NYC HEALTH + HOSPITALS

Testimony

of

Patricia Yang, DrPH, Senior Vice President
NYC Health + Hospitals

before the

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

Correctional Health

November 15, 2018
City Hall – Committee Room
New York City

Good afternoon Chairpersons Ayala, Powers and Rivera, and members of the Committee on Mental Health, Disabilities and Addiction, Committee on Criminal Justice, and Committee on Hospitals. I am Dr. Patsy Yang, Senior Vice President for Correctional Health Services, or "CHS," at NYC Health + Hospitals. I am joined by Dr. Ross MacDonald, CHS' Chief Medical Officer, Mr. Patrick Alberts, our Assistant Vice President of Policy and Planning, Mr. Carlos Castellanos, CHS' Chief Operations Officer and Ms. Veronica Lewin, our Director for Communications and Public Affairs. The Department of Correction is also here, represented by Assistant Commissioner Fazal Yussuff.

On behalf of NYC Health + Hospitals President and CEO Dr. Mitchell Katz, I want to express our appreciation for inviting us to talk about important issues in correctional health. I would also like to recognize Chairpersons Ayala, Powers, and Rivera for your commitment to the health of New Yorkers involved in the justice system.

Overview

NYC Health + Hospitals/Correctional Health Services (CHS) operates one of the largest correctional health care systems in the nation, with over 43,000 admissions per year and an average daily population of approximately 8,900 in 11 jails across the city. We provide services from pre-arraignment through discharge including medical and mental health care, substance use treatment, dental care, social work services, discharge planning and re-entry services.

CHS is an essential partner in New York City's criminal justice reform efforts. We believe we have the unique opportunity to cushion the impact of incarceration and the responsibility to address the health needs of our patients to better prepare them to leave jail and not return. It is through this lens that that we pursue our work of increasing access to high quality medical services for people while they are in the City's custody and as they rejoin their communities.

Restructuring under NYC Health + Hospitals

Since CHS moved to NYC Health + Hospitals in August 2015, we have built a framework for restructuring systems and changing the culture of service delivery. We have reduced our reliance on private contractors by 80 percent and replaced private contracts with CHS staff and service arrangements at Health + Hospital facilities. This has resulted in higher quality, and greater accountability and efficiency.

The move to NYC Health + Hospitals also boosted CHS' ability to attract highly qualified staff who share our commitment to high-quality care as a human right. In becoming the direct provider of health care, we underwent a major reorganization to improve supervision and support of staff at all levels and capacities within our division. This restructuring has been implemented in every clinical and administrative department in CHS, whether it was the creation of the Office of Quality Management reporting directly to me or the consolidation of our substance use services under the leadership of Mental Health.

We have also implemented new ways of delivering care to make sure our patients get the health care they need when they need it. In collaboration with DOC, we have increased access to health care in the jails by cohorting patients with select medical diagnoses into discrete housing areas matched with a nearby satellite clinic. This model brings our services closer to where are patients are and has reduced the need for escorts to the main clinic.

Given the comprehensiveness of our intake assessments and the high quality of our clinical work, we know which patients need to be seen and when, and we work daily with DOC to ensure that our patients get the care and medications they need. At the same time, we continue to have a high volume of sick call encounters, in part due to the higher standard held by the NYC Board of Correction compared to other large city systems. CHS also follows through and investigates to conclusion, every patient complaint or concern it receives from patients or their representatives.

Program and Services

As part of NYC Health + Hospitals, we have successfully leveraged the resources of the nation's oldest and largest public hospital system to improve the health of patients under our care before, during, and after incarceration.

Since CHS became the sole and direct correctional health care provider in 2016, we embarked on a five-year, City-funded plan to establish new programs and expand key services. I'd like to share a snapshot of the milestones we have reached in less than three years:

- We more than quadrupled the number of patients initiating Hepatitis C treatment in jail, with 158 patients treated in Fiscal Year 2018, compared to 28 patients in Fiscal Year 2016.
- While we run the nation's oldest and largest jail-based opioid treatment program, we nearly tripled the number of patients in our program since just last year. Last month, we had over 1,000 patients being treated with methadone or buprenorphine on any given day.
- Since December 2016, we have conducted nearly 4,000 group sessions as part of the Creative Arts Therapy program, one of the largest programs of its kind in the nation, and just last month celebrated the opening of our fourth annual art show in Chelsea.
- We distributed over 10,695 naloxone kits to members of the public at the Rikers Island Visitor Center and borough jails since the launch of HealingNYC in March 2017.
- We expanded to a total of six specialized housing units for patients with serious mental illness. The Program for Accelerating Clinical Effectiveness (PACE) has demonstrated efficacy in increasing medication adherence, reducing incidents of injury and self-harm, and lowering uses of force.
- We were the first in Health + Hospitals to establish a telehealth program for patient/provider encounters, to enhance access to specialty services on- and off-island, which now includes multiple specialties such as urology, hematology and oncology at Bellevue and Elmhurst, assessment for post-acute placements at Coler, and consultations among the jail facilities.

