NYC Health

Testimony

of

Deputy Commissioner Sonia Angell, MD, MPH
New York City Department of Health and Mental Hygiene

before the

New York City Council Committee on Health

jointly with the

Committee on Fire and Criminal Justice Services

regarding

Health Care Delivery in New York City Jails:
Examining Quality of Care and Access to Care

and

Intro. 440: Reporting on the Health of Inmates in City Correctional Facilities

March 3, 2015

250 Broadway
New York City

Good afternoon Chairs Johnson and Crowley, and members of the committees. I am Dr. Sonia Angell, Deputy Commissioner for the Division of Prevention and Primary Care at the New York City Department of Health and Mental Hygiene. I am joined by Dr. Homer Venters, the Department's Assistant Commissioner for Correctional Health Services, and Erik Berliner, the Deputy Commissioner for Strategic Planning and Programs at the Department of Correction. On behalf of Commissioner Bassett and Commissioner Ponte, thank you for the opportunity to testify today on the topic of health care delivery in New York City jails and Intro. 440. Ensuring delivery of quality health and mental health services in our jails is a critically important and very complicated issue, and I thank the Council for your continued attention to it.

Background and Provision of Services in NYC Jails

As you know, Commissioner Bassett testified before these Committees in June 2014 about the provision of correctional health and mental health services in the City's jails, and on the issue of violence against healthcare workers. In the interest of time, I will refrain from going into detail on the topics we discussed then, although I do think it's worth mentioning some of the basic facts and figures.

The Health Department is responsible, under the City Charter, with providing health and mental health services in the City's correctional facilities. Our mission is to provide the best possible medical assessment and treatment during an inmate's detention, as well as appropriate health and mental health-related discharge planning services. Our health system is a national leader in providing health care that not only addresses urgent needs for patients while in jail, but also provides preventive and chronic care interventions like testing for HIV, Hepatitis, and Sexually Transmitted Infections, as well as vaccines that can prevent illness later in life. We pursue these goals by focusing on patient safety, population health, and human rights as essential elements of our health system. High quality correctional health services are critical for patients' safety and health while they are in jail, but they are also important in safeguarding the health of communities to which individuals discharged from jail return.

All inmates receive a full medical intake examination within their first 24 hours of entering custody. New York City is a national leader in this regard, as it takes most jurisdictions between one and two weeks to complete such exams. This intake exam allows us to screen patients and guides referral to a range of services they may need, and includes a comprehensive health assessment, sexually transmitted disease screening, and initial mental health assessment. These inmates enter the jail system with a high burden of disease; rates of HIV, hepatitis C, asthma, hypertension, and substance use are all significantly higher than they are among the general population. The intake screenings help to guide further treatment, discharge planning, and entitlement applications.

Approximately 11,000 inmates are housed within the City's 12 jail facilities, and approximately 70,000 admissions occur annually in the jail system. Each month, the Department provides over 65,000 health care visits in jail facilities, most of which occur at Rikers Island. We also provide discharge planning to eligible inmates with mental illness. These services, which are provided to approximately 20,000 individuals annually, include arranging for post-release medical and mental health care, applying for or reactivating Medicaid, applying for public assistance, providing a supply of and prescription for

medications, arranging for transportation, and organizing post-release follow up. The Department is also a national leader in the adoption and use of prevention-oriented electronic health records in our jail facilities, allowing our health care workers to better coordinate care for their patients.

Oversight of Services

Although oversight of health services and discharge planning in City jails is the Department's responsibility, direct medical, mental health, and dental care services are performed by contracted personnel from the health services providers Corizon Health Inc. ("Corizon") and Damian Family Care Centers ("Damian"). Hospital inpatient services are provided by the New York City Health and Hospitals Corporation (HHC). Corizon, the largest private for-profit correctional health services provider in the United States, manages the day-to-day medical and mental health operation at Rikers and two other jail facilities, employing approximately 1,100 staff to deliver this care. Damian, which employs approximately 90 staff, provides services at the Vernon C. Baines Correctional Center, a jail facility in the Bronx which houses approximately 600 inmates. Damian is a New York State-licensed Article 28 Diagnostic and Treatment Center and a non-profit Federally Qualified Health Center with a long history of providing high quality healthcare to the City's underserved.

Correctional Health Services Contracts

Both Corizon and Damian were selected as vendors via a competitive proposal process. Solicitations for correctional health services were issued by the City in 2000, 2004, 2007, 2010, and 2012. During these solicitations, hospitals, Federally Qualified Health Centers, and health care networks in the City were contacted, along with national correctional health providers. Since January 2001, Corizon has received the contract to provide correctional health services for all of the City's jail facilities, with the exception of the Vernon C. Baines Correctional Center. The Corizon contract is approximately $140 million per year and expires on December 31, 2015. The contract with Damian is approximately $7.4 million per year and expires in November 2016.

Prior to 2007, solicitations were offered for the entire jail system. Beginning in 2007, solicitations were offered for individual or groups of jails, rather than a single contract for all jail facilities, with the goal of increasing the pool of potential vendor applicants, particularly community-based providers. Given that most of the patients inside City jails return to their community within days or weeks of arrest, community-based providers may be able to offer greater continuity of care. Since 2007, Damian has been the only non-profit vendor to submit a viable comprehensive proposal. In 2013, Damian won the bid to provide care at the Vernon C. Baines Correctional Center; the contract began in November 2013.

Vendor Monitoring

In addition to oversight of clinic operations, discharge planning, and all other aspects of health services, the Department is responsible for establishing and determining the medical and mental health policies that vendors are required to adhere to. We base all of our medical, nursing, mental health, and

substance use policies and procedures on evidence-based best practices. Although Corizon and Damian are included in policymaking discussions, ultimately health and mental healthcare policies are designed, implemented, and measured wholly by the Department.

The Department closely monitors our vendors through multiple lines of supervision. From a financial standpoint, our contracts are structured so that there is no incentive to limit care, medication or treatment. From a clinical perspective, we oversee the credentialing of physicians and physician assistants, and monitor compliance with all policies through a rigorous quality assurance process. Corizon and Damian undergo routine, quarterly comprehensive evaluations and are responsible for meeting performance 40 performance measures, in areas including Medical Care, Dental Care, Mental Health Care, Women's Health, Chronic Disease, Infectious Disease, Substance Use, Medical Records Management, and Preventable Hospitalizations. The Department meets weekly with our vendors to proactively identify issues and address them immediately. We also utilize rigorous morbidity and mortality reviews to assess potential errors in health care activities. If our vendors fail to meet the established standards, or if morbidity and mortality reviews reveal shortcomings in service, the Department employs a structured process to swiftly remediate issues. This process includes development of corrective action plans to ensure problems are addressed.

In addition to measuring compliance with existing standards, the Department is committed to improving the quality of care. To that end, we have created a Quality Improvement Executive Committee, which is chaired by Commissioner Bassett and includes senior Health Department leadership. This Committee is based on the approach to quality that is found in hospitals and other community health systems and meets on a quarterly basis to review data including quality assurance efforts, quality improvement projects, and performance indicators. As part of this effort we are focused on empowering health staff to deliver patient-centered, high-quality care, and fostering a sense of teamwork in each facility, especially among health and DOC staff in important processes, such as inter-facility patient transfers.

Finally, we must keep our health workers safe. Staff cannot be expected to meaningfully engage with patients when they are worried about their safety, and jail violence impacts workers as much as it does patients. Many assaults against staff occur in high-security housing areas, where health staff must provide care because of limitations on patient movement. The Administration is committed to protecting the health and safety of our healthcare workers and the Health Department has been working closely with the unions, Corizon management, and DOC to improve training and increase the availability of safety equipment such as cameras and alarms. These are difficult issues to address, but we are making progress: instituting routine safety communication between security and health staff; retrofitting clinics and other settings to improve staff safety; and closing units that are unsafe for staff and patients.

Intro. 440

With respect to Intro. 440, the Administration supports improving transparency throughout the jail system, including in the provision of health care services. We share a commitment to this approach, but as the providers of health care, we also have a legal and ethical responsibility to protect the

confidentiality of our patients' health information. Although the legislation as currently written would not require the reporting of patient identifying information, the information required by this law, combined with other publicly available data may cause the patient to become identified.

In some instances this unintended effect could violate our legal responsibility to protect the confidentiality of our medical records. This is of particular concern in the jail setting because inmates are identified on the DOC website; in certain circumstances it is statistically possible to re-identify individuals using separate sources of demographic information. The Department believes we can meet the goals of the legislation while still protecting patient confidentiality, and we would be glad to discuss this feedback in more detail after the hearing.

Lastly, I would like to reiterate that the quality of health care in the City's jails requires collaboration between the Health Department, the Department of Correction, and the vendors with whom we work. We are proud of the progress we have made to date – our Clinical Alternatives to Punitive Segregation (CAPS) program is one example of how, working together, we can improve health outcomes for individuals at Rikers. Furthermore, the Program for Accelerating Clinical Effectiveness (PACE) units function well because the health and security staff train and work on the units together, as a team. Likewise, the improvements that we have made in staff safety reflect routine, joint meetings that occur in every jail, which include line staff and managers from both health and security teams. In addition, our two agencies are working closely together to successfully implement initiatives developed through the Mayor's Task Force on Criminal Justice and Behavioral Health, which aim to enhance the jail system's capacity to provide therapeutic responses to inmates with acute mental health crises and connect individuals to care and services in the community at discharge.

However, despite the success of these new programs and innovations, we recognize our work is far from done. The Administration is committed to further bettering the services available to patients, and is evaluating the best approach and model for medical and mental health care delivery in the jails beyond 2015. An interagency team, including members from the Health Department, DOC, HHC, the Law Department, and OMB, is examining potential new strategies for health care delivery in our jails. We are using four guiding principles as we consider future directions: maximizing existing links to the extraordinary health care resources of the City, such as our local hospitals and medical schools; ensuring continuity of care between jail and the community; continuing to improve cohesion and partnership between DOC, DOHMH, and HHC; and applying national best practices for innovative, quality care. Our review will be complete this summer and we look forward to sharing the results of the analysis with the Council then.

Thank you again for the opportunity to testify. My colleagues and I are happy to answer any questions.

Elizabeth S. Crowley
Chair, Fire and Criminal Justice Services Committee
March 3, 2015

Oversight – Health Care Delivery in New York City Jails: Examining Quality of Care and Access

Opening Statement

Contact: Javier Lacayo – jlacayo@council.nyc.gov/ 562-293-6409

My name is Elizabeth Crowley and I am Chair of the Fire and Criminal Justice Services Committee. I want to thank Chair Johnson for his leadership on this issue and the staff for helping to prepare the committees for this oversight hearing. Today we will hear CM Johnson's bill, Intro. 440, which will bring much needed transparency into the medical care that is administered on Rikers Island.

As the Chair of the Criminal Justice committee, I have serious concerns about the quality of healthcare administered to inmates and the safety of healthcare providers in clinics on Rikers Island, especially when they are seeing violent inmates. My concerns are only heightened by the hundreds of lawsuits against Corizon that have been brought by inmates, not only here in New York, but throughout the country. The medical mistakes that have brought about lawsuits seem to be the result of medical staff being spread too thin. I would like to get at the root of why such mistakes occur at this hearing.

Providing medical services to those detained is a basic right. Inmates in need of medical attention must have timely access to such care. When someone is denied such care, the consequences are often tragic. Even worse, when inmates are seen by the medical staff and sent back to their cells with the wrong diagnoses, this not only wastes time, but it can lead to avoidable deaths.

An example highlighted by the Associated Press is an account of a 19-year old named Andy Henrigues who complained about chest pain for 7 months was seen 8 times and never given a chest x-ray. He died in 2013 from a tear in the aorta. I am concerned that Corizon, a for-profit company, has "INDEMNIFICATION" and is not responsible for malpractice as the City covers the costs of lawsuits.

I am also concerned about the costs of the contract and why our City does not incorporate these health services into the HHC system.

Over the past several years, the number of inmates with mental illnesses has grown substantially, accounting for approximately 40% of the population. I am concerned that there is an inadequate staffing level of mental health professionals on Rikers Island and I am interested in learning about how Corizon assesses and treats the growing population with mental illness, especially those who are under 21.

Equally troubling are reports about healthcare workers being beaten and physically abused by inmates. There are reports that inmate assaults on healthcare staff rose 144% from 2013 to 2014. This committee is concerned that the DOC is not doing enough to protect staff from often dangerous inmates, and possibly not providing enough staff to ensure their safety. The physical layouts of some clinics create safety risks that place an undue burden on doctors and medical staff. I am interested to learn about what plans are in place to address these physical structure issues.

The Mayor's Management Report provides insufficient performance indicators to determine whether or not inmates are receiving timely access to health services. Chair Johnson's bill addresses this deficiency and I have signed on as a co-sponsor.

Separate from these fundamentally important safety issues are the funding issues with correctional healthcare. This committee is interested in learning more about to what extent the state and federal governments fund our correctional health care system, and what efforts DOC has made to obtain such funding from outside sources.

Ultimately, we all would like an efficient and effective correctional healthcare system. This committee is interested in discussing what steps the DOC is taking to address the systemic problems that have continued to pervade our system. This committee is also interested in discussing what steps the Council can take to address these important issues.

I look forward to hearing from Corizon, from the DOC and DOHMH and from all interested parties.

1199SEIU
United Healthcare Workers East

NEW YORK CITY COUNCIL HEALTH AND THE FIRE AND CRIMINAL JUSTICE COMMITTEES

Hearing on Intro. 440
March 2, 2015

Good morning Speaker Melissa Mark-Viverito, Council Members Elizabeth Crowley, Corey Johnson, and members of the Health and the Fire and Criminal Justice Committees. My name is Lillie Cariño Higgins, and I'm the Director of the 1199 Political Fund. Thank you for this opportunity to speak about Intro. 440 on behalf of almost 600 1199 members providing health care services under a Department of Health contract with Corizon Health in inmate facilities under the jurisdiction of the New York City Department of Corrections.

1199 supports the concept of Intro 440. Quantitative data will better inform the discussion about staffing needs that we are concerned about, and better measure the outcomes of programs currently in place. We also want to be very clear. Reports alone will not resolve the problems that exist in our prison system. We need a creative and innovative approach, with increased collaboration, cooperation and coordination between all parties.

Mental Health Issues and Services

We have a serious societal problem when it comes to how we treat the mentally ill. It has been reported numerous times before this City Council that approximately 40% of today's inmates suffer from mental illness. Many are arrested and remain incarcerated due to their inability to post bail, at times for minor infractions. They end up in correctional institutions when they really belong in mental institutions. We must work to find more palatable solutions to problems arising from 20 years of "broken windows" policies that have resulted in use of prisons to warehouse the mentally ill and poor people, most of whom are persons of color, rather than placement in more appropriate mental health institutions where they can get the care they need in a medical, rather than a prison, setting.

To their credit, in acknowledging the results of two decades of neglect, the current administration is taking necessary steps in the right direction. While we – the workers – appear to be impatient, we do know that 20 years cannot be reversed in a short time. But we do expect the workers to have a voice. Their concerns must be heard. In fact, existing conditions cannot be corrected without their collective and individual contributions. We are on the inside looking to be part of the solution.

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Measures must be taken to ensure that proper health services are provided to those who need it; the goal being to prevent mental decompensation that pose threats to workers, visitors, other inmates and to themselves.

To better gauge service delivery, certain statistical data must be collected and analyzed. For example:

- How are we currently monitoring service provision? Can we track the number of appointments that are scheduled, cancelled, postponed, and/or completed? In the event of appointment cancellations, such as in the event of lock downs, how much time lapses for appointments to be rescheduled? Do we monitor backlogs, service needs, and timeliness of services? Do we track backlogs for those with inmates with conditions?

- How many psychiatrists are on duty at any given time? Are they sufficient to provide emergency care on a 24-hour basis? Do inmates have access to medical care and medication on an as-needed basis? Do they have access to care on weekends and at night? When cared for on an emergency basis, are adequate follow up and discharge plans developed and implemented to ensure ongoing quality of care?

- Is attention being paid to delivery of culturally competent care?

- How knowledgeable are correction officers in the area of mental health? Is it conceivable that they can maintain order absent a basic understanding of mental health disorders and behavior? If an inmate acts out due to psychosis, bipolar disorder or depression, can the officers recognize the signs and seek medical attention instead of resorting to use of force? Would de-escalation training benefit officers and inmates?

We feel strongly that joint training with officers and health care providers is a must. This cannot be stressed enough. Without it, we just have a very dangerous and volatile situation for all concerned. Moreover, while the health care workers under the Corizon contract are not

Staff Safety and Violence Prevention

We recognize that not all inmates are mentally ill, and most importantly, not all infractions or assaults are committed by those who are mentally ill. In fact, we should all be very concerned about mentally ill inmates becoming prey for other inmates, or becoming victims to cruelty, abuse and violence. In addition to mentally ill persons and non-violent offenders, prisons house violent criminals who are a threat to all who cross their paths. We also recognize that not all persons in these facilities are criminals. Many are awaiting arraignment or trial, have not committed any crime at all, and are not dangerous. There is just no other place to put individuals that have been apprehended and cannot post bail while awaiting trial.

Of course, violent incidents generate much media attention and interest, and in recent past, way too many unfortunate incidents have resulted in serious injuries to correction officers, staff and inmates. Fortunately, there are Safety Committees already in existence that meet

regularly discuss safety concerns. It could be a great vehicle having generated some excellent and well thought out recommendations, such as on-person panic buttons, officer escorts for staff visiting inmates in cells and housing units, having officers remain within sight lines of caregivers, and use of cuff bars. However, the length of time that transpires between connecting the meeting to implementation of solutions is quite troubling. We recommend that DOC, Corizon and other key players send decision-makers to these meetings so that issues are addressed in a more timely and effective manner.

Much public attention was given to an OSHA determination of willful violations against Corizon Health. Meanwhile a PESH complaint is pending against the City of New York for similar workplace safety violations. In their findings, OSHA reasons that health care services not be provided without the presence of a correction officer. However, the officers are under the jurisdiction of DOC and cannot be assigned to duties by Corizon. With staff comprised of a myriad of titles and represented by numerous Union locals, cross-training and protocols delineating clear lines of communication and chains of command covering all workers is essential to everyone's safety. They should not be working in silos.

Another area where we believe the Department of Corrections can better coordinate with Corizon Health is in the manner in which inmates are escorted in large clusters to the medical units' waiting areas. Having a person who is bipolar or schizophrenic waiting for long periods of time to be seen, to get medication, or to be returned to their housing unit increases anxiety and is counterproductive leading to unpredictable situations.

There are many areas where collaboration with DOC will greatly minimize threats of violence and increase safety.

- Are the facilities adequately staffed? Simply doing the math, if 40% of 11,000 inmates on any given day suffer from mental illness, the officers are outnumbered.

- Are there sufficient correction officers to escort inmates to and from the medical units, while patrolling the medical units to ensure the safety of the attending medical staff and others in the facility?

- Who should determine whether or not an officer is required when an inmate is being seen by medical personnel? Is the decision made based on staffing capacity? If feeling threatened, are the medical professionals providing care able to request that an officer be present? Who makes the final determination?

- What are the levels of communication between the officers and the medical staff? Are they adequate? Do they or should they have two-way radios for emergencies?

If we are looking to avoid and prevent mishaps, we must have sufficient staffing levels that will allow the officers communicate with other staff and do their jobs while inmates receive services.

Increased Staffing

Generally, it makes sense that the number of correction officers needed would have diminished when crime statistics are reportedly reduced. However, with the "broken windows" policies the City managed to reduce crime and increase arrests and as stated earlier, the City began warehousing mentally ill individuals, a population with very special needs that cannot and should not be met in a prison system.

Corizon Health workers are required to visit housing units and cells to dispense medication and for follow up care, at times without the escort of a correction officer. They cannot abandon their patients and doing so would have dire consequences. But fulfilling their obligations can put them in danger. Similarly, when inmates are able to roam freely, the absence of officers is equally dangerous. Staffing needs must be assessed and addressed so that the care, custody and control of all inmates, as well as the safety of all persons that may work or visit these facilities are improved.

In sum, it is incumbent upon us to ensure adequate staffing levels and the safety of everyone in the facilities.

Thank you.

Lisa Schreibersdorf
Services
Executive Director

Brooklyn Defender

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

&

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

BROOKYLN DEFENDER SERVICES
EXECUTIVE SUMMARY

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

As this testimony reflects, Brooklyn Defender Services has seen some positive results with the mechanisms provided by and alternatives available through the mental health court and Crisis Intervention Teams. Jail-based reforms to reduce the census in mental observation dorms, more frequent reevaluation of housing needs for mentally ill people, reducing obstacles to proper and continuous treatment such as escort rules would all bring significant improvements to local jails. Retraining of DOC staff so they can maintain safe, humane living spaces for people in their care and can provide mental health first aid and employ de-escalation techniques rather than brute force during conflicts would also be welcomed. However the primary driver of reform must be prioritizing the use of correctional facilities as a last resort only and reinvesting the savings produced by declining jail populations into the communities from which our clients come. By reducing the number of people incarcerated in City jails, programming and infrastructure can be implemented to meet the needs of this population. New York City should be a leader in the jail

reform and decarceration movement, rather than continue misguided policies that deny our neighbors, many with sicknesses that are not in their own control, basic human rights. Thank you sincerely for your prompt attention to this urgent matter.

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

GENERAL RECOMMENDATIONS TO IMPROVE HEALTHCARE DELIVERY

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

ADDITIONAL RECOMMENDATIONS RELATING TO INT 0440-2014

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

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

TESTIMONY OF LISA SCHREIBERSDORF,
EXECUTIVE DIRECTOR, BROOKLYN DEFENDER SERVICES

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

BDS represents over 45,000 clients each year who are arrested in Kings County, of which about 6,000 are incarcerated at some point during the pendency of the case and brought into the custody of the Department of Correction (DOC) and the care of the Department of Health and Mental Hygiene (DOHMH). According to DOHMH about 25 percent of the City jail intakes present with some kind of mental illness, with about 5 percent presenting with serious mental illness such as schizophrenia. (This tracks, generally, the overall population). In addition to diagnosed mental illness, almost all of our incarcerated clients have healthcare needs – some, serious ones. Our experience leads us to believe that the incidence of mental illness is actually much greater than DOHMH reports, an understanding supported by off-line conversations with medical staff in city jails who report a serious problem with identifying health and mental health needs upon intake. Furthermore many otherwise healthy people develop mental health symptoms such as depression, suicidality and trauma while incarcerated, in addition to communicable illness.

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

transitioning clients to the community upon discharge. This testimony reflects the collective experience of our tens of thousands of clients, as well as our team of social workers, our jail-based services, and over 150 attorneys. It is important to note that the health crisis currently playing out in City jails is not independent of other social policies and priorities in New York City. Access to housing, education, community healthcare, childcare and employment, for example, should all be considered building blocks to reducing the healthcare load at City jails.

THE NEED FOR FEWER ARRESTS

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

Under current practices, when our clients are arrested, they spend about 20 hours at the precinct and at central booking before they are arraigned by the court. During this time, most of our clients have not received any medication they were taking in the community. Many clients with health needs are treated dismissively by police officers. Only those people with what are deemed critical healthcare needs typically have a chance to gain access to hospital care. In an attempt to gain more information about this process our office has filed a Freedom of Information Act request to both the FDNY (which provides Emergency Medical Services screening at bookings) and the NYPD more than six months ago with no response. In October, a client of ours, Jasmine Lawrence, 22, died in police custody because of a failure to receive medical care.

Our experience is that police officers are generally unwilling to give any of our clients any medication while they are in custody immediately after arrest. There are hundreds of stories about family members at the precinct begging the officers to give their loved one blood pressure or asthma medicine to get them through the next 24 hours with little success. Last year an elderly female client of ours died right after her arraignment because she was not provided with diabetes medicine during her stay in custody even though her sister came to the precinct with the insulin. In 2013 Kyam Livingston died in Brooklyn Central Bookings after being denied needed medical care by officers who watched her perish rather than call an ambulance. In Ms. Livingston's case she was told by officers at Central Booking that her arraignment would be intentionally delayed by them, that they would "lose her papers" if she continued to make requests for a doctor.

Like Ms. Livingston, our clients who ask to see a doctor or go to the hospital are discouraged and even threatened by officers, resulting in few seeking treatment during this time. These practices are unacceptable on their face and result in serious harm (and even death) on a shockingly

regular basis. For people with a mental illness, this unwillingness to meet the medical needs of arrested people results in significant decompensation. We recommend that the committee review policies and practices at the time of arrest and until the arresting officer turns over custody of the individual. Certainly any person who needs medication should be able to receive this medical treatment even though they have been arrested.

For our mental health clients, the disruption of treatment and the path to possible decompensation begins at the moment police respond to the scene. This is why we believe that diversion is an essential starting point for reforms. We believe that the greatest good can be achieved by deciding not to arrest individuals with mental illness if there is another safe and viable alternative, particularly in low level offenses. In New York City today, when a 911 call comes in requesting emergency assistance for what is commonly referred to as "Emotionally Disturbed Person (EDP)," the options of the first responder teams, which are typically comprised entirely of police, are very limited. These first response teams should be expanded to include social workers and/or mental health clinicians trained to conduct critical assessments during moments of crisis. Additionally the police should be trained to interact with potentially mentally ill people and their families in a manner that de-escalates the situation. Linkages to treatment and hospitals or other service referrals should be the first steps before a consideration of further involvement by the criminal justice system. The recommendations of the Mayor's Task Force on Behavioral Health are promising, but implementation will be challenging if we continue to rely solely on the police to respond to community needs.

Many police calls come from family members or loved ones seeking crisis mental health services, referrals and assistance, not a criminal justice response. Discretion has been eliminated from the police in many matters, especially those that can be categorized as "domestic violence." Even if the police believe the mentally ill person should go to the hospital rather than jail, they are not permitted to do anything other than arrest the person. This is discouraging because many families call the police in the hopes of receiving help and feel betrayed by the arrest of their loved one. We believe this dynamic contributes to the dangerous escalation of some situations and adds to the tense relations between the police and the communities served by our office. By giving the police more options and more discretion regarding the response to people with mental health issues, especially on lower-level offenses, the moment of contact can be an opportunity to begin treatment rather than the start of a slide backwards.

Around the country there are various models, including multi-disciplinary "Crisis Intervention Teams," (CIT) which create better outcomes during the initial contact with the criminal justice system for people with mental illness. This model includes the possibility of going to a hospital rather than being arrested, diverting the person from the criminal justice system entirely. We are encouraged by commitments to fund a CIT pilot program, and hope the program will be implemented broadly in the future should it prove effective. If people are identified as having a mental illness, community-based services, not the legal system, are the best first option whenever possible. The impact of incarceration on public health cannot be overstated; being locked up negatively effects family and community ties, employment, housing options, treatment access, and the experience of incarceration often leads to new trauma. We are grateful that the health committee is taking a look at the intersections between the criminal justice system and health.

BAIL

Issues such as homelessness and substance abuse which frequently co-occur with serious mental health issues can leave this demographic more likely to have bail set and thus be incarcerated due to poverty. It is not uncommon for clients who have been identified with serious mental illness at arraignment and are charged with low-level, non-violent offenses to be detained and sent to City jails. The City Council should analyze and review the information regarding why people are in custody prior to conviction and consider significant changes to the current practices and policies surrounding the application of bail. There are many suggestions we can make about bail for misdemeanor cases, but some that would have the biggest impact on our mental health clients are (1) voluntary supervised release as an alternative to bail; (2) regular review of bail by the court with a presumption that bail should be lowered or eliminated if a person cannot post that bail; (3) presumptive release for a person with a mental illness if they are going to a treatment facility or a valid treatment plan has been proposed to the court.

