free time, taking away property, or anything that could be used in a way for a violent outburst while we take a look at what's causing that. And possibly, while this is a temporary, to look at a longer-range plan for this particular inmate. Right now, the answer is you write the inmate up. He gets a hearing, and maybe they'll put him in seg [sic]and may not. But this is kind of allowing the officer to have the ability to take immediate response to prevent violence prior to the actual incident occurring.

CO-CHAIRPERSON JOHNSON: So when you said you were looking to go to the Board of Corrections to make tools available, are you looking at larger policy change?

COMMISSIONER PONTE: Yes, sir.

CO-CHAIRPERSON JOHNSON: And I think it would be helpful for us, if when you're going to do

that, for the Council to be informed of what you're thinking in that regard so that we can weigh in on that as well. Just to make sure we have a collaborative process here. The point of today's hearing is that we care tremendously about what happens, and we have oversight over into what is going to go on.

COMMISSIONER PONTE: Sure. Absolutely.

CO-CHAIRPERSON JOHNSON: Thank you. I'm going to turn it over to my Chair.

CO-CHAIRPERSON COHEN: Thank you Commissioners. I appreciate your testimony. I have some questions regarding-- You mentioned that a significant portion of your population are people who are not able to make bail. Could you quantify that? What percentage of people are being held in Rikers for not being able to make bail during their court proceedings?

DEPUTY COMMISSIONER BERLINER: A little over 80% of our population are detainees. Some number that I cannot quantify for you right now, but I certainly can in a follow up, are remanded and so bail is not the issue. But the large majority, the overwhelming majority are not remanded. They are

some measure of bail. That could be anything from one dollar to many millions of dollars.

CO-CHAIRPERSON COHEN: I mean just the premise of that circumstance and these people -- A judge feels that these people don't necessarily have to be incarcerated at all. And they're only being incarcerated by virtually not being able to make bail. I mean that seems to me to be sort of fundamental to why we have this population, and we're dealing-- What I'm concerned about at Rikers is the mental health facility of last resort, and that people are simply getting there because of financial circumstances not being able to make bail. I don't know if that's reflected in your own management of people that are incarcerated there. But do you make some sort of-- Is the assessment when people come in with sort of a propensity for violence or like what happens? Like how do we sort the population as you get them?

COMMISSIONER PONTE: We do have a risk assessment that we use internally on how we hold inmates both look at them on the arrest prior history, and also medical and mental health needs.

But that doesn't do anything for setting the bail or risk to the community.

CO-CHAIRPERSON COHEN: In the assessment, the initial assessment, the health assessment, you determine-- I think Commissioner Bassett, you said that you identified like 46% who had a substance abuse problem, and you said you suspected it might be more. If I have a substance abuse problem, does that trigger a mental health assessment within three days?

DR. MARY BASSETT: Everybody on the initial assessment has a mental health assessment whether a substance use problem is identified or not. So part of the overall intake examination includes a general physical exam, a comprehensive health assessment, as well as a behavioral health screen. So anyone about whom there is further concern, has it within 72 hours an additional more comprehensive mental health assessment. So people are screened both for mental health issues, and substance use issues on intake.

CO-CHAIRPERSON COHEN: Would drug addition trigger a subsequent mental health assessment within 72 hours?

[Pause]

DR. MARY BASSETT: --to this question, but yes. The answer to that question is yes.

CO-CHAIRPERSON COHEN: So hypothetically if I-- if I-- I might ultimately be eligible for Methadone if I was a heroin addict. Might I not get treatment for that until 72 hours?

DR. MARY BASSETT: No, I believe is somebody comes in, is on Methadone and it's on their treatment record, that will be continued. That's one of the ways we identify people's substance use history. And they will be continued on either Methadone maintenance or Methadone detoxification.

CO-CHAIRPERSON COHEN: I guess I'm just wondering if you think the issues of detox are contributing to violence at Rikers?

[Pause]

DR. MARY BASSETT: There is no data to suggest that. So it's an interesting question whether people are coming who I think your hypothesis, if I may characterize it in that way, is that people come in who are not identified as opioid dependent, who are not treated for their substance -- for their addiction and, therefore, create behavioral problems including violence in the jail. I think

that's as they go into withdrawal or something of that sort. I don't believe that we have data on that, but I can discuss it with my team.

CO-CHAIRPERSON COHEN: I appreciate that, and I guess just finally in the 4 point -- I think you said 4.5% you identify as--

DR. MARY BASSETT: [interposing] Seriously mentally ill.

CO-CHAIRPERSON COHEN: Seriously mentally ill.

DR. MARY BASSETT: They're psychotic almost.

CO-CHAIRPERSON COHEN: How long doe sit take to get people --

DR. MARY BASSETT: [interposing] Many of whom we don't think should be in psychiatric hospitals either.

CO-CHAIRPERSON COHEN: You do not think that they should be in psychiatric-- Well, they could be -- they could function in the system --

DR. MARY BASSETT: [interposing] Yes, appropriately managed.

CO-CHAIRPERSON COHEN: --if properly managed?

DR. MARY BASSETT: Correct.

CO-CHAIRPERSON COHEN: What are the issues of getting those people on medication and that process? Is there, you know, in a transition, do we -- is that like sort of an inflection point of violence if you try to get those people appropriately managed?

DR. MARY BASSETT: I'm not sure whether you're talking about within the jail or outside of the jail. Is your question--

CO-CHAIRPERSON COHEN: [interposing] In the jail.

DR. MARY BASSETT: --in the jail?

CO-CHAIRPERSON COHEN: When they come into your gap.

DR. MARY BASSETT: So let me pass this to Dr. Parsons, but as I understand the question you want to know whether within that gap of 72 hours, or within the treatment plan is there sort of an opportunity for people who are psychotic or inadequately managed until they come under adequate treatment?

DR. AMANDA PARSONS: The first thing that I would note as part of our comprehensive intake, one

of the things that we check are the community medications for each patient. So assuming that the patient is on medication in the community, we are able to ascertain that. And that lets us know what kinds of medications we need to continue immediately. In addition, there is a screen that's done with both of us, but also in addition it's done pre-arraignment to determine whether or not this patient is at risk of withdrawal in general. Nobody is going to die from an opiate withdrawal, but we're particularly concerned about deaths related to alcohol withdrawal. But we screen for both on arraignment and then on intake. During medical intake we also ask patients to tell us what are their medical histories, and to tell us what medications they're on. And that's another way that we ascertain what kind of treatment we need to pull together. So in no way, shape, or form do I want to lead you to believe that we don't deal with any mental health issue until the 72-hour mark. We begin all of those. It's just to say that for people who need a more intensive treatment, and who can wait for 72 hours, we do continue their -- to do a much more thorough look at their mental health issues and a deep dive into those. For those who

need immediate mental health treatment, they get it daily.

CO-CHAIRPERSON COHEN: Thank you very much.

CHAIRPERSON CROWLEY: Earlier when the Public Advocate asked about in the questions is one your inmates are released back to the public, how far-- How much Brad H, how much did that lawsuit say that the Department of Health has to have a discharge plan for this particular individual? What is that discharge plan like? Are they giving housing insurance, do they have Medicare or Medicaid? How can we rest assured that these inmates while under the supervision are getting the care for their mental health diagnosis will be getting access to care outside?

DR. MARY BASSETT: Oh, thank you for that question. The discharge planning for persons with mental illness includes an effort to refer people to community services so that they have continuity of care to ensure that they have health insurance coverage, which in many cases involves either enrolling or re-enrolling the inmate in Medicaid prior to discharge. Working to ensure that any other

public benefits to which the inmate is entitled, they have applied for. So, as well as additional services for general medical care, substance abuse disorders that they have been provided a pathway to all of the services that they will need on discharge. Now we do not --

CHAIRPERSON CROWLEY: [interposing] What if they don't have a place to go? What if they don't have a home?

DR. MARY BASSETT: Well, I, yeah, my understanding is that they are referred to the shelter system.

CHAIRPERSON CROWLEY: But they come into Rikers often as we saw in the case of Mr. Murdough that he was homeless and he--

DR. MARY BASSETT: [interposing] He was homeless.

CHAIRPERSON CROWLEY: --he didn't want to go to the shelter system.

DR. MARY BASSETT: That's right.

CHAIRPERSON CROWLEY: Are there like the Fortune Society or other types of housing that you could work with to put inmates who are homeless?

DR. MARY BASSETT: Well, there are supportive housing for people with serious mental illness. I think that the general challenge that you're asking is one that I alluded to earlier where in the case of someone like Mr. Murdough where should he have gone? I want to refer again to the task fore, which I think is challenged to identify more streamlined approaches to ensure that we have places that people can go that they will be safe, in which their mental health needs will be addressed. And there are other broader social support needs will be addressed. Because it seems to me that one of the key challenges for providing a healthy population at Rikers is to ensuring that the people who don't need to be there are not there. So there are many steps along the way, and it begins with the encounter between a police officer, and a person who has a mental illness, and what options are available to that officer at that time.

CHAIRPERSON CROWLEY: What does it cost a year to house -- As the Commissioner of Department of Health, what does it cost to house somebody in place like a hospital. Not a jail. Like Bellevue.

DR. MARY BASSETT: Yeah, I mean hospitals are very expensive. So I would -- I haven't discussed this with Commissioner Ponte, but I would bet that a hospital bed costs a lot more than a bunk at Rikers. $1,200 a day.

CHAIRPERSON CROWLEY: [interposing] I would bet ten times as much.

DR. MARY BASSETT: Yes, but--

CHAIRPERSON CROWLEY: But $1,200 a day that's significantly much more than-- What does it cost a night at Rikers?

DR. MARY BASSETT: But that might not be the right comparator. The right comparator might be another community bases service.

CHAIRPERSON CROWLEY: [interposing] I just don't-- I mean I hear you with this financial hurdle. I mean Mayor Bloomberg had a task force put together, and he spent a few years trying to find creative solutions to this problem. So the problem the previous administration was well aware of, and yeah, I'm hopeful that this administration with this new plan of putting this task force together will essentially to a degree be able to implement programs that will stop people who don't belong at Rikers

Island, but from going there, from going there. However, you know, at the same time any real successful programs aren't going to the extensive care. Commissioner Ponte didn't share with us exactly how much he needs to implement programs for 600 people who are on the waiting list for mental health needs who are not getting the programs, but the 100 are. So within RHU where the CAPS unit is. So, I'm going to now recognize Council Member Dromm who has a bill that I mentioned earlier in my opening, and we're hearing that bill today. So I'm going to ask Council Member Dromm to ask a few questions and to give any type of introduction. Thank you.

COUNCIL MEMBER DROMM: Thank you, Chair Crowley. I appreciate you allowing us to hear this bill today as well. I did not in the testimony -- I'm sorry I was late. I had and Education Committee hearing, which I chaired the committee so I couldn't leave -- come over, but I did not see in the Commissioner's testimony either one any mention of the bill, and I'm wondering what your standing is on it.

COMMISSIONER PONTE: I think as the -- from what we know, we're obviously more interested in cooperating with the Council and developing matrixes that we all agree these are good measures moving forward. I think it would help us all build a better plan to be more effective and efficient with our City's resources. The Department of Mental Health and I are already working on matrixes with our two agencies collectively. We'll look at how our, what type of our program is and measurements to give us good indications that what works and what doesn't work. So we're very interested and willing to work with you on moving forward.

COUNCIL MEMBER DROMM: Very good because we've had a lot of difficulty in the past trying to get people's numbers, and that's why we actually had to write legislation to make sure that that happened. And we're very, very interested in see what those numbers are. So I just wanted to-- Let me go to these questions in regard to punitive segregation. The United Nations Special Rapporteur said that solitary confinement when used for the purpose of punishment cannot be justified for any reason. Precisely because it imposes severe mental pain, and

suffering beyond any reasonable retribution for criminal behavior. So I'm wondering why we're even in the business of that, particularly why we're in the business of that when we have mentally patients. I've questioned the Department both of them on previous occasions at other hearings. Why are we continuing to do that especially at lengths of stays that have been reported to us by people who have experienced solitary at Rikers? The State has passed legislation in regard to juveniles. What moves are you taking to move in the same direction?

COMMISSIONER PONTE: As it pertains to mentally ill offenders, I think we've already moved away from putting those inmates in punitive segregation. And we're very actively -- we've got a good program in place. It's productive, but those people that are clinically mentally ill those are somebody with a level of mental illness that's the RHU placements. I think we've already progressive moved down that road to look at alternatives, and we continue to look at the RHU mode as a good foundation for where do we need to go from here? I think we're already heading down the road. But as it pertains to juveniles, I agree. In most of the country, if you

look across the country, it's already walked away from the idea, the concept of punitive say for a juvenile. We don't call them juveniles. We call them adolescents. In every other state in the country they wouldn't be the developed system. It presents us with a unique problem that we are addressing. So we've got a pretty active committee looking specifically at that problem, not only how we house juveniles, how we use punitive seg, and how do we have appropriate programming to avoid the need for punitive seg. But all of those are big costly pieces that will add to our systems, but we're moving clearly in that direction.

COUNCIL MEMBER DROMM: So I think I've presented Rikers now four times since I became deeply interested in this issue. And on each of those visits to Rikers, I was shocked at the conditions that exist there physically. The hallways smell of urine or the condition of the cells in which inmates are held; the rusted beds; the lack of open air; the windows. And I thought the last visit when you were there Commissioner as well with us, there was one cell where papers had been taped up above the vent, which was directly above the bed. I would think

that's probably how that inmate died from it being too hot in the cell. That hot air and cold air coming down on top of you. Is there any plan for a capital program to reconstruct these buildings? I mean the conditions are absolutely horrendous.

COMMISSIONER PONTE: I agree. Most of our facilities are very old. They probably could stand to be replaced, most of them. It's very expensive, but it's one of the things we're looking at. We have one facility on design now that we're looking at a prototype, and what do we need in the way of bed space, but what type of bed space do we need. And we are heading in that direction, very long-term and very expensive.

COUNCIL MEMBER DROMM: So just to go back to the different programs that you're piloting the CAPS the Clinical Alternative to Punitive Segregation. From when we went out on a visit, I believe you said you had 20 people in that program?

DR. MARY BASSETT: 65 now.

COUNCIL MEMBER DROMM: 65 now, and how many would be eligible or are eligible for that program that you cannot accommodate?

DR. MARY BASSETT: This is punitive segregation or solitary. These are patients that would have previously been sent to solitary confinement with serious mental illness. So we feel that we have an adequate number of beds for that population, which is presently the population that's eligible for the CAPS facility. There are other solitary confinement facilities. Theses are called the restricted housing units, which are not -- have not transitioned to a non-solitary confinement approach to handling people who break jail rules.

COUNCIL MEMBER DROMM: So one other. How many rules are there that they can break?

DR. MARY BASSETT: I don't know the answer to that. I should ask my colleague but I think there are a lot.

COUNCIL MEMBER DROMM: [interposing] We were told there were over 100, over 100 rules they cold break--

DR. MARY BASSETT: Yes, there are a lot.

COUNCIL MEMBER DROM: -- that could get them--

DR. MARY BASSETT: Not all of the involving violence. I should point out.

COMMISSIONER PONTE: And not always will get them to solitary confinement or to punitive segregation.

COUNCIL MEMBER DROMM: What's the average length of stay for a person that's held in punitive segregation at Rikers?

DEPUTY COMMISSIONER BERLINER: The average sentence length posted in our sentencing reform for them last year is about 14 days. I have to calculate the length of stay and send it to you.

COUNCIL MEMBER DROMM Okay, I'd like to have that information. And what's the maximum length of stay?

DEPUTY COMMISSIONER BERLINER: There is none.

COUNCIL MEMBER DROMM: There's no maximum. So they could be there constantly for years and years and years if they keep coming back. What about time owed? Somebody that I know who was sentenced to 100 and something days completed the majority of them. Went Upstate. Came out and was in the Fortune Society. Unfortunately, got rearrested again. Went back in, and immediately had to do 30 days time owed. Is that practice still in place?

DEPUTY COMMISSIONER BERLINER: Time owed from a prior incarceration is still kept on one's record for one year post-release for most infractions, and for two years post-release for assaults on staff, assaults on other inmates causing injury or assaults with a weapon.

COUNCIL MEMBER DROMM: They go right back in.

DEPUTY COMMISSIONER BERLINER: They may not go right back in, but they --

COUNCIL MEMBER DROMM: [interposing] Because there's a waiting list?

DEPUTY COMMISSIONER BERLINER: Right, but there would be assist --

COUNCIL MEMBER DROMM: [interposing] How long is the waiting list for solitary?

DEPUTY COMMISSIONER BERLINER: Their waiting list for the general population in the punitive segregation area averages about 50 to 70 people, which is about a one to two days turnover. The 600 that Chair Crowley references is the waiting list for the RHUs, which is about -- averaging about 650 people.