- Following success in Manhattan, we extended our Enhanced Pre-Arraignment Screening Unit (EPASU) into Brooklyn Central Booking. EPASU allows us to better identify and respond to acute medical and mental health issues, avoid preventable runs to hospital emergency rooms that also disrupt case processing, and with patient consent provide courts with information that can support alternatives to incarceration. Of the 82,000 screenings since the 24/7 operation commenced in Manhattan, emergency room runs were avoided by 27 percent and defense counsel was provided with 2,839 clinical summaries.
- In an effort to improve the quality and timeliness of court-ordered psychiatric competency evaluations, we consolidated within CHS the management of the city's four Forensic Psychiatric Evaluation Court Clinics citywide that had been operated by Bellevue and Kings County Hospitals.
- In partnership with the Mayor's Office of Criminal Justice, the courts, prosecution and defense, we launched a pilot program at the Queens Forensic Psychiatric Evaluation Court Clinic to reduce the time it takes to complete court-ordered forensic psychiatric evaluations for defendants in the Queens Criminal Court. The goal of the pilot is to reduce the time to complete the 730 evaluation process from an average of 43 days to within 7 and 14 business days for misdemeanors and felonies, respectively. In the approximately five months since the pilot went live, CHS has met or exceeded our goal in the majority of cases, with an average completion time for misdemeanor and felony reports of 9 and 11 business days, respectively.
- As part of NYC First Lady Chirlane McCray's Women in Rikers initiative, we established the Healthy Lifestyle Therapies program, a wellness initiative that promotes healthy coping skills for stress and trauma through multiple modalities including cognitive therapy, exercise, acupuncture, and guided meditation. We also launched the Intimate Partner Violence Counseling Program to provide counseling, safety planning and referrals to community resources upon discharge, for women who experienced domestic violence prior incarceration.
- To address the unique needs of young people, we began conducting high quality screenings of every young person entering jail, regardless of mental health history. This program allows us to provide connections with in-jail services and re-entry planning.
- We created the Geriatric and Complex Care Service, the first and only jail-based program of its type in the country. This service provides integrated clinical care, court advocacy and re-entry planning to the oldest and most vulnerable patients in the jail system.

Thanks to ThriveNYC, we have received successive funding to implement a series of initiatives to address mental health and substance use issues among youth incarcerated in jail. We have enhanced our mental health programming for youth by offering comprehensive services including psychiatric assessments, creative arts programming, harm reduction, substance use engagement and discharge planning. These enhancements allows us to better serve a population where intellectual disability, new onset mental illness, and substance use are overrepresented and exposure to trauma is nearly universal.

We currently screen all patients for neurodevelopmental impairments during intake. This year, we started asking every individual entering jail whether they have ever had involvement with the Office for Persons with Developmental Disabilities. With this new question our identification of patients with neurodevelopmental disorders has jumped from 0.67 percent of new admissions to almost 3 percent. All individuals identified with a neurodevelopmental disorder are referred to mental health services for evaluation and determination of appropriate housing and treatment and to facilitate connections to appropriate care and services. Additionally, we dedicated a PACE unit to individuals with suspected or confirmed neurodevelopmental disorders.

Re-entry Planning and Discharge Services

To prepare our patients to rejoin their communities and not return to jail, we have revamped our discharge planning services to maximize our reach and optimize the impact of each interaction with our patients while they are in DOC custody. We have defined a core set of services that are integral to all our discharge planning efforts and are more closely coordinating the work conducted by various disciplines and programs within CHS, that impact successful re-entry. To help ensure that our patients have health insurance upon release, we launched a Medicaid Application Assistance Pilot at the Anna M. Kross Center (AMKC) and the Rose M. Singer Center (RMSC) to reconnect our patients with benefits including activation or enrollment in Medicaid. Approximately 45 percent of our patients rely on us for Medicaid application assistance. As of the end of September 2018, a total of 603 patients received an application at intake (an average of almost 65 patients per month).

In addition to providing Medicaid application assistance to our patients, we have been growing the reach of our discharge planning services to more patients with medical needs. Whether a patient has HIV/AIDS, is an older person with complex care needs, or a patient needing to complete his treatment for Hepatitis C in the community, we work to link that patient to a care provider in the community, notably leveraging the service capacity of the NYC Health + Hospitals system.

CHS offers discharge plans to all patients in the mental health service. Every patient with a mental health diagnosis is counseled on what is included in their discharge plan. In partnership with Empower Assist Care, or EAC, we created the Community Re-Entry Assistance Network as a unified provider system that has increased efficiency, allows for increased oversight of service delivery, and allows us to be more responsive to patient needs both pre- and post-release.