Below is a case example of one of our clients:

> *"Sarah", a woman in her late twenties, has no prior arrests, but a long mental health history. She lived in the community, with the support of an Assertive Community Treatment (ACT) team and her family. Sarah had no history of violence. Her family noticed she was decompensating and petitioned for a Mental Hygiene Warrant for involuntary psychiatric evaluation. Prior to the execution of the warrant, Sarah had an altercation with a family member. The police responded to the situation by arresting her. Unable to post bail at arraignments she was transported to Rikers Island where she swiftly began to decompensate further. She deteriorated rapidly and just a few weeks after arriving in City custody, she was admitted to Elmhurst Hospital prison ward for acute medical attention. Finally, her family, who never wanted her arrested in the first place, was able to secure her release on bail.*

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

Of course by now you have heard of Jerome Murdough, a homeless, mentally ill U.S. Marine Corps Veteran, who died in Department of Correction custody in 2014 after being neglected in a mental observation unit at Rikers Island. He had been arrested for trespassing after attempting to sleep in the stairwell of a public housing building. His bail was set at $2,500, an amount too high for him to pay. After approximately two weeks in Rikers Island he died as a result of a toxic combination of medication given him while in DOC custody, cell temperatures that exceeded 103 degrees and a lack of attention from medical and mental health staff during his incarceration.

These stories illustrate the most compelling problem we see on a daily basis—people with mental illness are arrested for low level offenses that could easily be a basis for hospitalization or other medical intervention. Our clients could be released by the court, but instead bail is set. Thousands of such people pass through Rikers Island without any thought to their individual health or safety nor any broader policies or principles that are proportionate to the alleged wrongful act and the condition of our client.

It is obvious to us that the amount of money being spent to essentially exacerbate the problems of sick, poor people in New York City could easily be re-directed into community treatment

options to address the health needs of these very same people. The current practice of utilizing jails and prisons as mental health "treatment" facilities, at an astronomical price, is not sustainable or effective. It has never been morally justifiable. Furthermore, the practices of New York City when it comes to incarcerating people who have committed nothing more than nuisance offenses must come to an end. There is no doubt that this type of charge is disproportionately used against people with mental illness who are unable to cope in our society and are trying to do what they can to survive—hurting no one in the process. Neither severity of charge, nor financial resources has proven to be at all reliable predictors of public safety or return to court rate. We urge City Council to reduce the number of people in correctional custody and invest in community-based high-quality mental health care, housing, education and targeted preventative, diversion and reentry services.

CURRENT STATUS OF HEALTHCARE DELIVERY FOR CLIENTS IN CITY CUSTODY

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

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

Some case examples:

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

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

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

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

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

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

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

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

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

Contrary to the testimony of DOHMH, many of our clients report that they do not promptly receive a mental health evaluation or medications once committed to City custody. In addition, there is not an appropriate range of mental health care options for people who are noticed to have needs by medical staff. Medication remains the only "treatment" for nearly all of our clients in City jails irrespective of mental health needs that require other interventions. Our clients report that they rarely receive the opportunity for group or individualized therapy, dual-diagnosis therapy, or treatment from specialists in trauma, posttraumatic stress, sexual violence, adolescence, family or other discrete fields, even though such modalities are considered part of, not supplemental to, medically appropriate treatment. One client summed it up like this recently: "Once a month someone renews my pills and asks me if I want to kill myself." There is widespread indifference by mental health professionals working in City jails of the traumatic effects that incarceration itself is having on their patients.

There are concerns with the medication as well. Medication should only be prescribed by a psychiatrist who spends adequate time with a patient. In our experience this is not the typical experience at Rikers Island. Not only are there not enough psychiatrists, the quality of doctors who work there is low. They are limited in what they will prescribe; keeping to low-cost medications that are not necessarily what the client was previously taking on the outside and which may not be medically appropriate. When they do get medication, most clients report disruption from their regimen at some point during their incarceration in city custody. This occurs due to a variety of reasons, starting with delay or denial in the first instance. Once on medication, clients report failure by staff to renew medications, difficulty getting medications due to escort restrictions or facility lockdowns, transfer between facilities, and housing restrictions. Many medications must be given consistently to work. Any break can have drastic consequences, such as rapid decompensation, which then results in the cycle described in our introduction. Pain medication is frequently withheld by medical staff who accuse our clients of drug-seeking rather than having a reasonable health need.

Confidential treatment space is extremely limited in DOC facilities; many mental health visits are performed at cell-front, or in dorms within earshot of other patients or DOC staff. In punitive segregation units these interviews are done through a small slot in a closed cell door through which a clinician and patient must actually yell to each other in order to communicate. Information significant to mental health treatment is at times withheld by our clients as a means of self-protection. Something as routine as discussing the side-effects of a particular medication, such as drowsiness, can create a safety risk if overheard and our client is determined by his peers or corrections officers to be vulnerable or potentially unable to defend themselves while in jail.

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

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

SOLITARY CONFINEMENT AND VIOLENCE

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

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

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

A report[1] by the Board of Correction (BOC) was issued on September 5, 2013, written by two mental health experts who determined that the City was not in compliance with its own Minimum Standards of care for people with mental health diagnoses. The doctors, James Gilligan and Bandy Lee, concluded that the DOC's use of "prolonged punitive segregation of the mentally ill violates" the standards. The report recommended that the Restrictive Housing Units (RHUs) that were created by the DOC under pressure by advocates in 2013 to provide housing for people with mental illness, "be eliminated because it is a punitive rather than therapeutic setting for people with mental illness." Recently our staff visited the RHU in the adolescent facility at Rikers Island and were horrified by the conditions there, which included filthy cells and tables set up for waist and leg chains for the few moments of free time enjoyed by the mentally ill sixteen and seventeen year-olds in the unit.

The BOC report found the prolonged solitary confinement that is practiced at Rikers Island to be "one of the most severe forms of punishment that can be inflicted on human beings short of killing them." The SHU Exclusion Law, which restricts the use of solitary confinement in upstate facilities, has no jurisdiction in county jails, such as Rikers Island. While there have been efforts to reform housing units for people with mental illness, they have not had sufficient reach to this point. While our clients typically decompensate while in DOC custody, no matter their housing assignment, those in solitary confinement decompensate much more rapidly. Mental health symptoms such as paranoia, psychosis, and suicidal ideation are exacerbated by the conditions of solitary confinement, described by the special U.N. rapporteur as torture. Meanwhile mental health services are severely restricted in these punitive units, leading our clients to decompensate even further and impeding their chances of recovering when returned to a less restrictive unit or discharged from jail.

Another significant concern is the level of violence that our clients are subjected to while in city jails. Because of their vulnerability and the frustration their symptoms can cause to others, individuals with mental health diagnoses are more likely to be subjected to violence in jail, including rape and serious assaults. Many of our clients are harmed by their peers without any intervention by corrections officials. In addition, corrections officers use physical violence quite often against such clients. Seventy-seven percent of serious injuries – fractures, stitches and head injuries – are suffered by someone with a mental health diagnosis.

Here is one client example:

> *"Sam" is a twenty-two year old client who suffers from mental illness. In many ways his story exemplifies the experiences of people with mental illness on Rikers Island – he was a victim of violence; he decompensated periodically due to his incarceration; and he faced harsh punishments when disagreements with staff were not effectively de-escalated. While in General Population housing designated for people with mental illness, Sam was the victim of slashing and burning attacks because he resisted pressure to join gangs in the unit. Staff was unable to protect him and others from violence that has become a daily reality for many on Rikers Island. When he had disagreements with staff about lost property during transfers between jails, conflicts quickly escalated and he was issued infractions. Eventually Sam was moved into the Restrictive Housing Unit (RHU), a unit closely resembling solitary confinement where people with mental illness are housed.*

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

While in the RHU, his mental health symptoms worsened; he began to more regularly experience auditory and visual hallucinations, and he became increasingly depressed and hopeless. When he expressed his feelings of hopelessness, he was placed on suicide watch under extremely harsh conditions. After he was released from suicide watch back into the RHU, he was stripped of all the limited privileges he had earned – he was no longer permitted to leave his cell a few hours per day, could not participate in mental health groups, and received welfare checks at cell-front from mental health staff during the 23 hours each day he spent in his cell. He was released directly in to the community from these deplorable conditions, no longer able to care for himself following the traumatic experience of incarceration.

In our opinion solitary confinement should not be used for anyone at all, but particularly must be eliminated for anyone with a mental illness or anyone who is not able to mentally cope with the isolation. Attempts by DOHMH to screen people have not thus far been effective. As it is now, there are regulations that say that a person who is placed in solitary must be found to be mentally fit prior to placing them in isolation. However, there are no concrete standards to define mental fitness to withstand solitary confinement. Our clients there rapidly lose weight, develop insomnia and anxiety, become agitated and easily frustrated and generally decompensate. Any discussion on healthcare in City jails must begin by considering the ways that the conditions of confinement actually create or exacerbate the existing healthcare burden. Despite regulations empowering DOHMH to request that people be removed from isolation if at risk of self-harm or other significant decompensation; people remain isolated on suicide watch for weeks in isolation units. During the February 10, 2015 Board of Correction meeting, the Board noted that such incidents occurred in at least June 2014, November 2014, and January 2015.

MENTAL HEALTH COURTS

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

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

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

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

See the following client story:

> *Robert, a person living with schizophrenia, was arrested on a non-violent felony. He reported experiencing auditory and visual hallucinations and a competency examination was ordered shortly after his arraignment. He was subsequently found unfit to proceed with his court case. He was ordered committed pursuant to C.P.L. 730.50. The delay for transfer from New York City Department of Corrections to the forensic psychiatric center for evaluation took 6 weeks[2]. Robert remained at the forensic psychiatric center for approximately two months. Upon his return to Rikers Island, Robert awaited approval for an alternative to incarceration offer from the prosecutor. By the time his case had been approved for a mental health program offer Robert had decompensated mentally and been the victim of serious assaults while at Rikers Island. His mental health deteriorated to the point that he had to be hospitalized at Bellevue Hospital Prison Ward. This destabilization prevented Robert's inclusion in mental health court.*

GENERAL RECOMMENDATIONS TO IMPROVE HEALTHCARE DELIVERY

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

ADDITIONAL RECOMMENDATIONS RELATING TO INT 0440-2014

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

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

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

CONCLUSION

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

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

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

Sincerely,
Lisa Schreibersdorf
Executive Director Brooklyn
Defender Services

URBAN JUSTICE CENTER

New York City Council
Committee on Fire and Criminal Justice Services
Committee on Health

Oversight Hearing – Health Care Delivery in New York City Jails: Examining Quality of Care and Access

Tuesday, March 3, 2015
250 Broadway, 16th Floor Committee Room
New York, NY

Testimony of
Urban Justice Center / Mental Health Project
40 Rector Street, 9th floor
New York, NY 10006

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We commend the Committees for convening this hearing on health care in the New York City jails. Jails are closed institutions; what happens there is hidden from public scrutiny. It is, therefore, imperative that the City Council use its power to shine a light on what takes place within these institutions, not only through oversight hearings but also through regular unannounced visits to the jails. Requiring the Department of Correction (DOC) and the Department of Health and Mental Hygiene (DOHMH) to report on the health care provided to individuals incarcerated in the City jails will make the system more accountable and allow for better outside oversight. We urge you to adopt legislation that will mandate such reporting.

The Urban Justice Center Mental Health Project has focused on the needs of people with mental illness in jails and prisons for more than fifteen years. Through our work as class counsel in the *Brad H. v. City of New York* litigation, we go into the City jails regularly and each year meet with more than a thousand people receiving mental health treatment. These monitoring interviews are specific to the discharge planning services individuals receive, but during these encounters, some individuals report treatment complaints as well. We are deeply familiar with the difficulties people with mental illness have within correctional facilities and in accessing services upon release.

Providing adequate health care in the City jails requires not only that the clinical staff providing the care be capable, well-trained, and properly supervised but also that there be cooperation and

coordination between correction and health staff. Currently the performance of both health and correction staff are deficient in meeting the health care needs of incarcerated individuals.

DOC Staff Fail to Recognize and Respond to the Treatment Needs of Incarcerated People

DOC staff are on the frontline when it comes to ensuring access to health care. They have the most direct and frequent contact with incarcerated individuals. They are in a position to hear and respond to requests for medical attention and also to identify untreated illness. Incarcerated people cannot access health care without DOC's cooperation.

The tragic deaths of Jason Echevarria, Bradley Ballard, Jerome Murdough, Mark Johnson, and Fabian Cruz are evidence of correction staff's complete disregard for the health and safety of the people in their care. These deaths are the most extreme result of correction staff's failure to act when an incarcerated person needs medical attention. But hundreds – possibly thousands – of others suffer needless pain and worsening conditions when correction staff ignore their treatment needs and do not assist them in obtaining medical attention.

The culture of violence in the City jails has been well documented, but possibly equally harmful is the culture of indifference that permeates the system. This indifference to the basic needs of incarcerated individuals results in their symptoms worsening and their health deteriorating and jeopardizes their lives.

Corizon Health Fails to Provide Appropriate Health Care

The City currently contracts with the for-profit company Corizon Health to provide health care in the jails. We objected to the renewal of Corizon's contract in October 2012 because of the company's performance failures in the context of suicides in the City jails in the preceding three years. The New York State Commission of Correction (SCOC), which is charged with investigating deaths in all correctional facilities in the state, had repeatedly cited deficiencies in Corizon's performance.

The SCOC report in the death of Bradley Ballard, issued December 16, 2014, exposed appalling treatment failures by Corizon staff. SCOC recommended that DOHMH consider whether Corizon "is fit to continue as a New York City service contractor in light of delivery of flagrantly inadequate, substandard and dangerous medical and mental health care to Bradley Ballard."

The report documents significant treatment failures by Corizon staff. The medical staff failed to provide follow-up care to treat diabetes, a known chronic condition. A fasting glucose laboratory study which was ordered was not carried out; an order for insulin was not renewed without clinical evaluation or follow up. Mr. Ballard missed numerous clinical appointments, but health staff did not take any action to follow up. Staff also failed to review the medical record before renewing medication. Mr. Ballard also received inadequate psychiatric treatment. His psychotropic medication was changed without documented clinical rationale; changes in his behavior after changes in his medication were not identified. Also, clinical staff failed to make daily rounds in the mental observation unit; thus, Mr. Ballard's need for medical attention was not observed and no intervention was initiated.

We fear that the treatment failures that characterized Mr. Ballard's care are pervasive. They suggest a system that does not evaluate individuals' overall health and is unconcerned with ensuring patient wellbeing. The City must provide adequate treatment to the people in its custody and must replace Corizon if it cannot provide such care.

Common Complaints about Lack of Access and Inadequate Treatment

The complaints we receive from incarcerated individuals reveal obstacles to accessing care as well as concerns with the quality of the care provided. These complaints include the following:

- Requests for sick call being ignored;
- Follow-up testing not being conducted;
- Treatment not being provided;
- Treatment being discontinued inappropriately;
- Prescribed medication not being provided;
- Medication being discontinued; and
- Medication being changed despite its efficacy.

The following examples illustrate the hardship that incarcerated people experience when they are denied care.

- Mr. S who was incarcerated at OBCC in November 2014 reported that he had signed up for sick-call four times and had not been seen. He complained of a serious problem with one of his eyes which was making it difficult for him to function.
- Mr. W reported waiting in the clinic for five to six hours and still not seeing a physician. He complained of excruciating pain.
- Mr. M, who was housed in a Restrictive Housing Unit, a form of solitary confinement for people with mental health issues, complained that his medications were not given consistently; his prescriptions expired at different times, often causing him to miss doses. He reported becoming agitated and distressed when not receiving medication.
- Mr. P, who was previously diagnosed with prostate cancer, reported that he had tried unsuccessfully to be seen by a doctor to address complications that had arisen as a consequence. He stated that he had signed up for sick call at least seven times to no avail and that when out of desperation, he addressed his request to health staff directly, he was told to sign up for sick call.
- Mr. A, who was also housed in the RHU, reported being denied his asthma inhaler and seizure medication.
- Mr. F reported that he has only one kidney and was not being given appropriate care. He described seeking medical care and being told that he would be taken to Bellevue Hospital for evaluation, only to be told when he returned from a visit with his family, that he was put down as refusing this medical appointment and would have to go to sick call to be have it rescheduled.

- Mr. L reported that the medication prescribed to treat his anxiety, depression and sleep disorder were changed, and that as a result, he was unable to sleep, and his anxiety and depression increased.
- Mr. T reported that mental health staff often attempt to provide counseling in his housing unit in the presence of his peers. He complained that the way these services were delivered kept him from engaging in mental health treatment and violated his confidentiality.
- Mr. S at NIC reported that his vision had deteriorated dramatically and that although he had been assessed by staff at Bellevue Hospital more than a dozen times, the necessary procedure had not been provided.

DOC and DOHMH Should Report Publicly on the Health Care Provided in the City Jails

To have a true understanding of the quality of health care in the jails, we need more comprehensive reporting. The limited information which has been reported pursuant to Local Law 42, which requires reporting on the use of solitary confinement (also known as "punitive segregation") and the services and treatment provided to the individuals incarcerated there, reveals serious problems in accessing care. The first quarterly report includes data from October through December 2014 on the number of requests for medical or mental health treatment made and the number of individuals who were seen for treatment. In the Central Punitive Segregation Unit at OBCC, more than 30,000 requests for treatment were reportedly made but only about 14,600 individuals were seen for treatment. Even in the Clinical Alternative to Punitive Segregation units at AMKC, where intensive mental health treatment is provided, 163 requests for treatment were made but only 94 individuals were seen for treatment. These numbers suggest either that many people request treatment and never receive it or that individuals must make multiple requests before being seen for treatment.

We support the enactment of legislation requiring both DOC and DOHMH to report on the health care provided to individuals incarcerated in all of the City jails. We recommend strengthening Int 0440-2014 by requiring reporting on specific data points, such as the following:

- The number of people who request medical attention throughout the jails, how many are actually seen and within what timeframe, and on average the number of requests an individual makes before being seen;
- The total number of admissions to jail during the reporting period, the total number of medical intakes, the number completed within 24 hours of admission, and details about what the medical intake involves;
- The number of appointments for follow-up care made, the number of appointments kept, the number of missed appointments broken down by reason (i.e., refusals, not being produced by DOC, movement stopped due to an alarm, etc.), and an explanation of what DOHMH and DOC are doing to ensure that incarcerated individuals receive follow-up care;
- The number of preventable hospitalizations broken down by diagnosis;

- The number of preventable errors in medical care broken down by types of errors.

We also recommend that reporting occur on a quarterly basis and that the information be provided to the public through posting on the DOC website.

* * * * *

The deep-rooted problems in the City jails must be addressed. We appreciate the City Council taking responsibility for oversight and hope that these efforts continue beyond this hearing. We encourage all Council Members to make unannounced visits to the jails regularly, but especially urge the Health Committee members to visit the clinics within various jails and North Infirmary Command where people with the most urgent medical needs are held.

Recognizing that the people incarcerated in the City jails are human beings whose health matters is fundamental to transforming conditions there. Correction and health staff must take responsibility for providing appropriate health care.

Thank you for this opportunity to testify.

The Fortune Society
BUILDING PEOPLE, NOT PRISONS

TESTIMONY OF
THE FORTUNE SOCIETY

The New York City Council

Committee on Health

Jointly with the Committee on Fire and Criminal Justice Services

Health Care Delivery in New York City Jails: Examining Quality of Care and Access to Care

March 3, 2015

Presented by: Barry Campbell

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Good morning. My name is Barry Campbell and I am Special Assistant to the Executive Team at The Fortune Society. I am testifying today on behalf of The Fortune Society and based on ongoing contact with and advocacy on behalf of justice-involved men and women who have been incarcerated in New York City jails. However, I would like to first start by thanking the various members of the City Council for convening this important public hearing on a Local Law to amend the administrative code of the city of New York, in relation to health services in city correctional facilities. Amending Chapter one of title 17 of the administrative code by adding a new section 17-198, which requires the department to prepare and submit an annual report, regarding the health of inmates in city correctional facilities, to the mayor and the speaker of the city council, has the potential to greatly improve upon transparency, oversight, and accountability regarding health care delivery in NYC jails, particularly in terms of health care quality and access. I would especially like to thank the City Council for allowing The Fortune Society ("Fortune") an opportunity to testify.

Recommendations:

- Increase access to sick call and specialty care for all jail residents, including those in punitive segregation or on "lock down;"
- Improve upon screening, treatment and care procedures during intake and throughout period of incarceration at Rikers jail;
- Improve treatment and supportive services for substance use and mental health disorders;
- Increase community involvement and consultation, particularly in reforming and improving upon medical and mental health standards;
- Inmate grievance policies and related oversight must be improved. The City Council must also be empowered to receive complaints of violence directly jail residents, and be directed to establish a secure system for filing them which fully insulates complainants from retribution;
- Numerous studies and reports support comprehensive reform of the NYC jails, which needs to move forward swiftly and ethically;
- Enact genuine comprehensive reform, increased transparency, and more community involvement in designing and implementing jail reforms;
- Increase mechanisms or guidelines for enhanced staff training, capacity building, and technical assistance;
- Increase transparency, accountability, or performance measures;
- Establish better guidelines for evaluation or data tracking of key changes or outcomes, which may provide useful data for guiding policy decisions;
- Prohibit prolonged punitive segregation for all inmates, particularly vulnerable populations;

- Partner with or refer to community-based service providers to facilitate holistic, coordinated, and integrated care (i.e. health care, education, and ongoing social support);
- Support alternatives to incarceration and detention that aid in addressing underlying challenges while maintaining and strengthening positive ties to families and communities;
- Support reform of NYPD and bail policies, which disproportionately affect those with limited resources and extend time in jail beyond that which is necessary or appropriate.

I would like to share with you a bit about Fortune's history. In 1967, David Rothenberg produced the off Broadway play "Fortune and Men's Eyes." Written by John Herbert, a formerly incarcerated playwright, the play captured the experience of people living in prison. Since its founding shortly after the off-Broadway play, Fortune has served as a primary resource for New Yorkers released from jails and prisons seeking to build constructive lives in their communities. Fortune now serves some 5,000 justice involved men and women via three New York City area locations: our service center in Long Island City and both the Fortune Academy and Castle Gardens in West Harlem.

All of our programs are designed and implemented to meet the unique needs of this population through skilled, holistic, and culturally competent assessments and appropriate service provision. We build initial relationships with clients that foster trust and safety to begin the healing, often a crucial prerequisite to providing services for people with justice involvement. This is further reinforced by the degree to which our staff reflects many shared life experiences of our clients. More than half of our staff are themselves either formerly incarcerated or in recovery. We believe in the importance of this cultural competency. However, it is this same cultural competency, specifically, the narratives told by our staff and clients regarding their experiences within correctional facilities, including Rikers, which allows us a deeper understanding of the degradation, inhumanity, and the physical as well as psychic injury experienced in such settings. As such, we started the David Rothenberg Center for Public Policy (DRCPP) seven years ago to "officially" utilize this experiential knowledge and unique understanding of the criminal justice system to shape and inform humane policy and practices.

Fortune is grateful to be situated among a community of social service agencies as well as public health and justice reform advocates who understand and seek to address the health challenges facing justice-involved men and women upon intake, during incarceration, and during the reentry period. Fortune operates two major programs on Rikers Island, including a program for individuals with HIV preparing for release and the Individualized Corrections Achievement Network (I-CAN) program for detainees and sentenced men and women. Fortune's Health Services team offer non-medical services, including HIV testing, prevention education, case management, and connections to community-based treatment and care, for people living with, or at risk for developing, HIV/AIDS. In addition, Fortune clients have access to a full spectrum of mental health services through the Better Living Center (BLC), which is the

first NYS Office of Mental Health-licensed Article 31 mental health clinic with services tailored specifically to the unique and complex needs of the justice-involved population. As part of a DOHMH-funded project, Fortune also supports providers in delivering culturally competent HIV prevention, treatment, and care services to justice-involved women and men.

Moreover, Fortune understands all too well the role that coordinated, culturally competent, and centralized services may play in preventing recidivism, relapse, poorer health outcomes, along with decreasing overall morbidity and mortality rates. Ultimately, we serve thousands of individuals with criminal histories, many of whom have spent time on Rikers Island at some point in their lives. We are trying to help these individuals rebuild their lives in the community through reentry services, as well as alternatives to incarceration (ATI) and alternatives to detention (ATD). However, the devastating impact of Rikers Island makes our work so much harder than it should be, because the trauma, violence, isolation, neglect, and limited opportunities that they have behind those walls cause huge damage and is, itself, reinforcement for criminogenic behavior, retraumatization, and poor health outcomes.

In general, justice-involved men and women face considerable health challenges during intake, incarceration, and upon reentry even in the best of circumstances. Young men of color from under-resourced communities are disproportionately represented in the NYC jail system. The pattern of repeated incarceration of young men and adolescents of color also further strain low income communities, where poverty, violence, health disparities, as well as lack of jobs and opportunity, exist amidst diminishing resources. Riker's average daily inmate population decrease from 14,000 ten years ago to 10,000 this past year, signals a gradual movement towards positive change. It is well-documented that 40% of Rikers inmates are living with mental illness. Unfortunately, justice-involved individuals are unlikely to access adequate, comprehensive substance use treatment while incarcerated, and risk relapse and recidivism after release.

We realize you are already familiar with the high levels of violence and counter-rehabilitative conditions on Rikers Island on the whole as well as the excessively harmful and isolating conditions in the punitive segregation areas, which have recently received widespread attention. For instance, the Associated Press obtained documents, which "raise serious questions about the quality and timeliness of the medical care many of these inmates received, with the treatment, or lack of it, cited as a factor in at least 15 deaths over the past five years."[1] The 2014 Department of Justice (DOC) report details systematic violence, including a "deep-seated culture of violence against inmates" and deplorable mistreatment of women and men incarcerated on Rikers Island. "The core problem and the heart of [their] findings: use of excessive and unnecessary force by correction officers against adolescent inmates and the lack of accountability for such conduct." The DOC provides irrefutable evidence of systemic failures in preventing correctional staff's use of excessive, unnecessary, and improper force, which occurs in extraordinarily high frequencies and includes excessive and inappropriate use of prolonged punitive segregation.

[1] See http://newyork.cbslocal.com/2014/10/22/ap-rikers-island-deaths-suggest-poor-medical-treatment-of-inmates/

Additionally, the New York State Commission of Correction also found "gross incompetence by medical personnel and correction officers at Rikers Island."[2] The agency's 2014 report states such incompetence led to the death of Bradley Ballard, who was living with diabetes and mental illness and was found naked and covered in feces after being locked in a cell for six days without appropriate care or medication.

> *The commission's report, which is dated Dec. 16, and was obtained by The New York Times, though not released publicly, describes how a warden, an assistant deputy warden, guards, doctors, mental health clinicians, nurses and others made at least 57 visits to Mr. Ballard's cell as he slowly deteriorated over a six-day period but did nothing to assist him.*
>
> *The commission's report makes clear that blame for the death lies squarely with the city's correction and health agencies, as well as the private jail health contractor, Corizon Inc.*
>
> *Mr. Ballard was locked "in his cell for six days prior to his death," the report said, "and was denied access to his life supporting prescribed medications, denied access to medical and psychiatric care, denied access to essential mandated services such as showers and exercise periods and denied running water for his cell."*

Ultimately, the commission finds, "The lack of coordinated care for and mismanagement of Ballard's [redacted] represents grossly negligent medical care by Corizon, Inc., endangered Ballard's life and subsequently caused his death."[3]

Further evidence of neglect and abuse of mentally ill individuals at Rikers has also recently come to light. Dr. James Gilligan and Bandy Lee prepared a 2013 to the Board of Correction DOHMH, which reported the role of jails' as *de facto* mental hospitals during the latter part of the twentieth century.[4] Dr. Lee and Gilligan also underscored that the DOC's use of prolonged punitive segregation of the mentally ill violates the Mental Health Minimum Standards. Moreover, data collected by the U.S. Bureau of Justice Statistics as a result of PREA confirms the women's jail on Rikers was among the facilities with the highest rates of sexual victimization in the U.S.[5] Further troubling, vulnerable populations, including individuals with mental illness, physical disability, or physical injury as well as victims of sexual assault, transgender women, and young adults, are at increased risk for experiencing violence, trauma and abuse within the walls of Rikers. As the above passages demonstrate, when at all possible incarceration should be avoided. Alternatives to incarceration or detention as well as connection to appropriate medical and social services should be prioritized in order to avoid incurring harm and further stressful and traumatic life experiences but also to facilitate healing and wellness.