COUNCIL MEMBER DROMM: One of the concerns that I've heard from people who have been in solitary is that they're in there basically 24 hours a day. I know that they are supposed to be allowed to come out one hour a day. When we visited Rikers a couple of the corrections officers told me that generally if they want to take advantage of that one hour a day, they are awakened at 5:00 a.m. and they will be there from 5:00 a.m. to 6:00 a.m. She said times it's even earlier from 4:00 to 5:00 a.m. Is that generally what the time is for getting out of their cell between 4:00 and 6:00 a.m. in the morning?

COMMISSIONER PONTE: It's scheduled. Everybody wouldn't be scheduled at 4:00 or 5:00. It would be unusual to have people scheduled at 4:00 a.m. but the day starts so the feeding and the rec. You have to start because there's only so much space. So it's a scheduled activity that some people would start early, but it would be happening throughout the day.

COUNCIL MEMBER DROMM: But generally how many people have to get up between 4:00 and 6:00 a.m. to take advantage of that?

COMMISSIONER PONTE: What's feeding is it 5:00?

DEPUTY COMMISSIONER BERLINER: 5:00.

COMMISSIONER PONTE: So the breakfast feeding starts at 5:00. I'm not sure of how many spaces you have in there.

COUNCIL MEMBER DROMM: So most inmates tend to skip that.

COMMISSIONER PONTE: They can.

COUNCIL MEMBER DROMM: If they do, then they don't get out of their cell at all for the day basically unless they have a visit or some type of clinical appointment or something like that, which doesn't happen all that often. So what's the average size of the cell in segregation at Rikers?

DEPUTY COMMISSIONER BERLINER: I think the dimensions of most-- The cells in the punitive seg are the same as the cells that are not in punitive seg depending on the age of the jail. But I believe they're 8x10.

COUNCIL MEMBER DROMM: 8x10. That's very small and they probably have like a very small window. What's the size of the window in there?

DEPUTY COMMISSIONER BERLINER: I'll have to get back to you with that.

COUNCIL MEMBER DROMM: Okay. So there used to be a lot of data on the DOE ... DOC. DOE, I guess I'm coming from the Education here. DOC's website, which is no longer available to the public in terms of the numbers, et cetera. Were you aware that that data is no longer available on the website as of yesterday?

COMMISSIONER PONTE: I know we're working on new data sets.

[Pause]

DEPUTY COMMISSIONER BERLINER: The website was really launched. There are links available, and we'll send you the links.

COUNCIL MEMBER DROMM: Okay, I hope the public would be made more aware of that as well so that we can look at those numbers. How many individuals in terms of segregation are 16 and 17 years old, and how many are 18 and 20 years old?

DEPUTY COMMISSIONER BERLINER: We'll have to get back to you with an age-by-age breakdown.

COUNCIL MEMBER DROMM: That's why my bill is so important because we definitely need to know

these statistics. It was mentioned I think that 20,000 patients a year by the Health Commissioner receive discharge planning. What percentage of those leaving is that?

DR. MARY BASSETT: I think I was referring to the discharge planning on the Brad H. Stipulation.

DR. AMANDA PARSONS: I'm smiling because I actually just requested this graph yesterday of looking at it annually how many people come into the system, and at what point do they exit? We know that for those who stay long enough to get the discharge plan to be eligible for the stipulation, it's about 93% of them who get it. But I cannot tell you what proportion of them leave without a complete discharge plan. But it's worth noting that the discharge planning is a process. It's not just a final document, and for people-- Most people leave, and we have no idea when they're going to leave. And so, what we end up giving them is a referral because they could go out tomorrow.

They could go out in three weeks, and so you cannot be making it and scheduling appointments. So what we're doing is we're giving people referrals.

Unfortunately, I'd looked at some of the data yesterday, and suggests that a lot of people don't follow up with their referrals. And so, we're trying to understand as part of the work we'll be doing with the committee what is the best way of reconnecting people to care when we don't have a way of planning for the release the way that we would like to. That way that you could for instance in the prison system. And for those who have a known release date, and that's a very small percentage of the population for those folks they do get appointments. And we follow up with them within three days of the appointment to make sure that they have seen their provider.

COUNCIL MEMBER DROMM: So, this holds true also for those who are in solitary, they can just be in solitary one day, go to court and then be released to the street without any planning?

DR. AMANDA PARSONS: So they could be released without any planning. In general, we try to get people referrals. We know that they are likely to be released without us knowing. So we try to give them a referral very early on in their say to say, If you are to be released, your referral to this place. If they're released from the jail, they're brought

down to clinic, and actually given a piece of paper and some more information. If they're released from the court, they have to go back to the notion of the referral that was cited to them. It could be several days to prepare it.

COUNCIL MEMBER DROMM: Just very quickly. One of the things that I did hear when I was on Rikers from the Department of Corrections -- from a correction officer when I went in association [sic] is the lack of communication in terms of the diagnosis for many of these people who have mental illnesses. Is there a way that the Department of Corrections, that corrections officers can be informed without violating any privacy laws. So that they can be supportive in the job that they have to do?

DR. AMANDA PARSONS: We're currently in discussions with DOC about what is the most useful piece of information. And the staff, the facility staff actually are saying they don't need a diagnosis. The DOC facilities staff are saying. Because again, what are you going to do if we tell you the person is schizoaffective? What does that mean for a corrections officer today? How would that

change how they approach the patient? And so, the correction officers are asking for things like, Is there anything -- do I need to know anything about this patient that's going to change my tour? Can you tell me if a patient is not taking meds? I don't need to know what the meds are.

I just need to know is there a chance -- do you know that the patient hasn't been taking their meds and, therefore, it's going to put them at risk of hearing more voices or they're potentially going to be less up or more down? Tell me that. Tell me the things that I'm going to need to be safe on my tour, and to take better care of the inmates. And that is not diagnosis and names of medications. That's pertinent up-to-date information about symptomotology and about behaviors that are changing day-to-day with a patient. And that's the level of information that we want to facilitate between the staff.

COUNCIL MEMBER DROMM: Thank you very much. I hope that that is communicated, and I'm now going to just turn it over to the Chair.

CHAIRPERSON CROWLEY: Thank you, Council Member Dromm. Before I recognize Council Member

Vallone for questions, a question following up on what was spoken about earlier in regards to Kendra's Law. Kendra's Law has to do with people with mental health diagnosis. So anyone who works with DOC that doesn't have access to DOH information, the care of those with mental health diagnosis wouldn't necessarily be in with those types of inmates when they are getting discharged. It is under your purview at all?

DR. MARY BASSETT: The decision this is a court-mandated referral. So the setting in which--

CHAIRPERSON CROWLEY: [interposing] But is that a partnership?

DR. MARY BASSETT: --we oversee at the Department, the program it's called the Assisted Outpatient Treatment and follow up these patients who have been given court-mandated services. So we don't make the -- we don't mandate these services.

CHAIRPERSON CROWLEY: [interposing] Right.

DR. MARY BASSETT: We do have--

CHAIRPERSON CROWLEY: [interposing] And inmates--

DR. MARY BASSETT: --a responsibility for managing the program following up the people--

CHAIRPERSON CROWLEY: [interposing] But the vast -- the vast majority of inmates.

DR. MARY BASSETT: --in mandated services.

CHAIRPERSON CROWLEY: --of inmates that are convicted of a serious felony are sentenced--

DR. MARY BASSETT: [interposing] I don't think -- I think that, yes.

CHAIRPERSON CROWLEY: Let me ask this. But some have been on Rikers Island for a number of years of years waiting for this, okay. There's a small percentage of inmates that finish their time served at Rikers, and then are going into-- back into the community. Now, there's a certain amount of them that fall within your Mental Health purview whereby they ask officials. It is DOC officials and DOH officials that will have to let the courts know that this particular inmate cooperated and participated in a mental health program. So they're ready to go out back into the community. Is that coordination that I want to get a better handle on? Do we at DOC and DOH have a good handle on the population that leaves and

goes back into the community because there is a way, and working properly together that we could ask the court to get involved, and the court may not be involved? And everybody who is here that-- I'm sorry just two commissioners needs to identify themselves for the record, too.

ASSISTANT COMMISSIONER VENTERS: So my name is Home Venters, and I'm a physician and I oversee healthcare in the justice system. I'm the Assistant Commissioner of Correctional Health. So we have two mechanisms to address to the point you just made. First of all, there are patients that have come through the AOT Program. And that's where people start off with some particular court mandate and our mental health staff routinely interact with the AOT staff from the courts. The other is and this is I think a little bit more precise scenario that both you and the Public Advocate have raised is that somebody on their way out the door exhibits symptoms that are worrisome.

So we routinely do what we call a civil discharge, which is our Mental Health staff because they are Mental Health staff and we follow the letter and the spirit of Kendra's Law and all the mental

health laws in the State. We will actually work with the Department of Corrections for somebody who is leaving the jails to take them directly to Elmhurst Hospital, or it could be another local CPEP or mental health emergency room. They're taken there under authority by us as the health providers to be assessed by-- Even though they're leaving the authority of DOC, to be assessed by those mental health providers in that emergency room because we're worried that there may be a threat of them harming themselves or others. So we do that routinely.

CHAIRPERSON CROWLEY: How often?

ASSISTANT COMMISSIONER VENTERS: I would have to check, but it certainly happens multiple times every month.

CHAIRPERSON CROWLEY: And do you stay on track to keep track of that particular person when they go into the community after they leave your care?

ASSISTANT COMMISSIONER VENTERS: No, we follow up with the hospital to assess, to find out what happened with them, but--

CHAIRPERSON CROWLEY: [interposing] But there's never been a time where you have worked with the court to mandate treatment, continued treatment?

ASSISTANT COMMISSIONER VENTERS: Well, actually the responsibility for the patient's care when they've left the jail system. So the City Charter says we're in charge of healthcare in the jails. We make sure that there's a secure transfer of that patient we're worried about to Elmhurst Hospital or another hospital. Then at that point, those physicians take over the care of that person. Then those are the physicians that would seek a court order or any other administrative process. But they would be beyond the scope of the authority of the health providers who don't care for the person.

CHAIRPERSON CROWLEY: [interposing] But there is some report that you give to that physician and the hospital--

ASSISTANT COMMISSIONER VENTERS: [interposing] Absolutely.

CHAIRPERSON CROWLEY: --and saying that over the past couple of years, because sometimes we have inmates that stay with you. I know it's rare, but there are cases, and they have not participated

in these programs. And you mandate that they go to Elmhurst and see a physician. But then it's sort of like you wash your hands of them, and now they're in the healthcare system. And it's the hospital that has to make sure that they're getting their care?

ASSISTANT COMMISSIONER VENTERS: [interposing] Well, I think this is--

CHAIRPERSON CROWLEY: [interposing] Their coordination with the hospital provider and somebody in probation that makes sure that this particular person is taking and participating in mental healthcare while they're in the community?

ASSISTANT COMMISSIONER VENTERS: That's actually quite routine. When a hospital assesses that someone is a threat to themselves or other. This isn't just for patients coming from my care. [soc] It could be patients who walk in off the street. Somebody who was admitted through the CPEP or into Bellevue or Elmhurst or any other hospital. There will be Social Services that assess not only does the patient need to stay in the hospital, but when they leave the hospital are there other services, Social Services that are going to be out there. So, they haven't returned there. [sic]

CHAIRPERSON CROWLEY: Is somebody on probation working with the hospital, the healthcare provider. When that person is in the community, and they stop going to the healthcare provider, who is alerted?

ASSISTANT COMMISSIONER VENTERS: We can certainly ask our colleagues at HHC what social services they enact with to answer the question.

CHAIRPERSON CROWLEY: I'm trying to get at the heart of what happened with St. Hubert, and he was not--

DR. MARY BASSETT: [interposing] So, St. Hubert--

CHAIRPERSON CROWLEY: --ordered, court ordered to continue care. So there was a loophole that he escaped with. And I want to make sure that anyone leaving Rikers under the City's responsibility is tracked. Anybody who is not participating in a program, who has a history of violent outbreaks of violence we're making sure they're ready to go into the community.

DR. MARY BASSETT: Yeah, I-- the only part of that question that I can answer for you is if they have a court order that mandates that they go

into AOT, then there's a whole set of follow-up questions.

CHAIRPERSON CROWLEY: [interposing] I realize that, but the question is--

DR. MARY BASSETT: [interposing] So you're asking about that gap or that --.

CHAIRPERSON CROWLEY: --who asked for the court order?

DR. MARY BASSETT: Well, that's--

CHAIRPERSON CROWLEY: [interposing] Are we relying on a mental health professional at the hospital --

DR. MARY BASSETT: [interposing] That's correct.

CHAIRPERSON CROWLEY: --who is not affiliated with DOC directly or indirectly who many not even know about Kendra's Law?

DR. MARY BASSETT: The request for AOT starts with the court. The request to assess someone for court-mandated services starts with us with a referral to the hospital--

CHAIRPERSON CROWLEY: [interposing] It starts with you?

DR. MARY BASSETT: -- that makes -- We refer the patient to the hospital to ask them to make the assessment and referral to the courts. That's my understanding.

CHAIRPERSON CROWLEY: Are you sure?

DR. MARY BASSETT: I think we ought to get back and clarify this, too, because I will do that.

CHAIRPERSON CROWLEY: Council Member Vallone.

COUNCIL MEMBER VALLONE: Thank you, Madam Chair. As much as I'm dying to ask questions for the past two and a half hours, I know my fellow council member Rory Lancman has to leave. So I'm going to slide this over to Rory.

[Pause]

COUNCIL MEMBER LANCMAN: Thank you. Paul, thanks very much. Queens are looking out for each other. It's good to see you, Commissioners, and I do appreciate the opportunity you afforded us with the coordination of our Chair to take a tour of the Rikers facility, Commissioner Ponte. A couple of questions for each of you, and I will go through these quickly. First, just when do you expect the

task force on Behavioral Health and the Criminal Justice System to make its recommendations? Because you can give them to the City and to the Board of Corrections as well as to the City Council for any legislation that might be necessary.

DR. MARY BASSETT: The first meeting for the task force on Behavioral Health and the Criminal Justice System is next week, a week from today. And there's a 100-day clock ticking.

COUNCIL MEMBER LANCMAN: A 100-day clock?

DR. MARY BASSETT: A 100-day.

COUNCIL MEMBER LANCMAN: Well, that's good. That's positive.

DR. MARY BASSETT: That's good.

COUNCIL MEMBER LANCMAN: That is good. Commissioner Ponte, let me just ask you about the additional eight hours of mental health training. What topics, if any will it-- Well have you determined which topics you're going to cover? Why eight hours? Why not 50 hours, why not four hours? What is it that you're going to give in those eight hours that you feel the correction officers don't currently have?

COMMISSIONER PONTE: This is something that we work with the officers and the Department of Mental Health to look at what training, what's missing? I think it's probably at the end of the day will be more than eight hours as we look at what's really needed. But this is, again, as the training is running we've got officers on the units these units doing the best they can. This is something we're offering in the meantime as we look at the overall complexity of the training that needs to happen. So aren't being entirely specific of what's being offered.

DEPUTY COMMISSIONER BERLINER: It's a mental health first aid course primarily. So we're talking about basic symptom recognition, basic behavioral change, and quick methods to adapt to that.

COUNCIL MEMBER LANCMAN: And this additional training was it developed in collaboration with the workforce?

DEPUTY COMMISSIONER BERLINER: This is training that was developed by the Department of Health. And we've worked with uniformed staff in the facilities to make sure that this is training that

they would find valuable yes. But not one that we developed specifically.

COUNCIL MEMBER LANCMAN: Let's go back to the budget. I know there were a lot of questions about whether or not the budget was adequate to reduce the tremendous amount of overtime, which I think the Commissioner agrees can be a contributing factor to the violence in the jails. Have you had an opportunity to examine the budget? And can you tell us whether or not the resources are there in your view as the Manager of this Agency to significantly reduce the overtime or to reduce the overtime in a meaningful way.

COMMISSIONER PONTE: I'd be guessing at this point to give you an answer for that question. I think we're a big organization. There's a lot of factors that contribute to violence. Lots of overtime and staffing are a couple of pieces to that. But we're working very hard to get those answers to offer you our opinions of the staffing levels, the overtime, and responses to all of those. And most of the budget work was done well before I arrived. So it's really a One billion dollar budget that we're trying to look at now in a pretty short span of time

to see where the pieces shake out, and is it enough to get the job done in a short amount of time.

COUNCIL MEMBER LANCMAN: I understand that, and I think everybody is willing to cut you some slack, or is cognizant of the fact that you didn't make this mess. And you've only been on the job two months, but the reality is the budget is going to get done in the next three weeks. And so, it is incumbent upon you to examine the budget, determine whether or not you have the resources that you need based on the problems that you have been able to identify, the overstaffing -- the overuse of overtime being one of them. And to speak candidly to the Mayor, if necessary, and say we need X more dollars to deal with these problems that we know exist. Because it will become incredibly difficult to address that problem after June 30th, until we get around to next year's budget cycle.