In addition, as part of our programming under ThriveNYC, we offer discharge planning for young patients, which includes care coordination across City agencies, providing referrals to court advocacy and transitional planning for youth 18-21 years of age.

We also expanded comprehensive discharge planning services through the Substance Use Re-entry Enhancement (SURE) program to include individuals with substance use disorders who are not already receiving this service. SURE provides court services, harm reduction counseling, Medicaid screening and application, and reentry planning. As part of the SURE program, we began an e-

prescribing naloxone pilot project for discharged patients trained in overdose prevention. Participating patients can fill the naloxone prescription at a community pharmacy along with their other discharge medications. Additionally, patients trained in naloxone prevention who enter residential treatment on jail release receive naloxone delivered with their other medications. SURE serves between 800-900 patients monthly in all facilities within the New York City jail system.

Conclusion

As the City embarks on its ambitious plan to create a smaller, safer, and fairer correctional system over the next decade, CHS will continue to be a critical partner in planning that future system and how the delivery of quality health care can be improved. We are committed to uphold our ethical obligation to improve the health of our patients and prepare them to live a healthy life as they rejoin their communities. We are grateful for the unwavering support of Mayor Bill de Blasio, the NYC Health + Hospitals' Board, and NYC Health + Hospitals' President and CEO Dr. Mitchell Katz; and we again thank you for your support of and interest in our work and mission.

NEW YORK CITY
BOARD OF CORRECTION

Statement before the New York City Council

Committee on Hospitals
Carlina Rivera, Chair
Committee on Mental Health, Disabilities and Addiction
Diana Ayala, Chair
Committee on Criminal Justice
Keith Powers, Chair

November 15, 2018
By Martha W. King, Executive Director
New York City Board of Correction

Good afternoon, Chairs Rivera, Ayala, and Powers and Members of the Committees on Hospitals, Mental Health, Disabilities, and Addiction and Criminal Justice. My name is Martha King, and I am the Executive Director of the New York City Board of Correction. Today I am joined by Emily Turner, Deputy Executive Director of Research, and Dr. Robert Cohen, a Board Member who was appointed by the City Council and is a correctional health expert and former Director of the Rikers Island Correctional Health Service.

The Board of Correction is the City's independent oversight agency for the jail system. We do not manage the operations and services within the jails. Rather, we regulate and monitor them on behalf of New Yorkers. The Board writes local regulations called Minimum Standards, which include chapters dedicated to health and mental health care. These Standards, covering everything from detection to treatment and patient protections, seek to ensure that services are maintained at a professional and quality level consistent with community standards.

In many ways, this City has been a leader in correctional health for decades. For one, New York City is exceptional because it has an independent health care provider in the jails. Most jails have one leadership that runs both the security and health operations, leading to challenging and inherent conflicts that do not always serve the patient well. Other examples of exceptional work have been Correctional Health Services' successful collaboration with the Department of Correction on intensive therapeutic mental health units, as well as CHS' long standing and effective opioid treatment program.

The Board monitors correctional health in multiple ways: observations in the jails by our staff who are on-the-ground daily; tours by Board Members; interventions in individual complaints

raised by people inside or their advocates and families; and investigations into deaths in custody. In 2016, we significantly improved our ability to monitor care by working with CHS to create a monthly access report which tracks compliance with the Board's Standards on access and the 55,000 scheduled health and mental health appointments each month. The CHS monthly access reports represents the most comprehensive reporting on health and mental health care access in jails nationally.

During the last six months of 2017, 79% of health and mental health care services scheduled in New York City jails were "completed." This means more specifically that 72% of appointments included a patient seeing a clinician and 7% included a patient refusing the service. Our analysis of this data has led us to focus on four priorities: 1) barriers to production; 2) extending best practices; 3) access to specialty clinic and mental health appointments; and 4) new protocols to monitor sick call and other key areas of the Minimum Standards.

Barriers to Production

Just over a fifth of all scheduled services were not completed in our study period. The proportions of missed appointments vary by service category and facility. However, the main reason that patients missed appointments for all months studied and across all services was because the patient was "Not Produced by DOC." Almost seventy percent of all missed appointments were due to DOC not producing the person to the clinician. CHS does not currently report reasons for non-production, and these reasons are not always known to clinical staff.

We all should better understand if failure to produce a patient is because of a lockdown, staff shortage, scheduling conflict, search, or some other reason. We need DOC and CHS to track and report on the reasons for non-production in a coordinated way. They need to develop a plan to track and address barriers to production, the main cause of missed appointments.