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[2] See http://www.nytimes.com/2015/01/23/nyregion/gross-incompetence-cited-in-rikers-island-death.html?_r=0

[3] See http://dissenter.firedoglake.com/2015/01/28/report-for-profit-medical-provider-killed-mentally-ill-inmate-in-solitary-confinement-on-rikers-island/

[4] See http://solitarywatch.com/wp-content/uploads/2013/11/Gilligan-Report.-Final.pdf

[5] See Beck, A.J., Berzofsky, M., Caspar, R. & Krebs, C. (2013). *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-12*. U.S. Bureau of Justice Statistics. Retrieved on July 15, 2014 from www.bjs.gov/content/pub/pdf/svpjri1112.pdf

Consultation and engagement with the communities -- to which 95% of those currently incarcerated will return -- are key. Fortune and other agencies have been working side by side with families and communities of those who have been justice-involved for decades. Plus, we have collaboratively served on numerous city, state and federal task forces designed to improve the health and well-being of some of our city's most vulnerable populations.

The Fortune Society's mission is to support successful reentry from prison and jail, and promote alternatives to incarceration, thus strengthening the fabric of our communities. We do this by believing in the power of individuals to change; building lives through service programs shaped by the needs and experiences of our clients; and changing lives through education and advocacy to promote the creation of a fair, humane, and truly rehabilitative correctional system. As a society, we at Fortune believe that we can do better and go farther in improving the health and well-being of justice-involved men and women plus their families and communities. Specifically, we must make a commitment to drastically decrease the number of men and women on Rikers Island and affected families and communities by reducing the number of incarcerations for low-level offenses, expanding ATI/ATD programs, and by exploring options for incarcerating men and women closer to home when incarceration is necessary. Reform of NYPD and bail policies, so as to assist men and women in being guided towards public health and social service interventions rather than relegated to jail, is fiscally and socially responsible.

We must ensure that justice-involved men and women receive the supports and services they need, including more educational opportunities, job training programs, substance abuse and mental health treatment, and creative arts classes and workshops while incarcerated, as well as solid discharge planning and needed services upon release. Linking clients to and partnering with community-based service providers, which specialize in serving and caring for justice-involved men and women, as well as facilitating holistic, coordinated, and integrated care, are crucial to successful health care and reentry outcomes. As justice reform and public health advocates, we seek to transform the response to people's needs and problematic behaviors -- from deprivation and retribution, to additional support, programs, and therapeutic strategies.

Fortune is eager to work closely with the City Council and the Mayor to be part of the solution to this entrenched problem. We applaud gradual efforts towards genuine comprehensive reform, increased transparency, and more community involvement in designing and implementing criminal justice reforms. We understand all too well the potential effects that fair reporting, transparency, oversight, and accountability efforts may have on incarcerated men and women, correctional staff, as well as families and larger communities. With programs both inside and outside Rikers Island for those impacted by the criminal justice system, Fortune stands ready to provide many of the supports that justice-involved individuals need. With increased funding for positive programming directed toward our population, we could do even more.

We urge ALL CITY COUNCIL MEMBERS and mayoral staff to learn more about the men and women affected by criminal justice system involvement by visiting our ATI/ATD, discharge

planning, and other reentry programs, and by interacting directly with those, like myself, who have been on Rikers Island. Listen to the trauma and pain that we at Fortune hear every day doing this work. Then, let's work together to address underlying challenges and heal rather than harm. Moreover, we aim to support you in creating more therapeutic settings as part of addressing challenges, building on strengths, and alleviating barriers to accessing and sustaining treatment, prevention, and care, which improve health and recidivism outcomes.

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TESTIMONY OF THE NEW YORK CIVIL LIBERTIES UNION[1]

before

THE NEW YORK CITY COUNCIL
COMMITTEE ON HEALTH and
COMMITTEE ON FIRE AND CRIMINAL JUSTICE SERVICES

on

INT. 440 (requiring the Department of Correction to issue a report regarding the health of inmates in city correctional facilities during the previous calendar year)

March 3, 2015

The New York Civil Liberties Union respectfully submits the following testimony regarding the City Council's consideration of Int. 440, which would require the Department of Correction to issue a report regarding the health of inmates in city correctional facilities.

With 50,000 members and supporters, the New York Civil Liberties Union (NYCLU) is the foremost defender of civil liberties and civil rights in New York State. Our mission is to defend and promote the fundamental principles and values embodied in the Constitution, New York laws, and international human rights law, on behalf of all New Yorkers, including those incarcerated in jails and prisons. The NYCLU is an outspoken advocate for evidence-based corrections practices that improve public safety and respect fundamental human dignity.

We support the City Council's efforts to bring much-needed oversight to the delivery of both medical and mental health care in city jails. Substandard health conditions for incarcerated people in New York City have persisted for far too long. Just last June, the Council held an oversight hearing on violence and the provision of mental health and medical services in city jails, where council members, experts, advocates, and other stakeholders raised serious concerns about the adequacy of health care services for individuals incarcerated in our jails These concerns include the following major barriers to the provision of fundamentally adequate health care services: (1) the rising number of individuals with mental health conditions in city jails; (2) the willful neglect

[1] This testimony was researched and co-written by Becca Cadoff and Deandra Khan.

of the City's contracted health care provider; (3) the excessive and punitive use of force by correction officers that is often used against individuals who are suffering from a lack of adequate mental health treatment; (4) training and qualifications of custody staff, and; (5) the conditions of the facilities on Rikers Island itself.

The data reported under Int. 440, with the amendments proposed below, will be a major step forward in addressing these barriers. First and foremost, it will permit the City to better assess the number of individuals detained at Rikers who suffer from mental health or medical conditions so serious that they should never be incarcerated in the first instance, and supports the laudable goals of the Mayor's "Action Plan" that calls for diverting many individuals from incarceration to a more appropriate therapeutic setting.[2] Second, the data will permit a long overdue comprehensive assessment of medical and mental health care at Rikers and can be used to inform sweeping improvements in the quality and delivery of that care. Below, we discuss some of these barriers in more detail, and then provide our recommendations for amending Int. 440 to make it as effective as possible in addressing and overcoming these barriers.

I. Barriers to Adequate Health Care & Reform Recommendations

a) Rising Numbers of People with Mental Health Conditions Incarcerated at Rikers and Need for Diversion from Incarceration

Deinstitutionalization and the closing of state psychiatric hospitals, the rise of managed care, the NYPD's focus on "broken windows" and enforcement of quality of life offenses, and systemic failures to fund community-based mental health services have contributed to the incarceration of thousands of people with mental illness in New York City.[3] This growing population on Rikers Island taxes existing systems and contributes to disruptions in health care provision for prisoners.

The overall New York City jail population has decreased since 2001, but the proportion of people being treated for mental illness has risen sharply, from twenty-seven percent in 2007 to nearly forty percent today.[4] These illnesses range in nature from depression and adjustment disorders to schizophrenia and bipolar disorder, and often co-occur with substance abuse issues.[5] Furthermore, many individuals enter the jail with medical needs; one national study indicated that individuals in state jails were "31 percent more likely to have asthma, 55 percent more prone to have diabetes, and 90 percent more likely to have suffered a heart attack," than the non-

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[2] Mayor Bill De Blasio, City of New York, "Mayor's Task Force on Behavioral Health and the Criminal Justice System, 2014. Available at http://www1.nyc.gov/assets/criminaljustice/downloads/pdf/annual-report-complete.pdf

[3] "Mentally Ill Offenders in the Criminal Justice System: An Analysis and Prescription." *The Sentencing Project,* Jan. 2002. Available at http://www.sentencingproject.org/doc/publications/sl_mentallyilloffenders.pdf

[4] Joseph Ponte, NYC department of correction commissioner, testimony, *New York City Council 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*, p. 19. 12 June 2014.

[5] *Ibid.*, Commissioner of NYC health department Mary Basset, testimony, p. 32-33.

incarcerated population.[6] These factors clearly pose a challenge for the DOC, DOHMH, and privately contracted workers whose job it is to provide "prompt and adequate access to all health care services," as outlined by the New York City Board of Correction, the agency that establishes and ensures compliance with jail minimum standards.[7]

One of the most impactful things the City can do to improve the level of care for New Yorkers in jail is to reduce the jail population by identifying and diverting individuals with medical and mental health needs so serious they should not be in a jail setting at all. [8] Given the high numbers of individuals who need care, it is clear that those with the most serious medical needs should instead be placed in a therapeutic setting where their needs can be easily met. Without system-wide changes aimed at reducing the population of incarcerated New Yorkers (the majority of whom are pre-trial detainees and people of color)[9], including a focus on diverting people with serious medical needs into more appropriate settings, challenges to providing adequate care will persist. Equally as important, city jails must comply with basic health care standards for the individuals who remain incarcerated. Jail healthcare policy and practice should achieve the community standard of care for all who remain, including rigorous monitoring and screening that can identify and transfer out people who develop serious medical or mental health issues after incarceration.

Currently, thousands of New York City residents -- who have lived in and will return to our communities -- are being jailed in harmful conditions. Without timely, competent, and consistent care for those diagnosed with and at risk for medical or mental illness, and without robust data to identify points of diversion, cycles of violence and incarceration will continue and place our communities at further risk for harm.[10]

b) Harmful Conditions of Confinement

The conditions of confinement for individuals in New York City jails hinder, and even worsen prisoners' mental and physical health. Among the worst aspects of these conditions are

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[6] Amanda Gardner, "Many in U.S. Prisons Lack Good Health Care," *U.S. News and World Report Health* 16 Jan. 2009. Available at http://health.usnews.com/health-news/managing-your-healthcare/articles/2009/01/16/many-in-us-prisons-lack-good-health-care

[7] New York City Board of Correction. *Health Care Minimum Standards.* §3-02(a). The BOC's Mental Health Care Minimum Standards, §2-04(a), further specifies that, "Adequate mental health care is to be provided to inmates in an environment which facilitates care and treatment, provides for maximum observation, reduces the risk of suicide, and is minimally stressful."

[8] The Mayor's Task Force on Behavioral Health and the Criminal Justice System is one solution that has been lauded by many, including the DOC Commissioner, for mapping out a plan to divert the mentally ill from the criminal justice system when they do not need to be there. See *New York City Council 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*, 12 June 2014.

[9] New York City Independent Budget Office, "Letter to Councilmember Melissa Mark-Viverito" 30 Sept. 2011. Available at http://www.ibo.nyc.ny.us/iboreports/pretrialdetainneltrsept2011.pdf.

[10] Multiple studies have demonstrated the link between mental illness and recidivism. See: Jacques Baillargeon, *et al*, "Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door," *American Journal of Psychiatry* 166(1), Jan 2009 (finding that inmates with major psychiatric disorders are more likely than those without to have had previous incarcerations).

the well-documented over-reliance on force by Correction staff (discussed later in this testimony) and the use of solitary confinement to punish people for breaking jail rules.

The damaging effects of solitary confinement on an individual's mental health are well documented.[11] A recent study of New York City jails confirms a strong link between self-harm and solitary confinement.[12] For healthy adults, the impact of solitary confinement can be devastating even after a short period of time; but the risk is especially acute for adolescents, individuals with mental illness or disabilities, and those with serious health conditions. Both the DOC and DOHMH have acknowledged the limited utility of solitary confinement in improving an individual's behavior, and have taken significant steps to eliminate its use with adolescents and people with serious mental or physical disabilities or conditions; they have also taken steps to limit its use with adults, which we applaud.[13] [14] Now is the time for rigorous oversight to ensure that these new reforms to solitary confinement are a true break with the past and the first step in comprehensive reform of all segregation practices throughout Rikers.

c) Rising Violence and a Culture of Brutality

The culture of brutality that exists on Rikers Island places inmates at even greater risk for mental and physical harm. The U.S. Department of Justice last August exposed one small segment of this culture by highlighting the devastating ways in which adolescents were subject to excessive force by correction officers. The report found that "while adolescents made up only about 6% of the average daily population at Rikers, they were involved in a disproportionate 21% of all incidents involving use of force and/or serious injuries."[15]

This pattern of brutality against adolescents is no different for individuals with mental illness, who bear the brunt of correction officer abuse leading to serious injuries often requiring hospitalization, according to a New York Times investigation.[16] These examples are part of a

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[11] *See* Stuart Grassian, "Psychiatric Effects of Solitary Confinement," *Washington University Journal of Law & Policy* 325, 336 (2006) (noting impulse control and self-harm are psychiatric symptoms associated with solitary confinement); Craig Haney, "Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement," *Crime & Delinquency* 49 (2003) 124, 131 (noting the association of suicide and self-mutilation with isolated housing).

[12] Fatos Kaba et al., "Solitary Confinement and Risk of Self-Harm Among Jail Inmates," *American Journal of Public Health* 104 (2014) 442 (explaining that "[i]nmates punished by solitary confinement were approximately 6.9 times as likely to commit acts of self-harm" even after researchers controlled for other factors including length of jail stay, serious mental illness, age, and race/ethnicity).

[13] 40 Rules of the City of New York ("RCNY") § 1-16.

[14] Dr. Homer Venters, asistant commissioner, bureau of correctional health services New York City department of health and mental hygiene, testimony, *New York State Assembly Committee on Correction with the Committee on Mental Health Regarding Mental Illness in Correctional Settings* 13 Nov. 2014. Available at: http://www.nyc.gov/html/doh/downloads/pdf/public/testi/testi20141113.pdf

[15] U.S. Department of Justice, *CRIPA Investigation of the New York City Department of Correction Jails on Rikers Island*, 4 Aug. 2014, p. 8.

[16] Michael Winerip & Michael Schwirtz, "Rikers: Where Mental Illness Meets Brutality in Jail." *New York Times*, 14 July 2014. Available at: http://www.nytimes.com/2014/07/14/nyregion/rikers-study-finds-prisoners-injured-by-employees.html?_r=3

larger trend: In 2014, incidents of force by guards were at their highest in more than a decade.[17] In these instances, New Yorkers most in need of care and support have been denied their basic rights by the very institutions entrusted to house them. This again underscores the need for diversion of those with the highest needs and most serious medical and mental health conditions out of jail and into therapeutic housing, where licensed medical professionals and behavioral specialists can best help. It also demonstrates the need for Correction staff to receive specialized training focused on, for example, adolescent development, identifying symptoms of psychiatric illness, and conflict de-escalation techniques best suited to vulnerable populations that remain.

The DOC Commissioner has acknowledged that these recent increases in violence perpetuated by both inmates and correction staff are "clearly unacceptable, and reversing them is [his] top priority."[18] To this end, Int. 440 is one tool the City Council can utilize to maintain oversight over whether quality medical and mental health services are provided to individuals at Rikers and whether staff is receiving the appropriate training. In addition, we recommend the Council use its oversight power to identify barriers to reporting violence and disciplining Correction staff. The culture of brutality must be met head-on with transparency and accountability.

d) Failure to Meet City and State Minimum Standards

The New York State Commission of Correction's (SCOC) recent investigation into the death of Bradley Ballard illustrates the level of neglect and indifference to basic human rights characteristic of health care service provision in New York City's jails. The SCOC determined that "the medical and mental health care provided...was so incompetent and inadequate as to shock the conscience."[19] For six days, Mr. Ballard was locked in his Rikers Island cell and denied access to life-saving care and basic services, like prescribed diabetes medication, psychiatric care, showers, and exercise. He was found unresponsive in his cell, and his death was ruled a homicide by the New York City Medical Examiner.[20] SCOC determined that the conditions leading up to Mr. Ballard's death ran counter to "New York State Correction Law, NYS Minimum Standards and Regulations for Management of County Jails and Penitentiaries, and Ballard's civil rights."[21] The poor conditions surrounding Mr. Ballard's death also violated many of the New York City

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[17] Michael Winerip & Michael Schwirtz. "Even As Many Eyes Watch, Brutality at Rikers Island Persists." *New York Times*, 21 Feb. 2015. Available at: http://www.nytimes.com/2015/02/22/nyregion/even-as-many-eyes-watch-brutality-at-rikers-island-persists.html

[18] Joseph Ponte, NYC department of correction commissioner, testimony, *New York City Council 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*, p. 19. 12 June 2014.

[19] New York State Commission of Correction. *Final Report in the Matter of the Death of Bradley Ballard*, p. 2. (December 16, 2014).

[20] *Id.*

[21] *Id. p. 3*

Board of Correction's minimum standards.[22] These findings shed harsh light on the glaring disconnect between jail standards in theory and practice.[23]

The SCOC cites the "compounded failures" of the DOC and its contracted healthcare provider, Corizon Correctional Care, as the reason for Mr. Ballard's death.[24] There have been widespread allegations of neglect against Corizon (across the country, Corizon has been sued 660 times for malpractice over the last five years). [25] We think the City should have serious reservations about contracting with any for-profit company to provide medical and mental health services to incarcerated people. The City must ensure that the provider abide by stringent mental health and medical standards, with built-in accountability and oversight mechanisms. Int. 440 is a step toward assessing that compliance and then making the necessary changes in the delivery and quality of care.

II. Legislative Recommendations: Need for Data to Guide Evidence-Based Reforms

Public access to accurate data is a critical first step to reforming our jails. Indeed, as we have seen with so many other issues, good data can be the foundation for broad policy reform. [26] The NYCLU applauds the City Council's efforts to bring transparency and accountability to medical and mental health care practices in New York City jails. Int. 440 will allow the City to lead the country with respect to such reporting.

This bill is directly connected to furthering the goal of diversion from incarceration. Identifying the medical and mental health needs of individuals entering and already in city jails can lead to better identification of the corresponding the levels of care needed to achieve the goal of diversion from incarceration, rehabilitation, and reintegration into the community. Indeed, diversion can have the additional effect of lowering the jail population to more accurately gauge and improve adequacy of care for those who remain. Mr. Ballard's case is unfortunately just one example of why it is so imperative that DOC's and Corizon's data management and record-keeping is scrutinized.

The Council and the public must better understand how health data is collected, maintained and utilized in our jails. This includes both records that pertain to individual care and data used to drive continuous quality and performance improvements within the facility. We recommend DOC's public reporting requirements be unified and streamlined into one report, and that de-identified data pertaining to all aspects of conditions of confinement (from healthcare to education to complaints against guards) be reported regularly in a machine-readable format.

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[22] See, e.g New York City Board of Correction. *Health Care Minimum Standards*, §3-06(a). Available at http://www.nyc.gov/html/boc/downloads/pdf/healthcare_standards.pdf . Last visited 2 Mar. 2015.

[23] *Id.*

[24] *Id.*

[25] Corizon has been sued 660 times for malpractice over the last five years and yet generates an estimated $1.4 billion every year. *See* Jesse Lava, *Meet the Company Making $1.4 Billion a Year off Sick Prisoners,* American Civil Liberties Union (October 8, 2013), *available at:* https://www.aclu.org/blog/prisoners-rights/meet-company-making-14-billion-year-sick-prisoners

[26] Data collection and analysis has been the starting point for successful reforms to solitary confinement in Washington, Colorado, Illinois, Maine, and New York City.

Subject to the legislative recommendations outlined below, the NYCLU believes that Int. 440 will help lay a foundation for reforms to access to health care and mental health care in New York City jails. If successful, this initiative could be a model for the rest of the country. This data should be thoroughly analyzed and then used both to enhance the health care delivery system at Rikers and to guide the direction of future reforms. Based on what we already know anecdotally about the dismal quality of care at Rikers and what the comprehensive data shows, the Council should be prepared to use its budgetary power to ensure adequate resources are allocated to undertake such corrective measures, then exercise its oversight authority to ensure that those resources are being used appropriately and with proper assessment.

We propose the following recommendations to clarify and expand the reporting requirements at issue today.

a) Shared Reporting Responsibilities

First, provision of and referral to health services is a responsibility shared by the Department of Correction, the Department of Health and Mental Hygiene, the Health and Hospitals Corporation, and often contractually with an outside provider, like Corizon Correctional Care. The involvement of these multiple entities and providers creates a risk that responsibility for data collection and reporting will be too diffuse to effectively achieve the goals of Int. 440. Therefore, we recommend that the bill be amended to clarify that any agency involved in the delivery of medical or mental health care in the City's jails be required to collect and report all the data necessary for compliance with the requirements of Int. 440, and that one agency should be identified as having final responsibility for compiling and publicizing the final report.

b) Definitions

Second, we recommend that definitions be added in order to clarify the types of information that will be reported under Int. 440. The reporting requirements currently required under section one (for example, "intake" and "patient safety") are very broad. We urge the City Council to consult with correctional, medical, and mental health professionals to develop appropriate definitions and patient privacy protections in order to clarify the reports that would be produced in compliance with Int. 440.

c) Relation to BOC Minimum Standards of Care

We also recommend that the reports required under Int. 440 be aligned with the minimum standards of care outlined by the Board of Correction.[27] Alignment with these standards would

[27] See, generally, New York City Board of Correction. *Mental Health Minimum Standards*. Available at http://www.nyc.gov/html/boc/downloads/pdf/mental_health_minimum_standards.pdf. Last visited 27 Feb. 2015. See also, New York City Board of Correction. *Health Care Minimum Standards*. Available at http://www.nyc.gov/html/boc/downloads/pdf/healthcare_standards.pdf . Last visited 27 Feb. 2015.

also capture the minimum standards set by the SCOC.[28] Reporting on the care that is delivered in a way that allows for easy comparison to what is required under the minimum standards will provide an important opportunity to identify deficiencies and gaps in service provision, and specific areas for improvement. Specifically, BOC's minimum standards address the following categories, which should be reported on under Int. 440:

- Sick calls
- Mental health services
- Emergency services
- Infirmaries
- Outpatient specialty clinics, including referrals
- Medical isolation
- Care requiring close medical supervision
- Hospital care
- Intake screenings
- Pharmaceutical services, including psychotropic medication
- Ongoing treatment
- Dental services
- Vision and eye care
- Pregnancy and child care
- Diagnostic services
- Surgical and anesthesia services
- Prosthetic devices
- Alcohol and drug treatment
- Prisoner refusals of care
- Inmate deaths

Under each category, the following should be reported:

- Number of prisoners requesting care
- Number of requests for care
- Number of prisoners receiving care
- Average length of time between a request and a call
- Median length of time between a request and a call
- Duration of treatment (if ongoing)
- Availability of services (e.g., number of beds in the infirmary, types of treatment programs and number of openings in a treatment program)

d) Training of Staff on Medical and Mental Health Care

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[28] N.Y. Comp. Codes R. & Regs. Tit. 8, § 7010.1-2 (2015). Available at https://govt.westlaw.com/nycrr/Document/I4fb24d54cd1711dda432a117e6e0f345?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default). Last visited 2 Mar. 2015.

Appropriate training is vital to ensure that quality medical and mental health services are provided to individuals in New York City Jails. We recommend that Int. 440 require reporting on training of correctional staff on health care. Any reporting on training should include:

- A list of trainings for custody staff related to medical and mental health care offered since the previous reporting cycle, with brief descriptions and the length (hours) of each training; and
- Number of staff who attended each training broken down by rank and title..

e) Report Key Demographic Information

Identifying populations of individuals receiving types of care is of utmost importance to identifying discrepancies and deficiencies, developing targeted responses and policies, including identification of who should not be held in New York City jails at all. In order to fully understand the delivery of care in New York City jails, we recommend that any data involving the number of inmates requesting or receiving care be disaggregated by important demographics. At minimum, data should be disaggregated by:

- Age
- Gender
- Race
- Borough of primary residence
- Mental health diagnosis upon arrival
- Mental health diagnosis during incarceration
- Charge type
- Detention length
- Facility in which the inmate is currently housed, as of the last day of the reporting period

f) Policy and Fiscal Reporting

In addition to quarterly data reporting, we urge the Council to help improve transparency surrounding polices on medical and mental health care. To this end, Int. 440 should include a requirement that the DOC post on its website any policies, memoranda of understanding, or contracts relating to the delivery of medical and mental health care to individuals under its custody. We recommend that any change to an existing policy, MOU, or contract be updated online within 15 days. Additionally, Int. 440 should direct the DOC to post quarterly fiscal reports relating to the delivery of medical and mental health services.

g) Quality Assurance, and Monitoring and Evaluation

The Board of Correction permits variances from its minimum standards and currently posts these variances on its website.[29] Additionally, the minimum standards also require regular reporting, monitoring, and quality assurance relating to any medical or mental health services,[30] We request that such reports, be they created by the DOC, BOC, DOHMH, a contracted organization, or other party, be posted and available to the public.

III. Additional Reporting

The New York Civil Liberties Union applauds the City Council's support for greater transparency, including the passage of Int. 292 in 2014 and the support for Int. 643, which has been introduced and requires reporting on individuals waiting for placement in segregated housing. We ask that the Council consider additional legislation to further enhance transparency. We urge the Council to require reporting in additional areas, such as the population awaiting trial and bail, the population in segregated housing other than punitive segregation, and continuity of care through connection to post-release community-based services.[31] Additionally, statistics on the general jail population are necessary to give context for all other reporting.

IV. Conclusion

We thank the Council for providing this opportunity to share our recommendations for reforming the quality of medical and mental health care in city jails. As we have tragically seen in the past year, this is an issue with serious human costs. Achieving greater transparency is a first step toward diverting individuals with serious needs away from incarceration, and toward improving conditions for prisoners at city facilities; policymakers and the public must have access to information on the level of care and oversight afforded New Yorkers in our jails. We urge the City Council to maintain rigorous oversight of Rikers Island and look forward to working together for continued reform.

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[29] New York City Board of Correction, *Variances Granted by the Board of Correction.* Available at http://www.nyc.gov/html/boc/html/rules/variances.shtml. Last visited 27 Feb. 2015.

[30] New York City Board of Correction. *Mental Health Minimum Standards*, §2-08(d). Available at http://www.nyc.gov/html/boc/downloads/pdf/mental_health_minimum_standards.pdf. Last visited 27 Feb. 2015. See also, New York City Board of Correction. *Health Care Minimum Standards*, §3-09. Available at http://www.nyc.gov/html/boc/downloads/pdf/healthcare_standards.pdf . Last visited 27 Feb. 2015.

[31] Regarding continuity of care, the City and Rikers Island are under obligations to engage in appropriate discharge planning under the class action lawsuit, *Brad H. v. City of New York.* Successful discharge planning can only prevent additional recidivism and is consonant with the larger goal of diversion. Advocates involved in this case may provide appropriate *Brad H.* overlays to Into 440. See Urban Justice Center, *Brad H. v. City of New York, available at* http://mhp.urbanjustice.org/mhp-bradH.v.cityofnewyork

THE LEGAL AID SOCIETY

TESTIMONY

The Council of the City of New York

Committee on Health Jointly with the
Committee on Fire and Criminal Justice Services

RE: Int. No. 440 - In relation to health services in city correctional facilities

AND

Oversight: Health Care Delivery in New York City Jails: Examining Quality of Care and Access to Care

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March 3, 2015

New York, New York

Presented by:
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Testimony of the Legal Aid Society

Before The New York City Council Committee on Health Jointly with the Committee on Fire and Criminal Justice Services

March 3, 2015

I am John Boston, Project Director of the Legal Aid Society Prisoners' Rights Project, which is part of the Legal Aid Society Civil Appeals and Law Reform Unit. Thank you for the opportunity to testify today concerning the serious risk to New Yorkers posed by inadequate medical and mental health care in the New York City jails. In addition, we testify in support of the pending legislation to amend the administrative code of the City of New York in relation to the Department of Health and Mental Hygiene (DOHMH) providing an annual report to the Mayor and to City Council concerning the health of individuals in our City jails. We submit this testimony on behalf of The Legal Aid Society, and thank Chairs Corey D. Johnson and Elizabeth S. Crowley, and the Committee on Health and the Committee on Fire and Criminal Justice Services for inviting our thoughts. We applaud the Council for tackling these important topics and considering this legislation, which will increase accountability and transparency in the City Jails.