And that's more of an admonition than a question. Let me ask just a quick question from the Commissioner of Health and maybe it's appropriate for both of you. I represent a lot of folks who work in the correctional system, blue-collar men and women, and I am very, very concerned about the extent to

which the jails have become sort of the mental health provider of last resort or first resort in the city. But my primary concern is the safety of the men and women working those jobs. Uniformed officers and your folks in health. I have heard the concern repeatedly that individuals will use, or detainees rather will use, the mental health excuse to avoid the consequences of the infractions that they might commit in the jail.

And let me ask you whether or not when you have 25% of the detainees being evaluated at the outset as having a mental health issue, but overall 38% of those inside the system have a mental health issue. I understand you attribute that difference to some degree to people who have a mental health diagnosis stay longer. So I guess over time they accumulate, but is there some percentage that you feel have been gaining the system? And do you have plans in place, or are you thinking of having plans in place to make sure that we are diagnosing people correctly? And that those who have legitimate mental health issues are getting the treatment that they need in the setting that they need. But that violent

inmates are not -- are misusing that diagnosis to avoid responsibility, and then posing danger.

DR. MARY BASSETT: Thank you for that question. Let me begin and then I'll ask Dr. Parsons to comment who has been overseeig the system for longer than I've been the Health Commissioner. The first thing to tell you is that as Health workers, we do not involve ourselves in the punitive component of activities at Rikers. There are two sort of sets of goals on Rikers, and we share our desire to have a safe and healthy population. And the principal objective of our health workers is to ensure the health of the patients. So when a patient is seen, we are not trying to assess whether they should be punished or not. We are trying to assess them on the basis of the complaints that they give to us. And that is our responsibility as doctors, nurses, psychologists, psychiatrists to assess the health and wellbeing of the patient when they come to us. Quite apart from the issue of what brought them there, what infractions they may have incurred. We are their healthcare workers. So, to say a little bit more about this, I'll turn it to Dr. Parsons.

DR. AMANDA PARSONS: I think I would say overall that people in the jails don't feign a mental illness. I think the issue that you're referring to is that for people who are about to go into CPSU, who tell us, the mental health staff, that they want to kill themselves, or make some attempt to do so. We are often asked by the corrections officers to say, Tell us the real from the fake. And if there were a way to do that, we would, but we can't. There is no way to tell whether or not somebody is serious when they say they're going to kill themselves or not. And if we try to guess and we guess wrong, people kill themselves and indeed they have. And, therefore, it's our responsibility as medical providers to take what we hear and assume to the best of our knowledge that it is true unless we know otherwise.

And it is very hard to know otherwise what is in somebody's head. Compounded by the fact that when we actually look at the research, people in punitive seg do try to kill themselves more than in other places. And so, it's very hard to do what it is that you are asking us to do, which is to tell the real from the fake. And I think anybody who's got

kids, anybody who's got a young girl who says, I'm going to kill myself. And if you think you know whether or not she's going to do it, you need to talk to some parents of the people who didn't listen. And we cannot be those people. It is our duty to protect the health of the inmates, and we will do so even if we can't tell whether they are telling the truth or a lie.

COUNCIL MEMBER LANCMAN: Well, I respect that and this committee and this Council from the time that I've been here has been very committed to the mental wellbeing of inmates in the correction system, but there's a dual responsibility. And it's not just to the inmates. It's to the staff, the correction officers, and the health staff. And so I hope, and I'm not a psychiatrist or a psychologist, but I hope that your training incorporates the context in which these diagnoses are made. And that is people who have an incentive, or a very strong incentive to mislead about their mental state.

DR. MARY BASSETT: I think Dr. Parsons' remarks stand for the record.

COUNCIL MEMBER LANCMAN: All right, thanks very much. Paul, thank you very much.

CHAIRPERSON CROWLEY: Also, it's important to remember, and Council Member Lancman's line of questioning when you have an inmate whether or not they have a mental health diagnosis, but they are continuing to commit infractions, and there is no consequence to that, of course, staff's lives are at risk and they're in danger, but so is the entire population. So all those other inmates, it's not right to those other inmates. And for me, if you have a mental health diagnosis or you don't, if you're disruptive and you're violent, you're not to be with the rest of the population. It's not fair to the other inmates, and it's not fair to the staff. we've heard today that although there are inmates that have committed infractions, they're not getting any type of punishment. I'm not saying to put them in punitive segregation. Maybe they need a program, but the fact of the matter is they cannot be with other -- the general population because they're going to continue to do this. And that's why the violence, which is spiraling out of control. Rikers Island does not have the plan in place. You have 650 people on a waiting list--

DR. MARY BASSETT: [interposing] Let me--

CHAIRPERSON CROWLEY: --and those are the same people. Two or three weeks ago when a corrections officer got their head beaten in, it was by somebody who had a mental health diagnosis, who had committed infractions and was on the waiting list. And if you look at the violence, you'll see that they're much more likely, those that have infracted in the pat, to reinfract again. And unfortunately, there is no discipline and order because you do not have the facilities to house those who need to be segregated properly.

DR. MARY BASSETT: I'm not sure whether that is a question, but let me just refer the Committee to a set of facts that are based on --

CHAIRPERSON CROWLEY: [interposing] Everything that I said is facts.

DR. MARY BASSETT: --research that was were done by -- that reflect the research done by the Correctional Health Team on Rikers. They --

CHAIRPERSON CROWLEY: [interposing] This Committee has never asked for somebody with a mental health diagnosis to put in -- to be put in central punitive segregation. We are asking that they be removed from the general population so they're not

continuing to commit violent acts against other inmates or a correction officer. They're in a facility that has control, not with the general population. You have 650 people who have committed infractions who are more likely than other inmates to commit more infractions, and right now you do not have the facilities to help this population, and who's at risk? Other inmates and the staff. Council Member Vallone.

COUNCIL MEMBER VALLONE: Thank you, Madam Chair. We are talking about a correctional facility, are we not and are we not talking about the largest correctional facility in the world? Are we talking about a correctional facility that has the oldest buildings that were never meant to house over 10 to 12,000 detainees. Sometimes I listen to what's going on, and I think the finger is unfairly pointed at Corrections and the officers and staff that's on the island for the mess that we're talking about. So as we put this task force together, and we talk about changes, we have to talk about all of it together. But the problem is we have to support those who are on the frontline now there at the island and short term.

And that was why Council Member Crowley and all the chairs worked so hard at the budget hearings, to have you have it not be so hard for the Mayor to increase the budgets. To get our officers, to get our health staff, to get our clinicians and our psychologists and our grand contract. But if we can't get any better than that, we should fight for it. But we can get those resources now, and all of the violence that we talk about. And the things that are happening, we tend to say, Well, you know what, the officers they didn't do the right thing. They put somebody in segregation, or they didn't have the tools. And I think I'd like to redirect what the purpose of this is, and think you on the Board of Corrections--

And by the way, Commissioner, I heard you say that the Department of Health is bound to the court's on treatment, for health treatment, and mental services and I'm in agreement. I have to tell you I voted for minimum standards for years ago, the Department of Health, the Department of Corrections. And there are many, many rules in our statutes regarding discharge planning. Regarding the amount of hours that have to go by. The amount of treatment

that is mandated. It has nothing to do with the court system. So we can't sit back and say, Oh, the courts told us, or we have to wait for a court to tell us with a detainee or an inmate. So is that actually what your testimony saying that the courts are the ones?

DR. MARY BASSETT: What I was referring to is what I understood that Chairman Crowley, Chair Crowley, sorry, to -- Chairwoman, to say about ensuring that people are in treatment, people being mandated to be in treatment. And that is something that can occur under what's known as Kendra's Law and when people are referred for assisted outpatient treatment that is pursuant to a court mandate. And that we in the Department cannot mandate individuals to get treatment. We can advise them, refer them, try and ensure that there are no barriers to them getting appropriate treatment. But a mandate that they continue treatment is something that comes from the courts.

COUNCIL MEMBER VALLONE: You also said that there is no way for you to tell on a diagnosis if someone is going to kill themselves or if someone is not. Then, how can we take the next step in

anything? How can we tell our correction officers at the Department of Corrections to make that determination on how they're supposed to provide safety in the jails if the Department of Health can't give that type of clinical diagnosis?

DR. MARY BASSETT: I don't think that any of us pretend that we can see the future. I think what Dr. Parsons was saying is that there's no way that we can tell for sure that somebody who has -- who says that they want to kill themselves will do it or not. And this is something no physician, no psychiatrist wants to err on. There are certainly ways in which all of us trained to assess a claim, to try and figure out how likely it is to happen.

COUNCIL MEMBER VALLONE: [interposing] But that was the mental health assessment?

DR. MARY BASSETT: Yes.

COUNCIL MEMBER VALLONE: Okay, have you see a rise on those -- on the mental health assessments over the last couple of years in the percentage of inmates or detainees that have been assessed? Are those numbers increasing through that assessment?

DR. MARY BASSETT: I mean I can't answer the time trend, and I want to clarify. Are you trying to see whether we assess on entry whether people have suicidal thinking?

COUNCIL MEMBER VALLONE: No, no, just on the mental health, the scale.

DR. MARY BASSETT: [interposing] Whether the proportion of people-- ?

COUNCIL MEMBER VALLONE: Uh-huh.

DR. MARY BASSETT: So right now, as you know, or as you said or someone else said that we are finding 25% of people have mental illness on initial screen. Because they're more likely to stay in longer, it rises to 38%.

COUNCIL MEMBER VALLONE: Have you seen a the percentage increase over the years?

DR. MARY BASSETT: The serious mental illness that's a 4.5% who have psychotic mental illnesses is stable. Mental illness is slightly up.

COUNCIL MEMBER VALLONE: Has there been any change in the staffing priorities over the increase with the mental health diagnosis?

DR. MARY BASSETT: Hold on. Let me hand you to Dr. Parsons.

[Pause]

DR. AMANDA PARSONS: I'll hand you to Dr. Venters. [sic]

ASSISTANT COMMISSIONER VENTERS: So it's important to remember that during the time when we probably had a 10 or 15% increase in the number of people who come into the Mental Health Service. During that time we've also had a concomitant decrease about 15% in the average daily population in the jails. The jail's population is quite down. However, we do think that in the Mental Health units, the units where we have the people with the highest level of acuity, there are a lot of things we need to do to reach every one of those units. And we think probably one of them is staffing, not just the amount of staffing, but the type of staffing. We have social workers.

COUNCIL MEMBER VALLONE: Has anything been done?

ASSISTANT COMMISSIONER VENTERS: We're in the midst of probably a three-month redesign because we need to look at not just staffing, not just workflow, but the physical plan that these units are in. How interact with our partners in Corrections

and sharing the information. So there is no switch to flip to make these units better overnight, but we're committed with some of the bad outcomes that we discussed to--

COUNCIL MEMBER VALLONE: [interposing] Have there been any budgetary adjustments to hire additional clinical psychologists and professionals to deal with this rise?

ASSISTANT COMMISSIONER VENTERS: We actually have preliminary -- we had some discussions internally, but this will take several months because I think one of the things we need to discuss with the staff and the correctional staff is do we simply -- I'm not sure if we want to ask them for more social workers for instance. I think we may need more support by psychologists.

CHAIRPERSON CROWLEY: [interposing] I'm sorry to interrupt, but the task force that the Mayor has put together, have any of you served on the task force that Bloomberg had that dealt with this population?

ASSISTANT COMMISSIONER VENTERS: Yes.

CHAIRPERSON CROWLEY: Who did? How many of you? Just one, two, that's it? Commissioner, you didn't.

DR. MARY BASSETT: [off mic]

CHAIRPERSON CROWLEY: Okay, and do you know how this task force is going to be different than that task force?

ASSISTANT COMMISSIONER VENTERS: Yes. So that task force had a very specific proposition to get people out of jail who met a certain profile. That's a relatively small group of people. This task force is a comprehensive group of people at every point along the continuum of interaction with the police, the courts, arraignment, in jail, leaving jail. So it's a comprehensive look, and part of it is reassessing how we do things in jail, but as the Commissioner said, it's much broader than that.

COUNCIL MEMBER VALLONE: Doctor, what information is being provided to the officers at this point? Because you had said-- You were speaking for them and said they don't want to know the type of treatment or what meds they're on. They just want to know how to be safe for that tour. So what information is being provided now to make sure that

the safety of the staff on the island is first? As everyone is saying is first and foremost?

ASSISTANT COMMISSIONER VENTERS: Chair, so I was just asked to re-introduce myself. Homer Venters, Dr. Homer Venters with Correctional Health. So in the Mental Observation units where there's the most acute safety concern, and also there's a lot of information that's important. We've started tour by tour, and I think you might have -- Some of you visited GRVC, the Mental Observation units. On those units every time the mental health staff changes over on the tour with the DOC security staff, they're talking about who is doing well, and who is not doing well. When we look at the safety problems people have had; either been assaulted or harmed themselves, what we inexorably find, including all the cases we've talked about today, there were bits of information that health staff had and that security staff had.

What we have now in place in GRVC and those mental observation units is that they share that stuff every single tour. And what's important to assess risk of violence or risk of self-harm is how is the person behaving right now? And so that's

the information we share. Things like, Did they eat today? Did they come out for recreation? Did they yell. Did they put their clothes on? Did they do anything wild or weird, or did they refuse to engage with us in some way on the health side. All that information is being shared, and the Correctional staff is sharing with us their experiences: The person was resistant. They wouldn't talk to me. They swore at us when we came by. Things like that that are really important for us to integrate. That is the most powerful way to predict a bad outcome and prevent it in the jails.

COUNCIL MEMBER VALLONE: Well, I'm optimistic. We started the hearing by saying that the communication between the departments, and I think that traditionally has always been sometimes, as I sat on the Board of Corrections for years there would be no Department of Health, no Department of Corrections, no Board of Corrections, no -- And I think these are the steps that are wavering. I know the Commissioners are optimistic they'll change. I just -- I go back to the front line that's there, and I think the way we can look at everything in the short term and long term. I think a lot of the stuff

we're talking about is probably going to be long term.

So what do we do short term to address what the public sees as a rise to the street that our officers and our staff on the island have to deal with? And then we as elected official put more pressure and give us results right now, and it's not fair. And I think there needs to be accountability that we can look at what we can actually accomplish. So I was at the last Board of Corrections meeting, and I'll just state this. And there was a study performed, and I think it's good for the knowledge here because no one else was here -- at that meeting. To compare Rikers Island to any other large city in the country to see if there is something being done in the country that we're not doing here in New York or at least in Rikers.

And the report came back that there is none. And in San Francisco, the closest one that is providing additional services, the main difference is that they had an entire facility, brand new building with like a mental health observation. With wings of treatment that could be provided for all -- It's like we're talking about CAPS, like expanding CAPS. We

don't have that at Rikers Island. So unless we talk about a real infrastructure commitment in the budget, and making changes so that we can -- the changes that we come up here, we're asking an old outdated structure to do something it can't do.

So we're going to need your support to fight for those budgetary increases for infrastructure, for the proper staff that's going to be there. Otherwise, all of these great ideas, you're going to -- If anyone spends five minutes on Rikers Island knows those facilities can't make these changes. And I think when you go into the wings, and CAPS always says, Well, this jail is not really able to do that. It's old, it's weak, and it's got no way to provide these services. So I'd like to continue that. Is there anything that we foresee that can be immediately done to address that this year or next year? Or do you see it just waiting on an infrastructural change overall?

COMMISSIONER PONTE: I think there are things we're doing now. We're doing some significant renovations for all of our buildings, adding cameras a lot of systems in place. But like the overall structure is bad. So it's hard to overcome that, but

there is an ongoing substantial amount of money being put into these old facilities to improve on them, both ventilation, fire safety, and a couple of other things. But it doesn't change the design. Still small cell blocks, not a lot of programming space. So those are the bigger hurdles to overcome.

COUNCIL MEMBER VALLONE: And there is one new facility on that is being planned now?

COMMISSIONER PONTE: There is one 1,500-bed facility being planned now, yes.

CHAIRPERSON CROWLEY: [interposing] Thank you Council Member Vallone. Council Member Andy King -- Andy Cohen. [laughter]

CO-CHAIRPERSON COHEN: Andy from the Bronx. I don't know if it was -- I meant to ask before in terms of the role of medication in managing the population on the Island. I don't know if the 4.5% that are severely anti-psychotics or are there anti-depressants available or other mood altering or mood stabilizing medications? Do you think they play a role. Is that role -- should that role be expanded? Is it adequate? I'm just curious about that.

DR. MARY BASSETT: So your questions is about the sort of standard of care, and I would say that in general we seek to meet the community standard of care. So that patients who are seen on Rikers are getting the same type of treatment. That obviously would include talk therapy. It would include taking medications. Both of these are part of the treatment of people with mental illness. So people -- there is a big pharmacy operation. There's a full range of psychotropic medications available for the treatment of the inmate population. I don't know whether you're asking whether they're over-treated. I haven't heard that concern raised before.

CO-CHAIRPERSON COHEN: I'm not suggesting that they're over-treated or not treated, that they're adequately treated. I don't know if there's a correlation -- if you have any idea of what percentage of the population is currently -- is taking --

DR. MARY BASSETT: [interposing] Well, I can give-- Well, of the portion of people who have mental illness diagnosis, what proportion are getting -- That would be possible for us to get from our electronic record, but I'll have to offer to get it

to you at a later time. Unless either one of the team here -- Half. About half.

CO-CHAIRPERSON COHEN: Of the 37%, approximately half of those people are receiving -- I mean.

ASSISTANT COMMISSIONER VENTERS: About half of the people in the Mental Health Service are receiving some sort of mental health or psychotropic medication. Most of the people who have a serious mental illness diagnosis obviously are on medication.

CO-CHAIRPERSON COHEN: On initial intake if I didn't want to disclose that I was taking anti-psychotic medication, is there any vehicle by which you would find that out, or just that it would make itself evident at some point?

DR. AMANDA PARSONS: So we have a process in place now where we-- As I mentioned before, we can look up the community med history. So as long as they have had medications in the history that are captured, they didn't pay for them by cash, we can come to know of that. We're also connected with our -- we've also connected our electronic medical record to the State Health Information Exchange, and over time as information because populated in that, we'll

be able to pull down not just medications, but also other issues. And then the other third way that we can find out from using technology, is we are connected to Psychease, which is the Medicaid claims history for all of the patients. And so, assuming that we can match, and we can't match everybody, and not everybody is on Medicaid. But assuming that we can match for a Medicaid eligible patient, we're able to pull down actually a very easy to use comparatively speaking -- easy to use format. We can look at where they were last hospitalized; where their last treatment was; what their medications are; and actually come to know a fair amount about the patient. So we don't have to be 100% reliant on the patient's self-history.

CO-CHAIRPERSON COHEN: Just one thing, you don't think in other words that there is a correlation between the violence and a lack of the proper application of the mental health medication?

DR. MARY BASSETT: We don't have data to suggest that, no.

CO-CHAIRPERSON COHEN: Thank you.

CHAIRPERSON CROWLEY: Thank you. Council Member Cornegy.

COUNCIL MEMBER CORNEGY: Good afternoon and thank you, Chairs. So sitting here and listening to this testimony, I'm having flashbacks because I was on 95, 74, and in Rows E [sic] as an employee. And I started as the Supervisor for Social Services, and then went on to be the Assistant Director of Substance Abuse. So I was very familiar with working in the MO Unit. And one of the things I'm having flashbacks because I'm thinking of those hot nights on Rikers Island and lack of support. And the decreased amount of psychiatrists that were there. So just the staffing pattern was horrible in trying to support those individuals with substance abuse issues, and with mental health issues. And then on the discharge, you talked about recidivism.

The recidivism rate for mental health is way higher than the general recidivism rate because at discharge, the discharge planners are forced to place these individuals in facilities that are substandard, halfway houses and those kinds of things. So the cycle just continues. So everything about the way that the individuals who have mental health issues are handled in the system, attributes to increased violence. The best way that the

violence was decreased while I was there was by providing adequate services. So most officers and employees will tell you that if you give people what they need while they're there, it decreases the amount of violence on these units and in the housing area.

So I think that there has to be an increase in budgeting for staffing especially as it relates to those people that dispense medication, psychiatrists, psychologists and all those kinds of things. And until that happens I think we're just going to be spinning our wheels. The support has to be in place, and I think one of the things with the officers weren't equipped to deal with the wide range of increases of violence, and increases of diagnoses that they were seeing while I was there. So it was really an awful situation. From the time that you come over to Rikers Island on the bus, and you could be on the bus with everybody from a visitor to inmates to -- Just the whole system is set up seemingly not to support officers as well as inmates.

So I think there has to be an overall change to way the system is dealt with. And until you do that like wholesale, we're going to deal with

these problems increasingly. So, I just wanted to know is there a plan to deal with everything from transportation, and the way that officers are supported? Because I think it was a tragic -- I'm just amazed that I didn't see more incidents of violence even being transported from one building to another based on everybody riding on the same bus. I mean it was -- it seemed like such a recipe for disaster. I'm truly amazed that the years that I was there, there was never an incident in transfer. So everything from that suggests that there's really no support for officers from the core staffing patterns to the transportation system. So all of those things kind of contribute to violence against staff and officer. So I just want to know if there is anything being done to address that.

DR. MARY BASSETT: There's observations and the question. I don't know whether you were in the room, Council Member Cornegy, when Dr. Parsons was talking about some of the findings about violence against staff occurring on the Mental Observation Units. Most of the incidents that we have observed are what we call splashings, and they've done some work talking with inmates about what drives them to

initiate splashings. And she recounted how the inmates often in their view resort to these actions because they have not received the benefits to which they feel they're entitled. Or they want to have more interactions with people, get out of their cell, and numbers of reasons. So my answer to your many observations is that it's my hope, and I'm sure Commissioner Ponte shares this thought that the task force that's recently been established on Behavioral Health and the Criminal Justice System.

It's led by Deputy Mayor Barrio-Paoli, and the Criminal Justice Coordinator Liz Glazer, will address the whole continuum. We've heard from Dr. Venters that this -- this mandate is broader than the one that was previously convened under the previous administration. It's intended to begin and follow along the whole course from arrest to arraignment, incarceration, discharge planning, to return to community and re-entry. Two members of my staff are involved in co-chairing subcommittees. There will be somebody from OMB to speak to your budget question, who is associated with each one of these work groups. And it's our -- we've been tasked to tackle these tough issues, and map our way forward in 100 days.

COUNCIL MEMBER CORNEGY: Well, I thank you for that response, but I just want to make sure that we include -- When we talk about mental health issues, that we include the staff and officers that work there because they have probably the highest rate in public service of heart attacks and mental illness and suicides are on the Island. So, you know, there was a common referral that when you worked there, whether you're doing one, two, or sometimes three chores, you're incarcerated as well. And there aren't substance abuse report services for officers. And if you check the rates, and I'm sure that the doctor can statistically support the fact that the rate of heart attacks between 40-year-old officers and staff is off the chart as well as suicide, and as well as every other -- And mental health issues. So as we're addressing the inmates, I just want to make sure that we address those issues as it relates to the staff as well.

CHAIRPERSON CROWLEY: Thank you Council Member Cornegy. Council -- not council member, but our Public Advocate James.

PUBLIC ADVOCATE JAMES: Just a couple comments because I know the hour is long. The hour

is late, and a number of other individuals want to testify. I really want to look at this Corizon contract, and who is monitoring Corizon's compliance with the contract, and where can one find the annual evaluation? Is it online?

DR. MARY BASSETT: This is the responsibility of the Health Department. And Dr. Venters also could comment on it. [sic]

ASSISTANT COMMISSIONER VENTERS: Sure. VENDEX, which is the citywide system we use to evaluate contractors is online. And I believe the most evaluation either was done in the last couple months. Either it's online or will be online very shortly.

PUBLIC ADVOCATE JAMES: And is the Department of Health satisfied with the performance Corizon?

ASSISTANT COMMISSIONER VENTERS: So, Corizon --

PUBLIC ADVOCATE JAMES: Corizon.

ASSISTANT COMMISSIONER VENTERS: --we have 30, we have 40 performance indicators that we use to access the adequacy of care. These are taken straight from HHC and other health systems. And

there are consistently areas, every quarter when we evaluate them it is probably similar to other big hospitals or other health systems. There are some areas where there is definitely improvement needed, and there are areas where the care is adequate. And some areas where the care is very, very high. So recently, as we've all discussed here, most -- much of our scrutiny about the adequacy of care. But also the health system that we designed, and our own policies have focused on the mental observation areas. And so, we believe that we've had errors in those settings. We believe also we had to change our policies and we need more resources. But to sum up your question, the area of the greatest scrutiny for us has been the Mental Observation areas.

PUBLIC ADVOCATE JAMES: So in this budget, as we are reviewing this budget, have you sought an increase in your budget to address the mental health deficiencies?

ASSISTANT COMMISSIONER VENTERS: We actually are in it. We're just beginning the process of the re-tooling of the Mental Observation. So I think we're one step behind whatever budget is ours that has been proposed. We're actually just

beginning the re-evaluation of this, but as forewarned, I think that's part of it.

PUBLIC ADVOCATE JAMES: So of the inmates with mental health histories, are most of them convicted of non-violent crimes? Anyone know. Yes. Anyone have any idea?

DR. MARY BASSETT: I don't know the answer to that question, but it's an interesting question.

PUBLIC ADVOCATE JAMES: And we talked a lot about mental illness today. To what extent does violence have -- how much of the violence on Rikers Island is attributed to gang violence, and what are we doing with respect to gang violence. And are those deficiencies on staff related to that issue.

COMMISSIONER PONTE: It's a major issue for us. I mean gang violence now we've got gangs that we never heard of years ago. So the ability to separate and keep these gangs at a level where they're not preying on each other or injuring staff is a very difficult and complicated task, and one that I think we need to greatly improve on. But it's amazing how gangs in general the different -- just on the recent arrests of gangs, they're neighborhood

gangs. So it's getting much more complex than ever, and we definitely need to apply more resources to it, and much better skill of our staff and training.

PUBLIC ADVOCATE JAMES: And more resources meaning more correctional officers?

COMMISSIONER PONTE: That's correct.

PUBLIC ADVOCATE JAMES: So you're advocating for additional, for an increase in correctional officers?

COMMISSIONER PONTE: To the -- we call it a gang unit, an INTEL Unit--

PUBLIC ADVOCATE JAMES: [interposing] Yes.

COMMISSIONER PONTE: --that really manages that population. Yes, I think we need more resources in that unit.

PUBLIC ADVOCATE JAMES: And you support the call of the City Council as well as the Public Advocate for additional correctional officers?

COMMISSIONER PONTE: Specific to that unit I think without any question that unit needs more manpower. Yes.

PUBLIC ADVOCATE JAMES: Thank you.

CHAIRPERSON CROWLEY: I have a few suggestions to share with you comparing our most recent data. We'll call it Fiscal Year 2013 because Fiscal Year 2014 is not complete, although early indications shows that there's an even greater increase in violence since last year. I looked all the way back to the year 2005, and in the year 2005, there were 30 stabbings and slashings. For Fiscal Year 2013, there's been 73 stabbings and slashings. So that's more than doubled. It's like almost 150% increase. And this is also keeping in mind that the daily population back then was 15,000. Today the daily population in 2013 is closer to 11,000 or 11-1/2 thousand. And we look at another indicator or a use of force where injury occurs, there were 72 incidents.

And if we look at last fiscal year, there was 147 so that is more than double as well. What is another interesting performance indicator that I believe is important, and it's something that I started out with my questions earlier today had to do with overtime. And overtime let's not just say we understand the budget is always moving and getting larger because of the cost of living increase and

expenses they continue to go up. But if you look at 2005 when the budget for the Department of Corrections $819,962,000. It wasn't quite a billion yet. It's not near where the budget was in 2013 when you had $1 billion $90 million. Back then in 2005, of the overall percentage, you were -- less than 7% of your overall budget was spent on overtime. It was 6.8%.

You're in line this year to spend double that as it relates to your overall budget. You're in line with your $140 million that you're spending on overtime, that's closer -- it's greater than 13% of your $1 billion $90 million allocated in your financial plan. So it's just a number that I think as you -- as we as a council negotiate with the Mayor over the next two and half weeks for Fiscal Year '15. And it would be wise, I believe, to reduce that number of overtime. And it may be that your staffing needs an increase, but with officers working -- And I saw some high ranking officers, captains, wardens actually working over 80 hours a month. It's just not acceptable. In order to keep violence under control we really need to reduce the number of overtime.

I think that it's something basic that we could work together to do. I want to thank the Administration for being here today. I look forward to hearing the results of the Task Force Study. I want to thank my colleagues, and encourage them to continue to stay on with the administration. If everyone could identify themselves for the record so that we could have it in our written testimony everybody's name accurately. And I would implore the Administration to stick around and listen to -- We have advocates from the public that are going to testify. I believe you'll hear a contradictory story, and as we have heard in other hearings that we've had where people will give you examples of inmates not getting the care, especially the healthcare that they deserve. So once you're ready just identify, and anybody who spoke today, themselves for the record.

DEPUTY COMMISSIONER BERLINER: Erik Berliner, Deputy Commissioner, Department of Corrections

COMMISSIONER PONTE: Joseph Ponte, Commissioner, Department of Corrections.

DR. MARY BASSETT: Mary Bassett, Commissioner, Health Department.

DR. AMANDA PARSONS: Amanda Parsons, Deputy Commissioner, New York City Health Department.

ASSISTANT COMMISSIONER VENTERS: Homer Venters, Assistant Commissioner, Correctional Services, DOHMH.

CHAIRPERSON CROWLEY: Thank you again to our Commissioners and to the staff from the Department of Corrections, the Department of Health. I would like to now call up Norman Seabrook who is the President of the Correction Officers Benevolent Association.

[Pause]

CHAIRPERSON CROWLEY: Okay, Mr. Seabrook, once you're -- once you're ready if you could identify yourself, and your colleagues.

NORMAN SEABROOK: Good afternoon. My name is Norman Seabrook. I'm the President of the New York City Correction Officers Benevolent, the association to my left is Elias Husamudeen, 1st Vice President. To my right is Thomas Farrell, the Legislative Chairman. Madam Chair, first, you know, it's kind of strange how we went through, I don't

know, two and a half hours and testimony. Then everybody leaves, and it's almost like I might as well just give you my testimony and walk, too. But anyway --

CHAIRPERSON CROWLEY: Please don't.

NORMAN SEABROOK: But anyway, the events of the past couple of months has thrust correction officers into the public consciousness. The tragic death of Jerome Murdough; a series of assaults on correction officers; the arrest of correction officers; questions about punitive segregation and mental illness are in the news, as they have been in the past. With the new Mayor comes the New York City -- with the new Mayor comes a new New York City Department of Corrections, Commissioners, et cetera, et cetera. And commissioners are intent on making sweeping changes into the way that we are allowed to our jobs. These proposed changes range from the process that a inmate is due before he or she has infracted to the protection to be afforded, and medical treatment of the alleged 40% that are mentally ill.

How punitive segregation can be used, how violent 18-year-olds are treated, and even whether

24-year-olds are to be treated as if they were in the mid-teens. New York City Correction Officers are sworn peace officers in the State of New York. They have a very tough job and they do a very tough job as well under these circumstances, 24 hours a day seven days a week. What's become very alarming is that correction officers are now faced with dealing with some of the most psychologically challenged individuals in society, the mentally ill detainees. They're also charged with dealing with a growing number of homeless individuals. Has Rikers Island become the dumping ground? Rikers Island is part of a penal system that was established to detain individuals who have been accused of committing crimes.

It appears now that we are in the business of housing inmates that need mental health assistance -- Excuse me. We are in the business of housing the homeless. We are now charged with three different types of individuals that are in our care, custody, and control. Things are going wrong. The City Council, the City of New York, and government in the city are responsible for providing services to the citizens of the city that need services. Rikers

Island is not a mental institution where correction officers can be made responsible for medicating those in our charge. To ensure that they are receiving the proper treatment that they so likely deserve, and that the City of New York has a fiduciary responsibility to provide.

Rikers Island is for individuals who have allegedly committed crimes. Mentally challenged individuals do not commit a crime. The only crime that the people want to accuse them of committing is not receiving their health or medication. We don't have solitary confinement on Rikers Island, a New York City jail. We are just a system and not a prison system. We have punitive segregation, and there's a difference. Terms like the box, the hold, or solitary confinement doesn't apply to Rikers Island New York City jails. Punitive segregation has been an effective tool in controlling criminal violent behavior and enforcing rules and regulations within the jail system. It is a non-violent way of effecting a punitive action on offenders after a due process hearing is conducted.

Punitive segregation is like a jail within a jail. Punitive segregation is the most non-

violent, non-adversarial tool in the Department of Corrections for enforcing rules and regulations. Limited the use of punitive segregation is already having a negative effect on Rikers Island. The increase in violence by inmates who when they break the rules are not punished, they continue to commit infractions. The managers of the New York City Department of Corrections have decided to house gangs separate from each other. Bloods in one house, Crypts in another house; Latin Kings in another house rather than do what is done in state prisons. That is, inmates should be housed according to their classification, and not gang affiliations. There's an 800 back-up of inmates waiting to go to punitive segregation because of crimes and infractions committed by inmates since being incarcerated.

In 2013, there were a total of 3,285 use of force incidents. Of these 3,285 use of force incidents, 73 were inmate-on-inmate slashings and stabbings; 195 were serious injuries from inmate-on-inmate incidents; 147 Class A use of force incidents where inmates and/or correction officers were injured; and 196 incidents with correction officers receiving serious injuries including broken bones,

sutures, fractures, et cetera. There is an increase in violence, but a decrease in the amount of arrests. How is that possible. Correction officers are not opposed to change. We are not opposed to pursuing a multi-faceted approach of handling inmates. We're opposed to being subjected to violence by inmates who become unpunishable or untouchable behind the mentally ill label.