The Legal Aid Society is the nation's oldest and largest provider of legal services to low-income families and individuals. From offices in all five boroughs, the Society annually provides legal assistance to low-income families and individuals in more than 300,000 legal matters involving civil, criminal, and juvenile rights issues. The Legal Aid Society Prisoners' Rights Project (PRP) has addressed problems in the New York City jails for more than 40 years. Through advocacy with the Department of Correction (DOC) and DOHMH, individual and class action lawsuits, PRP has sought to improve medical and mental health care and to reform the systems for oversight of the use of force and violence in the jails. Each week PRP receives and investigates numerous requests for assistance from individuals incarcerated in the City jails, their families, and their defense lawyers from the Criminal Defense Practice and elsewhere. Years of experience, including daily contact with incarcerated individuals and their families, has given the Legal Aid Society a firsthand view of problems in the New York City jails.

Medical and mental health care, as provided by Corizon Health under contract with DOHMH, are among the most frequent subjects of complaints by and on behalf of individuals housed in our City jails (the others are violence or the threat of it from other detainees or jail staff). PRP is contacted every day by individuals in the jails, their family members or attorneys with complaints about medical care issues such as denied access to sick call, failure to provide ordered care, psychiatric emergencies, and the need for special medical diets. PRP routinely advocates with Corizon officials, DOHMH, the Board of Correction (BOC) and, when (as is frequent) the complaint implicates correctional staff, DOC officials. Although PRP is not able to follow up

systematically on each of these complaints,[1] there are clear patterns in the complaints, which reflect ongoing deficiencies in the jail medical care system.

Conclusion and Recommendations

In our view, based on complaints and other available information about jail medical care, the care provided to the jail population by Corizon Health is all too often substandard. However, the problems with medical care are compounded by the failure of the DOC to carry out its responsibilities to get individuals in their custody to medical care, or vice versa, in an adequate or consistent fashion. We set out the bases for these views in the body of the report.

Based on our testimony, we make the following specific recommendations:

- Current Proposed Legislation, Int. 0440-2014 – Pass the proposed legislation, but enhance it by
    (a) Making the proposed DOHMH report public, along with the underlying data, preferably in .csv format, and preferably on a quarterly basis;
    (b) Adding additional data points, such as a meaningful assessment of access to sick call (see discussion of this problem at pp. 4-5, below), a summary of patient complaints and a measure of patient satisfaction through a survey or other evaluation tool, and measures of continuity of care between the jails and the civilian or institutional settings the patients occupy before admission and after discharge.
- Orthopedic Unit - Require DOHMH to establish a treatment and residential unit in the City jails for individuals with physical disabilities that is handicapped accessible in accordance with the Americans with Disabilities Act and is under the supervision of a suitably qualified specialist. The unit must be sufficiently staffed to provide physical therapy and assistance with daily living, and equipped with the physical therapy equipment and services necessary to allow patients to recover or regain as much function as possible.
- Suicide Watch Unit – Require DOHMH to establish a suicide watch unit in the City jails within a mental health treatment area, and conduct all suicide watches there.
- New Medical Provider – Require DOHMH to seek or develop a medical provider that will provide high quality, respectful treatment to individuals in the City jails. The City jail medical provider should be community-based and should have close ties to community providers who will implement reentry and provide the necessary continuity of care upon discharge to the community.

[1] Reports and statistics about the medical care program are compiled internally by Corizon, the Department of Health and Mental Hygiene, and the Board of Correction. *See New York Times*, "Inmates' Medical Care Failing in Evaluation by Health Department," June 10, 2005, http://www.nytimes.com/2005/06/10/nyregion/10jail.html?module=Search&mabReward=relbias%3As%2C%7B%221%22%3A%22RI%3A11%22%7D; *New York Times*, "Jail Health Care Fails Again; City Fines Company $71,000," January 27, 2006, http://www.nytimes.com/2006/01/27/nyregion/27jail.html?module=Search&mabReward=relbias%3Ar%2C%7B%221%22%3A%22RI%3A11%22%7D.

- Board of Correction – Fund the Board of Correction sufficiently and support its efforts to monitor DOHMH and DOC compliance with the Board Standards related to medical and mental health care (including the new amendments concerning punitive segregation and the enhanced security units). There is an urgent need for more field staff for BOC to respond to and report on problems in the jails, among other unmet needs at BOC. Urge the BOC to exercise its right to investigate and report on all deaths in the City jails.
- North Infirmary Command – Replace the decrepit facility with a modern medical facility.

Overview of the New York City Jail Health Care System

The provision of health care services to individuals in the New York City jails is mandated by the City Charter, Section 556(d)(8), which charges DOHMH to "promote or provide medical and health services for the inmates of prisons maintained or operated by the city." This responsibility—and authority—is reinforced by the Board of Correction's Health Care Minimum Standards, which explicitly provide that "[a]ll decisions regarding need for medical attention shall be made by health care personnel," § 3-02(b)(4), and that "correctional personnel will not diagnose any illness or injury, prescribe treatment, administer medication other than that described in §3-05(b)(2)(iii), or screen sick-call requests." § 3-02(c)(2)(ii). DOHMH acts through the Office of Correctional Health Services (CHS), which is part of the Division of Health Care Access and Improvement.

Since the 1970s the DOHMH has contracted with private medical groups to provide direct care services to individuals housed in the City jails. Between 1973 and 1997 health care on Rikers Island was provided by a local teaching hospital, Montefiore Medical Center, with care in the borough jails provided mostly by CHS civil service doctors. During the 1990s St. Vincent's Hospital provided medical services at the Manhattan Detention Center jail. Between 1997 and 2000, most health care services in the jails were contracted to St. Barnabas Hospital, which elected not to seek renewal of its contract after a series of news reports of preventable deaths and allegations of profiteering. Subsequent contracts have wisely been structured differently. Today, medical, dental and psychiatric care services to individuals housed in City jails are contracted to Corizon Health, formerly Prison Health Services, Inc., a Tennessee for-profit corporation. New York City is Corizon's largest contract. It has been reported, and DOHMH officials have stated to the Board of Correction, that DOHMH has asked local hospitals to take on the jails contract but that none have been willing to do so.[2]

Complaints about Medical and Mental Health Care

In our view, based on complaints and other available information about jail medical care, the care provided by Corizon is all too often substandard. However, assessment of medical care is

[2] *New York Newsday*, "City Renewed Contracts With Rikers Health Provider Despite 4 Inmate Deaths," Sept. 24, 2014, http://www.dnainfo.com/new-york/20140924/east-elmhurst/state-renewed-contracts-with-rikers-health-provider-despite-4-inmate-deaths.

complicated by the failure of the DOC to carry out its responsibilities to get individuals in their custody to medical care, or vice versa, in an adequate or consistent fashion.

Sick Call Access

Sick call is the gateway to all medical treatment in the jails. The BOC Health Care Minimum Standards require that "Sick-call shall be available at each facility to all inmates at a minimum of five days per week within 24 hours of a request or at the next regularly scheduled sick-call" and that "correctional personnel shall not prevent or delay, or cause to prevent or delay an inmate's access to medical or dental services." § 3-02(1, 2). Yet individuals in City jail custody consistently report that they cannot get to sick call or cannot see a practitioner if they do get to the clinic.

Individuals in the City jails consistently complain to us about inability to get to sick call at one of the largest Rikers jails, the Anna M. Kross Center, or AMKC. They report that they sign up for sick call but are not taken there for days or even longer. For example, one person, who said he was on a treatment regime for pancreatic cancer when he was arrested, reported that he had not been able to get to sick call in the three weeks since his arrest, until he was sent to emergency sick call vomiting blood. Another reported that he was unable to get his prescription medication renewed because there had been no sick call in his housing area for several days. He said, "There's a million people here trying to get to sick call and they're not calling us." *See* Appendix A, p. 23 below, for additional examples.

Complaints from AMKC and other jails indicate that sometimes only a fixed number of those wanting to go to sick call are taken there by DOC staff, and they sometimes must choose among themselves who needs to go the most. For example, clients at AMKC complained that sick inmates were "going ballistic" because they could not get to sick call; staff reportedly told them that only two of them could go to the clinic "because they have too many people there." (See Appendix B, p. 24 below, for additional examples.) This problem is not visible in Corizon's reports because the metric in the Corizon contract for measuring whether patients are seen for sick call records only whether someone from each housing area shows up in the clinic, and does not look at whether everyone who signed up for sick call got there. Dr. Venters, Assistant Commissioner of Correctional Health Services, agreed that sick call access is a problem because there is no reportable accountable way to know who asked to go to sick call. DOHMH only knows who showed up. Dr. Venters stated that "until they know how many people want to go to sick call from each housing area each day, it cannot be enforceable as a performance indicator."[3]

In 2013, the AMKC jail began requiring that a DOC officer must escort individuals who needed to go to sick call. Predictably, we received many complaints that officer escorts were not "available" for individuals who wanted medical care. After we complained to DOC, we were told that escorts are no longer required for individuals housed at AMKC who are going to the medical clinic. However, as indicated in Appendix A, we continue to receive complaints from individuals in general population that DOC officers will either not contact the clinic or will not allow them to leave their housing areas to go to the clinic, either with or without an escort. We also receive

[3] New York City Board of Correction Meeting Minutes, March 11, 2014, at pp. 8-9. Minutes are available at: http://www.nyc.gov/html/boc/downloads/pdf/Minutes/BOCMinutes_20140311.pdf.

complaints that when individuals do get to the AMKC clinic, they are turned away without being seen. One client complained to us on August 14, 2014 that he went to the clinic because of a painful growth on his inner lip, but when he arrived was told there were no doctors to see him. Another went to the clinic on June 6 and 10, 2014, because his throat and tongue were swollen, he was choking, and spitting up yellow phlegm, but on both those days he was unable to see a doctor.

These problems are not limited to AMKC. At other jails, and particularly in punitive segregation housing areas, individuals complain that sick call is not held or that DOC staff ignores their requests for medical assistance. If they get to the clinic, individuals complain that correction officers have turned them away at the waiting room and in some cases have falsified forms saying that they refused treatment. One client reported on February 24, 2015 that for a week he has had lacerated fingers, with an open, bleeding gash which had become infected with pus, but had not been treated because there has been no sick call for his GMDC housing unit. On September 25, 2014, residents of a housing unit in the Otis Bantum Correction Center reported that sick call had not been held in their unit for a week. See Appendix C, p. 24 below, for additional examples.

The sick call access problem has been aggravated in recent years because DOC adopted the practice of locking down an entire jail when there is a fight or disturbance in one part of the jail, stopping all movement including to and from the medical clinic regardless of proximity to the incident. This practice, which disrupts all programming, appears to continue unabated under the present administration.

Emergency Sick Call

BOC Health Care Minimum Standards require that "All inmate requests for emergency medical or dental attention shall be responded to promptly by medical personnel. This shall include a face to face encounter between the inmate requesting attention and appropriate health care personnel." § 3-02 (d)(1). Yet we receive frequent complaints that access to emergency care is denied, or an individual's request for help is second-guessed, particularly by untrained DOC staff, in violation of BOC Minimum Standards. Individuals housed in the City jails have reported to us they were told by officers "you must be bleeding or dying or unconscious" to get emergency care. For example, on 1/28/14, E.B. reported that he was unable to get to sick call for a complaint of high fever and sore throat with exudating white pus, despite requests to officers over three days. *See also New York Post*, "$8M over Rikers Death," September 1, 2013, http://nypost.com/2013/09/01/8m-over-rikers-death/ (jury award in wrongful death case of Jose Santiago whose chest pains were ignored twice by DOC staff over 30 minutes).

Deaths in Custody

A number of deaths of individuals in the custody of the City jails have been reported, including at the jail infirmary. Some of these deaths appear to have been medically preventable, based on initial reports. See also *Newsday*, "Officials Question Care in 15 NY Jail Deaths," October 23, 2014, http://bigstory.ap.org/article/f2481e09ceba4ef0a88b5b2c2dd0199f/ap-newsbreak-care-questioned-15-ny-jail-deaths. Despite these incidents, the BOC no longer formally investigates deaths in the City jails although it has Charter authority to do so.[4] Instead,

[4] New York City Charter § 626 ("The board, or by written designation, a member of the board or the executive director, may conduct hearings, or study or investigate any matter within the jurisdiction of the department [of correction], and

deaths in custody are investigated internally by DOHMH and externally by the State Commission on Correction (SCOC) and the New York City Medical Examiner (for physical cause of death determinations only). The death review reports of SCOC are generally issued 11 to 15 months after the death, but they do examine how medical care failed and issue recommendations for improvements to jail health care systems.[5] We discuss one such report, concerning the needless death of Bradley Ballard, at pp. 15-20, below.

Mental Health Treatment and Suicide Prevention

The Scope of the Problem

The prior City administration was aware that even as crime in NYC had declined, individuals with mental illness comprised an increasing percentage of the City's jail population. Approximately 40% of the individuals incarcerated in the City jails were reported to have a psychiatric diagnosis with many of that number suffering from major mental illness.[6] In December 2012, The Justice Center of The Council of State Governments (CSG) completed a report, *Improving Outcomes for People with Mental Illnesses Involved with New York City's Criminal Court and Correction Systems*.[7] The CSG Report findings included that individuals with mental illness stayed in jail roughly twice as long and were less likely to make bail than individuals with no mental illness. It identified 1300 individuals who were in jail even though they were eligible for community based treatment and supervision and had a low risk of failure to appear for their court dates. It identified failures in linking individuals with mental illness to alternatives to incarceration, and a lack of sufficient community alternatives willing to serve people involved in the criminal justice system. Information gathered by DOHMH at the time of the CSG report demonstrated that incarcerated individuals with mental illness were more likely than others to be injured while in custody and were more likely to end up in punitive segregation.[8] DOHMH's study of DOC, *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*[9] made numerous findings that illustrated that solitary confinement is a dangerous and self-defeating practice:

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the board may make recommendations and submit reports of its findings to the appropriate authorities.") We understand that the reason the BOC no longer convenes a Death Review Board is the Department of Correction's lack of cooperation, dating back many years. This is a subject that should be explored with the BOC and also with the present administration of DOC.

[5] See http://www.dnainfo.com/new-york/20141027/elmhurst/families-of-rikers-island-inmates-not-told-real-reasons-for-deaths "Rikers Inmates' Deaths Blamed on Health Care Provider Were Kept Secret." DNA Info website, October 27, 2014.

[6] Gilligan, Lee, *Report to the New York Board of Correction* (Sept. 2013) at p. 3 available at http://www.nycjac.org/storage/Gilligan%20Lee%20Report%20%20Final.pdf.

[7] The report is available at: http://www.nyc.gov/html/doc/html/events/FINAL_NYC_Report_12_22_2012.pdf.

[8] Andrea Lewis to Homer Venters, Memorandum, March 14, 2012, "Medical Informatics, New York City Department of Health and Mental Hygiene and Correctional Health Services." This independent analysis conducted by DOHMH is cited in endnote 9 of the CSG Report.

[9] Kaba, Lewis, Glowa-Kollisch, Hadler, Lee, Alper, Selling, MacDonald, Solimo, Parsons and Venters, *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 AM.J. PUBLIC HEALTH 442, 445 (2014) available at: http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2013.301742. The report indicates a need to reconsider the use of solitary confinement as punishment in jails "especially for those with SMI [serious mental illness] and for adolescents," and cites the American Psychiatric Association and American Academy of Child Adolescent Psychiatry

- The risk of self-harm and potentially fatal self-harm in solitary confinement was higher than outside solitary, independent of prisoners' mental illness status and age group.
- Self-harm is used as a means to avoid the rigors of solitary confinement – inmates reported a willingness to do anything to escape solitary confinement.
- Patients with mental illness become trapped in solitary confinement, earning new infractions resulting in more time in solitary.[10]

Yet, at that time, DOC continued to increase reliance on solitary confinement, failing to implement procedures that would protect individuals with mental illness from its harmful effects.[11]

Recent Developments

This City administration, through the work of the Mayor's Task Force on Behavioral Health in the Criminal Justice System, is taking steps to expand the ability to divert individuals with mental illness from criminal justice involvement.[12] Efforts to expand diversion options pre and post-arrest, as well as improved community mental health services will, we hope, reduce the percentage of individual in the City jails with mental illness (and keep many out of jail altogether). In addition, the BOC has implemented new standards concerning the use of punitive segregation and permitting the DOC to create "Enhanced Supervision Housing."

On January 13, 2015, the Board of Correction unanimously passed amendments to their standards which created Enhanced Supervision Housing (ESH) and placed limits on the use of

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as professional societies that recommend against the use of solitary confinement for adolescents and individuals with serious mental illness.

[10]The study includes the "extreme" example of a patient breaking a sprinkler head to use to self-harm and receiving an institutional infraction as well as a new criminal charge for the destruction of government property. *Id.* at p. 446.

[11] The percentage of the New York City jail population in punitive segregation increased from 2.7% in 2004 to 7.5% in 2013. The number of solitary confinement beds increased in number from 614 in 2007 to 998 in 2013. Gilligan, Lee, *Report to the New York Board of Correction* (Sept. 2013) at p. 3 available at http://www.nycjac.org/storage/Gilligan%20Lee%20Report%20%20Final.pdf. *See also* Department of Justice, letter to Mayor DeBlasio *et al.* re: CRIPA Investigation of the New York City Department of Correction Jails on Rikers Island (August 4, 2014) ("DOJ Report") concerning adolescent males on Rikers Island, which specifically found that "DOC's use of prolonged punitive segregation for adolescent inmates is excessive and inappropriate." (DOJ Report, p. 4.) The DOJ Report is available at

http://www.justice.gov/usao/nys/pressreleases/August14/RikersReportPR/SDNY%20Rikers%20Report.pdf. There were some changes in the jails but those changes were poorly executed and fell far short of needed reforms. The Mental Health Unit for Infracted Inmates (MHAUII) at the George R. Vierno Center, which held individuals serving punitive segregation sentences identified as having mental illness, was abolished in favor of Restrictive Housing Units, for the same population but intended to provide more mental health care than MHAUI. Informed observers questioned the efficacy of the RHUs, The City also created Clinical Alternatives to Punitive Segregation (CAPS) units for men and women with serious mental illness, which appear to be a genuine improvement but serve only a fraction of the relevant population and do not provide the needed treatment until after the individual has experienced difficulty in the jail environment.

[12] The action plan of the Mayor's Task Force on Behavioral Health in the Criminal Justice System is available at: http://www1.nyc.gov/assets/criminaljustice/downloads/pdf/annual-report-complete.pdf.

punitive segregation in the City jails.[13] The new rules went into effect on February 21, 2015 and we are not able to report on their efficacy, or lack thereof, as of yet. Individuals excluded from *both* ESH and punitive segregation include: all 16 and 17 year olds, this will extend to "young adults" 18-21 year olds by 1/1/2016 if necessary funding is available, and anyone with serious mental and physical disability. §§ 1-16(c) & 1-17(b). The decision to exclude vulnerable individuals, especially those with mental illness, from the harsh setting of punitive segregation and provide needed programming will significantly improve the health and well-being of those individuals, in part by reducing exposure to conditions that can cause or exacerbate mental illness.

To accomplish these changes in the City jails, it is essential that the BOC is able to monitor their implementation, both to ensure that punitive segregation reform is meaningful and the rehabilitative and therapeutic purposes of the ESH are achieved, and to be prepared to take action if the Standards are not complied with. It is apparent to us that the BOC presently lacks the jail-level staff to conduct this monitoring system-wide.

In addition to the changes required by the new BOC standards, the City has invested in improved mental health treatment in the jails. Four (4) of the existing twenty (20) mental observation housing areas (general population housing for individuals with mental health needs) will provide more services than were previously available: the Program for Accelerating Clinical Effectiveness (PACE) is designed to provide the level of services that is available in the successful Clinical Alternatives to Punitive Segregation (CAPS) program. This is an appropriate effort to identify and provide treatment to individuals with serious mental health needs upon their entry into the City jails, rather than waiting for them to deteriorate and end up in disciplinary trouble. The City is also providing additional mental health training for DOC staff and deploying Crisis Intervention Teams (CIT) inside the jails to respond and de-escalate incidents. The CIT teams are comprised of both DOC and medical staff.

These changes, taken together, may provide some reduction in the need for mental health services and create a structure within which it is easier to provide adequate services. How much difference they will make for the very serious problems in delivery of mental health services remains to be seen.

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[13] The amendments are available on the Board of Correction website at: http://www.nyc.gov/html/boc/downloads/pdf/BOCRulesAmendment 20150113.pdf. The ESH is a new restrictive setting within the jails that has a reduced amount of out-of-cell time and other restrictions. The ESH is for those who present "a significant threat to the safety and security of the facility if housed elsewhere." BOC Standard § 1-16(b). There are specified criteria for placement into the ESH, along with due process protections, including periodic review of the need for continued ESH confinement. By July 1, 2015, DOC is supposed to provide individuals housed in the ESH with "both voluntary and involuntary, as well as both in- and out-of-cell, programming aimed at facilitating rehabilitation, addressing root causes of violence, and minimizing idleness." *Id.* § 1-16(d)(3). Changes to punitive segregation include a limit to a sentence of 30 days for any single infraction and a limit to 30 consecutive days overall, with 7 days out of punitive segregation before an individual may be placed back into punitive segregation. In addition, no one can be held in punitive segregation for more than 60 days in a six-month period unless the person continues to engage in "persistent acts of violence" that can't be addressed by placement in the ESH. § 1-17(d)(3). Only violent offenses may result in 23 hour lock-in punitive segregation. In addition, the practice of imposing punitive segregation sentences from prior incarcerations ("owed time" or "old bing time") is ended. § 1-17(e).

Mental Health Care: What the Clients Say

There are at present, and will continue to be, large numbers of individuals with mental illness in DOC custody who must receive adequate mental health treatment. The most frequent mental health-related complaints received by Legal Aid are about medication. As noted below (see Continuity of Care section at p. 11, below), jail practitioners frequently change existing drug regimens, and it does not appear that the reasons are well communicated to their patients. Also some of the changes seem to arise from decisions by the provider or Correctional Health Services not to include some widely used medications in their formulary. We also receive complaints that individuals whose medications have been discontinued are not able promptly to see a practitioner and receive a new prescription, and those whose prescriptions require renewal are sometimes unable to do so timely, or simply do not receive medications that are prescribed. In some cases, persons with mental health problems are not able to get access to mental health care at all. For example, on February 17, 2015, one client at the Eric M. Taylor Center reported that he had not received his psychiatric medications since February 2; DOC staff told him that Corizon staff said "they will get to him when they get to him." A client at AMKC said he had not been able to renew his psychiatric medications for a week, and was "feeling funny" and "having weird thoughts"; the officer whom he asked to contact mental health refused, saying, "I don't work for mental health." *See* Appendix D, p. 26 below, for additional examples of this problem.

Responses to Suicidality and Crisis

We also receive complaints from incarcerated individuals and advocates about inadequate responses to threats of suicide. Although DOHMH says that its policy is to require psychiatric hospitalization of suicidal individuals, many individuals who express suicidal thoughts or attempt to kill themselves or who commit repeated acts of self-harm are not hospitalized, but instead are placed on a jail "suicide watch" or may be transferred to a mental health treatment area elsewhere in the jail system, such as the AMKC Mental Health Center, the Restrictive Housing Unit (RHU) (for individuals serving disciplinary sentences who have mental health problems), the Clinical Alternative to Punitive Segregation Unit (CAPS) (similar), or one of several "mental observation" housing areas. We receive numerous complaints about the care provided, or not provided, for individuals in great psychiatric distress including those who harm themselves or give evidence of suicidality, or who otherwise suffer from mental illness. Thus, in late February of this year, a 21-year-old client, in jail for the first time, reported that he was on suicide watch in the AMKC Mental Health Center told us that he has a pre-jail history of psychiatric treatment, attempted suicide in jail earlier, felt afraid from a "deep, deep depression," and was receiving no medication. Though he said he could not control his suicidal feelings, he had been told he was being discharged from suicide watch and mental health housing because "you can't stay here forever." On September 30, 2014, a client at GRVC reported that he was unable to see a psychiatrist for four or five weeks despite the fact that he was "decompensating" and believed he needed to have his medications adjusted. Other similar examples are listed in Appendix E, p. 27, below.

The failure to respond appropriately to acts of self-harm, threats of self-harm, and other signs of psychiatric deterioration can and does have tragic outcomes. Most recently, Fabian Cruz

committed suicide on New Year's Day when an ordered suicide watch was not initiated.[14] Far too many individuals incarcerated in our jails have committed suicide or died amid circumstances that suggest their deaths could have been prevented.[15]

The new BOC standards limiting punitive segregation and excluding individuals with mental disabilities from punitive segregation and ESH housing are encouraging developments to reduce suicide, suicide attempts and acts of self-harm. However, at the February 10, 2015, BOC meeting, DOC and DOHMH reported plans for implementing suicide watches in the ESH, in the OBCC Central Punitive Segregation Unit (CPSU) and in 5 North, an RHU located on one floor of the CPSU. These suggestions are extremely troubling and should be reconsidered. It was reported by BOC member Dr. Robert Cohen that multiple individuals were on suicide watch for weeks at a time in the OBCC Central Punitive Segregation Unit (CPSU) and that it was a terrible situation with little clinical attention paid to them. Dr. Venters from DOHMH did assert that neither CPSU nor ESH were appropriate for suicide watches. However, he endorsed the plan to use Five North, the RHU that is literally one housing area located within the CPSU, as the appropriate alternative for suicide watch. The RHUs have never successfully provided clinical care, although they were supposed to provide treatment for individuals with mental illness serving punitive segregation time.[16] DOHMH and DOC must provide an appropriate clinical setting in a treatment area for suicide watches. No one who is suffering from suicidality requiring the restrictions on clothing, bedding and amenities that is characteristic of suicide watch, should be housed anywhere other than a treatment setting in the City jails, *and* utilization of suicide watch should be time limited. If

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[14] See CBS News, "Suicide watch ignored, Rikers Island inmate dies," January 2, 2015, available at http://www.cbsnews.com/news/suicide-watch-ignored-rikers-island-inmate-dies/.

[15] In June of 2014, we testified before the City Council Committees on Fire and Criminal Justice Services, Health and the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services concerning violence and the provision of mental health and medical services in New York City Jails. In that testimony we described the deaths of Mr. Bradley Ballard, Mr. Horsone Moore, Mr. Gilbert Pagan, and Mr. Jerome Murdough. The testimony is available at: http://www.legal-aid.org/media/185933/061214_city_council.pdf*See* Associated Press, "NYC Jails Neglected Suicide Precautions," June 27, 2014, http://bigstory.ap.org/article/ap-impact-nyc-jails-neglected-suicide-precautions (In 9 out of 11 jail suicides between 2009 and 2014, established protocols were not followed). *See also New York Daily News*, "Father Demands Answers After His Son At Rikers Island Deliberately Swallows Soap, Dies," October 3, 2012, http://www.nydailynews.com/new-york/son-soap-swallow-death-outrages-father-article-1.1174478 (Captain ignored Jason Echeverria for 20 minutes after he swallowed a ball of soap in the Mental Health Alternative Unit for Infracted Inmates (MHAUII)). In this case, the Bronx District Attorney declined to prosecute; the captain—by then demoted to officer—was later indicted on federal civil rights charges. *New York Times*, "U.S. Accuses Rikers Officer of Ignoring Dying Plea," March 24, 2014,

http://www.nytimes.com/2014/03/25/nyregion/correction-officer-charged-with-indifference-in-death-of-rikers-island-inmate.html?module=Search&mabReward=relbias%3Ar%2C%7B%221%22%3A%22RI%3A10%22%7D .