We are opposed to not being able to punish inmates who commit crimes and violate the rules while in jail. Rikers Island continues to deal with inmates who commit crimes against the public. Rikers Island also has to deal with the huge gang population and the continue to stab, slash, and attempt to murder each other within the confines of the jail. While doing all of this, correction officers are very short staffed. We don't have the staffing levels we need to combat the problems. We don't have the equipment we need to combat the problems. Yet, everyone continues to say, What are we going to do about the problem? Well, the answer is simple. The money that's allocated to provide services to the homes, let that money go to the homeless.

And provide housing for the homeless. Let that money go. The money that's allocated to treat mentally ill individuals let that money go to those individuals so that they can be treated in institutions that have the equipment to treat them like Bellevue Hospital, Creedmoor. Like Upstate facilities where they have institutions that have already been set up to deal with the problems we face everyday in the City of New York. Direct the Department of Health to concern themselves with their business, and stop dumping their responsibilities on the New York City correction officers. They continue to neglect individuals that need services in this city and just rubber stamp the paperwork until something goes terribly wrong. They then begin to back peddle, blaming others for their shortcomings.

According to statistics, the Department of Corrections mentally ill inmates make up 37.5% of the population n New York City jails, but are responsible for 61.30% of the use of force and assaults. Why is this? According to the experts, this is a direct response to being placed in punitive segregation. Nothing could be further from the truth. Part of the reason for this spike is that a

small group of inmates have learned how play the system, and the correction officers are no longer in charge of the jails. Inmates know that they just have to request to see a mental health worker to be classified as an inmate with mental health issues, and they can't be housed in punitive segregation. It is a fact that when we have inmates in our system that are mentally ill, the correction officers are conscious of this.

But we're also conscious of the fact that mentally ill inmates are not members and leaders of gangs. Correction officers believe that programs such as Clinical Alternatives to Punitive Segregation, CAPS, and Restricted Housing United, RHU, are progressive, and if provided to the inmates who are truly mentally ill without a doubt it can be successful. But inside the CAPS and RHU programs are inmates who are gang members, and inmates who are guilty of crimes of assault against other inmates, civilians, and correction officers. The reality is inmates who have mental problems should not be housed on Rikers Island. They should be housed in a mental institution and/or Bellevue Hospital or a prison

ward. They should be in custody of mental health professionals, and not correction officers.

A newly appointed correction officer receives a total of 21.5 hours of mental health training while assigned to the Correction Academy. Thereafter, correction officers receive a one-day refresher course. COBA, which is the Correction Officers Benevolent Association isn't opposed to our members receiving additional training and mental health to better handle inmates who are truly mentally ill. New Yorkers are a unique group of people who are made up of individuals from all walks of light -- all walks -- all walks of life. I'm sorry -- who suffer mental illnesses. It's not just the minority community. All walks of life suffer homelessness. It's not just the minority community. Yet, when we look at Rikers Island, you would look at it as a dumping ground for individuals that come out of these same communities where gentrification is taking place.

We have to do a little bit more. We have to work a little bit harder, and we have to give correction officers and correction staff the equipment they need to combat these problems. The

Rikers Island dilemma is that the focus of the Department has shifted from running an efficient organization to numerical results. It's more concerned with a parade of inmate advocacy groups than running a proper detention facility. On Rikers Island, violence among inmates and toward correction officers is considered normal, and the blame is placed on the correction officer charged with patrolling this beat. What did the City or the Department do about the crimes of assault that took place last year? What does the department or the City do for the victims of these crimes.

What the City and the Department do about the crimes committed inside the jails. In March at the City Council Budget Hearing for the Department of Corrections, there was no money in the budget for hiring additional correction officers although the previous commissioner testified that the Department of Corrections was under its staffing level by more than 900 correction officers. There was no money for additional mental health training for correction officers. There was no money to hire additional correction officers to work in the gang intel [sic]unit to deal with the gang activity and gang

violence. We welcome the new Correction Commissioner that has come to the City of New York, Joe Ponte. We are going to work diligently together, give Joe the power.

If you give Joe the power to dismiss all that have been a part of the problem under previous commissioners, and let us do our job. As President of the Correction Officers Benevolent Association, I want to take -- I want to make this an environment where not only can inmates, correction officers, and civilians be safe, but it's important that the public be kept safe as well. If the individuals are not secure in the facilities, and they begin to escape into the City of New York, they will continue to commit more crimes. Correction officers have been the step-kids of law enforcement. A police officer interacts with these individuals for approximately 60 minutes. We then have them for 60 days. We have Dr. Dora Shiro who failed the system. We have Martin Horn who failed the system.

We now have to work diligently to be able to tell the Mayor of the City of New York, No, Rikers Island is not a dumping ground for the mental health inmates. Rikers Island is not a dumping ground for

the homeless. Rikers Island is a penal system established for those individuals who have committed infractions against the law, and have been placed there pending the outcome of their trial and/or until a judge decides he or she can go home. The Rikers Island is simple. We will -- I'm sorry. Will the professionalism of the responsible for the care, custody, and control of 12,000 detainees continue to be questioned, or will the stakeholders in the City's jail system start to act in a more collaborative fashion for the betterment of all?

And let me say -- and I will answer any questions that you have Council Member -- it is really in my opinion as a professional law enforcement officer, and President of the unit for the past 19 years that mental health has no -- in my professional opinion should not be testifying alongside of the Department of Corrections. They wouldn't put Fire next to Sanitation. They wouldn't put Police next to Health and Hospitals. Putting the Department of Corrections side by side with Mental Health defeats the purpose of security and care, custody, and control. I think that the Department of Health continues to negate their situation. They

have allowed inmates to circumvent the system, and I sat here for two hours and I listened to them testify.

I listened to a lot of filibustering. I listened to a lot of yeah, yeah, yeah, no, no, no. There is nothing that's going to be done. And I think that the Department of Corrections needs to be able to testify alongside a law enforcement agency as opposed to being lumped in with the Department of Health who does not have our best interests at heart. And continues to circumvent the efforts of the job that they are responsible to do. Like I don't want to call them Verizon, Corizon or whatever, but the health group that the City of New York hired for tens of millions of taxpayers' money, and supposed to be helping these people, and it's not helping them at all. So I will answer any questions that you or your colleagues may have.

CHAIRPERSON CROWLEY: Thank you Mr. Seabrook. Thank you for being here today. Thank you for your testimony, and for being here for, it was actually three hours.

NORMAN SEABROOK: Yeah.

CHAIRPERSON CROWLEY: Three hours of testimony from the Administration. I understand how you see that as a misfit of the two different departments testifying together. However, in the past we've had one without the other, and they'd point the finger, Oh, that's not under our responsibility. It's under DOH's, and so that's why I felt it was important the constraints we're up against here as a Council. Now, you must have had the opportunity to meet with the new Commissioner. Have you a little sit-down, you know.

NORMAN SEABROOK: Several times.

CHAIRPERSON CROWLEY: Okay. Do you think or have you heard any plan that is in place to change or stop this tide from turning in the wrong direction back into something to bring down the levels of violence to make the jail safer? Is there anything that you think that he's focused on right now that you heard today or that you've had in your conversation?

NORMAN SEABROOK: Well, I think that the commissioner has indicated that he wants to make this a safe environment, and environment for not only correction officers, but inmates and non-uniform

members alike to be safe, secure. And I think based and his and my private conversations, this will become an environment that next year at this time we can look back on it and say he's changed the system. As opposed to the previous commissioners that have been here that have, I guess destroyed this agency. And I will use that word.

CHAIRPERSON CROWLEY: Well, that's good. So you have faith in the new commissioner in that he's determined to turn the department around? I also have faith in him, but he's asking the Mayor the resources. You mentioned in your own testimony he's come -- he's only two months, but we're only two weeks away from passing the budget. And our budget has to balance, and we have to allocate the resources to various different agency so that those agencies can run efficiently. And he did not ask for any more resources in the budget than he did last year. In fact, he asked for less, and we're currently in line to spend.

NORMAN SEABROOK: Well, I think that, and I certainly can't speak for Joe Ponte, but I think that in the position that the Council sits in, and I think that in the position that Union sits in, we

should be asking the Mayor to give us more resources. Because certainly an individual that works for the Mayor is not going to ask the Mayor for anything. Because we saw what happened when a certain commissioner asked the Mayor for more officers, and he was sort of like -- You don't hear him asking any more for more officers because he works for the Mayor. So, in other words, don't go out there an embarrass me.

CHAIRPERSON CROWLEY: [interposing] Right.

NORMAN SEABROOK: So hopefully the Council and the Public Advocate that was here would be the first to stand up with the union and say, Give us the finances and the funds that we need so that we can better be able to combat the problems that we face everyday.

CHAIRPERSON CROWLEY: What's an acceptable level of overtime?

NORMAN SEABROOK: Well, it depends on who you ask. I mean, what's the overtime for?

CHAIRPERSON CROWLEY: I mean you wouldn't have the overtime if the staff positions they already knew that they had to staff. It's almost planned.

NORMAN SEABROOK: Well, that's the mismanagement of the last administration that was here. And you and I both know that we've talked about this over and over until we're blue in the face. And I think that what has to happen is that the mismanagement has to strop. And Joe Ponte has to dismiss those that were part of the mismanagement practices that took place more than two months ago. So an acceptable amount of overtime? I guess it would depend on what are staffing the overtime for? I'm certainly not going to sit here as a union president and become management, and say, Don't give them no overtime. Hell, I think we should all make a ton of money. You, too. You get overtime?

CHAIRPERSON CROWLEY: [interposing] Yeah, but aren't your members tired?

NORMAN SEABROOK: It's not -- it's not a point of being --

CHAIRPERSON CROWLEY: Don't they have families?

NORMAN SEABROOK: No, it's not. It's not.

CHAIRPERSON CROWLEY: Are they more likely to get sick or get hurt on the job?

NORMAN SEABROOK: No, listen, Council Member, I think it's mismanagement. If you -- if you -- I heard a question that was asked earlier in which an inmate assaulted a -- I think it was a clinical staff member, and when asked, the inmate said something to the point of he or she didn't get what they were supposed to have. If the Department of Corrections would staff each and every facility with steady officers, steady tours, and put stability in a person's life, they wouldn't have these problems. But when you have inconsistency everyday -- Today you have Correctional Officer Farrell. Tomorrow you have Correctional Officer Seabrook. The next day you have Correctional Officer Husamudeen. You have three different directions that this inmate is receiving because we're all different. If you have Correction Officer Farrell everyday four, five days in a row, and the Correction Officer Seabrook and Correction Officer Husamudeen everyday, that's consistently the person knows their program. They know what it is they're supposed to have. So if the Department of Corrections would just concentrate on the basics of staring back at basics and giving individuals stability in their lives, they wouldn't have as much

overtime. But I'm certainly not going to sit here and tell you what the overtime numbers should because like I said, I think we should make a ton of money because we don't make enough money as uniform members of the City of New York as we are right now.

CHAIRPERSON CROWLEY: Well, before I pass it along to my colleagues to ask questions --

NORMAN SEABROOK: You didn't say that you support us on that.

CHAIRPERSON CROWLEY: No, I don't.

NORMAN SEABROOK: Okay, okay.

CHAIRPERSON CROWLEY: I think we're all human, and we all need time to rest --

NORMAN SEABROOK: [interposing] Okay.

CHAIRPERSON CROWLEY: -- even as council members.

NORMAN SEABROOK: Okay, so we're talking about overtime. We're not talking about --

CHAIRPERSON CROWLEY: [interposing] Yeah, I don't have a job with you.

NORMAN SEABROOK: [interposing] You're right.

CHAIRPERSON CROWLEY: I'm not enforcing the peace and --

NORMAN SEABROOK: [interposing] You're right

CHAIRPERSON CROWLEY: --and go on an island to everyday.

NORMAN SEABROOK: [interposing] And everybody that testified today don't have the same job that we have, and everybody that asked questions today, don't have the same job that we have. And they never had urine and feces thrown in their mouth. And they've never been punched in the eye, and had their eye socket broken. And they've never had their nose broken. And they've never had their finger bitten off. And they've never had their arms broken. And they've never been doused with blood mixed in, and you don't know whether this inmate is HIV positive or not. So, until you've walked into the shoes of a correctional officer, nobody should pass judgment on us.

CHAIRPERSON CROWLEY: And I have a tremendous amount of respect for the work that your members do.

NORMAN SEABROOK: Thank you.

CHAIRPERSON CROWLEY: That you do and your two colleagues that are here today. I bet you

wouldn't do the job if you didn't need to, right? If everybody was good and didn't commit crimes, there would be no need for jail and the world would be a better place. But your job would be easier. You members' job would be easier if there were people that shouldn't be inside Rikers weren't. So those with severe mental health diagnoses, or a certain population that are in there that you spoke about in your testimony, and that you --

NORMAN SEABROOK: [interposing] That's correct.

CHAIRPERSON CROWLEY: And just tell us how frustrating it is that there's a line or a long list of -- waiting list for people to get into RHU or CAPS. We have 650 people who have infracted. Sometimes the re-infract. Is it frustrating for you as a correction officers to your members?

NORMAN SEABROOK: [interposing] It's very frustrating.

CHAIRPERSON CROWLEY: You know, is that the contributing to the violence? What's the plan? How do you handle this?

NORMAN SEABROOK: It's very frustrating that's first of all, and I think more paramount to

that is, is that the individuals that are waiting to go in have committed serious -- some serious infractions of violating the rules and regulations inside the confines of the jail. It's equivalent to violating the rules and regulations in the law in the five boroughs of the City of New York. You break the law, here's a penalty that goes along with it. You run a red light, you pay a ticket. You punch an officer in the eye, you go to punitive segregation. It's not solitary confinement. Solitary confinement you have no windows. There's a leaky ceiling. There's bulb that doesn't work and there's a mouse that eats your food. Punitive segregation is totally different. Punitive segregation you get your visits, you go to the law library.

You get everything that you're supposed to have, one hour of recreation. The only thing that you are not allowed to do in punitive segregation is that is run the corridors any more, and commit a crime against other inmates any more. You're not allowed to slash other inmates any more. You're not allowed to extort other inmates anymore. That's the only difference between punitive segregation, and the person being out in the general public in population.

As a matter of fact, I would think that inmates in the City's jail system if you ask them, they would say they're safer because the guy that's extorting them or slashing them or raping them or beating them is in punitive segregation. Because at the end of the day this is not a punishment. Punitive segregation is not for punishment.

Punitive segregation is to prevent further crimes being committed against inmates and corrections officers. If that be the case, what are we supposed to do with them? People are going to tell you well there shouldn't be punitive segregation. And I say, What the hell do we do with them? Just allow them to continue to prey on those that they have preyed upon, and destroy the lives and the fabric of those children that come to the Department of Corrections that their parents want to see them go home the same way that they came. Not everybody in the city's jail system is guilty of a crime. There are some people in jail that have not even committed that crime. But at the end of the day, our job of care, custody, and control is to treat everybody equally and fairly. And protecting them, and keeping them safe is part of what we do by

placing an individual that has committed an infraction in violation of the rules and regulations in punitive segregation.

CHAIRPERSON CROWLEY: Thank you. Council Member Johnson.

COUNCIL MEMBER JOHNSON: Thank you Mr. Seabrook.

NORMAN SEABROOK: Uh-huh.

COUNCIL MEMBER JOHNSON: I too--

NORMAN SEABROOK: I'm sorry.

COUNCIL MEMBER JOHNSON: No, it's okay. I, too, respect the work that you all do on a daily basis, which I know is dangerous, and I know you take with a very high level of seriousness. I want to understand currently what is the staffing level in number of correction officers?

NORMAN SEABROOK: I would think that the staffing level in some facilities would probably be three to one.

COUNCIL MEMBER JOHNSON: Three to one?

NORMAN SEABROOK: Yes, sir.

COUNCIL MEMBER JOHNSON: But what is that raw number? How many corrections officers are there? How many union members do you have that are active?

NORMAN SEABROOK: We have 8,900? 8,700?

MALE SPEAKER: [off mic]

NORMAN SEABROOK: The average number is 8,000.

COUNCIL MEMBER JOHNSON: Okay, and to do the job in a safer way without huge amounts of overtime to get a force that you feel like can be doing the control and custody work at Rikers and other facilities, what type of increase do you think you would need from the City of New York for new officers?

NORMAN SEABROOK: I think I would need a 20% increase.

COUNCIL MEMBER JOHNSON? 20% so that's about -- that could be like 1,500?

NORMAN SEABROOK: Yes.

COUNCIL MEMBER JOHNSON: That's a lot.

NORMAN SEABROOK: That's not a lot considering the job that we have to do. If we're spending twice as much money on overtime as we did last year, and we had more members, then certainly the math would work out that if we got an additional 1,500 officers. Starting them off with a starting salary less than what you're paying a person with top

salary with overtime I think it works out very well for the City of New York. But unfortunately, we don't have those that really advocate for Correction, because Correction is out of sight, out of mind. And as long as it's not in my neighborhood it's okay. As long as crimes are not being committed in front of me, it's okay. But if you give all of those individuals to the correction officers that patrol the toughest precincts in New York, the city jails 24 hours a day, then there's a problem when mental health is the issue.

But when mental health wasn't the issue, there was no problem with Corrections. They did whatever they wanted to do us. They disrespected us. They did whatever it is that they wanted to do. And I've got to be honest with you Council didn't really step up to say, Hey, what about correction officers? Oh, it's great we have these hearings, but at the end of the day nothing happens. There's not going to be anybody that writes any letters on the Council that say, Hey, Mayor, by the way, Correction needs more money. We aren't going to get no letters for that. You're not going to get anybody to advocate for correction officers. You'll get them to advocate for

police officers, for fire fighters, for Sanitation, for teachers, but you're not going to get anybody to advocate for criminals.

COUNCIL MEMBER JOHNSON: You're talking about the public.

NORMAN SEABROOK: Yeah.

COUNCIL MEMBER JOHNSON: Yeah, I think you're right. It is an out of sight, out of mind issue --

NORMAN SEABROOK: [interposing] Absolutely.

COUNCIL MEMBER JOHNSON: --very much. There have been talks last week. And members of the Council, the Chair of the Public Safety Committee, Council Member Gibson from the Bronx held a press conference that I attended talking about civilianization. And getting police officers that are currently doing desk jobs, roll call. And are being paid a good wage to actually get them back into the force doing the type of work that they were trained to do, and that only they can do. There has been conversations around civilianization [sp?] with correction officers as well. That there are currently correction officers that are doing what

could be civilian jobs currently in the department. Would you support civilianization to actually get some of your correction officers back doing this type of work and handing some of those jobs that could be done by civilians back over to civilians?

NORMAN SEABROOK: Well, we support that now because we have a piece of legislation that's called Anti-Privatization where you cannot use a civilian to do the job a correction officer. And I certainly would not interfere with a person that is supposed to get a job and my members are interfering with their livelihood. Everybody deserves a job, but every job is not for everybody. So to answer your question, I have no problems with individuals that are working out of title, and they are correction officers. Let them be correction officers. Because I'm not going t interfere with someone that also needs to be working at the same time.

COUNCIL MEMBER JOHNSON: You spoke in your testimony about the clinical alternatives to punitive segregation, the CAPS Program. Currently there are three at Rikers. They were only able to handle a very small number of the inmates that are currently there. Both Commissioners testified that they think

that CAPS is a success, that they think that handling these patients who have been diagnosed with mental illness to get more holistic treatment to be programmed in some way is actually helping. Would you assess that CAPS has been a good helpful program for the inmates that are in your custody and care?

NORMAN SEABROOK: I think it -- Listen, I think it has been helpful, and I think that it could be even more helpful if we had the staffing levels to do it. We don't have the staffing levels to do it. I think that it goes back to what I originally said about mismanagement. We could have the correction officers to do it, but then Mental Health is holding us up on certain parts of it. And I guess key questions to the entire program is, Okay, Mental Health, do you have enough staff that when the Department says they're going to up four or five more CAPS programs, can you provide the service for it. They're going to tell you they can't do it. So it's easy for them to come here and sit here, and make believe that it's all good. But at the end of the day it's not. It's an environment where you're supposed to make tours, you're supposed to do certain things. They don't do what they're supposed to do

all the time, and I have no problem saying it. Correction officers are not going to take the responsibility for bring a mental health clinical doctor, psychologist --

COUNCIL MEMBER JOHNSON: [interposing] Nor should they.

NORMAN SEABROOK: Exactly right. So they have to be held accountable to do what it is that they are charged to do, and they don't do that. Now, if they did their job, we would better be able to do our job. But our job is so bureaucratically bottlenecked that when we ask for certain things, we can't get information. A correction officer needs to know that this person here is dangerous. You don't just give this inmate to a correction officers, and you don't tell him, or you don't diagnose him as being schizophrenic. You need to tell us, Listen, this guy is dangerous. Be very careful. He could possibly go off any minute. That tells us we need to prepare in a different environment from this person. You don't put this person in an environment where you release them to the general population. I'm not saying put them in punitive segregation. I'm not

saying any of that. I'm saying put them in an environment where you know they can be controlled.

COUNCIL MEMBER JOHNSON: So I was not on the Council for the previous 12 years under the previous administration --

NORMAN SEABROOK: [interposing] You got lucky.

COUNCIL MEMBER JOHNSON: --with the previous commissioners that you had so sweetly mentioned in your remarks. But I -- maybe I'm just an eternal optimist, but I would hope that with a new administration, a new commissioner, a new Council, and us having this hearing today, I think hopefully shows you that the Council does take this seriously. And that many of the questions that were raised today that have been asked that you have raised and that other folks have raised are hopefully going to start a serious substantive conversation. Not just on these short-term fixes, which I know are important for your members, for the inmates. The short-term stuff matters, but to have a broader conversation about what are some of the large scale things that we can be doing to actually help change what is going on

at Rikers and our other detention correctional facilities in the city?

And this task force that is set up, I am always slightly wary whenever someone puts a task force together or a blue ribbon commission to look at something. Because a lot of times reports are written, and not much change comes out of it. It's my hope that with a Council that has real oversight authority, and with the Public Advocate that's engaged that hopefully with our Commissioner that really does want to do the right thing and change things in the system that we all can work together on these issues. I know that I take it seriously. I know the colleagues here today really care about this issue. So I would just say that today I think is a starting point, and I know that we need resources to actually move this. You can't talk about these things in a pie-in-the-sky Pollyannaish way without confronting the realities that are going to happen day in and day out in these facilities.

So I would just say that we have to do this together, and that's why I mentioned to the Commissioners that whatever recommendations come out of this task force, everyone needs to be involved,

whether it be the correction officers, the mental health professionals, the healthcare workers, even the inmates to understand what's going on. To have real broad scale change in a way that's meaningful, I think everyone needs to come together and do that. I know I'm committed to that. I know you're committed to that for the safety of your members, and for the future of the Correctional system. And I would say that let's work together. Let's work on this together. It's not the sexiest issue. It's not the issue as you said the public is calling us about, but it's an issue that really matters I think morally. But also there is a cost to our city both financially, and in letting people back out onto to streets that have been -- that have not been rehabilitated in any way. And they are committing crimes, and put right back into the system.

NORMAN SEABROOK: And Council Member, you are a thousand percent correct about what you've said. And that's why this year I sent my vice president, my first vice present, and my second vice president and a couple others over to the West Coast to look at the city -- the jail systems over there. And, they came back and the reports are that they

have a building. It's a jail, but it's strictly for individuals with mental illnesses. They know how to work with them. The officers know how to work with them. The staff knows how to work with them, and they're in their own type of environment that they get the help that they need. If we're spending tens of millions of dollars, and we're not getting any results for it, there's something seriously wrong here.

And if the money that is allocated in the budget that is for housing is not going to housing it's going to :arks and Recreation. Or the money that is supposed to be going to mental illnesses or mental health issues are not going to mental health issues. They're going some place else, there's something wrong. We need to take the monies that's allocated, and use it for the people that it's allocated for to give these people the help that they need. Or we are going to have a major problem in the Department of Corrections before the end of the year. Yes, sir.

CO-CHAIRPERSON COHEN: Thank you, Mr. Seabrook. I appreciate your testimony, and I appreciate your patients. I know it took a long time

to get you up there. And also I was the Law Secretary in the Bronx Supreme Court, and we would do criminal arraignments periodically. And I did have interactions with your members, and I do have a small sense of the great difficulty and challenges in that work. Could you just expand a little bit because I'm not clear on your testimony regarding the interaction between the Department of Mental Health and the Department of Corrections, and dumping their responsibilities. Do you think --- is it something happening in the system, or is it -- are you referring to sort of the bigger picture that people are not getting the resources they need?

NORMAN SEABROOK: It's something that's happening in the system, and what do I mean by that? If an inmate barricades himself with five other inmates in the housing area, and starts a mini riot, the inmate is then -- after the security is breached, and we go in and we take the inmate out, the inmate then goes down to the clinic and is then seen. The inmate then goes, and has to be seen by a mental health physician. The mental health physician says, We charge [sic] him. Why? It's mental health. Okay, we can't put him in punitive segregation.

Okay, so what do we do with this person? That's what I mean. Now, before he came to Rikers Island, there was no indication that he had any mental problems. All of a sudden because they're in the system for a month they have psychological problems. But when they came to us they didn't have any psychological problems.

So they're hiding behind the fact that they are mentally ill, and the mental health staff is allowing them to hide behind it because it makes their job that much easier. As opposed to signing off on it say, You know what, this person jeopardized the safety and security of the institution. The safety and security of the other inmates in the housing area. The safety and security of the staff, and should be moved and/or placed in punitive segregation. They won't do that. So the problem becomes our problem again. So now we put him right back in the housing area that he came from. So he goes back in the housing area that he came from, and he says, Look at me. Nothing can happen to me because I'm mentally ill because I'm dribbling on myself. Now, there are legitimate individuals in the

Department of Corrections that have mental illness problems, and they need help.

Not the guy who's making believe that he has mental illness problems and he's the head of the Bloods. Not the guy who's making believe he has mental illness problems, and he's the head of the Latin Kings. We have people that legitimately need help, and these individuals that have gone to school for many, many years to determine a person's capability or thinking, is going along with the program. And to me, that's just ludicrous. So I think that what needs to happen is that we have to hold those accountable for the areas in which they are responsible. Just like I'm held accountable as a correction officer. You're held accountable. Council members are held accountable, she's the Chair. Everybody has to be held accountable. We can't allow this to continue because it's only getting worse, and it's going to get someone killed, if you will.

CO-CHAIRPERSON COHEN: I mean I guess it's part of the problem also, I mean what we talked about earlier the backlog that there is no -- if someone -- it is hard I guess to ultimately determine

briefly whether a person is really -- it's mental health issue or a it's a pretext. But I guess because there's no capacity to deal with that problem, and then they're ending up back in general population. I mean in order -- The goal I think everybody is interested in keeping -- in reducing violence across the system. Obviously, it would confront your officers as well as anybody else in connection with the system.

NORMAN SEABROOK: Well, Mr. Cohen, I think that part of that comes with communication. If they were communicating with correction officers more, there would probably be a better understanding of how to deal with an individual because the officer is with that inmate for 8 hours and 31 minutes a day. The clinical staff that comes through, comes through on a skate board. In and out and they're gone. But for 8 hours and 31 minutes this correction officer sees, deals, interacts with this person, and I'm going to be able to tell you whether or not this person has got a problem or not. There is no way that you could sit in front of a person for 8 hours and 31 minutes and not tell me that this person has a person. There's no way. So I think that what has to

happen is there has to be more communication between the clinical staff and the correction officer, and give the correction officer a little bit more I guess information about the person, and then we will be able to combat a problem before it gets worse.

COUNCIL MEMBER COHEN: I'm going to apologize for my ignorance, but do you have -- do your officers have an opportunity to get input back like this guy doesn't exhibit any symptoms at all except when confronted? I mean do you have an opportunity to go on the record and tell that side of it?

NORMAN SEABROOK: I don't have that opportunity. We don't have that opportunity. We don't have the opportunity to sit down and say, You know, Doc, you were here for five minutes. And after you left, for the next 8 hours and 25 minutes, this person was interacting like nothing was wrong with them. But as soon as you walked in, they went in the corner and started dribbling on themselves. So at the end of the day, something has got to give. Something has got to change.

COUNCIL MEMBER COHEN: Thank you.

CHAIRPERSON CROWLEY: Council Member Vallone.

COUNCIL MEMBER VALLONE: Again, thank you Mr. President, and I appreciate you staying for this entire testimony. You know, I think we should have a day in the life of a correction officer, an hour in the life of a correction officer, and see how things change. Because you can hear how sometimes it's so easy to put the blame on what the people think is the Corrections responsibility. As you heard in my questions to the Department of Health, it's not the case. And that's -- when we put these groups together and we talk about changes, I think what you said there at the end is one of the most telling points that no one is communicating with us. So I think is one of the first things we have to address, and it has to be more than one hour a month at a Board of Corrections meeting, and it has to more than having to come to testify here. I think that the real communication with the officers has to take place. Because like you said, it's not me or Council Member Crawley or King that's there in the jail with them. So how do you think that's -- What change would you envision through legislation, through

policy to get the officers to have that communication with that we need?

NORMAN SEABROOK: I think that it's probably going to have to happen through some type of legislation because of what individuals will hide behind called the HIPAA Law where you can't divulge a person's medical records and/or illnesses. But I think that being incarcerated should supersede that because what you're doing is preventing perhaps a more serious crime being committed in the confines of a jail. So I would think that it would have to probably be legislation wise. But to make it easier, I think just having I guess weekly meetings with management, and the officers assigned to that area in CAPS, if you will. Saying, you know what, these are all the officers assigned to CAPS. Today, we're all going to be here at 4 o'clock to have a discussion about each one of the individuals that are in our care, custody and control. Have the doctor there. Have the officer there. Have the supervisor there. Have the warden there. Have the deputy warden. Have everybody that plays a role in this in that room, and then you'll get a better sense of what's wrong with this person, if anything is wrong with this person.

COUNCIL MEMBER VALLONE: I mean the Commissioner testified that she thought, or the doctor thought that the officers don't need this information, that they don't want the health information. They just want to be safe, and I don't think that's a true statement.

NORMAN SEABROOK: I don't think it is either. I definitely don't think it's a true statement, but I don't want to be disrespectful to the doctor who spent many years in school to get that degree. But at the end of the day, we're talking about safety and security and law enforcement. And we're talking about justifying their job, if you will.

COUNCIL MEMBER VALLONE: Well, whether or not they're allowed or not is one thing. Whether you need the information is different.

NORMAN SEABROOK: [interposing] This is true.

COUNCIL MEMBER VALLONE: And that's what we're saying about statutory changes, and I think Council Member -- Chair Crowley is right that if -- if they're not allowed, then we have to look at why not. And I think the HIPAA law that you mentioned,

and not many people are familiar with that, the boundary or defense that people can throw up and say, Sorry, you can't get that. But I do believe that if someone has committed a crime within Rikers Island or other watch, and has knowingly violated that trust, then I think there is -- there should be a way for those officers to -- for the safety for everyone at the island to know what's going on without revealing whether someone has a disability. It's more to the point that basic information could be -- would be given to the officers. And I think that's important. There is one other thing you put here in your testimony, which made the little hair I have left stand up. The correction officers are no longer in charge of the jails.

NORMAN SEABROOK: That is true.

COUNCIL MEMBER VALLONE: Can you expand on that?

NORMAN SEABROOK: Well, it goes back to what I was talking to Mr. Cohen about where inmates barricade a housing area. They do whatever it is that they want. They destroy property; they slash, cut stab each other; assault correction officers. They're taken out of the housing area. Goes down to

Mental Health. Mental Health says, Send them back to the housing area. You can't move them. You can't do anything. So at the end of the day, hell, we might as well just give them the keys, and, you know what, let them do whatever it is that they want to do because there is no more security of these jails. What's happening is we've become babysitters, if you will. I'm not talking about punishing people because, Council Member Vallone, I don't think a kid that's 16 years old that gets caught smoking a cigarette should go to punitive segregation. I don't think that a kid that's horse playing should go to punitive segregation. But at the end of the day, I think that people that commit violent acts' jeopardizes the safety and security of the jail, and barricades a housing area in an attempt to escape, if you will needs to be placed in punitive segregation. And that being said --

COUNCIL MEMBER VALLONE: [interposing] And do you think helps the rest of the staff? [sic]

NORMAN SEABROOK: That being said, the correction officer has no more authority because he or she is told by the supervisor, Before we move this inmate to OBCC or any other facility that person has

to be cleared by the Mental Health staff. We take that person to be cleared by the Mental Health staff, and Mental Health says, You can't move him. Why can't you move him? Well, we can't tell you. Okay, so you can't tell me why I can't move him. So you're telling me to put him back in the same area that I just took him out of. So at the end of the day, there's a serious problem here. A perfect example is there was an incident that occurred last month in AMKC. The inmates, 12 of them or so, barricaded the housing area. The emergency unit had to respond. It was a whole big thing. The inmates were then transported to another facility to be placed in segregation. They were then ordered back to AMKC because the mental health doctor had not cleared there. I was standing in the corridor at 1 o'clock in the morning when these inmates came back. They weren't acting unruly. They were like church mouse. So shouldn't these guys be put in punitive segregation?

COUNCIL MEMBER VALLONE: Is there a statistic follow the amount of inmate on officer --

NORMAN SEABROOK: [interposing] Yes.

COUNCIL MEMBER VALLONE: --crime? And has that been followed up with actual explanations and incidents just like you've done today?

CHAIRPERSON CROWLEY: I'm sorry to interrupt. Council Member Vallone, we mentioned that earlier. It's out of control. What Norman is saying is it's out of control. I said it in my earlier opening statement. The violence be it staff, inmate on staff or inmate on inmate, it is doubling and nearly tripling what it was years ago when there were more inmates. And I'm sorry. I appreciate you coming in today. Norman, I'm sorry you had to wait--

NORMAN SEABROOK: [interposing] Thank you.