He was subsequently convicted. *New York Times*, "Ex-Captain at Rikers Is Found Guilty of Civil Rights Violation in Inmate's Death," Dec. 17, 2014, http://www.nytimes.com/2014/12/18/nyregion/rikers-captain-guilty-of-civil-rights-violation-in-inmates-death.html?_r=0 ; *New York Daily News*, "Rikers Island captain who ignored dying inmate guilty," Dec. 17, 2014, http://www.nydailynews.com/new-york/nyc-crime/rikers-island-captain-dying-inmate-guilty-article-1.2048686.

[16] Gilligan, Lee, *supra* note 6 at 10-11 (reporting that the RHU was a complete failure and non-therapeutic, recommending elimination of the RHU model because it remains punitive in nature and does not grant any relief from the use of solitary confinement. The report detailed the lack of access to treatment (even in the purportedly therapeutic RHU), the lack of an appropriate range of available treatment modalities, and the utter lack of a physical environment conducive to providing confidential treatment in a clean and private space.

an individual is unable to regain stability within a few days, they should be transferred to a psychiatric hospital.

Continuity of Care

We receive many complaints that Corizon will not continue medicines prescribed prior to arrest, or at the City hospitals by specialists to whom the patients were sent by Corizon itself, or sometimes even when transferred from one jail to another. These complaints include medications for pain, psychiatric problems, asthma, heart disease, diabetes, epileptic seizures, and HIV disease. Thus, a client at GMDC who suffers from reflex sympathetic dystrophy, which is characterized by chronic, severe pain, and who was temporarily transferred to City custody for a court proceeding, reported in August 2014 that a Corizon nurse informed him that a doctor (who did not perform an examination) cut his dosage of one medication prescribed in state prison in half and eliminated another medication entirely. CHS has confirmed that generally the jail practitioners are not bound by prescriptions written or recommended elsewhere. We also receive complaints that medication that *is* prescribed in jail is not in fact provided, or not provided on the schedule ordered. Patients do not receive explanations for changes in medication regimes even when they have taken the same medication successfully for years. Patients complain that they are unable to obtain renewals of their medications before their prescriptions expire. In addition, as a result of evidence of hoarding and abuse by some patients, DOHMH no longer provides certain pain medications at all (*e.g.* Oxycontin, MS-Contin and Oxycodone), except in the most extreme cases, such as pain from advanced cancer. Under this policy, patients with severe conditions, such as scoliosis, or documented painful injuries from steep falls, car accidents, brain trauma and other diagnosed problems, complain that they are left without effective relief for severe pain—even when the prescription has been written by City doctors from HHC hospitals, such as Bellevue. Thus, a client at the Brooklyn Detention Center reported on January 21, 2015 that he did not receive pain that was prescribed for him by the Bellevue Hospital pain management clinic the preceding November for pain caused by a fractured skull and herniated disks. Additional complaints of this sort are listed in Appendix F, p. 29, below.

Long Delays in Specialized or Hospital Care

We receive many complaints about long delays before seeing a dentist, even for patients in immediate pain, who should be treated as emergencies. Delays of a month or two in such emergency cases seem to be common. We also receive complaints that even when individuals do get to see a dentist, they are told that only one or two of their problems can be addressed and they will have to seek a new appointment for the rest. For example, on January 22, 2015, a client at EMTC reported that he was unable to see a dentist for severe dental pain on the left side. He had been to the dental clinic three weeks previously, and the dentist had dealt with a similar problem on the right side, but declined to deal with the left side problem even though the patient was present in the clinic. Other examples of delays and problems in obtaining dental care appear in Appendix G, p. 31, below.

In addition to dental care, we receive many complaints that individuals incarcerated in the City jails cannot get appointments, are not taken to scheduled appointments, or are not given follow-up appointments with specialists in the City hospitals and sometimes in clinics on Rikers Island. In some cases individuals tell us that DOC did not provide transportation; we do not know

the reason for other failures. In some instances where patients were not taken to appointments, they report that they were falsely listed as refusing treatment. We have encountered cases of extreme delays in colostomy reversal as well as delays in other surgical procedures. One client's attorney reported that his colostomy, which was done in connection with surgery to address multiple gunshot wounds to his intestines, was to be reversed after six months, which expired in September 2013, but on December 19 we were informed it had not been done. On July 25, 2014, we were told he had been evaluated at Bellevue Hospital about four months previously but that the surgery had not been performed. After we protested about the excessive delay, the surgery was finally performed on 9/5/14. This February, a client at AMKC reported that he had been waiting since June 2014 for a hospital clinic appointment for a hernia that was worsening with the passage of time; numerous requests at sick call had been fruitless. Other examples of such delays appear in Appendix H, p. 32, below.

Failure to Provide Medical Diets

We receive many complaints about failures to provide medically ordered special diets, *e.g.*, for heart problems, diabetes, and allergies. Such diets are prescribed by Corizon medical personnel, but the dietitians who are required to implement them are employees of DOC. Some incarcerated in the City jails complain that they *never* get to see the DOC dietitian. Even when a special diet is ordered, it may not be provided. Last month, a client at AMKC reported that he was not receiving a low fiber diet that was prescribed by Bellevue Hospital for Crohn's disease and ulcerative colitis, and that he was in pain as a result. In January 2015, a client's defense attorney reported that he had not received the soft food diet he was prescribed, even though the attorney had contacted the OBCC clinic a couple of weeks previously and had been told they were aware of the need and would take care of it. The client had a serious stomach infection for which he had been hospitalized and which had caused sufficient damage that he would require surgery. Other examples of failure to provide medical diets are listed in Appendix I, p. 33, below.

Incarcerated Individuals with Disabilities and Lack of Orthopedic Care

Many individuals are admitted to the City jails with severe injuries or handicaps requiring intensive care and physical therapy to prevent permanently disabling conditions. Yet, to our knowledge, there is no organized system of treatment oversight or appropriate housing to accommodate individuals with physical impairments. Many are housed in the North Infirmary Command (NIC) on Rikers Island. We have long advocated to DOHMH officials and others that care for individuals with physical disabilities should be supervised by a qualified orthopedist. Individuals in the jails with physical disabilities are housed in large dormitories with poor facilities that do not provide necessary accommodations. Physical therapy, when it is offered, is held in a cramped, poorly equipped room at the NIC men's infirmary. Bathroom areas are deteriorated and have barriers that prevent individuals with disabilities from safely using toilets, sinks and showers. Many individuals with mobility impairments complain that they are relegated to general population housing areas, often requiring them to climb stairs which are difficult or dangerous for them to navigate. In October 2014, a client reported that he was recently discharged from the NIC infirmary to AMKC in a wheelchair. He was thrown out of his wheelchair in the intake area at AMKC. He remained for over 24 hours in a filthy intake cell because DOC would not provide a wheelchair to take him to a housing area. When he was finally housed, he did not receive a

wheelchair and had to slide himself around on a bucket to move. Other examples of failure to accommodate such disabilities are listed in Appendix J, p. 34, below.

Patients also complain that they do not get the early treatment or therapy that is often critical to preventing loss of function or range of motion. We have repeatedly received complaints from individuals who are not provided the physical therapy that is prescribed for them. Some individuals with severe disabilities have complained to us—or others have complained on their behalf—that they are not provided with necessary assistance with daily living even in the infirmary and sometimes are left in appalling conditions as a result. Thus, in December 2014, a client who cannot walk and uses a wheelchair stated that he had on numerous occasions been denied a plastic urinal, forcing him to urinate and defecate on himself. Further, he has been denied a medical mattress and bed, and has been denied an ADA-compliant shower or toilet chair. Other complaints of this nature are listed in Appendix K, p. 35, below.

At public oversight hearings, we have urged that the City Council require that DOHMH establish a treatment unit for individuals with physical disabilites that is competently administered, handicapped accessible in accordance with the Americans with Disabilities Act and that is under the direction of an orthopedist, with enough staff to provide assistance with daily living and the physical therapy equipment and services necessary to allow patients to recover or regain as much function as possible. DOHMH and the City have not acted to create such a unit, and the complaints continue.

DOC Interference With Medical Orders For Individuals with Disabilities and Medical Problems

Individuals incarcerated in the City jails frequently complain that DOC uniformed staff confiscate medically ordered canes, wheelchairs, crutches, braces, and orthopedic shoes without first checking with medical staff to find out whether the individual has a valid doctor's order, or whether an expired order should be renewed. We have complained to DOC, DOHMH and BOC officials about this practice for years, but it still continues. Thus, in January, a client at AMKC reported that an AMKC captain confiscated a medically prescribed mattress (i.e., thicker than the standard mattress) despite his showing the captain his medical permit for it. Other similar examples appear in Appendix L, p. 36, below.

The Rikers Island Infirmary – North Infirmary Command (NIC)

Individuals in our jails who are very sick, suffer from physical disabilities or are recovering from serious injuries, are housed in a decrepit building that was converted over twenty years ago from a Department of Correction garage. It is called the North Infirmary Command, or "NIC." This outmoded building was supposed to be a temporary location until a modern jail infirmary was built. That plan, known as the "C-133 Project," never happened,[17] leaving infirmary patients living in and doctors struggling to deliver care in, sub-standard conditions.[18] In recent years there have

[17] Most recently, in December 2013, a new medical center was proposed by the City for Rikers Island but that proposal was withdrawn soon after it was announced. See http://www.nyc.gov/html/doc/downloads/pdf/press-releases/dec18-2013.pdf.

[18] There have been some substantial renovations at NIC but these are chiefly in the main building, not the converted annex where the infirmary is located.

been outbreaks of infections, such as *clostridium difficile* colitis (also known as "C-diff.") which causes severe diarrhea, and has at times spread from patient to patient in NIC. Meanwhile, the City has spent millions of dollars to construct jail cells both on Rikers Island and at the Brooklyn jail.

The NIC infirmary should be replaced with a modern medical facility.

Individuals who are in the infirmary regularly complain that it is harder to see a doctor in the infirmary than in general population[19] and that they are discharged from the infirmary when they are still too ill or injured to function in general population.[20] Some individuals report that they are threatened with discharge if they complain about their treatment while in the infirmary.

Corizon Staff Abuse and Retaliation

We receive numerous complaints from individuals in DOC custody against Corizon staff at the NIC infirmary and at other jails. Individuals report that they are treated with great disrespect, are sometimes called names, or threatened with discharge from the infirmary, or with disciplinary action for questioning their treatment or complaining to Legal Aid about their medical care. In January 2015, a client at MDC reported that he fell and injured himself, and lay on the floor for some time before a Corizon doctor appeared and said, "I'm tired of this shit. Get the fuck up. There's nothing the fuck wrong with you." The doctor then grabbed him by the neck, "yanked" him up painfully, and when he complained of neck pain, "jammed" a neck brace on him. The client was later taken to the hospital. Other examples of this sort appear in Appendix M, p. 37, below.

These complaints raise questions about how Corizon screens its applicants for professional temperament, what the Corizon staff qualifications are, and what Corizon senior staff do to enforce appropriate standards of behavior towards patients. For example, PHS hired a doctor whose medical license was suspended in two states, including New York, after patients died under his care because of "gross negligence" as the Court described his conduct.[21] We notified the Department of Health about this several years ago but do not know if he remains employed and treating our clients in jail. Under the former not-for-profit medical provider in the jails, Montefiore Hospital and Medical Center, it was extremely rare for our office to receive complaints of this sort of abusive treatment from medical personnel. That was because the strong message from the top at Montefiore was to treat patients in jail with the courtesy and respect that patients in any other setting would receive. We do not think that Corizon is sending or reinforcing that message.

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[19] *E.g.*, infirmary patient M.C. complained on 2/25/15 that he is morbidly obese and suffers from disk damage, and that the thin mattresses provided by DOC leave him in pain. He has been told he must see the Chief Physician at NIC to get authorization for a hospital style mattress. However, he has been unable to see the Chief Physician.

[20] *E.g.*, on 2/25/15 C.S. reported that he was being told to pack up for discharge from the infirmary, even though he had a fractured jaw that was surgically wired, the wires had come loose, and that he was scheduled to go to Bellevue Hospital to repair the damage. He was to be discharged to EMTC, the jail at which his jaw was broken in a gang assault.

[21] *See In the Matter of Edward M. Berkelhammer, Petitioner, v. Thomas Sobol, as Commissioner of Education, Respondent*, 543 N.Y.S. 2d 177 at 178; 147 A.D.2d 265 (1989).

Quality of Care: The SCOC Final Death Report on Bradley Ballard

PRP obtained the Final Report of the New York State Commission of Correction (SCOC) In the Matter of the Death of Bradley Ballard. Mr. Ballard died on September 11, 2013, while in DOC custody. (We represent Mr. Ballard's estate.) The report (cited below as SCOC Report) reviews his chart and other evidence in great detail[22] and reveals shocking derelictions by DOC, and by Corizon and its medical and mental health staff, in providing for the medical and mental health care of Mr. Ballard.

Mr. Ballard was admitted to DOC custody on June 13, 2013 and was noted to have a history of diabetes and mental illness. He was placed in the Mental Health Center at Anna M. Kross Center (AMKC) on Rikers Island in early August 2013 after a period of inpatient hospitalization at Bellevue Hospital psychiatric unit. The AMKC Mental Health Center is the Unit on Rikers Island that is for individuals identified as needing enhanced mental health treatment services while in the City jails. There, on September 4, as observed on video, Mr. Ballard removed his shirt, twisted it into a phallic shape and made a lewd gesture, reportedly towards a female correction officer. About an hour later, he was confronted by officers in the day room and then locked into his cell. SCOC Report at 13-14. That is the last time he was out of his cell until the night of September 10, when he was taken to Elmhurst Hospital, where he died early the next morning. SCOC Report at 14-26. This six-day round-the-clock lock-in was imposed despite the Board of Correction Standard requiring 14 hours of out-of-cell time daily applicable to the Mental Health Center. § 1-05(b). It was also in violation of the requirements of daily showers and daily exercise periods which appear both in the State Commission of Correction regulations, SCOC Report at 15-17, and the Board of Correction Standards. §§ 1-03(b) and 1-06.

During this period of unauthorized lock-in, Mr. Ballard was deprived of adequate medical and mental health care, as described below, in what appears to have been a course of unauthorized punishment by staff on the unit. However, the State Commission review of Mr. Ballard's medical records show that he was subjected to neglect and maltreatment long before the fatal week of lock-in. This negligence included DOC and Corizon staff and was not limited to staff on the housing unit.

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[22] Mr. Ballard's gruesome death and its aftermath was widely covered by the press. *See, e.g.*, M. Schwirtz & M. Winerip, "Gross Incompetence Cited in Rikers Island Death, *New York Times*, Jan. 23, 2015, p. A20 (http://www.nytimes.com/2015/01/23/nyregion/gross-incompetence-cited-in-rikers-island-death.html); Associated Press, "Lawsuit Filed over Inmate's Death in NYC Cell," *New York Times*, Sept. 10, 2014 (http://www.nytimes.com/aponline/2014/09/10/nyregion/ap-us-nyc-jail-death-.html); B. Weiser & M. Winerip, "Family of Rikers Inmate Sues New York City Over His Death," *New York Times*, Sept. 11, 2014, p. A21 (http://www.nytimes.com/2014/09/11/nyregion/family-of-mentally-ill-rikers-inmate-sues-new-york-city-over-his-death.html); R. Shapiro, "Mentally ill Rikers Island inmate dies after languishing in jail cell for 7 days," *New York Daily News*, May 22, 2014 (http://www.nydailynews.com/new-york/nyc-crime/rikers-island-inmate-dies-7-days-cell-report-article-1.1801606); P. Barrett, "Still no one charged eight weeks after death of mentally-ill Rikers Island inmate was declared a homicide," *New York Daily News*, July 31, 2014 (http://www.nydailynews.com/new-york/bronx/330-days-death-mentally-ill-inmate-no-riker-officers-charged-article-1.1887858); Associated Press, "Jail system under scrutiny after 2 gruesome deaths," *New York Post*, May 22, 2014 (http://nypost.com/2014/05/22/jail-system-under-scrutiny-after-2-gruesome-deaths/); Associated Press, "NY panel urges feds to probe death of sexually mutilated Rikers inmate," *New York Post*, January 23, 2015 (http://nypost.com/2015/01/23/ny-panel-urges-feds-to-probe-death-of-sexually-mutilated-rikers-inmate/).

Diabetes Care

Mr. Ballard was prescribed Metformin, aspirin, and insulin for his diabetes and was also ordered to receive finger sticks and glucose readings twice daily. The records indicate a number of alleged refusals by Mr. Ballard and failures by DOC to produce him at the clinic for glucose monitoring. The State Commission found: "No member of the clinical or security staff encountered Ballard with this history of refusals and failures to produce him at clinic to determin[e] the reasons therefor or to counsel him accordingly. This represents substandard medical and mental health treatment." SCOC Report at 4-5. Overall, he should have been seen 58 times for finger sticks from August 7 to September 5, but was only seen 10 times. SCOC Report at 2.

Mr. Ballard was at Bellevue Hospital psychiatric unit from July 1 until August 7. Upon his return to jail, his medications (Metformin and insulin) and diabetes monitoring were restarted. SCOC Report at 6. On August 12, his insulin was reordered for directly observed therapy for 14 days. However, a fasting glucose test ordered on August 7 was not completed. On August 14, Mr. Ballard was scheduled to be seen for a diabetes care clinic, but was not seen, and was rescheduled. There is no indication in the chart why he was not seen. SCOC Report at 7. He was scheduled for the diabetes clinic on August 20, but it was "documented" that he refused to come to the clinic. However, there was no signed refusal form in his file, nor was he medically encountered and counseled about the refusal. SCOC Report at 8. On August 22, he was again scheduled for the diabetes clinic, but was not seen by the provider and was rescheduled, with no explanation for why he was not seen, and no indication he was subsequently seen and counseled. He *was* seen in the clinic by a physician on August 26 for a skin complaint. However, no action was taken on his insulin order which expired the same day, and there was no inquiry as to why he had missed three diabetes clinic dates. The State Commission declared: "The lack of follow up for a known chronic condition such as diabetes, after Ballard had three missed appointments and was present in the clinic for a benign complaint (dry skin), constitutes uncoordinated and incompetent medical care." SCOC Report at 8. He was again scheduled for diabetes follow-up on August 29, but the progress note is blank and unsigned, with no indication as to who was to see him or why he was not seen. SCOC Report at 9.

On September 4, a physician reordered Mr. Ballard's Metformin, but there is no reference to any insulin even though his prior insulin order had expired on August 26. There is no indication that his chart was reviewed. The Commission stated: "This represents inadequate medical care." SCOC Report at 10-11.[23] Mr. Ballard did receive insulin until August 30, but not thereafter. The Commission stated: "It is apparent that as of 8/30/13, Ballard's insulin was dropped without any clinical exam or follow-up performed." SCOC Report at 11.

On September 5, a doctor generated a progress note for a diabetic clinic appointment, indicating that it was "rescheduled" with no explanation why Mr. Ballard was not brought to the clinic or any indication of follow-up. This was the *fourth* missed diabetic clinic appointment in 30 days. SCOC Report at 11. On September 6, Mr. Ballard's chart indicates, he received a finger stick

[23] The Commission added: "NYC DOH-MH's assertion that sliding-scale insulin was not appropriate for this patient begs the question that Mr. Ballard died from being deprived of needed insulin for 11 days, a severe lapse for which there is no explanation and for which no defense is offered." SCOC Report at 11. It also begs the question why sliding-scale insulin was prescribed for him in the first place, and renewed, if it was inappropriate. *See* SCOC Report at 3, 6 (noting re-starting of insulin after return from Bellevue), and 7 (noting renewal for 14 days).

and blood glucose check, but the Commission found that this entry is false: video evidence showed that on that day, no medical staff were present at his cell, and he was not removed from his cell. SCOC Report at 11.

On September 10, Mr. Ballard's chart was reviewed, and the review indicated that *no* medications were prescribed at that time. (The previous Metformin order had expired on September 6.) The review referred to pending or missed labs (not identified) and stated that all necessary labs (not identified) had been ordered. It also stated inaccurately that Mr. Ballard did not suffer from "Serious Persistent Mental Illness," despite his designation as such and his extensive mental health history. The Commission stated that it is "apparent that a proper and thorough chart review was not completed" by the doctor. SCOC Report 11-12.

Later on September 10, Mr. Bradley was removed from his cell, and shortly thereafter died, as described more fully below. The cause of death was diabetic ketoacidosis caused by withholding of diabetes medications.[24] SCOC Report at 3. The State Commission summarized: "The lack of coordinated care for and the mismanagement of Ballard's diabetes represents a grossly negligent medical care by Corizon, Inc., endangered Ballard's life and subsequently caused his death." SCOC Report at 11.

Mental Health Care

Mr. Ballard had an extensive history of serious mental illness, dating back to age 13, including several psychiatric hospitalizations and at least one suicide attempt. The State Commission described him as "severely and persistently mentally ill" upon admission to DOC. He was referred to be seen by mental health staff after his medical intake assessment on June 14. He initially refused mental health services at a June 17 examination and a June 19 assessment after transfer to GRVC. SCOC Report at 4.[25]

Mr. Ballard subsequently displayed "radical changes in his behavior and became assaultive." SCOC Report at 5. On July 1, he was referred to the AMKC Mental Health Center,[26] where he was found to be "acutely paranoid and delusional." Mr. Ballard was referred to and admitted to the Bellevue Hospital psychiatric unit, where he was diagnosed with paranoid schizophrenia. He was medicated involuntarily with Risperdal while the hospital sought a treatment over objection order, which the court denied. His condition improved in the hospital and he was discharged back to DOC and sent to GRVC on August 7, with a prescription for Risperdal. SCOC Report at 5. He remained delusional and his medication was continued. SCOC Report at 5-6. Mr. Ballard refused medication on August 8 and was referred to the AMKC Mental Health

[24] Mr. Ballard also suffered from severe tissue necrosis of his scrotum area as a result of restricted circulation after he tied a ligature around his genitals. SCOC Report at 27. However, this genital stricture was isolated from his circulation and did not contribute to his death. SCOC Report at 3.

[25] According to the SCOC Report, Mr. Ballard's prior history of suicide attempts was reviewed at the June 19 assessment. SCOC Report at 4. Regardless of his refusal of treatment, his psychiatric history should have resulted in placement on the mental health caseload for monitoring and follow-up.

[26] The Mental Health Center is described in DOC policy as designated for "[a]n inmate with severe mental health problems. The MHC can medicate greater than twice daily as appropriate and has twenty-four (24) hour, seven (7) days per week psychiatric, medical, and nursing coverage." DOC Directive 4020R-A, Department Definitions of Inmate Categories (Jan. 19, 2007), at p. 6.

Center again, where he refused Risperdal but accepted Seroquel to help him sleep. The Seroquel was then disapproved by a doctor since no request had been made for this non-formulary drug, and the doctor continued him on Risperdal. SCOC Report at 6-7. On August 14, he was found compliant with his medication. SCOC Report at 7.

On August 15, Mr. Ballard was seen by a nurse practitioner, and stated that he was doing better and his medications were working. The nurse practitioner continued his diagnosis as paranoid type schizophrenia, but changed his medication, discontinuing Risperdal and switching him to the previously disapproved Seroquel, at a dosage that is "a sub-therapeutic level for psychosis," and without ordering re-evaluation or titration after the initial 14 days of that medication. The nurse practitioner explained that he did not notice that Seroquel had been disapproved or that Risperdal was currently prescribed. SCOC Report at 7. The State Commission stated:

> The lack of a documented clinical rationale for changing a psychotropic medication for patient with reported efficacy of the current medication regimen supported by a physician's order and the failure to thoroughly read a patient's medical chart and history constitutes incompetent psychiatric care.

SCOC Report at 7-8.

On August 21, Mr. Ballard was seen for mental health follow-up by a social worker, who reported that he was "all right" and had been compliant with his medications. SCOC Report at 8. However, the social worker stated to the Commission that Mr. Ballard still had symptoms of paranoia and grandiose thoughts, and that she referred him to be seen by a psychiatrist. No such referral appears in his chart. SCOC Report at 8. On August 28, the social worker saw him again for follow-up; he was locked in his cell because he had been in a fight. She found him to be in some psychiatric distress and told the Commission she referred him to a psychiatrist, but again there was no psychiatric referral in his chart. SCOC Report at 9.

On August 29, Mr. Ballard was seen by an R-PAC (Registered Physician's Assistant—Certified) because Corizon received a letter from his Legal Aid defense attorney expressing concerns over his mental health because he had seemed paranoid and delusional at a court appearance. Mr. Ballard stated that he did not need to speak to mental health and everything was OK. The R-PAC referred Mr. Ballard to the Hart's Island Clinic for the morning of August 30. There is no documentation that he was seen at that clinic. SCOC Report at 9.

On August 31, Mr. Ballard was seen by another R-PAC, who found him mildly anxious and irritable; he requested medication to help him sleep. He was continued on Seroquel. Later that day he was involved in a fight. On September 1, he was seen by a doctor for self-inflicted injuries—abrasions to forehead and arms—and was reportedly hitting his head on his cell wall. He said he would hurt himself until seen by mental health. He saw a psychiatrist on September 2, but said he was fine, denied injuries, and was continued on Seroquel. SCOC Report 9-10. The Commission stated:

> It is noted by the Medical Review Board that Ballard's irritability, agitation, and aggression all significantly increased after being discontinued from Risperdal 3 mg

> bid on 8/15/13 and then started on Seroquel 100 mg hs, both contrary to physician orders. No comprehensive clinical review or assessment of Ballard's medication efficacy was documented by any psychiatric provider in relation to his changes in behavior in the face of subtherapeutic and otherwise ineffective therapy not authorized by a physician. This represents inadequate psychiatric care by Corizon, Inc.

SCOC Report at 10.

On September 3, Mr. Ballard was transferred to a different mental health observation housing area in the AMKC Mental Health Center. He was to be seen by a social worker on September 4, but was not, because of the transfer. He was supposed to be rescheduled and seen in his new location, but was not. The Commission stated that Mr. Ballard "had no further clinical encounters with mental health clinicians or psychiatry through to the terminal event despite specific orders in his treatment plan for weekly clinician visits and biweekly psychiatry visits." SCOC Report 10.

September 4 was the day Mr. Ballard was locked into his cell for what proved to be the rest of his life. His prescribed medications (which may have been limited to Seroquel at that point) were not provided during this period, as confirmed by the Commission's review of video surveillance tapes. SCOC Report at 2, 15, 19, 20, 22. Nor did Mr. Ballard receive any substantive treatment from mental health staff. Although DOHMH policy requires "a daily account of the inmates on the mental observation unit" and directs that "Mental health staff shall conduct rounds on the MO Unit seven (7) days a week," the video record shows that he was either not seen by a mental health clinician at all, SCOC Report 16, 18, 19, 22, 24, or a clinician engaged in what the Commission describes as a "drive-by" encounter of a minute or less. SCOC Report at 15, 19-20 ("This is insufficient to properly assess the daily status of a patient with serious persistent mental illness."), 21 (same).The Commission's observations of mental health staff's interaction, or lack of it, with Mr. Ballard during this period are as follows:

- On 9/5/13 at 4:48 p.m.: "a mental health clinician appears to stop at Ballard's cell and speak with him. The clinician is at Ballard's cell for less than one minute." SCOC Report 15.
- On 9/5/13 at 7:24 p.m.: "a mental health clinician is observed making rounds on the unit. The clinician does not stop to speak to Ballard." SCOC Report at 15.
- On 9/6/13 at 7:00 p.m.: "a mental health clinician conducts rounds on the unit. The clinician looks in Ballard's cell but does not engage in any conversation with him." SCOC Report at 18.
- On 9/7/13 at 12:59 p.m.: "a mental health clinician stops by Ballard's cell and speaks with him briefly. The clinician leaves the area within the minute." SCOC Report at 19.
- On 9/8/13 at 7:23 p.m.: "a mental health clinician was at Ballard's cell. The clinician leaves the area by 7:24 p.m." SCOC Report at 20.
- On 9/9/13 at 5:06 p.m.: "a mental health clinician is observed doing rounds in the unit but Ballard is not seen." SCOC Report at 20.
- On 9/10/13 at 9:49 a.m.: "a mental health clinician is seen on the unit but Ballard is not seen." SCOC Report at 24.