CHAIRPERSON CROWLEY: --as long as you did to testify. I'm sorry to interrupt your questioning. I've got a list of about 15 people.

NORMAN SEABROOK: I'm not leaving yet. [laughs] I want to stay for three hours more, and thank you gentlemen.

CHAIRPERSON CROWLEY: I won't probably be as long as that, but I have to --

NORMAN SEABROOK: [interposing] Okay, thank you Madam Chair.

CHAIRPERSON CROWLEY: --see exactly who is still here to testify to figure out how much to allot them in terms of time. But you do represent nearly 10,000 staff members that work on Rikers Island. So thank them for the work that they do on behalf of the city.

NORMAN SEABROOK: Well, listen, and I thank you, Council Member Crowley and Vallone and Mr. Cohen and the other members that were here for the work that you do. But I would just like to add that I hope that you would consider separating Correction from Mental Health. If you want to join us up with someone, join us up with that Police Department. Join us up with the Fire Department, join us up with those agencies that maintain safety and security for the City of New York as opposed to someone that's trying to circumvent what we do every single day. All right. Thank you.

CHAIRPERSON CROWLEY: Thank you, Norman Seabrook and to COBA. Now just by a show of hands if these people are still in the room James Gilligan, are you still here? No. A Dr. Kirk Anthony James. We're not ready for him yet. Just checking. Sarah Kerr? Michelle Bellaine [sp?], Joanna Miller, Mary

Beth Anderson, Dahlia Albertson, Beth Powers, Dr. Henry Weinstein. Someone from the Jail Actions Coalition. Anybody from the--? Oh, okay. Someone named Nick Malainowski [sp?]. Thank you. I'm going to call up first the Doctors Council SEIU. I have Dr. Frank Pasca - Proscia and Maya Escalona

[Pause]

CHAIRPERSON CROWLEY: And unfortunately because we do have so many people testifying, if you don't lead off from your testimony, it would be better. I mean we can refer to it, but we're going to limit your testimony to five minutes, and we're going to limit the questioning.

DR. FRANK PROSCIA: Could I just say I have a little laryngitis and I have not been able to read this repeatedly out loud. So I need to read from the testimony. I apologize. My name is Dr. Frank Proscia, the President of Doctors Council SEIU. Good afternoon, Chairs and the City Council Members. I'm Dr. Frank Proscia, as I just said. We're a union of doctors, and a voice for patients. Thank you for the opportunity to speak today. We represent doctors throughout the country including those that work in HHC hospitals, facilities, DOHMH and Rikers Island

and other city agencies. Today's oversight hearing comes at a volatile for time for healthcare workers and other professionals who have been faced with a marked increase in violent assaults while providing care at Rikers Island.

Rikers saw eight assaults on healthcare staff in 2011; 22 in 2012; 32 in 2013 according to DOHMH. It is worth noting that the uptick in violence has coincided with an increasing number of mentally ill offenders in our jails. Thirty-seven percent of inmates, as was said, on Rikers in any given day had a mental health diagnosis according to the IBOs you reported. We support Intro 292, which aims to track and assess punitive segregation -- in segregation especially with respect to those inmates with mental health issues. These statistics may help the various agencies involved make informed decisions on how to better address certain volatile behavior in the prison setting, and enhance safety for everyone at Rikers, and actually throughout the City.

Through working with the Board of Corrections, and through our contact with Corizon, the Doctors Council has advocated for immediate changes that can improve the work environment for all

staff. Steps are being taken in the right direction, but recent incidents show that this continues to be a serious issue. First, we are calling for more training of staff across all agencies. This is key. The DOHMH is training their staff. The DOC is training their staff. Corizon is training their staff. That's not the way it's done in hospitals. It's cross-training police, techs, nurses, the LPNs, doctors. We respond as a team. Each one knows we're part of the healthcare team, and that's key. And we call on Corizon and the City agencies to make trainings and safety protocols more of a priority.

Sufficient staffing of doctors and COs is also a critical issue, as you mentioned. Excuse me. The inmate wait times in medical clinics are excessive causing over-crowding and agitation, and putting inmates, correction officers, and healthcare professionals at risk. In 2013, almost half of 65,000 inmates scheduled for important follow-ups and care were not seen, and had to be cancelled, more than half. And that just creates, it just promotes-- The next day when they have to return to the clinics it's even more people waiting longer periods of time, and especially if a lot of them are mentally ill it

causes agitation. With respect to CO [sic]staffing more individuals are clearly needed to provide a safer environment in all the clinics.

In some clinics inmates can walk around unescorted, and in other clinics there are no COs at all. Another critical area is the physical setup of the health clinics. Clear sightlines so that the correction officers can see doctors is important. We would like more input into how clinics are physically set up, and maximize the security. We are pleased to see that panic buttons have been added in several clinics recently, something we have long been advocating for. But now all of a sudden they find the funding in order to provide that. But that is jus the first step. While doctors are called on for on-person panic buttons, cuff bars in all clinics and emergency egress for medical staff in treatment areas.

Any mental health practitioner knows that when you're dealing with the mentally ill, if a patient is walking in from that side of the room, you want your back to the door. There has to be another way out of that room. You just can't have way in and one way out. Working with the Board of Corrections

and the DOHMH Doctors Councils has helped convene and take part into two interagency working group meetings in recent months at Rikers. And we will continue to take a leadership role in this, and to collaborate with other various parties including the Council to improve the safety standards and quality care at Rikers Island. We would also like to thank the Mayoral Administration and various City agencies for reaching out to us recently in phone calls to address this work safety issues at Rikers.

This we would not have believed to have occurred in any other previous administration. It is this type of inclusive dialogue that will help effect change on this difficult issue. We welcome the Administration news on the formation of the task force on Behavioral Health and Criminal Justice system [bell]. Our doctors understand, though, that many of the challenges involved will need collaborative change [sic]. We just can't have agency heads as part of the task force. They're going to have to reach out to community groups, to inmate groups, and to staff groups to bounce back any type of dialogue or opinions. Thank you very much.

CHAIRPERSON CROWLEY: You're a colleague from the Doctors Council?

MAYA ESCALONA: I'm a member of NYSNA actually, New York State Nurses Association. My name is Maya Escalona [sp?]. I'm a psychiatric nurse practitioner working at Rikers Island. Thank you for allowing me the opportunity to speak to day. For going on three years, I've worked mostly full-time in the Mental Observation Units. These are the areas where mentally ill inmates with higher treatment needs are housed. I enjoy working with these patients, although there are challenges at times, of course. But it's an opportunity to help people in the community who are in great need. Many of them have serious chronic mental illness, and the jail is one of the few places where they have access to treatment. But some of these inmates can be violent, as we all know. In the last year assaults against civilian medical staff have spiked.

Most of these attacks have occurred in the Mental Observation or MO Units as they're called. One intern was punched in the face unprovoked, and she sustained multiple fractures, a broke jaw, nose and eye orbit. Another intern was sexually

assaulted, and assaults against officers has also risen. Sadly, I've seen few changes to improve the safety of these areas despite worsening violence. As a result, I refuse to visit MO patients in their housing areas. Many of my colleagues who continue to work in the MOs are in constant fear and anxiety. Being escorted by an officer onto these units does not necessarily guarantee safety, as some of the most recent attacks have shown. These clinicians were attacked unprovoked and they had an officer next to them. I recommend that until conditions improve, clinical staff should not visit patients in their housing areas.

This is a high risk interaction for caregivers, officers, and patients. Instead, the patients should be brought to the staff in secure clinic offices. I understand that City wants to increase programming and treatment to the patients in the MO areas. And as a mental health professional, I certainly understand the value of this. But this would require an increased clinical presence in the housing areas. If conditions continue as they are, then more staff would be placed at risk. If Rikers or part of Rikers is to operate like a psychiatric

facility, then reforms need to be made so that we can treat patients safely and effectively. I chose to reduce my hours, work part times and with patients in the general population rather than in mental observation to avoid becoming another statistic. We understand, I understand we work in a potentially dangerous place, but we don't have to be in danger.

I urge the agencies on Rikers to work collaboratively, and to develop solutions to this very serious problem. We need safe levels of staffing at all times, of all staff, and that includes both healthcare workers and officers. We need better protocols for healthcare is delivered on the Island. The City Council Resolution being considered today will create more transparency, which is an essential first step. But we need to go further to address -- excuse me. To address these issues at their roots to create a safe environment for workers and inmates at Rikers. Our union is an ongoing construction dialogue with the Mayor's office, and with City officials regarding the assault on caregivers a Rikers. And we appreciate both the City Council's and the Mayor's commitment to addressing this situation. We look forward to

working with all parties to find a long-term solution. Thank you.

CHAIRPERSON CROWLEY: Thank you. I want to thank both of you for coming in and representing the staff. I know that my office has been in touch with SEIU and Jeff from my staff has been out to the meetings and has been giving me an update. And unfortunately it seems like the Department of Health is painting a rosier picture than it actually is. In a previous hearing, I asked the Commissioner if he was going to change the policy of escorting inmates into all Mental Health Observations rooms with maybe more officers or an additional officer, and there was no internal plan to change that process, which frustrates me. I want to make sure that you're safe, and I think that has everything to do with what I was bringing up earlier. I don't know if you agree, but there must be a need for more officers. If you are going into a housing unit rather than them coming into office, either way you're in a dangerous situation if there isn't enough oversight. If you're an inmate then you're seen as violent and known to be violent. 40% of the population is, thus committing violent acts. So we're going work with this new

administration. I mean I feel heartening that they've reached out to you, and will be working with you. It makes me feel that you're being included, and that shows there's a change within the new administration in terms of the task force. We'll reach out to them, and also let the know that -- I'll let them know I think it's a good idea to include representatives from labor both from the healthcare and from the correction officers and their task force. Thank you. Thank you both for being here today. We're going to get the --

COUNCIL MEMBER: [interposing] Madam Chair one second. Maya thank you and doctor, thank you. Is there office space now, clinical to do these evaluations or is this something that has to be also related to the structural concerns.

DR. FRANK PROSCIA: It is a problem. You know -- I'm sorry. You know, the main problem with Rikers is that it's a jail facility.

COUNCIL MEMBER: Yeah, it's supposed to be.

DR. FRANK PROSCIA: Doctors, you know, mental health practitioners they work in hospitals or healthcare facilities. The doctors and nurses are in

charge. The healthcare professional are in charge. On Rikers they're not. Their employers are totally different. It's either the DOH and the DOC on one side, or it's Corizon --

COUNCIL MEMBER: But Maya made a point about that you can't provide that type of observation or care because it's not safe to walk the halls. But we want to bring it back to a place that would be safe to do that. So is there existing space at this point or --?

DR. FRANK PROSCIA: Maya would be best for that. That's it.

COUNCIL MEMBER: Thank you, doctor.

MAYA ESCALONA: In many of the Mental Observation Units there are no office spaces for us to use. So we'd have to go into a corner or meet the patient at his cell. More needs to be done in that area. Sometimes we're in a closet that has cleaning supplies, and we're seeing patients in there. I suggested that --

CO-CHAIRPERSON JOHNSON: interposing] Well, Maya, thank you for coming today because we wouldn't have know that if you didn't tell us.

MAYA ESCALONA: Yes, and not only should there be more clinic offices, but these mental observations, which are not CAPS, which are not -- They're other programs RHU, they're overcrowded and the inmate to officer ratio is high, and I feel it's unsafe.

CO-CHAIRPERSON JOHNSON: Thank you.

CHAIRPERSON CROWLEY: Thank you both. And next we're going to call up the Jail Action Coalition. We have Deborah Hertz and we have Elizabeth Myers, and then there's somebody else? Five, is that somebody's first name?

[Pause]

CHAIRPERSON CROWLEY: Please begin your testimony, whomever would like to go first.

[background discussion]

ELIZABETH MYERS: Thank you for this opportunity to testify concerning the brutality and violence that are endemic throughout the jails at Rikers Island, and which fosters an environment that is extremely destructive for all who are confined there. I am a new member of the Jails Actions Coalition. JAC includes formerly and currently incarcerated people, family members, and other

community members working to promote human rights, dignity and safety for people in New York City jails. I am please to be active with this dedicated group about the devastating problems that are part of life on Rikers Island, a place I could not have imagined before my visits there.

I have been a visitor at Rikers for 2-1/2 years, accompanying the mother of a young man, now 20 years old who has been in the vine [sic], a/k/a solitary confinement for much of this time. We have never understood why he has been in the bing so frequently and long. What we do know is that he has a mental illness, and has been taking medication since he was eight years old. Presently, he is in protective custody, which is solitary confinement with a TV. Those of us who are on the outside have very little knowledge of what goes on inside. This opacity is profoundly troubling, but seems to be the modus operandi at Rikers.

For this reason, I am grateful for what we have learned from recent information obtained through the Freedom of Information Law. Information which would not otherwise have been available to those outside the department and the Board of

Corrections. These documents shed some light on the secret activities in the jails, but flourish like mushrooms in a dark and damp environment. For example, because of information contained in an email sent by the Executive Director of the Board of Corrections to members of the Board on November 13,2013, we know about the plight of Jose Bautista, who was admitted to the Otis Bantum Correctional Center on January 10, 2013.

According to email, after admission Mr. Bautista was quote, "Subject to a new admission medical exam after which he was sent to an intake pen. In the pen, he attempted to commit suicide by tying himself up by his neck on the bars of the cell. A video shows inmates taking him down, officers entering the cell, and then use of force and rear cuffing of the inmate on the ground. The inmate appears to jump to his feet at one point, and is then subject to more force. He and the officers move out of the camera's view [bell] and then..."

CHAIRPERSON CROWLEY: I'm sorry you don't have the time you would like or we would like you to have.

ELIZABETH MYERS: Can I finish my paragraph?

CHAIRPERSON CROWLEY: You can finish your paragraph you can please submit your testimony --

ELIZABETH MYERS: [interposing] Okay, okay, okay.

CHAIRPERSON CROWLEY: -- for the record, and it will be entered as part of the record. I apologize. That was part of the reason I was rushing trying to trying to rush testimony of the commissioners earlier, which took almost an hour. So it delayed the whole hearing, and there are a lot of people today after you, about ten people who want to testify.

ELIZABETH MYERS: Okay. Finish my paragraph? Yes? Thank you. "He and the officers move out of the camera's view, and then come back into view where the officers are seen repeatedly punching the inmate on the floor. The inmate sustained potentially life-threatening injuries requiring emergency for a perforated colon and hospitalization. Almost finished." Although this email contains descriptions of three deaths, two by suicide and acts of use of force on four other

incarcerated persons, I chose this particular case to highlight because it includes issues of mental health, brutality, and lack of transparency. A man with mental illness attempts suicide, and corrections officers' officers response is to use significant force against him, including while he was on the floor and handcuffed. A portion of the incident cannot be seen on video because the video line of sight is partial. But we know the truth of what happened because it was captured on a video. Unfortunately, these brutal acts are often committed outside the camera's range. And I thank you for this opportunity to speak.

DEBORAH HERTZ: My name is Deborah Hertz. I'm a member of the Jails Action Coalition. I thank you for the opportunity to speak today. I actually want to clear up a common misconception both here and in the press that there is no difference between punitive segregation and solitary confinement. I have had the opportunity working at the Urban Justice Center to -- I go on -- I do Brad H interviews, and I speak to roughly 20 incarcerated individuals per week that also are dealing with mental health issues. And I've spoken to many who are in solitary, and the idea

that they are two separate things is simply not true. And the idea that it's not a punishment is -- it's flawed because it the word 'punitive' in the title itself. But in any event, the -- Sorry.

And the fact that one can owe days to the box means you can at one time during your incarceration have committed infractions and be released. And then at a later date, be expected to complete those days. So that -- it's so far removed at that point from the actual infraction that that's not going to be a deterrent for that, or proper punishment for that behavior. I have submitted some copies for all of you. This is called Voices from the Box, and it is a collection of personal accounts of people that -- you use the term punitive segregation but we use the term solitary confinement. And as you can see, there are really-- When you read through this, there really aren't many differences, and just very quickly for example being locked into a cell, and a very small cell for a minimum of 23 to 24 hours a day.

It's not always -- you don't always get your hour of recreation. Sometimes you're denied recreation. People are denied food. They're denied

showers. They are -- they do not have any human interactions or very few. There's no human contact. The idea is to truly isolate you from any kind of social role, and this has really detrimental effects. And, in fact, has been called 'torture' by the United Nations Rapporteur on Torture, and people's mental health deteriorates when you're inside, and if you -- and it exacerbates those symptoms that one has. But also, people without any mental illness can become so [bell] while in solitary confinement. Thank you.

CHAIRPERSON CROWLEY: Thank you and you both. We're going to try to stay as brief as we can. You know, I'm going to follow up with some questions. We have your content information. We have Sarah Kerr here from the Legal Aid Society. I'm going to call a few people up at the same time. Mary Beth Anderson from the Urban Justice Center.

[Pause]

SARAH KERR: Good afternoon. Thanks for staying so long and hearing from us. You'll see I'm handing out a term paper. Don't worry. I never plan to do that as a my oral testimony, and I've now cut my oral testimony significantly. The scope of problems in our jails are well known. The tragic

outcomes of the failure to act are also well known, and a number of you have brought up some of those tragedies today, and I'm not going to repeat them. I could recount stories of medical neglect. I could recount seemingly endless stories of brutality inflicted on people who are incarcerated in our city jails. But we need to talk about reform, and we need to take action. Our jails have a culture of violence that is unacceptable. Staff resort to force first and fail to implement interventions that would stop the cycle of violence, and address root problems in an appropriate management of the individuals who are in their care.

The increase in the use of punitive segregation in the Bloomberg Administration was outrageous. While New York State prisons and the rest of the country were implementing reforms, New York City, my city, our city inexplicitly was increasing its use. This was irrational, tortuous and harmful to countless people in the jails. The absurdity of the punishment continues to be obvious. The wait list for punitive segregation, and there is a policy to implement old bing time regardless of whether individuals later adjust to the jails and

don't reinfract. The wait list, you don't get taken off of the wait list if you don't have more problems. You stay on the wait list. This is wrong. We must have rational policies that eliminate this punishment for the sake of punishment. Sentences are too long. The 22 to 24-hour isolation is to onerous for our fellow human beings.

Individuals with serious mental health needs and our young people in particular cannot withstand this isolation. Yet, we continue to use it against them. When someone cuts themselves in punitive segregation cell, our policies must recognize that this is a cry for help. The attitudes that suggest that individuals are gang leaders or manipulative are wrong headed and result in tragic cases of neglect that we have seen all too recently. Many studies have already been done. I was happy to hear a lot of them mentioned today. The Justice Center, the Council of State Government did a study as part of their -- Bloomberg's task force and DOHMH has done a number of studies demonstrating the likelihood of injuries to people in jails who have mental illness. The Board of Correction has also conducted some studies. We know we need to increase

the beds in CAPS. We know we need to increase access to CAPS. We need municipal leadership to implement long-lasting reforms, and we need to change the violent culture [bell] in our jails. I'll stop.

CHAIRPERSON CROWLEY: Can we have your testimony?

[Pause]

MARY BETH ANDERSON: Thank you for allowing us to testify here today. I similarly am not going to read from my testimony, but will highlight some of the reforms that I think are needed. That--

CHAIRPERSON CROWLEY: Please state your name.

MARY BETH ANDERSON: Oh, I'm so sorry. Mary Beth Anderson. I'm the Director of the Urban Justice Center, Mental Health Project. But before that for many, many years I was a colleague of Sarah at the Legal Aid Society in the Criminal Defense Division where I worked as an attorney representing people with serious mental health problems for about 15 years. I also got my Social Work Degree during that time period because I found it helped informed my practice. So I'm also now a licensed social

worker. And that our jails have experienced an uptick in violence does not surprise me, but it does dismay me because I cannot believe that it's getting worse. I do believe that the increased use of punitive segregation does help contribute to the culture of violence, and that, therefore, elimination of punitive segregation is warranted.

I think that the Department of Corrections does need to have additional training and, in fact, I know they are going to be implementing the Mental Health First Aid Training, which is a model done for our public safety officers, and I hope that that helps. But they're only starting with the new training class. So I hope that they expand, and provide this training throughout the Department of Corrections. They do, indeed, have a difficult job, but they -- it's the job the signed up for and they have to expand and provide this training throughout the Department of Corrections. The do, indeed, have a difficult job, but it's the job they signed up for, and they have to do it in a way that is consistent with professional ethics as well as safety.

In addition, we would recommend that all employees -- all employees, everyone who works in a city jail facility be trained on trauma informed care. Many, many, many people, in fact, the vast majority of people who come in contact with the Criminal Justice System as defendants do have trauma issues. It's not a soft-on-crime approach. It's an approach that's been shown in other prison systems to decrease incidents. Finally, I think that for us to have any true difference, meaningful difference on mental health in our society, we have to become more transparent, and eliminate the stigma and discrimination that people with mental illness face. Norman Seabrook showed how terrible it can be for a person with mental illness when he said --

And I'm sure he didn't mean it this way. He said they should use the money to send people with mental illness Upstate to institutions. We are trying to help people engage in recovery in the community, not in institutions, and ideally that's what we do, be more open, and promulgate policies that promote more openness and recognition of mental health issues. The City does have an Initial Psychiatric Episode Initiative. [bell] So, for

people who have first grade episode of psychosis, I am on the advisory board. I think initiatives like that need to be expanded. Thank you.

CHAIRPERSON CROWLEY: Next, we're going to hear from the Fortune Society, Dr. Kirk, Anthony James, and at the same time I would like to invite the Brooklyn and the Bronx Defenders. We have from Brooklyn Nick Malinowski [sp?]. I'm sorry. I can't read your handwriting, and Pagenette Franklin, and then Skylar [sp?] Albertson from the Bronx.

[Pause]

CHAIRPERSON CROWLEY: Move in so you feel comfortable. [sic]

DR. KIRK ANTHONY JAMES: My name is Dr. Kirk Anthony James from the Fortune Society, and I just want to say thank you for allowing us an opportunity to testify. I have often heard the saying that insanity is doing the same thing over and over and expecting different results. We've known for probably 200 years that solitary confinement does not work. There is a lot of research that has been conducted that has shown that solitary confinement has led to psychosis in various settings. A question that hasn't been asked here today, which I think is

really interesting, is that if we can acknowledge that so many people in prison are mentally ill, why are we not asking then why are they going to prison?

And maybe this is not the hearing for that, but if we're all under the understanding that there's a large amount of people in prison that are mentally ill, I think a question should be asked why are they in prison to begin with? The first person -- I'm also a licensed therapist, and I remember working with an individual once they were released from prison. And their crime was actually during a psychotic episode they tried to kill themselves, and do you know what happened? They were arrested and charged with possession of a weapon. And I thought that's a real problem in regards to our understanding of mental health. So the person that testified spoke about trauma, and the pervasiveness of trauma in prisons.

And I think we listened to a lot of testimony today that makes me really very aware that our understanding of mental health is still very limited. And what we're actually doing is we're actually creating the environment for a lot of this violence to happen in prison. And we're actually

creating the environment that will actually continue the violence in the community once released. So I think the answer is for all sets of society to develop a greater understanding of mental health, and also a greater understanding of what works, right? Because it's not - -doing the same thing over and over and not having the results that we're looking for. So we're seeing solitary confinement doesn't work.

It doesn't work for the correction officers. It doesn't work for the individuals. And a personal item that I wanted to share right, was that I'm also formerly incarcerated. And I can tell you, you know what, I spent nine years in prison under the Rockefeller Drug Laws, and the experiences that were the worst for me was actually going to the box or the bing or whatever you want to call it. And I was sent there for a minor offense. I was sent there because I worked in the law library, and I possessed somebody's legal document, which I was making a copy for them, right.

And this was considered enough of an infraction to send me to the box. And I was fortunate that I only got a chance to spend a week

there before a riot in the prison actually allowed me to leave and them to put other people there. But I can tell you that it was the lowest period of my life, and I only spent a week. So imagine all these other young men, women mentally ill, pregnant women that are being sent to solitary confinement. I think it's really in humane that as an advanced society we still feel that punishment is a way to respond to social ills. Thank you.

[Pause]

SKYLAR ALBERTSON: Good afternoon. My name is Skylar Alberstson, and I'm the Assistant to the Executive Director of the Bronx Defenders. In this capacity, I have been conducting interviews since January with clients of the Bronx Defenders currently or formerly held in solitary confinement at Rikers Island, including in RHU. I would like to thank the Council for the opportunity to testify on this matter. One year ago I graduated from college excited to begin my first full-time job at the Bronx Defenders. Having interned at a public defender office as a undergraduate student, I assumed that not much would shock me. For several months, this

expectation held true. Then in January, I began meeting with clients held in solitary.

Nothing could have prepared me for what I would hear. The treatment of individuals placed in solitary confinement at Rikers Island goes far beyond what I ever imagined could be possible in the United States. It is horrifying and it is shameful. Roughly three months ago I sat across the table from Luquan [sp?] Berkeley in a cramped interview in Rikers. Laquan was hunched over with one arm handcuffed to a wall. The fear in his eyes was painfully clear. In a word, he looked broken. Prior to arrive at Rikers, Laquan had been diagnosed with multiple mental illnesses and learning disabilities. Yet, once Laquan entered solitary confinement, he found it incredibly difficult to access even the most basic services such as medical care, phone calls, and showers.

On more than one occasion, Laquan was ordered to hang himself so that he could see a mental health professional. The correction officers responsible for Laquan would taunt him telling him to hang it up really good, and to call them when he was about to die. I wish I could say that Laquan's

situation is unique, but based on the interviews that I have conducted over the past six months, many aspects of his experience are all too common among our clients at Rikers. Inexplicitly, solitary confinement is the only form of punishment used for most infractions at Rikers. Once a person faces allegations and appears at an internal hearing for which there is no right to counsel, the only question remaining is just how long he or she will be locked away in solitary confinement.

The median age for our male clients interviewed this year about their experiences in solitary is only 20 years old. Once our clients enter solitary, it becomes shockingly easy for correctional officers to pile on tickets for alleged infractions. The median amount of solitary time for our male clients interviewed this year is 105 days. At least two of our clients have received tickets totaling well over 1,000 days. The proposal at hand is crucial for developing meaningful changes to the use of solitary confinement at Rikers. It is inexcusable, but arguably the most severe punishment that the government inflicts upon individuals in this city is shrouded in secrecy.

Unfortunately, transparency is just the first of many changes that must be made. Despite the guarantees contained in the Minimum Standards, our clients are often denied access to phones, showers, medical care, mental health professionals, and outdoor recreation. Solitary confinement, as it is practiced at Rikers Island, is cruel, unusual, and inflicts both severe harm to our clients. [sic] It will take much more than monthly reports to check the over-use and abuse of solitary at Rikers. But without knowing the full scope of the problem [bell] and without being able to monitor any progress that we achieve, we have nowhere to begin. Thank you.

CHAIRPERSON CROWLEY: Thank you.

NICK MALINKOWSKI: My name is Nick Malinkowski. I'm here on behalf of Brooklyn Defenders Services, and we represent 40,000 people a year in criminal and family court in Brooklyn. About 6,000 of our clients have spent time in city jails. Hundreds of them will be subjected to solitary confinement, which we've heard from everyone today is torture, unqualified. I agree with a lot of stuff people have said before me, including from Jails Action Coalition, and the Justice Center and Legal

Aid, and would just like to add a few points. One, I want to express my disappointment that there doesn't seem to have been much effort to include people who are housed within the cells on Rikers Island in this discussion. It's over 100,000 people a year, and over a million in the last ten years, and you would think that they would have a representative here.

I think solitary confinement needs to be abolished. Like my colleagues said, there's centuries of research on this that it creates problems that it's pathogenic, that it leaves people more prone to violent and anti-social behavior. There should be zero tolerance for brutality from correctional officers. Adolescents should not be in adult facilities. They shouldn't be in jails of any kind, but as we work towards that goal, I think one option would be to use their borough-specific facilities to have 16 and 17-year-old in their community where they would have better access to services, their communities and family members. As we heard from just about everyone today, the infrastructure and personnel in city jails are not set up for managing complicated mental health needs.

So people with complicated mental health needs shouldn't be there until that is rectified. We don't see the RHUs as a good model to resolve that. As for the bill, we fully support it. Over the years, the transparency from the Department of Corrections has decreased, and we find it inexcusable that so many people would be subjected to these policies without any kind of oversight. In addition to the reporting outline in the bill, as attorneys we would like notification from the Department of Corrections when any of our clients are subjected to an infraction hearing. When any one of our clients is moved from an observation to punitive segregation, there's typically an interview, which often has criminal consequences.

People are asked to waive their rights to self-incrimination, and things like that. And we think it's important to have an attorney there. We've seen this benefit in our immigration practice where after the City Council funded us to defend people in deportation hearings, the success rate for people went from 3% to 50%. The circumstances did not change. You just gave them an advocate, and 50% of the people were able to assert real defenses that

they belong in this country and were not guilty of what they had been -- the administrative conflict. Lastly, I just to share two stories that I think kind of exemplify situations that would hopefully be rectified by the Bill 292.

CHAIRPERSON CROWLEY: [off mic] [interposing] You have only one minute. [sic]

NICK MALINKOWSKI: Okay. One client was issued an infraction ticket on May 12th because a correctional officers alleged he had found something in his rectal cavity during his cell search. [bell] As a result, our client was placed in isolation --

CHAIRPERSON CROWLEY: [interposing] Your testimony will be submitted for the record. You don't have to read it. I understand that you hope for more people who have been victims of solitary confinement to come to the public hearing. Everybody was invited. The next time I have a hearing with the DOC if you want to bring any of your clients, please do. We'll read through your testimony, and it will be part of the record. If I have any questions, we leap [sic] back at you. I'm sorry. We're pressed for so much time, but it's almost 6 o'clock, and there are people who wanted to close this room almost

an hour ago. My apologies. Thank you for the work that you do. We have Dr. Henry Weinstein [sp]. We have Joanna Miller and Michelle Bollaire [sp?]

[Pause]

MEAGAN O'TOOLE: Hi, I'm obviously not Dr. Henry Weinstein. He had to leave. My name is Meagan O'Toole. I'm the Executive Director of the New York County Psychiatric Society. We represent -- we have some non-profit membership association, with psychiatrists in Manhattan and Staten Island with over 1,800 members. We're pleased that the three committees are here today on this important issue, and the recent deaths at Rikers Island have obviously shed light on what many of us already knew that we're not adequately treating and caring for people with mental illness who end up in our jails.

And while overall jail population may be decreasing, we heard already today that the population with mental health needs is actually increasing. We believe that much must be done at all stages of the process from pre-trial detention to incarceration to post-release supervision and treatment. And we're proud that many of our members are already making strides in the process including

having members on the Mayor's task force. I'm going to be very brief and just say that we're encouraged by your attention to this issue, and we know that addressing the problems are not going to be quick. It's not going to be easy, but we stand by ready to be a resource to the Council whenever our doctors are needed.

CHAIRPERSON CROWLEY: [off mic] Thank you for your testimony. [sic]

MICHELLE BIHA: Hi, my name is Michelle Biha, and I actually work mostly in Rhode Island. I work as an intern, a medical intern in the Mental Observation Unit in both the women's medium security facility and the men's high security and medium facility. And I just wanted to share that recently I spoke with the Colorado Director of Corrections who directs the whole state's Corrections Department so it's prisons and jails. But he actually reduced -- He made headlines in New York when he spent a night in solitary confinement. But he reduced the population of their numbers in solitary confinement from the triple digits to the single digits. And his first priority is leaving all mentally ill inmates out of segregation.

And he did that without any increases in violence. So I just wanted to throw that out there because a lot of the evidence today that sort of suggests how it's been predicted of hypothesis about increases in violence or decreases in violence depending upon the use of punitive segregation. But it's been done in Colorado very successfully, and he also previously worked in Wyoming, or in this context. So you can talk to him about it, and I hope the Council does seek his advice. He's very open to sharing his techniques that he used for that because I think they really need it here in New York. And as a medical worker, I also want to echo what the nurses said about needing specific rooms.

We don't see any patients at all in their cells whether they're housed in segregation or not. We have our own medical room and we see them in clinics. And I think that's really fundamental. So to the extent that you've all supported that health and safety, I would make that environmental and structural change as quickly as possible. And then I also want to echo what everyone else had to say about changing punitive segregation. We should not have any youth awaiting trial in punitive

segregation. There should be no use of punitive segregation for people who have a non-violent infractions. There was one youth that I spoke to in several of my interviews that I've done in Rhode Island. He was given an infraction for having an expired prescription bottle in his room, and then he would --

In his cell and he was given a sentence of 300 days in punitive segregation. And it seems like those were, you know, the situations that Seabrook described where you have inmates rioting. There are situations where the Corrections Department needs ultimate authority in determining those. But that's not what's being used for the majority of people held in these units. They're small infractions. They're things that need to be dealt with like throwing out the prescription bottle and making sure that person is taking their medication. They don't need to be put in segregation that causes more pain and psychiatric illness and all these sorts of things. They can be fixed immediately. So if you're looking for solutions now in the short term, that's a really good place to start is changing the infractions that they use. And looking to other

departments that were able to reduce their population dramatically. So thank you for your time.

CHAIRPERSON CROWLEY: Thank you both. I want to thank everybody for staying so long today especially those that had to wait a long time to testify. The Committee will follow up with questions. So please if you could respond that will be great, and we'll add it to the Committee Report. This concludes the hearing of June 12, 2014, co-chaired by Council Member Andy Cohen who chairs Mental Health, and co-chaired by Council Member Corey Johnson, who Chairs Health. And I'm Council Member Elizabeth Crowley, and this concludes the hearing. [gavel]

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date June 19, 2014