- On 9/10/13 at 5:28 p.m.: "a mental health clinician conducts rounds in the unit but does not see Ballard." SCOC Report at 24.

On 9/10/13 at 5:45 p.m.: "a mental health clinician was observed doing rounds on the unit. Psychiatrist Dr. N. is documented as leaving the housing area at 6:45 p.m. Ballard was not seen by the clinician. Ballard had not had a therapeutic clinical encounter with mental health or psychiatry since 9/2/13." SCOC Report at 24.

During this period of neglect, Mr. Ballard was decompensating in ways that were obvious. On September 5 at 12:08 a.m., he was flooding his cell. On September 6, he was observed flooding his cell again at 9:31 a.m. and at 10:24 a.m., and maintenance staff turned off the water in his cell. His water remained turned off and unchecked until his death. SCOC Report at 15-18. When he was removed from his cell on September 10, he was lying on the floor, covered in filth and feces; the cell was documented as "unkempt with food on the floor"; there was "a pungent odor of perspiration and feces." SCOC Report at 25. The filthy conditions had been evident for some time.[27]

The failure to provide treatment for Mr. Ballard, when his need for it was well known, amply demonstrates the abysmal lack of mental health treatment services in our City jails. The evidence demonstrates that Corizon and DOC staff at the AMKC Mental Health Center left Mr. Ballard locked in his cell without needed medical and mental health treatment as they watched him deteriorate, but that this conduct was only the culmination of a pattern of neglect that had begun weeks previously. As the State Commission concluded:

> The medical and mental health care provided to Ballard by NYC DOC's contracted medical provider, Corizon Inc. during Ballard's course of incarceration was so incompetent and inadequate as to shock the conscience as was his care, custody and safekeeping by NYC DOC uniformed staff, lapses that violated NYS Correction Law and were directly implicated in his death. Had Ballard received adequate and appropriate medical and mental health care and supervision and intervention when he became critically ill, his death would have been prevented.
>
> The events that lead to Ballard's death were directly caused by the compounded failures of NYC DOC and its contracted medical provider, Corizon Inc., to maintain care, custody, and safekeeping of this inmate in accordance with New York State Correction Law, NYS Minimum Standards and Regulations for Management of County Jails and Penitentiaries, and Ballard's civil rights.

SCOC Report at 2.

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[27] On September 6 at 7:22 p.m., an Assistant Deputy Warden "makes motions that indicate that the area near Ballard's cell was malodorous." SCOC Report at 18. The next morning an officer is observed using a deodorizer spray in front of his cell. SCOC Report at 19. On September 10, inmates and staff are observed several times reacting to the malodorous conditions. SCOC Report at 24.

The Current Legislation: The Need for Increased Transparency, Communication and Reporting

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

This legislation should not be controversial. It proposes that DOHMH provide the Mayor and City Council with an annual report regarding the health of individuals housed in our City jails. It requires reporting on intake, follow up care, patient safety, preventable hospitalizations, preventable errors in medical care, and information about the quality management and quality assurance measures of the medical provider contracted to provide medical and mental health services. The legislation requires that the report include the metrics utilized for the evaluation of the medical contractor and the results of DOHMH compliance evaluation. Many of these reporting requirements mirror the problems that we hear from individuals incarcerated in the jails and have reported on herein (*e.g.* failure to provide follow-up care, preventable errors in medical care, and suicide prevention). Such an annual report, that requires DOHMH to carefully consider its evaluation and performance of the medical contractor, will assist in improving oversight by DOHMH, may improve the performance by the medical provider, and should provide essential information concerning how to construct future contracts with medical providers. The legislation should be passed.

However, we believe the legislation should be enhanced. In addition to reporting to the Mayor and to City Council, the legislation should require that the DOHMH report be available to the public. Collecting and sharing the information will permit advocates, community health providers, family members and friends of individuals in the jails, and the community, to understand conditions in the City jails, and identify areas that require improvement and better coordination with community providers. This data must be collected by DOHMH in order to inform itself regarding the consequences and effects of its policies and the health care needs of the people housed in the City jails. The data should be public so that the proposals made by DOHMH (and budget decisions made by the City) can be subject to rational and informed input from the community.

Additional data points could and should be added to the legislation to further improve the collection and dissemination of information by DOHMH. For example, we reported herein on the failure of the current metrics to permit DOHMH to evaluate the response to sick call (see p. 4, above), and DOHMH should also track and review patient complaints and measure patient satisfaction through a patient survey or other evaluation tool. The area of continuity of care between the community and the jail (both entering custody and reentry from custody), between jails, between the jails and state prisons, and between the jails and outside medical providers are also areas requiring improvement and quality assurance by DOHMH.

* * *

We are hopeful that the additional resources for mental health treatment and the newly amended Board of Correction standards will result in substantial improvements in the City jails. We are also hopeful that creation of additional alternatives to incarceration will help individuals with behavioral health needs remain out of the criminal justice system and provide them with the medical and social service interventions that they require in the community. Improvements to

medical and mental health care in the City jails will create better public health throughout the City. The opportunities and services available in jail directly affect the skills, problems and needs individuals will have at the time of their release. For individuals with medical or mental health needs, this includes their willingness to accept and participate in treatment; if medical or mental health programs in jail are unavailable, ineffective or harsh or punitive in implementation, the individual may be less likely to seek and participate in necessary treatment after release.

We thank the Committees for this public forum to discuss vital areas of concern about the management of our City jails. The City Council should continue to provide public forums so that the important issues of medical and mental health care in the City jails continue to be the subject of informed public discourse. We support the passage of the proposed legislation that requires DOHMH to report on outcome measures of quality assurance and oversight of the health care provider to Council and to the Mayor. We believe this important annual report should also be available to the public. The City Council plays and must continue to play an important role in understanding, monitoring and tracking the conditions of confinement for individuals incarcerated in the City jail system.

Dated: March 3, 2015
New York, New York

APPENDICES

Appendix A

Failures to Call Sick Call at AMKC

- 2/21/14, E.M. reported that in housing area West Annex 18 Upper "they don't call sick call" and he had been unable to get to the clinic for follow-up of a painful fracture; on 3/7/14 he made a similar complaint.
- 3/10/14 we received and forwarded a complaint that there had been no sick call in AMKC 12 Upper for a week.
- 4/8/14, J.C. reported that he had not been able to get to sick call for several days after an altercation with a correction officer that caused injury and vision loss to one eye.
- 4/8/14, A.W. reported that sick call had not been held for his housing area for two weeks.
- 6/24/14, E.H. reported a leg infection that had grown to "the size of a dollar bill" and asked that he be seen as quickly as possible; two days later, he called again to say he had yet to be seen at sick call.
- 7/24/14, M.P. complained he was unable to get to sick call because DOC officers falsely reported that he was refusing care (in one case, he was in the shower and was deemed to have refused; in other instances he did not even know whether escort officers had come for him).
- 8/26/14, B.W. reported that his housing area had been denied sick call for two days (Monday and Tuesday); a DOC officer told him that since sick call was held on Friday it need not be held on Monday.
- 9/2/14, V.A.—who said he was on a treatment regime for pancreatic cancer, interrupted by his arrest—reported that he had not been able to get to sick call in the three weeks since his arrest, until he was sent to emergency sick call on 9/1/14 vomiting blood.
- 9/23/14, O.P. complained he was unable to get to sick call for several days for follow-up treatment for injuries, partly because sick call was not held and partly because officers refused to allow attendance.
- 10/7/14, A.L. complained that his housing area, West Annex 17 Lower A, gets called for sick call only once or twice a week.
- 1/9/15, T.R. stated that he had been having chest pains since Wednesday night but had been unable to get to sick call as of Friday morning because of a security lockdown.
- 1/29/15, T.P. stated there had been no sick call in the AMKC West Annex for several days: "There's a million people here trying to get to sick call and they're not calling us." As a result he was unable to renew his prescription medication.
- 1/29/15, K.D. stated there had been no sick call in his AMKC housing unit for days and he had been unable to seek treatment for back pain as a result.

- 2/3/15, persons held at AMKC West Annex 19 Upper reported that sick call was not being held, and in general it was held only two days a week.
- 2/24/15, J.M. reported that he had not been able to get his prescriptions renewed for Baclophen (to relieve muscle cramping) and Tylenol (for hernia pain) because sick call had not been held since Thursday, 2/19 as a result of jail lockdowns.

Appendix B

Examples of Informal Quotas Imposed on Sick Call Access

- 2/5/14, individuals housed at the Eric M. Taylor Center (EMTC) reported that on successive days in one housing area, only 1 of 8 and 3 of 10 individuals who had requested sick call were allowed to go.
- 3/24/14, individuals housed at EMTC reported that only 2 or 3 individuals from 9 Main were allowed to go to sick call even though more had signed up.
- 7/11/14, individuals calling from the Manhattan Detention Center, 7 West, reported that on 7/8/14, only 2 of 8 individuals who requested sick call were allowed to go by the DOC officer in charge, and on 7/10/14, no one from that unit was allowed to go to sick call.
- 8/13/14, we received a complaint from AMKC 14 Lower that only five individuals could attend sick call.
- 12/15/14, E.M. reported that officers sometimes imposed a quota on sick call from her RMSC housing area, allowing only two prisoners a day to go regardless of how many signed up.
- 1/28/15, clients at AMKC West Lower B complained that sick inmates were "going ballistic" because they could not get to sick call; staff reportedly told them that only two of them could go to the clinic "because they have too many people there."

Appendix C

Lack of Sick Call Access for Jails Other than AMKC

- 3/24/14, A.A. reported that after he and others were sent back without being seen from the Eric M. Taylor Center (EMTC) clinic, he signed up every day for the next five days but was not taken to sick call.
- 4/9/14, J.G. reported that he was unable to get to the clinic for treatment of nausea because sick call was not held in his Robert N. Davoren Center (RNDC) housing area for an unspecified period.
- 4/17/14, M.W. reported that he needed treatment for a dislocated finger but was not being allowed to go to sick call in OBCC.
- 4/18/14, M.E.'s defense attorney reported that officers prevented him from going to sick call at RNDC despite his complaint of chest pains.

- 7/31/14, J.R. reported that he had not been able to get to the OBCC clinic for treatment of severe leg pain because officers would not take him there.
- 8/26/14, D.F. reported that his housing area at the Manhattan Detention Center (MDC) had been denied sick call since the preceding Wednesday; he said that his housing area was "on the burn" because of some individuals' misbehavior.
- 9/25/14, it was reported that sick call had not been held for individuals housed in the Otis Bantum Correction Center (OBCC) unit 2 Upper for a week.
- 9/29/14, J.F. reported that he had been unable to get to sick call at MDC for a week for follow-up treatment on a broken hand, for diabetes, and for deep vein thrombosis because his requests were ignored by DOC staff.
- 10/6/14, F.A.'s defense attorney reported that his attempts to seek care at MDC for a heart condition and asthma had been impeded by the unavailability of escorts to take him to the clinic and by Corizon staff's refusal to let him see a doctor when he managed to get there.
- 12/15/14, R.C. reported that he had chest pains but correctional staff in his OBCC housing unit were not allowing him to go to the clinic.
- 12/15/14, E.M. reported that she had been unable to renew a prescription at RMSC because, though she got to sick call several times, she was turned away without being seen.
- 1/6/15, J.F. reported that he had a seizure in his cell, followed by a profuse nosebleed, but was not allowed to go to the clinic because of a lockdown at the George R. Vierno Center (GRVC).
- 1/6/15, four individuals from 6 Main B side in the George Motchan Detention Center (GMDC) reported that sick call had not been held in that housing unit for two weeks; they signed up but were not taken to the clinic. Their complaints included the need for a new asthma inhaler (two people), suicidal feelings resulting from a mental illness, and a painful hernia and vomiting.
- 1/8/15, J.O. reported that he tried to go to sick call at GMDC because of a hard lump behind his knee, but the clinic officer turned him away.
- 1/22/15, prisoners complained that at GMDC 6 Main there was no sick call for a protracted period of time.
- 1/26/15, C.M., in GMDC 6 Main B, reported that he was denied access to sick call for over a week after officers confiscated his asthma inhaler, despite his signing the sick call sheet daily. Corizon had prescribed Advair and Albuterol.
- 1/29/15, J.O. reported that he was unable to get to sick call at GMDC to renew his medication for five days; officers told him that the clinic was only accepting "life-threatening emergencies." The next day he renewed his complaint, adding that the area captain had refused to contact the clinic because the Corizon employee who answers the phone will not accept DOC staff requests for sick call access.
- 1/30/15, D.J., at MDC, reported that he signed up for sick call the previous evening because he felt very ill and believed he was running a fever. However, sick call was not called in his housing unit, and hours had passed since he asked to go to emergency sick call.

- 2/2/15, N.E. reported that he was assaulted by staff on January 26, and that he needed follow-up care for injuries sustained from kicks to ribs and torso, but had been unable to get back to the EMTC clinic via sick call.
- 2/3/15, persons held in unit 6 Main B at GMDC stated that sick call had not been held in that unit for almost three weeks.
- 2/4/15, S.C., a sentenced prisoner at EMTC, reported that he could not get to sick call in order to renew his medical excuse from work, which he requires because of lower back pain and other medical issues. This is a recurring problem because he is only given short-term excuses even though his problems are chronic, and he can never get to sick call to timely renew them. He is constantly at risk of discipline for refusing to work when his excuse expires.
- 2/17/15, D.S. reported that he could not get to sick call at GMDC, though he was in terrible pain from a hernia, because the officers in his General Population Escort housing area refused to take him and falsified refusal-of-treatment forms. The same day we received a complaint from C.D., who reported that he could not get his prescribed asthma medication refilled at GMDC because he could not get to sick call, for the same reason.
- 2/18/15, S.W. reported that he had fallen in the shower at GRVC the previous day and had injuries to his hands, ankle, and back, but had been denied emergency sick call that night and the next day.
- 2/19/15, T.T. requested mental health services after receiving a lengthy prison sentence. T.T. was able to go to the clinic at GRVC but was not seen by Corizon staff. T.T. was told that he would be called to the clinic again on the next day but was not called down as promised.
- 2/24/15, G.S. reported that he signed up for sick call at GMDC every day for a week because of respiratory congestion but it was not called in his unit for a week.
- 2/24/15, T.T. reported that he has a fungal infection on his toe and a swollen foot but has not been treated because there has been no sick call for his GMDC housing unit for a long time despite his signing up several times.
- 2/24/15, T.S. reported that for a week he has had lacerated fingers, with an open, bleeding gash which has now become infected with pus, but has not been treated because there has been no sick call for his GMDC housing unit.

Appendix D

Lack of Access to Mental Health Medications

- 1/21/14, J.P. reported that his prescriptions for Klonopin and Celexa were discontinued eight days previously and he had not received a new prescription for his bipolar disorder, or been able to see a psychiatrist, for the ensuing 8 days. He reported "starting to feel a little crazy" and was obviously very stressed on the telephone.
- 1/23/14, M.B. reported he had been waiting 3 weeks to see a psychiatrist to renew prescriptions for Seroquel and Trazadone.

- 2/21/14, G.G., who has a long psychiatric history, reported that he entered jail with only one day's dosage of medications. He was not yet seen at the clinic and had been without medication for 6 days.
- 3/26/14, R.M. stated that he returned to DOC custody on 3/18/14 from Mid-State Psychiatric Center and had not yet received any of his prescribed mental health medications (Adderall and Wellbutrin); he asked if he has to "put a rope around [his] neck" to get medical attention.
- 4/8/14, E.O.'s attorney reported that E.O. had a diagnosis of Axis I Bipolar Mood Disorder but was unable to see a psychiatrist for three weeks at the Rose M. Singer Center.
- 8/1/14, J.M. reported he was not always provided with his prescribed Trazadone although he is housed in an RHU at RNDC.
- 12/18/14, another incarcerated person informed us that in his housing unit, another person was visibly decompensating, had stopped taking showers and was malodorous and seemed to be soiling his bed. Officers and supervisors were said to be either ignoring him or threatening him with a forcible shower, but not seeking mental health assistance for him.
- 1/12/15, J.R. stated that he has a psychiatric history going back to age 12, diagnoses including bipolar disorder and schizophrenia, a history of self-harm, and was taking medication but it "was not working." He sounded quite agitated to the layperson who took his telephone call. He said he had not seen a mental health practitioner in a month—and when he did, the doctor "walked away from him."
- 1/29/15, S.S. reported that for the past two weeks, after transfer from Brooklyn Detention Center to OBCC, he had not received the prescribed morning dose of Remeron, a psychiatric medication.
- 2/17/15, K.A. reported that he had not received his psychiatric medications at EMTC since 2/2/15. DOC staff reported to K.A. that Corizon staff told them "they will get to him when they get to him."
- 2/18/15, D.C. reported that he had been unable to renew his psychiatric medications for a week and the AMKC officer whom he had asked to contact mental health refused, saying "I don't work for mental health." D.C. reported "feeling funny" and "having weird thoughts."

Appendix E

Inadequate Response to Persons Who Are Suicidal or in Psychiatric Distress

- 3/4/14, U.W., who has a history of suicidal ideation and self-destructive behavior, reported that she was placed in punitive segregation upon her return from Elmhurst Hospital. On 4/21/14, she reported that she is claustrophobic and has flashbacks. She panicked and cut her arms but the DOC officers did not report her self-harm to the medical clinic. She reported that a DOC officer told her to "bang her head on the wall and hang myself."

- 3/20/14, J.C. reported that he was unable to see a mental health practitioner at OBCC for months (since October 2013), despite suffering from anxiety attacks, depression, and bad dreams related to previous trauma.
- 4/7/14, I.G.'s attorney reported that I.G. was placed into punitive segregation (23-hour lock-in) at the Otis Bantum Correction Center (OBCC) after he slit his wrists.
- 5/5/2014, R.A. reported that he was returned from Elmhurst Hospital to GRVC after attempting suicide over the weekend; he reported that this was not his first attempt and he had not seen a psychiatrist since returning to jail.
- 6/27/14, O.B. was housed in punitive segregation at OBCC despite being found unfit on several prior occasions and awaiting a 730 examination.
- 7/31/14, J.W. was housed in GRVC 12 Main (a punitive segregation unit) doing poorly. J.W. reported that no matter what symptoms he shares with clinical staff, their only response was to place him on suicide watch, a punitive response to his treatment needs.
- 7/31/14, I.F. reported that though he was on suicide watch at AMKC, there was no one watching him all the previous day and he was told that no one would be there to watch him until 4:00 p.m. that day.
- 9/12/14, R.S. reported on that he tried for several days to see a psychiatrist for his depression while at AMKC. We received additional complaints after reporting his needs on 9/22 and 9/23/14. 9/22/14, R.C.'s mother reported that her son, who suffers from depression, was told to "pack up" to leave mental observation housing (MO) for general population, without seeing a mental health practitioner about this proposed discharge; in response he tried to commit suicide. A second attempt to discharge him from MO led to another suicide attempt. A month later, he threatened suicide again after being told by a Corizon practitioner that he was "faking" and would be discharged to general population.
- 9/19/14, 10/3/14, T.I.'s attorneys reported that T.I. was delusional and in a seriously deteriorated condition and that they had requested a 730 examination. Despite T.I.'s deteriorated condition, history of serious mental illness, history of trauma and at least one known prior finding of incompetency, she was serving "old bing" time and was housed in punitive segregation. A request to move T.I. to CAPS or to the hospital was not heeded. On 10/3/14 T.I. was in the RHU serving "old bing time." She was found unfit and her criminal charges were dismissed on 9/30/14. While awaiting transfer to a psychiatric hospital she stayed isolated and naked in her RMSC cell without needed treatment and without timely transfer.
- 9/30/14, R.D reported that he was unable to see a psychiatrist at GRVC for four or five weeks despite the fact that he was "decompensating" and believed he needed to have his medications adjusted.
- 11/6/14, J.R. reported that he intended to harm himself and commit suicide at AMKC. He reported that he had been requesting mental health treatment for 3 weeks with no response from Corizon staff.
- 12/5/14, while A.R. was on suicide watch in the AMKC Mental Health Center, he reported that he took 22 pills, and at another point had cut himself badly enough to require 12 sutures; he requested that he be protected from himself more effectively.

- 1/28/15, 1/29/15, A.M. was on a suicide watch at AMKC. A.M. reported that he had not been seen by a psychiatrist and required medications. He also complained of being extremely cold wearing only the anti-suicide garment. On 1/29/15 we were informed by another incarcerated individual that A.M. had cut himself in a suicide attempt the prior evening while on suicide watch.
- 2/19/15, 21-year-old R.A., in jail for the first time, reported that he was on suicide watch in the AMKC Mental Health Center but had been told he was being discharged from suicide watch and mental health housing because "you can't stay here forever"; he stated that he he has a pre-jail history of psychiatric treatment, attempted suicide in jail earlier, and felt afraid from a "deep, deep depression" and was receiving no medication; he said he could not control his suicidal feelings.

Appendix F

Lack of Continuity of Care

- 1/7/14, M.T. complained that a doctor refused to renew his prescription for a seizure medication he had been prescribed since he sustained head trauma in 2004. He had been "detoxed" from his former seizure medication Klonopin and given a substitute medication. The new medication caused diarrhea and vomiting. On 2/5/14 he reported that he had a seizure and injured his back. He asked for resumption of his medication and was told by a doctor "we don't give that type of medicine here," though M.T. said he had been taking the same medication for 10 years in both City and State institutions.
- 2/18/14, V.H. stated as a result of transfers between City jails, he had not consistently received his prescribed medications for HIV.
- 2/18/14, B.B. stated that he had not received hormone replacement medication for six months, although "they say that they ordered it" at the jail clinic.
- 3/3/14, J.A. reported that he did not receive medication prescribed for him after knee surgery because it was "not there" when he went to the pharmacy window.
- 3/14/14, R.M. reported that his prescriptions for Adderall and Wellbutrin from the following week had not been filled by the pharmacy. On 4/14/14 he reported that he was still not receiving these medications despite the prescriptions. On 9/4/14, he stated that he was required to take his medications under direct observation, but that he did not receive them consistently because DOC staff did not reliably escort him to get the medication.
- 4/29/14, C.G. reported that staff at NIC were administering his prescriptions for Dilantin, an anti-seizure medication, and Tylenol 3 either late or not at all. Later, on 7/16/14 he reported that he had been discharged from the North Infirmary Command (NIC) infirmary to EMTC where Corizon staff discontinued his seizure medication.
- 4/30/14, R.A. reported that he experienced repeated failures to provide medication for his seizure disorder, resulting in at least two seizures in the preceding week, one of which required his hospitalization.
- 6/9/14, S.R. reported that his prescriptions for neuropathy (Neurontin) and Hepatitis C were discontinued when he was charged with an infraction, and then were not renewed when the

infraction was dismissed. On 6/17/14 he stated that he was still not receiving Neurontin. He did not understand why a disciplinary infraction would affect his receipt of medication.

- 6/16/14, N.B.'s attorney reported that N.B. was prescribed Haldol and Cogentin daily before arrest, but that Corizon discontinued those medications and provided no substitute.
- 6/27/14, R.R. stated that he has a history of heart instability and seizures, and had not received his seizure medication for three days. He reported that Corizon staff told him there are "problems with the computer" and would not provide him with a stat dose of the medication. The previous year, he reported that he was sent to Elmhurst Hospital with severe cardiac symptoms and was stabilized on Klonopin and Methadone, then prescribed Klonopin and Oxycontin; upon return to jail, his prescriptions were changed to Tramadol and a much smaller dosage of Klonopin.
- 8/13/14, R.C., a GMDC client who suffers from reflex sympathetic dystrophy, which is characterized by chronic, severe pain, and who was temporarily transferred to City custody for a court proceeding, reported that a Corizon nurse informed him that a doctor (who did not perform an examination) cut his dosage of one medication prescribed in state prison in half and eliminated another medication entirely.
- 12/15/14, E.M. reported that she receives Lyrica, a medication for neuropathic pain, for her fibromyalgia, but that her prescription had expired a week previously and she had not been able to get it renewed because she was turned away from the RMSC clinic.
- 12/15/14, K.J. reported that he was supposed to receive pain medication three times a day per a physician's order, but he only received it twice a day, and some days not at all, because he could not get escorted to the GRVC clinic. At one clinic visit after he had missed a number of doses, the nurse asked him why he had been refusing his medications—which he had not—indicating that someone was falsely recording that he had refused.
- 12/30/14, A.R. reported that he had been examined and treated at Bellevue a week previously for an elbow injury and had been prescribed Tramadol for the pain; as of his letter, he had not been provided that medication. On 1/8/15, he telephoned and reported that he still had not received this medication. He also stated that he had seen a bone specialist at GMDC who went over his Bellevue x-ray and prescribed Tylenol III; he did not receive the Tylenol either.
- 1/12/15, J.O. reported that he was suffering from his third recurrence of melanoma on his head since 2008 (as he understood it, it is stage 3, presenting as a bleeding lesion at this point), but that he had received no treatment for it since his arrest in late October 2014, even though the judge in his criminal case had repeatedly directed that he receive treatment.
- 1/21/15, R.S. stated that he did not receive pain medication at the Brooklyn Detention Center that was prescribed for him by the Bellevue Hospital pain management clinic the preceding November for pain caused by a fractured skull and herniated disks.
- 1/29/15, T.P. stated there had been no sick call in the AMKC West Annex for several days: "There's a million people here trying to get to sick call and they're not calling us." As a result he was unable to renew his prescription medication.
- 2/17/15, C.D. reported that he was unable to get his prescribed asthma medication refilled at GMDC because he could not get to sick call because escort officers, required in his General Population Escort housing area, did not bring him to the clinic and falsely reported that he had refused to go.

- 2/19/15, 2/26/15, C.S.'s mother reported that she visited C.S. at AMKC and found him to be extremely depressed. C.S. received Wellbutrin, Depakote and Seroquel in the community but was only receiving Abilify in DOC. DOHMH was notified but on 2/26, C.S.'s mother reported that C.S. was not re-evaluated or seen by mental health staff.
- 2/26/15, J.M. reported that he had received a prescription for Tylenol 3, but he was dispensed Ibuprofen instead, which he says is insufficient to relieve his pain. He also stated that he had been unable to get Corizon staff in the clinic to provide renewals for two other medications which are about to expire.

Appendix G

Delays and Problems in Obtaining Dental Care

- 5/28/14, B.B. reported on that he had been waiting since April at MDC for extraction of a "dead" molar and that there was a hole in his gums which seemed to be extending into his jawbone. He missed one appointment because DOC failed to escort him to it, and another because the surgeon did not show up.
- 7/22/14, C.A. reported that he tried to get treatment for an abscessed tooth for nearly two months without success at GMDC.
- 8/6/14, S.F. reported that he had a painful abscessed tooth which was causing his face to swell. He had been seeking emergency dental treatment for days without success.
- 9/14/14, P.E. reported that he had been trying to get dental treatment for a year and that "my teeth are rotting out"; his numerous grievances yielded only a promise to refer him to an "outside" dentist, but no actual treatment.
- 10/1/14, C.S. reported that she needed a root canal and that when she asked the oral surgeon at RNDC, whom she saw for another problem, he said he would not examine her for this purpose because he could only perform one procedure per visit.
- 12/8/14, T.L reported that on November 27, he had a carious tooth removed, but a broken piece of the tooth remains in his gum and is painful. His efforts at GMDC to have the fragment removed on an emergency basis resulted in statements that a "dental referral" was submitted. His pain medication was discontinued despite continuing pain.
- 1/22/15, T.C. reported that he was unable to see a dentist at EMTC for severe dental pain on the left side. He had been to the dental clinic three weeks previously, and the dentist had dealt with a similar problem on the right side, but declined to deal with the left side problem even though the patient was present in the clinic.
- 1/28/15, D.C. reported that he had been trying to see a dentist since January 23 because of a severe toothache probably requiring extraction of a molar, but he was unable to get to emergency dental sick call for this purpose despite his complaint of severe pain.
- 1/29/15, J.O. reported that he had tried four times at GMDC to have his teeth cleaned (a service that is required by the Minimum Standards on Health Care § 3-06(c)(3)(vi, ix), which requires oral prophylaxis and periodontics), but had been told all he could receive was an examination and that he would be called back for cleaning. He was not called.

Appendix H

Delays in Specialized or Hospital Care

- 5/1/13, C.J.'s attorney reported that C.J. was told that his colostomy, which was done in connection with surgery to address multiple gunshot wounds to his intestines, was to be reversed after six months. The six months expired in September 2013, but on 12/19/13 we were informed it had not been done. On 7/25/14, we were told he had been evaluated at Bellevue Hospital about four months previously but that the surgery had not been performed. After we protested about the excessive delay at a meeting with DOHMH officials, the surgery was performed on 9/5/14 (ten months late).
- 9/13/13, K.F.'s attorney reported that his client's colostomy was supposed to be reversed in September 2013, but that he was not assessed for this procedure as of yet. On 4/7/14, he reported that K.F.'s colostomy was still not reversed.
- 1/28/14, R.S. complained that two podiatry appointments for follow-up on a fractured foot with posterior tendon tear had been cancelled on 1/3/17 and 1/4/17 respectively. After our complaint he was rescheduled for 2/14/14. On 2/19/14 he reported that he missed that appointment because he was informed after the bus to Bellevue had already left the jail.
- 2/11/14, J.G. reported that he had been waiting since November for a neurologist appointment; he suffered symptoms including increased pressure behind his left eye with blurred vision, a pounding feeling in his head, periodic "locking" stiff of his neck, and swelling on the side of his face.
- 3/6/14, J.A. reported that he had been waiting at AMKC since August 2013 for hip replacement surgery to correct a severely painful degenerative condition.
- 5/29/14, A.W.'s defense attorney reported a two week delay removing the wires from his client's jaw that was wired shut because of an injury that occurred before he was incarcerated. A.W. informed us that Corizon staff were telling him that since Corizon didn't put the wires in, Corizon wouldn't take them out. A.W. could not eat solid food until the wires were removed, and one of the wires had popped out and was cutting his mouth.
- 7/8/14, G.O. reported that he missed a Bellevue clinic appointment when a DOC officer at MDC falsified a report stating that he refused. Medical staff learned of this and objected, but it was too late by then to get him to Bellevue on time for the appointment.
- 8/14/14, E.M.'s sentencing judge had directed removal of a tumor. On 10/27/14, nothing had been done to diagnose, treat, or remove the tumor since that order.
- 10/7/14, O.P. reported that he missed a scheduled sonogram of his liver after being held in an intake area without transport. He was then taken to the clinic and asked to sign a refusal form, he declined to sign the false report.
- 10/21/14, I.S. reported that he had been waiting for two months to see an orthopedist for follow-up treatment for an injury to his left leg.
- 12/4/14, A.N. reported that he had not received hand surgery to repair cut tendons he sustained when assaulted by other prisoners in August 2013. He said he was told to wait until he got to state prison or was released, and the Corizon doctor at AMKC "threw a fit" and told him to leave the clinic. We had written about this delayed surgery on 9/16/13 and on 10/15/13. He was scheduled for surgery at Bellevue but it was not performed because

the patient would require 12 weeks of physical therapy twice a week and the Bellevue doctor did not think DOC could reliably bring him to the hospital. Our request on his behalf that he receive the surgery and that DOHMH and DOC resolve the transportation problem was disregarded.

- 12/15/14, E.M. reported that she was told she would be referred to a neurologist (she has "excruciating" pain in her hands) but had waited "months" at RMSC without being sent to one.
- 12/22/14, D.C., in custody since 2011, reported that he had been waiting two and a half years for surgery to repair torn ACL and meniscus ligaments and tendons in his knee, which he stated were diagnosed in August 2012 on an MRI. He stated that he can "barely walk" and has had to use crutches since then, but when he tries to get treatment for this injury "all I get is the runaround."
- 2/10/15, R.R. reported that he had had a skull fracture on December 9, 2014, and had been held for observation at Bellevue for four days and was supposed to be taken back for a follow-up MRI; a month later, he had not been taken for the MRI.
- 2/11/15, V.P. reported that he had been waiting at AMKC since June 2014 for a hospital clinic appointment for a hernia that was worsening with the passage of time; numerous requests at sick call had been fruitless.
- 2/26/15, R.S. reported that he was not taken to his scheduled pain medication clinic appointment at Bellevue because DOC mistakenly took him to a neurology clinic at the West Facility; as a result, he continues to receive only Motrin for continuing pain from a fractured skull, jaw, back, and other injuries.

Appendix I

Failure to Provide Medical Diets

- 2/11/14, G.V. complained that he was not provided a diet consistent with his severe allergy to tomatoes (an issue he had raised as early as October 2012), stating that some days two of three meals served to him contained tomato products.
- 4/1/13, 4/4/13, 4/22/13, 5/6/13, and 2/19/14, R.A. complained on each of these dates concerning failure to provide the soft diet with protein shakes prescribed for him.
- 4/18/14, K.G.'s attorney reported that K.G. was not receiving the renal diet prescribed for him as a result of kidney disease.
- 6/24/14, S.B.'s attorney reported that S.B. required a liquid diet for a broken, wired jaw, and was not consistently received it.
- 8/1/14, J.M. reported that he is not provided alternative meals based on his allergies.
- 8/19/14, D.F. reported that he was not being provided the diet prescribed due to his allergy to red meat; no protein substitute was provided when red meat was on the menu.
- 9/8/14, F.H. reported that he was not receiving the fish free diet conforming to his allergy to fish.

- 10/20/14, A.W. reported that he had not received his diabetic and allergy-related diet for several weeks.
- 1/2/15, J.V.'s defense attorney reported that he had not received the soft food diet he was prescribed, even though the attorney had contacted the OBCC clinic a couple of weeks previously and had been told they were aware of the need and would take care of it. The client had a serious stomach infection for which he had been hospitalized and which had caused sufficient damage that he would require surgery.
- 1/6/15, G.V. reported that he was being provided food containing tomatoes, to which he is allergic. He has been in DOC custody for several years and DOC confirmed to us in 2012 that he had been issued a special diet for his tomato allergy. However, we responded to complaints on 10/22/12, 2/11/14, and 1/6/15 that he was again receiving meals with tomatoes or tomato products.
- 2/6/15, B.H. reported that he was not receiving a low fiber diet at AMKC that was prescribed by Bellevue Hospital for Crohn's disease and ulcerative colitis and that he was in pain as a result.

Appendix J

Failure to Accommodate Disabilities

- 4/16/14 and on 6/25/14, W.H. reported that he has a prostate disorder that makes it painful for him to walk long distances, but that he was held on the third floor at a considerable distance from the messhall and medical clinic which he had to walk to in order to receive meals and medical care.
- May and July 2014, D.W., in a series of complaints over several months, reported that he was discharged from the NIC infirmary when he was released on bail, but when he returned to jail he was not returned to the infirmary. He had limited range of motion in his legs and required a walker, but was not provided a walker in DOC custody. He also required handicap accessible transportation to court, which he did not receive, and as a result he was not taken to court on numerous occasions, as corroborated by his defense attorney.
- 6/5/14, L.C.'s attorney reported that this client has AIDS, neuropathy, and severe arthritis in knees, hips, and back, along with asthma. L.C. was housed on the second floor of the Rose M. Singer Center (RMSC), where she struggled to get up and down the stairs. She was not provided with a cane and not permitted to use the jail elevator.
- 7/16/14, C.G. reported that he was discharged from the NIC Infirmary to the EMTC, where his wheelchair was taken from him. He reported difficulty walking to program services.
- 8/14/14, O.H.'s attorney reported that this client is 71 years old, had spinal surgery within the previous year, and had a problem with his hip. He walked with difficulty with a cane, yet was housed by DOC far from the medical clinic where he needed to pick up his medications. The walk included long corridors and going up and down stairs.
- 10/2/14, R.S. reported that his wheelchair was confiscated at NIC, although he used a wheelchair because of chronic spinal pain, and had done so for ten years.

- 10/6/14, J.D. reported that he was recently discharged from the NIC to AMKC in a wheelchair. He was thrown out of his wheelchair in the intake area at AMKC. He remained for over 24 hours in a filthy intake cell because DOC would not provide a wheelchair to take him to a housing area. When he was finally housed, he did not receive a wheelchair and had to slide himself around on a bucket to move.
- 10/13/14, W.S. reported that he has muscular dystrophy, but the Chief Physician of NIC confiscated his motorized wheelchair and failed to provide the Clinitron bed necessary to prevent bedsores that was ordered by Bellevue Hospital. He developed bedsores.
- 10/27/14, G.C. reported that he was discharged from the NIC infirmary despite having left side paralysis as a result of a gunshot wound to his head; he reported that he had a brace but it was broken and in need of repair and replacement.
- 12/19/14, D.W. reported that he was discharged from the NIC infirmary to the Central Punitive Segregation Unit, despite the fact that he uses a walker with wheels (which was taken away from him) and has chronic bone infections.

Appendix K

Lack of Physical Therapy and Assistance with Activities of Daily Living

- 12/26/13, S.M. reported that he had been receiving physical therapy for a broken leg and knee but was transferred from NIC to GRVC, where he did not receive the therapy. He reported he still was not receiving therapy on 1/28/14.
- 1/13/14, W.S. stated that he was prescribed physical therapy at Woodhull Hospital for a fractured leg sustained before his arrest, but that Corizon did not provide the ordered physical therapy.
- 1/21/14, we received a complaint that an unnamed elderly and incontinent patient in NIC Dorm 3 was being neglected. He reportedly defecated on himself and was left to lie in his own waste in the absence of nursing or patient aides to help him to the bathroom or to help him clean himself and change his soiled clothing. A week later we received a further message reporting that he still was not receiving assistance with daily living and was still defecating and urinating in his bed and on the infirmary floor.
- 12/19/14, D.P., who cannot walk and uses a wheelchair, stated that he had on numerous occasions been denied a plastic urinal, forcing him to urinate and defecate on himself. Further, he has been denied a medical mattress and bed, and has been denied an ADA-compliant shower or toilet chair.
- 1/23/15, A.L. reported that he had not been provided physical therapy that was ordered for him, and that staff had told him to sign a refusal form even though he was not refusing.
- 2/19/15, J.M.'s attorney reported that he is paralyzed and must wear a diaper; Corizon staff at the NIC infirmary told him he has to change his own diaper, but he cannot do so because of his paralysis and because he has a surgically installed external fixation device around his leg which makes it difficult for him to maneuver and turn his body. A nurse told him she was surprised he was discharged from Bellevue to DOC in his condition.

- 2/25/15, J.R. stated he must wear a colostomy bag, but his right arm is amputated so he requires help cleaning and changing the bag; but he is unable to get help from the Corizon staff. He is held in general population in AMKC.

Appendix L

Correctional Interference with Medical Orders

- 11/12/13, 9/8/14 and 11/24/14, K.T. is a disabled Iraq War veteran with mobility impairments resulting from a war-related gunshot wound to his leg. He has a permanent rod in his leg, neuropathy, and "drop foot," aggravated by a motorcyle accident. In 2013, he reported that he was not permitted to wear supportive footwear provided by his family. When he returned to custody the following year he sought medical authorization for the footwear in September, 2014. In November, 2014, he reported that was seen by a Bellevue podiatrist but was still waiting for footwear.
- 2/5/14, F.R. reported that the cane that he needs because he suffers from nerve damage to his ankle and wears a "triple ankle brace" was confiscated by DOC staff the previous week.
- 3/24/14, B.J.'s attorney reported that B.J. had a broken leg and his crutches had been taken away by DOC staff.
- 4/29/14, D.A., a diabetic, reported that his medically authorized athletic shoes were confiscated the previous week and he developing foot sores.
- 6/16/14, J.W. reported that he had a broken leg but that an officer tried to take away his crutches, stating that J.W. could "hop" wherever he needed to go. J.W. reported two weeks later that he was made to hop on one leg, without his crutches, to use the bathroom.
- 10/24/14, I.R.'s attorney reported that EMTC staff confiscated I.R.'s cane and asthma pump upon his return to jail from the hospital.
- 12/8/14, D.W. reported that although he has a medical exemption from the use of "tube mitts" because of nerve damage to his wrist and thumbs, an MDC captain continues to use them on him.
- 12/15/14, W.M. reported that two AMKC captains confiscated his medically authorized cane (which he needed because he was recovering from knee surgery).
- 1/5/15, O.P. reported that an AMKC captain confiscated a medically prescribed mattress (*i.e.*, thicker than the standard mattress) despite showing the captain his medical permit for it.
- 1/13/15, G.H. reported that his medical permit for open toe slippers was confiscated during a search at OBCC; he was told this is because it was "not from this building," *i.e.* from a different DOC jail.

Appendix M

Abusive and Retaliatory Conduct by Corizon Staff

- 3/5/13, J.N. reported that he was threatened with discharge from the infirmary (return to general population), and he believed it was in response to his complaints about his care. The chief physician first told him "call your lawyer" and then told him "you don't need to be here," even though he suffered from stage 4 pancreatic cancer, needing continuing chemotherapy, and had three open ports in his neck for chemotherapy infusions.
- 3/14/13, R.S. reported that when he questioned the termination of his pain medications, the chief physician of the infirmary at NIC responded, "Just deal with it" rather than providing any explanation or expressing any concern about the patient's pain. The patient's medical records confirm that he suffers from a degenerative spinal condition.
- 7/24/13, D.B. reported that when he tried to talk to the chief physician of the North Infirmary Command about inadequate pain medication, the doctor called him an "addict" and threatened him with an infraction if he "knocks on my door again."
- 1/13/14, R.A. reported that a Corizon doctor discontinued his Lithium because he complained to Legal Aid about his care. The doctor was reported to have said: "You made a complaint about your lithium? We fixed that already. You don't want to talk to me? I'm taking you off it." The patient was given substitute medication to which he reported he was having a bad reaction.
- 7/22/14, R.D. reported that he got into an argument with a Dr. Kahn (phonetic) and used an epithet, and the doctor said, "Just for that I am taking you off Seroquel."
- 10/14/14, D.G. reported that she was discharged from the infirmary with an infection in a gunshot wound that was exuding pus. She reported that the discharge occurred after she complained about not getting IV antibiotics and hospital-based treatment.
- 1/6/15, G.S. reported that he fell and injured himself at MDC, and lay on the floor for some time before medical staff appeared, in the person of a Corizon doctor who said, "I'm tired of this shit. Get the fuck up. There's nothing the fuck wrong with you." The doctor then grabbed him by the neck, "yanked" him up painfully, and when he complained of neck pain, "jammed" a neck brace on him. He was later taken to the hospital.
- 2/26/15, W.S. reported that four days previously a doctor at NIC refused to treat him for symptoms including fever, chills, and "violent shaking" when a nurse brought him to the doctor. The doctor refused to give his name. After another hour, a different doctor did see him after the intervention of a DOC captain, and ordered him sent to Bellevue Hospital, where he was admitted and remains.

We think there are major problems with the delivery of medical care to prisoners in the city jails

Detailed description of what our clients describe to us is in our written testimony

Affects virtually all aspects of the system

Sick call, gateway to all care

Mental health care

Access to timely specialty care

Access to dental care

Provision of medically required diets

Accommodation of disabilities, especially mobility disabilities, in a jail system that's full of stairs

Inadequate infirmary facility

Major issue of quality of care

We don't have clients' charts analyzed by doctors when they complain to us

But the State Commission of Correction does in connection with its mortality reviews

Bradley Ballard, the man who was in a mental health area, and who on September 6, 2013 was locked away and ignored, in an apparent episode of covert punishment for disrespect to staff, for six days during which he received no medical or mental health attention despite the fact that he was visibly deteriorating, and was ultimately removed from his feces-smeared cell with his body covered in filth and feces, and also with a ligature tied around his genitals, which had become necrotic, and his scrotum was gangrenous. He died a few hours later.

But his medical neglect started long before he was locked away. He actually died of diabetic ketoacidosis. He was a known diabetic, but his insulin prescription was allowed to run out on August 26 without renewal. Apparently he still received it until August 30, but after that, until his death on September 11, 2014, this known diabetic received no insulin. Even before that, he repeatedly missed clinic visits for diabetes monitoring without any inquiry into why or any attempt to counsel him, despite his diagnosed mental illness.

As for his mental health care, he was apparently stabilized on medication, but a nurse practitioner changed his medication, dropping his anti-psychotic medication Risperdal and substituting Seroquel, which had been previously disapproved by a physician, at a level that was sub-therapeutic for psychosis. The nurse explained essentially that he hadn't noticed what was in Ballard's records about medication. No one followed up on the efficacy of the medication even though he displayed behavioral changes. The SCOC concluded:

> The medical and mental health care provided to Ballard by NYC DOC's contracted medical provider, Corizon Inc. during Ballard's course of incarceration was so incompetent and inadequate as to shock the conscience as was his care, custody and safekeeping by NYC DOC uniformed staff, lapses that violated NYS Correction Law and were directly implicated in his death. Had Ballard received adequate and appropriate medical and mental health care and supervision and intervention when he became critically ill, his death would have been prevented.
>
> The events that lead to Ballard's death were directly caused by the compounded failures of NYC DOC and its contracted medical provider, Corizon Inc., to maintain care, custody, and safekeeping of this inmate in accordance with New York State Correction Law, NYS Minimum Standards and Regulations for Management of County Jails and Penitentiaries, and Ballard's civil rights.

So what to do about all of this?

1. Pass the proposed legislation, but enhance it.

   Should be available to the public

   Underlying data should be public as well, in a widely used format like .csv

   Quarterly reports

   Add measures: meaningful measure of sick call access

      Complaints, patient satisfaction

2. Get a new medical provider—community-based, with ties to community providers to assist with re-entry and with continuity of care upon discharge.

3. Establish a unit for the accommodation of physically disabled prisoners, especially those with mobility disabilities, under the supervision of orthopedist and staffed and equipped to provide necessary physical therapy and assistance with daily living.

4. Establish a suicide watch unit in the jails within a mental health treatment unit—no more suicide watch in punitive segregation or for that matter general population.

5. Replace the decrepit North Infirmary Command with a modern medical facility. This is a project that appears and disappears in the City budget and it just needs to get done.

6. Fund the Board of Correction so it will have adequate staff to respond to and report on problems in the jails.

TUESDAY, MARCH 3, 2015

TESTIMONY OF DR. JAY COWAN
PRESIDENT
CORRECTIONAL MEDICAL ASSOCIATES OF NEW YORK, P.C.

Thank you, Dr. Johnson. And thank you to Chair Johnson, Chair Crowley and the members of both committees for this opportunity to address you this morning concerning the quality of and access to health care at Rikers Island.

I am Dr. Jay Cowan. I am the president of Correctional Medical Associates of New York, commonly known as CMA. As Dr. Johnson mentioned, my colleagues and I provide the actual medical care to the Rikers Island inmates.

I am board certified in internal medicine and gastroenterology, and licensed to practice medicine in New York. I have been practicing internal medicine for more than 25 years. I am a graduate of Brown University, and the Howard University Medical School. Prior to my current position, I practiced medicine in Harlem for 15 years at both Harlem Hospital and North General Hospital.

I am joined by my partners, Dr. Neil Leibowitz who is a board certified psychiatrist and our director of mental health services, and Dr. Luis Cintron, my Deputy Medical Director who is also a board certified internist.

As Dr. Johnson explained, CMA operates all of the medical and mental health practices on Rikers Island. It is our responsibility to make sure that the medical care is provided at the highest level, a responsibility that I take very seriously.

Our services begin as soon as an inmate enters DOC custody. We are charged with providing a thorough and complete examination of every patient prior to their being housed. This is a service that is provided 24 hours a day, 7 days a week, 365 days a year. Each patient receives an

examination that takes, on average, one hour to complete. This is an underserved population that suffers from disparities in health care. Some, of course, have been through the system before; but no matter how recently, they still receive an examination.

We give each patient a careful and thorough examination. The clinician determines what lab tests and other screening needs to be done for each patient. Mental health screening is also conducted, and inmates with mental illness are referred for further evaluation and treatment. In addition, patients are tested for Tuberculosis, provided counseling with regard to their respective conditions, given the appropriate medication and offered the opportunity to take an HIV test and counseling with regard to sexually transmitted diseases. About 35% of new admissions have a chronic medical problem. Since the institution of electronic medical records, we are better able to follow-up on their care.

Our doctors, physicians' assistants, nurse practitioners, nurses, pharmacists, psychologists, and others provide comprehensive services in 11 different facilities. We provide primary care, specialty care, and emergency care. There is on-site dialysis, a communicable disease unit, OB-GYN services, a nursery, methadone maintenance as well as drug and alcohol detoxification, among others.

We do this in a complex environment for a patient population that is not there of their own choice.

We staff medical clinics 24 hours a day. Patients can access these services through sick call, chronic care follow-ups, medical emergencies, and specialty care.

On site emergency care is also available 24 hours a day at the Urgicare Center. This Center is staffed by Board Certified emergency room doctors and is equipped to handle a wide range of medical emergencies. Patients who have needs that cannot be met on the Island and those with life threatening conditions, are transferred to an HHC hospital by FDNY Emergency Medical Services.

As you all know, the percentage of inmates with mental health issues has greatly increased. This has put an additional strain on our ability to care for all of our patients. We are deeply appreciative and thankful for the

additional funding that the Mayor and the City Council provided which has allowed us to almost double the number of mental health professionals that we employ on the Island.

Violence continues to be a major problem on the Island, but as an employer who cares about the well-being of the patients, the correctional staff and every one of our employees, I want to acknowledge the reforms begun by Mayor de Blasio and Commissioners Bassett and Ponte.

For example, panic buttons are now being installed in mental health cubicle areas where corrections officers cannot be within hearing distance for privacy reasons. Also, the DOC is working with us on enhanced safety training for our staff.

No one should have to come to work and worry about their personal safety. We will continue to work with our counterparts to secure a safe working environment for our staff.

Finding people who want to enter such an environment is difficult. It takes a special person to want to work in a jail setting. Our 900 employees come to work everyday to provide the highest quality of health care to the approximately 11,000 individuals on Rikers Island daily. They come to work with the understanding that they deliver this care in an often hostile environment. Our employees see it as a calling to help others who don't have any other health care.

We work very closely with officials at DOHMH and Corizon to find new and innovative ways to deliver care. Over the last year, our partnership with DOHMH has enabled us to institute some cutting edge programs that are already leading to better results for our patients. For example, there are now specialized housing units for the mentally ill, which provide more nurses, more observation opportunities, and more programming. Medication compliance has increased.

Our medical staff keeps up-to-date on new advances and trends in medicine. To further this, we have instituted Island-wide monthly conferences and weekly lectures specifically concerning correctional medicine so all of our practitioners can continue learning and giving back to their patients.

Our employees are ethnically diverse, and most of them are from New York City. Virtually all of our employees are members of 1199 SEIU, New York State Nurses Association, and Doctors Council SEIU. They deserve the respect that they earn through hard work.

Providing comprehensive health care in this complex environment is a daunting task, but one that we are honored to perform every day on behalf of the citizens of this great city. We are committed to working with the de Blasio Administration, the Department of Health and Mental Hygiene, the Department of Corrections, and the City Council in any way we can to continuously improve the quality of health care at Rikers Island.

Thank you.

TUESDAY, MARCH 3, 2015

STATEMENT OF DR. CALVIN B. JOHNSON, M.D., M.P.H
CHIEF MEDICAL OFFICER
CORIZON HEALTH

Good morning.

Chairman Johnson, Chairwoman Crowley and members of the City Council's Health and Fire and Criminal Justice Committees. Thank you for the opportunity to speak to you today. This is a timely and important hearing, at which we can discuss our shared objective of improving the quality of health care at Rikers Island.

I am Dr. Calvin Johnson, the chief medical officer of Corizon Health. I am a graduate of Morehouse College and I earned both my medical degree and my masters in public health from Johns Hopkins.

Working to protect the public's health and safety has been a prominent and continuous thread throughout my entire career. I had the opportunity to serve several years as the secretary of health for the Commonwealth of Pennsylvania, where among other things, I was successful in significantly increasing the funding for HIV/AIDS prevention and early detection, and in establishing data-driven management systems to improve performance management and outcome measurements. Earlier in my career, I had the privilege to be the medical director of Family Health Services at the New York City Department of Health.

With me today are Jessica Lee and Susan Schranze. Ms. Lee is a registered nurse, who is the vice president of operations for Corizon Health here in New York City and oversees the implementation of our contract with the City. Ms. Schranze is Corizon Health's chief operating officer for the Northeast Region.

I am also joined by my colleague Dr. Jay Cowan, the president of Correctional Medical Associates of New York, whom you will hear from later.

Corizon Health is the founder of modern contract correctional health services. Our company, whose origins are more than 35 years old, was created by the merger of Prison Health Services and Correctional Medical Services. We serve approximately 345,000 inmates in 27 states. We operate the health care systems in jails such as Philadelphia and St. Louis, in addition to New York City. Our CEO is Dr. Woodrow Myers, a nationally recognized public health expert and a former Commissioner of the New York City Department of Health.

Corizon Health, first through its predecessor, PHS, has provided comprehensive health care services to New York City's inmates since January 1, 2001. Our contract with New York City is unique. First, New York City provides more services to inmates than any other jurisdiction in the United States. The care you require to be provided is more complete and comprehensive than anywhere else in the country, something that I think we should all be proud of.

Second, the DOHMH program for Rikers actually has three components, Corizon Health, Correctional Medical Associates of New York (CMA), and Correctional Dental Associates of New York (CDA). In the most simplified description, CMA is the entity that provides all the medical and mental health services, while CDA provides all the dental and oral surgery services. Corizon Health provides the administrative and business management services, such as overseeing the entire contract and making sure that there is full compliance with its terms on such issues as staffing, purchasing, and IT support. We provide all human resources services including credentialing, screening potential employees, orienting new hires on safety procedures and policies, and tracking the statistical data of all patients. We are the administrative liaison to the Department of Health and Mental Hygiene and the three unions. We also coordinate the care of the patients, for example, scheduling and coordinating their off-island appointments such as when they need to see a doctor at Bellevue or Elmhurst Hospitals. Corizon Health, CMA, and CDA each contribute their expertise. To the outside world, this consortium appears seamless, as it should. And like the public hospitals, many of the approximately 78,000 admissions we have each year present with at least one chronic illness and

associated complications, and many of our patients had not received regular or consistent care.

We work very closely with DOHMH and want to thank Dr. Angell and Dr. Venters for their assistance, guidance and collaboration, and Commissioner Bassett for her leadership and personal interest in improving correctional health. Working in partnership with the Department, our program is constantly evolving to meet the needs of this underserved segment of our community and to bolster DOHMH's public health initiatives.

We also especially appreciate Commissioner Ponte's interest and direct involvement in addressing safety issues on the Island. Both commissioners have opened up new channels of discussion and cooperation, unheard of previously in the history of this contract, to better serve the patients on Rikers Island and to address issues of concern amongst us. We have seen a significant change in the last year or so and are greatly appreciative of it and look forward to expanding this collaboration even further. We also applaud Mayor de Blasio for his reforms and innovations especially in the area of mental health and look forward to implementing those initiatives. We could not agree more that mental health services at Rikers need to be viewed as part of a continuum from police encounter to discharge after incarceration, for those who cannot be diverted along the way.

Before I turn to Dr. Cowan, let me make one more point. Every person who works for CMA or Corizon Health is personally affected when a patient suffers an adverse outcome.

Our goal is to give the best care that we know how to give. We don't cut corners. We have no incentive to do anything but give outstanding care.

Let me explain. We have what is called a "cost plus" contract. Staffing levels, the range of services, and quality measurements are all established by DOHMH in our contract. Failing to provide these services is wrong and contrary to the values of our company and our providers. Anyone who says otherwise simply does not understand this contract, or anything about the dedicated men and women who work with us.

Dr. Cowan will now talk about medical services and operations on Rikers and then I would be happy to answer any questions that you have for me.

Thank you for this opportunity to address you this morning.

New York City Jails Action Coalition
c/o Urban Justice Center
40 Rector Street, 9th floor
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New York City Council
Committee on Health
&
Committee on Fire and Criminal Justice Services

Oversight Hearing:
Health Care Delivery in New York City Jails: Examining Quality of Care and Access to Care

March 3, 2015

The New York City Jails Action Coalition would like to thank the Committee on Health and the Committee on Fire and Criminal Justice Services for holding this hearing and for the opportunity to testify on this critical issue. The New York City Jails Action Coalition (JAC) is a collective of activists that includes formerly and currently incarcerated individuals, family members and other community members working to promote human rights, dignity and safety for people in New York City jails. Our goals include increasing transparency in Department of Correction (DOC) policies in NYC jails and accountability for DOC practices and abuses; ending the use of solitary confinement (commonly referred to as SHU, the Box, the Bing, or punitive segregation) in NYC jails; addressing the physical and mental health needs of people in NYC jails and ensuring access to continued care in the community upon release; advocating for increased rehabilitative services in NYC jails to promote reintegration; and fighting the racist and discriminatory policies leading to mass incarceration. We exist because the treatment, including health care, of people in New York City jails is fundamentally inhumane.

JAC was formed in December 2011 because people in New York City's jails are far too often neglected and abused by the very agencies designed to protect them. People are often in effect punished by devastatingly inadequate health and mental health services. We urge the City Council to take steps to protect the rights of people while they are incarcerated, to invest in quality health and mental health care in the community, and to implement other prevention, diversion and reentry services to keep people out of the jail and prison system entirely.

As you are well aware, within the past several years there have been numerous reports on and investigations into the dangers that incarcerated individuals face due to healthcare-related negligence, negligence that is perpetrated by staff in every department within the jails. Countless

people have suffered. Many have lost their lives. The Associated Press has reported on the numerous deaths due to the negligence or direct actions of health care and correction staff.[1]

The death of Bradley Ballard demonstrates both the individual (in)actions and endemic problems at the heart of a broken system. In September 2013, Mr. Ballard, who suffered from documented, severe psychiatric symptoms, was placed on a mental observation unit at AMKC. In this unit, he was supposed to be monitored at regular intervals and provided with treatment for mental health and medical conditions. Instead, Mr. Ballard was locked in his cell for seven days, and denied his medication and medical attention. After seven days of horrific neglect, he was carried out of his cell covered in feces and blood. He died a few hours later. Unmedicated and unmonitored, he had been self-mutilating for five days. His death was ruled a homicide at the hands of the corrections officers and medical providers who denied him the care he required.[1] The New York State Commission of Correction's (SCOC) investigation into Mr. Ballard's death documents appalling negligence, deliberate indifference to his suffering, and falsification of documents by staff to cover up for their inaction. The SCOC concluded, "the medical and mental health care provided to Ballard by NYC DOC's contracted medical provider, Corizon Inc. during Ballard's course of incarceration, was so incompetent and inadequate as to shock the conscience as was his care, custody and safekeeping by NYC DOC uniformed staff, lapses that violated NYS Correction Law and were directly implicated in his death."[2] To date, nobody has been held accountable for Mr. Ballard's death.

Hundreds of people are currently suffering from inadequate and often counterproductive care. For many, mental health treatment consists solely of medication management. Family members of people who are currently incarcerated report that individuals needing mental health therapy rarely receive adequate treatment, as they may meet with a different therapist each visit, for just a few minutes per session. People who suffer with suicidal thoughts or demonstrate self-injurious behaviors are often denied needed treatment and are instead ignored or labeled as malingering. One individual, Favian Cruz, committed suicide on New Years Day 2015. A psychiatrist had ordered his placement in a special observation unit because of suicidality but this was not carried out, in violation of DOC protocol.[3]

Health care providers in city jails must listen to family and community-provider input. Similarly, discharge planning must include, whenever possible, the involvement of family members and linkages to providers that people trust. Incarceration does not make an individual's health care an issue isolated from their previous conditions. The son of one JAC member is currently receiving haphazard mental health treatment while incarcerated at Rikers Island. The timing and

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[1] Pearson, J. (December 28, 2014). *Widespread Problems on Rikers Island Tough to Fix*. Associated Press. Available online at http://www.apnewsarchive.com/2014/Decades-in-the-making-violence-misconduct-neglect-at-Rikers-could-take-as-long-to-overcome/id-1d49c8ea13ac4a57bdb1a75e1ba3e827

[1] CBS New York. (June 2, 2014). *September Death of Mentally Ill Rikers Island Inmate Ruled a Homicide.* Available online at http://newyork.cbslocal.com/2014/06/02/september-death-of-mentally-ill-rikers-island-inmate-ruled-a-homicide

[2] New York State Commission of Correction. (December 14, 2014). *Final Report of the New York State Commission of Correction: In the Matter of the Death of Bradley Ballard, an inmate of the Anna M. Kross Center.*

[3] CBS News. (January 2, 2015). *Suicide watch ignored, Rikers Island inmate dies.* Available online at http://www.cbsnews.com/news/suicide-watch-ignored-rikers-island-inmate-dies

dosage of his medication had been changed several times despite the dangerous impact those changes have had on his mental and physical health. When his mother tries to contact the medical professionals overseeing his care, her questions and calls are ignored. It is important that a message be sent from the city level that family members' involvement — in the assessment and treatment of their loved ones in correctional settings — is valued.

Not only is health care in city jails inadequate, but DOHMH and DOC are not held accountable for their systemic and individual violations. For example, in September 2013, James Gilligan and Bandy Lee presented their findings that the mental health services in New York City jails violate the Board of Correction's minimum standards. They described the following violations:

1. Group therapy is not provided confidentially, and is observed and interrupted by non-participants;
2. Punitive segregation diminishes and interferes with the mental health practitioners' opportunity to observe patients;
3. Other treatment modalities should be used by the mental health staff, other than Dialectical Behavior Therapy (DBT);
4. Many of the inmates with mental illness are housed in a stressful environment;
5. The physical environment is not conductive to facilitate care and treatment. [4]

We have yet to hear the DOC or DOHMH report on how they will improve the quality of mental health treatment and overall mental health environment. While DOC reported that they no longer put people with mental illness into punitive segregation or ESH, there is a lack of transparency around the conditions in which people are being held. Similarly, as reported by the Associated Press, despite the unprecedented public attention on the City jail system, people continue to die in custody due to horrific behavior of staff.[5]

As the population of people with mental illness in NYC jails continues to grow – now at roughly 40% of the jail population- the health and mental health care systems within the jails appear to require a complete overhaul. The quality and accessibility of treatment must be dramatically improved immediately. Therapy must be provided in therapeutically appropriate settings that protect the patients' privacy, instead of being administered at cell-side or in open corridors and communal spaces. DOHMH must employ psychiatrists who specialize in the treatment and care of their specific client populations, for example in adolescent brain development and traumatic brain injury. Mental health interventions must include awareness of the impact of trauma and PTSD on patients' health and must recognize how incarceration itself, as well as experiences such as solitary confinement, can be particularly traumatizing. DOC must facilitate people's access to health care.

Ultimately, DOC and DOHMH must be accountable to meeting standards set by outside bodies and to the public at large. Numerous investigations over the past few years have documented individual cases and structural flaws in the provision of health care in our city jails. We urge the City Council to pass introduction 440 to require reporting about the health of people in city

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[4] Gilligan, J. and Lee, B., (September 5, 2013). *Report to the New York City Board of Corrections*. New York City.
[5] Pearson, J.

correctional facilities as another step towards transparency and accountability. While we appreciate that deep, structural change may not happen overnight, and efforts like the Mayor's Taskforce on Behavioral Health and the Criminal Justice System are designed to make long-term reforms, the Departments must immediately remedy the suffering of people today in our city jails because of substandard and negligent health care. This cannot wait for another study or another death.

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Testimony of Matthews Hurley, M.D.,
First Vice-President of Doctors Council SEIU
Before the New York City Council Health Committee

March 3, 2015

Good Afternoon Chair Crowley, Chair Johnson and members of the Health and Criminal Justice and Fire Committees. My name is Dr. Matthews Hurley and I am the First Vice-President of Doctors Council SEIU which represents thousands of doctors in the Metropolitan area, including in every HHC facility, the New York City Department of Health, and New York City jails including Rikers and Vernon C. Baines Barge (also known as VCBC). Thank you for the opportunity to testify today.

Doctors Council SEIU is here today in support of Intro 440 and to provide input on the state of access to quality care at Rikers Island and VCBC from the perspective of the front line medical workers.

Over the course of the last two years, Doctors Council SEIU has worked with the New York City Board of Corrections in helping convene various parties, including the Department of Corrections, Corizon, DOHMH, NYSNA, 1199, COBA and other stakeholders, to ensure that stronger workplace safety standards at Rikers Island continue to be a priority.

The environment in which doctors, nurses and other healthcare staff operate has clear implications for patient care.

Last year, the US Department's of Labor's Occupational Safety and Health Administration cited Corizon for two violations of federal workplace safety laws. The allegations include a charge that the company willfully failed to protect its employees from violence. We call on Corizon and DOC to work together to follow the important recommendations that OSHA made to correct the safety violations.

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While many of our members are incredibly dedicated doctors who have worked at Rikers for 10+ years, recruiting and retaining doctors and psychiatrists in this difficult, and sometimes dangerous, work environment can be challenging. And at VCBC, an outside vendor has recently taken over medical services and continues to face significant recruitment challenges.

Healthcare workers need to know that the work environment is secure and that there exists a culture of engagement and collaboration among agencies working at Rikers.

Employee training on safety and security procedures is critical for Corizon staff, as well trainings on how to prevent or minimize risk of assault. Doctors Council supports the recommendations in the OSHA findings which recommend protocols for treating inmates that pose a high risk for violence, and implementing physical plant changes such as reconfiguring treatment areas for better egress and sight lines with Correction Officers; installing Panic Alarm systems; cuff bars; and plexiglass in treatment rooms. Collecting statistics on medical worker assaults is important to understanding the climate that our doctors work in.

Currently, staffing is below where it should be at Rikers and at VCBC. For example, there are 11 full-time vacancies and 1 psychiatry vacancy at Rikers out of 60 full-time doctors – that is a 20 percent full time vacancy rate. Furthermore, mandated overtime totaled almost 3000 hours in 2014. One psychiatrist was mandated 300 hours overtime in 2014 which equals 37 tours. This is not including voluntary overtime.

While the overall number of inmates at Rikers has declined, the complexity, acuity and percentage of mentally ill inmates has sharply increased. More doctors are badly needed on the island to address these demographic changes.

While Corizon is the employer of health care staff at Rikers and they have a responsibility to act, the reality is that all involved parties must work

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together to enact change. For example, getting inmates to the clinics for treatment in a timely fashion is the domain of DOC.

The number of cancelled follow-up appointments, wait times, and overcrowded waiting areas at Rikers are all indicators that access to care falling short. Emergencies and lock downs that shut down clinic operations on a regular basis, as well as lack of escorts, further limit access to care.

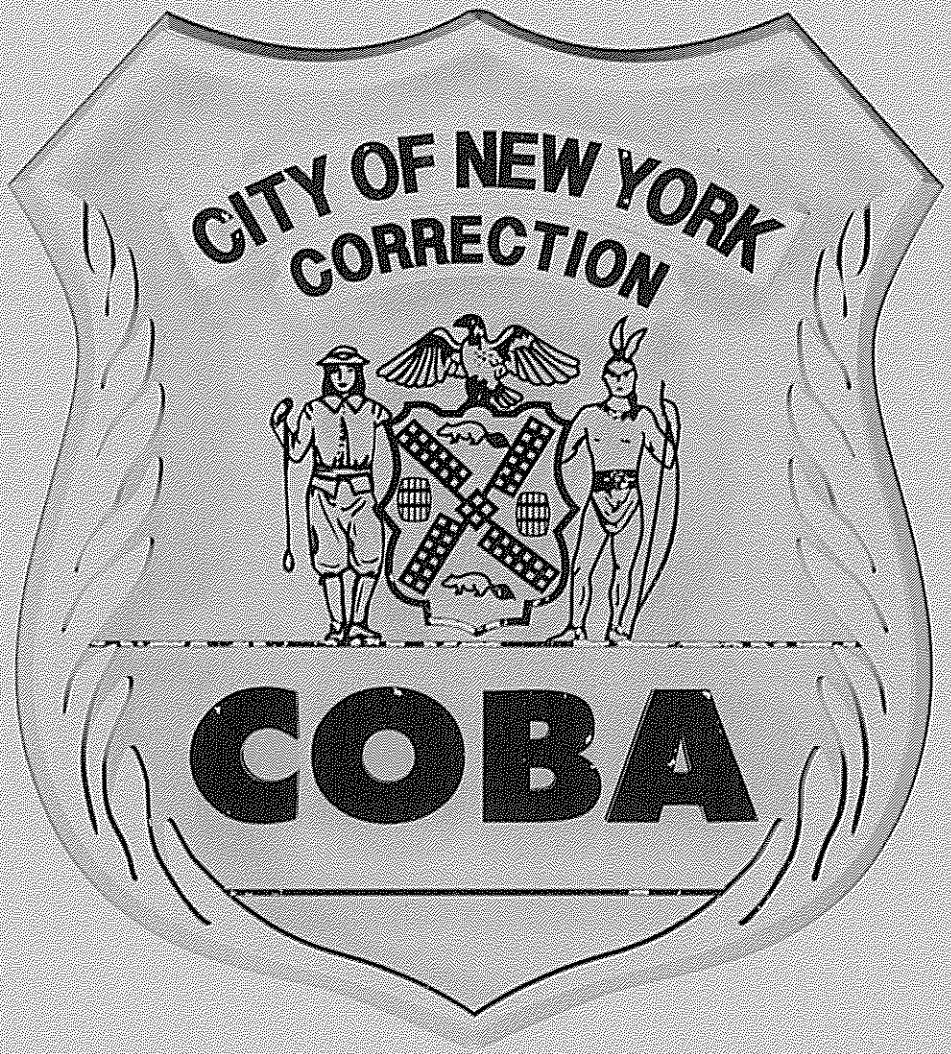
During the second half of 2014, of more than 15,000 follow-up appointments made in AMKC, 8,000 of those were cancelled. That is more than 50 percent of follow-ups cancelled. We feel that it is imperative that better scheduling and escort systems be established to reduce wait times for sick inmates and to ensure their follow-up care.

Inmates at Rikers and VCBC are not in jail for the long term; they may be there for several weeks. Patient care means ensuring that the bureaucracy is streamlined so that health records are available to medical staff immediately at intake. Furthermore, upon release, we would recommend coordinating follow-up care in the community at an HHC facility or hospital of choice, and focus on including health insurance access, clinic appointments and any necessary prescriptions.

In conclusion, Doctors Council supports the collection and reporting of data on the health of inmates in city correctional facilities and recommends looking at appointment wait-times and cancelled follow-ups; examining transfer protocols and times; and streamlining health record access; along with increasing workplace safety standards to make Rikers a viable place of employment and accessible in terms of healthcare.

Thank you for the opportunity to testify today. I'm happy to answer questions.

Testimony of Norman Seabrook, President FOR THE RECORD



New York City Council, Joint Oversight Hearing
Committees on Health and Fire and Criminal Justice Services

"Health Care Delivery in New York City Jails:
Examining Quality of Care and Access"

March 3, 2015

Chairman Johnson, Charwoman Crowley and members of the City Council. My name is Norman Seabrook and I am the President of the Union representing the largest population of workers who interact with the increasingly challenging population of inmates in the New York City Department of Correction. On behalf of nearly 9000 Correction Officers, I am grateful for this opportunity to chime in on the debate concerning the provision of health care services by Corizon.

It is especially critical at this time when the Board of Correction – which sets minimum standards in the City's jails – has taken away the authority of the Department of Correction to classify and properly house inmates to maximize safety and security for all involved. Now, with no more than the unreviewable "say so" of "medical staff" employed by Corizon, inmates can be barred from secured housing areas known as "Enhanced Supervision Housing." However if Corizon is not making sure that the medical needs of inmates are met, it is not surprising that some marginalized inmates lash out and also violate jail rules in place for everyone's well-being.

According to the City's Independent Budget Office, the Department of Correction houses almost as many mentally ill people as all of the City's inpatient psychiatric facilities combined. I've attached a graph from that Office. Our concern as workers who spend all of our time with the inmates – not just a few minutes – is that the failure of Corizon to properly diagnose, medicate and provide follow-up to an increasingly mentally ill population leads to a backlash against Correction Officers. By and large, the numbers of assaults that occur are primarily to other inmates, and secondly to members of COBA. However, although permitted by various privacy laws, the staff employed by Corizon do not share information that would help keep Correction Officers safer. As reported in June of last year by the AP, "Communication breakdowns between mental health staff and [Correction Officers], sloppy paperwork, inadequate mental health treatment and improper distribution

of medication were frequently cited by investigators as factors in [inmate] deaths . . ..[1]"

As so many other jail and prison systems in the country learned the hard way, mixing the provision of mental and physical health care with a profit-driven model is a mistake. Time and time again this company, Corizon, has failed to meet the minimum expectations for which they were contracted. Maine. Idaho. Maryland. Alabama. Pennsylvania. Minnesota. Tennessee. The City of Philadelphia. This list of contracts pulled or lost goes on – involving mismanagement, outright illegal conduct and poor care for those that society does not see. Corizon has faced well over 700 malpractice suits since 2008, and Moody's even downgraded this huge company in 2013 based on their bleak track record[2]. Since the list of Corizon's failings goes on so long, and the information very readily available, I will nott go on much more. I just want to highlight a few of points.

The first touches on Workplace Violence. In two meetings between staff, management and the Unions, Corizon sent dozens of managers to Rikers but made absolutely no changes in their operations recommended by the Unions - including COBA. The major recommendations made, by the way, involved clearing lines of communication, sharing inmate triggers and other mental health information, increasing the number of doctors and psychiatrists, increasing the number of Corrections Officers doing escort and clinic duty, reducing waiting time for inmates to curb frustrations, and have increased training between the health and mental health workers and Corrections staff. Several months later the federal government found Corizon had violated its own workers' rights by failing to address workplace violence, fining them $70,000. Interestingly half of the incidents cited were those where Corrections staff – not Corizon staff- were victims.

The second point is one that intimately involves our current Commissioner, Joseph Ponte. Although the Commissioner had an entirely different system back in

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[1] http://nypost.com/2014/06/27/city-jails-ignored-safeguards-to-save-suicidal-inmates/, last viewed March 1, 2015.

[2] https://www.prisonlegalnews.org/news/2014/mar/15/corizon-needs-a-checkup-problems-with-privatized-correctional-healthcare/ , last accessed March 1, 2015.

Maine, one common problem he faced – and now faces again – is that Corizon (or rather its predecessor) was the medical provider for that system. As I am sure he could better discuss, the independent report made underscores a culture at Corizon that speaks volumes to this current oversight hearing[3].

The report, issued in November 2011, cited various deficiencies in medical care at Maine's prisons – including medications not always being properly administered and recorded by staff. Although the company was notified of the problem, no corrective action was taken. Employees did not follow policies related to medical intake and medical records, and more than a third of prisoners' medical files had inadequate or inaccurate documentation. Moreover, files were not complete or consistently maintained. The report found over one in 10 sick calls reviewed were either not resolved timely or had no documented resolution. The report in Maine also cited one of Corizon's predecessors – Correctional Medical Services (CMS)- for inadequate staff training[4].

Any of this sound familiar? Well it should. The same was true of the other company that merged with CMS to form Corizon – Prison Health Services (PHS). In a 2005 audit report from the New York State Office of the Comptroller many of these – and more- deficiencies were noted[5]. Fool me once, shame on you. Fool me twice, shame on me. What we have now is a third case and it seems as though it is the City Council and the taxpayers that are going to be fooled by this deer tick which must be removed from the City's Jail system.

Thank you for your time. May God Bless you and keep you and your families safe.

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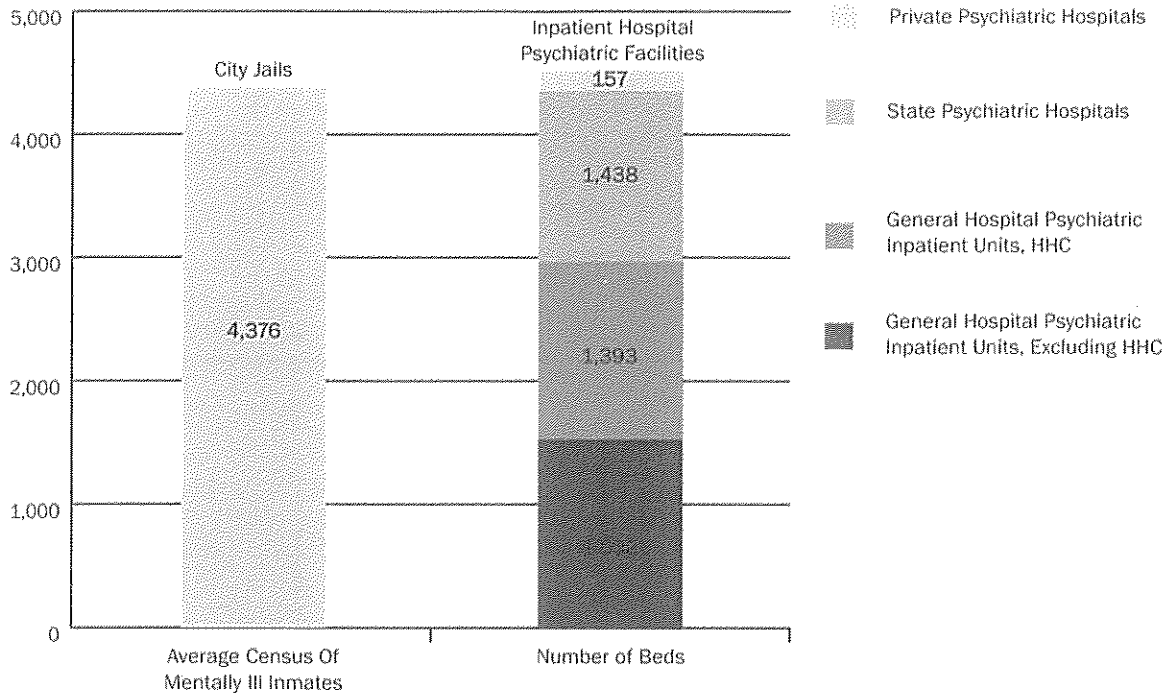
[3] https://www.prisonlegalnews.org/news/2014/mar/15/corizon-needs-a-checkup-problems-with-privatized-correctional-healthcare/

[4] *Id.*

[5] New York City Department of Health and Mental Hygiene: Contracted Health Care Services for New York City Prison Inmates. New York, NY: Office of the New York State Comptroller, Division of State Government Accountability; 2007:1–25 Report 2005-N-5. Available at http://osc.state.ny.us/audits/allaudits/093007/05n5.pdf last accessed March 1, 2015.

How Many Mentally Ill Inmates Are in City Jails?
How Does This Compare with the Capacity of the City's Psychiatric Facilities?



NOTES: Jail numbers are the average for all of fiscal year 2013 and include inmates as young as 16.
Psychiatric facility capacity numbers are point in time numbers as of April 2014 and are for adults only.

- Of the daily average of 11,827 inmates in New York City jails, 37 percent, or 4,376 inmates on any given day, had a mental health diagnosis.
- The combined capacity of all New York City inpatient psychiatric facilities is only slightly higher at 4,518.

Prepared by Christina Fiorentini and Nashla Rivas Salas
New York City Independent Budget Office

SOURCES: Mayor's Management Report Fiscal 2013; New York State Division of Budget; New York State Office of Mental Health

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 440 Res. No. _____

☑ in favor ☐ in opposition

Date: 3.3.15

(PLEASE PRINT)

Name: EVELYN LITWOK

Address: 2 HANSON PL 1L BROOKLYN NY

I represent: NYC JAC

Address:

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Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Rosa Goldensher

Address: _____

I represent: DNAinfo (press)

Address: _____

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Appearance Card

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☑ in favor ☐ in opposition

Date: 3/3/15

(PLEASE PRINT)

Name: Jennifer J. Parish

Address: 40 Rector St., 9th fl., New York, NY

I represent: Urban Justice Center

Address: Mental Health Project

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 440 Res. No. _____

☑ in favor ☐ in opposition

Date: 3/3

(PLEASE PRINT)

Name: EVIE LITWOK

Address: 3 MACDONOUGH ST BROOKLYN 11216

I represent: JAC

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 440-2014 Res. No. _____

☒ in favor ☐ in opposition

Date: 3/3/15

(PLEASE PRINT)

Name: Deirdre Shore

Address: 40 Rector St 9th Floor

I represent: Jails Action Coalition

Address: NY, NY

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THE CITY OF NEW YORK

Appearance Card

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☒ in favor ☐ in opposition

Date: 3/3/15

(PLEASE PRINT)

Name: Alex Abell

Address: 57 Lincoln Pl.

I represent: JAC / Urban Justice Center

Address: 40 Rector St.

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Appearance Card

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☑ in favor ☐ in opposition

Date: 3/3/15

(PLEASE PRINT)

Name: Victoria Phillips

Address: 40 Rector St, 9th Floor

I represent: Legal Aid Society

Address: 199 Water St, New York, NY 10038

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: March 3 2014

(PLEASE PRINT)

Name: Ms. Kerry Hubbard

Address: _____

I represent: JAC

Address: _____

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: 3/3/2015

(PLEASE PRINT)

Name: Riley Doyle-Evans

Address: _____

I represent: Brooklyn Defender Svcs

Address: _____

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THE CITY OF NEW YORK

Appearance Card

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Date: _____

(PLEASE PRINT)

Name: Lillie Carino

Address: 330 W 42 St 7 Fl. 10036

I represent: 1199

Address: 310 W 43 St 10036

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Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Jay Cowan

Address: _____

I represent: CMA

Address: _____

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THE CITY OF NEW YORK

Appearance Card

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☒ in favor ☐ in opposition

Date: 3/3/15

(PLEASE PRINT)

Name: Deandra Khan

Address: 125 Broad Street 19th FL

I represent: NYCLU

Address: _____

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Jay Cowan, Calvin Johnson MD

Address: CMA + Corizon Health

I represent: _____

Address: _____

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THE CITY OF NEW YORK

Appearance Card

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☑ in favor ☐ in opposition

Date: 3/3/15

(PLEASE PRINT)

Name: Dr. Matthews Hurley

Address: 50 B'way NY, NY

I represent: Doctors Council SEIU

Address: _____

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THE CITY OF NEW YORK

Appearance Card

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☑ in favor ☐ in opposition

Date: 3/3/15

(PLEASE PRINT)

Name: John Boston

Address: 199 Water St NYC

I represent: Legal Aid Society

Address: 199 Water Street

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: 3/3/15

(PLEASE PRINT)

Name: Homer Venters

Address: _____

I represent: DoHMH

Address: _____

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Appearance Card

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☐ in favor ☐ in opposition

Date: 3/3/15

(PLEASE PRINT)

Name: Sonia Angell, Deputy Commissioner

Address: 42-09 28th St.

I represent: DoHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: ERIK BERLINER, DEPUTY COMMISSIONER

Address: DEPARTMENT OF CORRECTION

I represent: _____

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Calvin Johnson

Address: 123 Powell Court, Brentwood, TN 37027

I represent: Covenant Health

Address: _____

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