Extending Best Practices

Appointment completion rates varied by facility during the last six months of 2017, ranging from a 67% overall completion rate at VCBC to a 92% completion rate at NIC. Completion rates for medical and dental services, in particular, varied widely across facilities. Medical services ranged from a low 54% completion rate at AMKC to a 98% completion rate at MDC. Dental completion rates ranged from 48% at VCBC to 84% at RNDC.

There are jail services that have had consistently higher rates of production and access. DOC and CHS should review the reasons for this and the best practices from jails with high rates of completed appointments, including NIC, West Facility, and Rose M. Singer Center. This information should be used to generate benchmarks and plans for improvement in other service areas and facilities where current rates are unacceptable.

Access to Specialty Clinic and Mental Health Appointments

During the last six months of 2017, about 30% of mental health appointments were missed. In this critical service area, 64% of all missed services were due to DOC non-production, and 19% were due to CHS rescheduling the appointment, the highest rate of rescheduling across all services. Over 39,500 mental health appointments were missed in this period. This is over five times as many missed appointments than any other area. Considering that 45% of people

detained in the City's jails have mental health needs and that these patients are some of the most vulnerable, reviewing and minimizing barriers to access for them should be a priority.

The next category of service most likely to be missed was on island-specialty clinics -27% of these appointments were missed. In addition, too many appointments of this type are refused by patients. BKDC had a refusal rate of 55% for on-island specialty clinic appointments. Specialty clinics are reserved for some of the most medically vulnerable patients who are awaiting advanced surgeries, procedures, and appointments that cannot be carried out in facility clinics.

Almost half of completed off-island specialty clinic appointments, and 31% of completed on island specialty clinic appointments involved a patient refusing services. Seven jails had refusal rates of 50% or higher for off-island appointments. People in custody and jail staff report that high rates of patient refusals for these appointments are due to lengthy wait times, overbooking, waiting area conditions, including a lack of space, and transportation challenges.

DOC and CHS should conduct an in-depth review of access in these areas to identify and address factors thought to be related to patient refusals. BOC will also release an in-depth look at specialty clinic access in 2019.

New Protocols to Monitor Sick Call and Other Key Areas of the Minimum Standards
After intake, sick call is the primary way people in custody access care. The proposed Council bill will greatly enhance the accurate tracking of sick call. Our monitoring suggests people requesting sick call regularly do not receive it. We have called on DOC and CHS to implement new tracking protocols to assess compliance with the Minimum Standards on: sick call; the intake process; timeliness of services; and substance use treatment services.

Access to health and mental health care in NYC jails has been discussed at twelve public Board meetings since January 2016. During these public discussions, Board members have frequently cited their concerns related to access to care including lockdowns, production, escorting, transportation to Bellevue and Elmhurst hospitals, sick call, and specialty clinic policies. Discussions on these issues have repeatedly confronted the need for improved tracking and outcomes related to the Minimum Standards on Health and Mental Health Care. This information is necessary to minimize barriers and improve access to and ultimately improve the quality of care via measurable reforms.

In closing, access is a fundamental policy and principle of the Board's Minimums Standards and of all nationally recognized jail standards. It is supported by longstanding legal opinions that require the state to provide quality health care to people while in its custody, and it is central to safe and more humane jails. We look forward to working with DOC, CHS and the Council on efforts to improve it. Thank you for the opportunity to testify, and we are happy to take any questions.

Access to Health and Mental Health Care in NYC Jails

Summary report on scheduled service outcomes

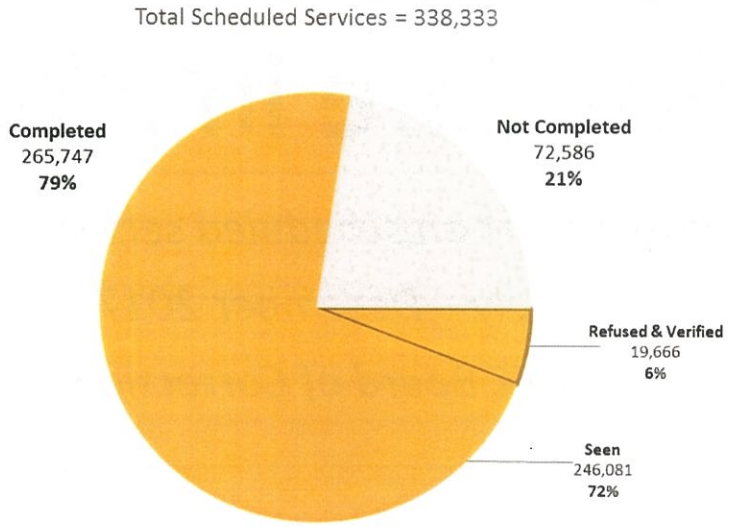
July – December 2017

NYC Board of Correction

Service Completion

(July – December 2017)

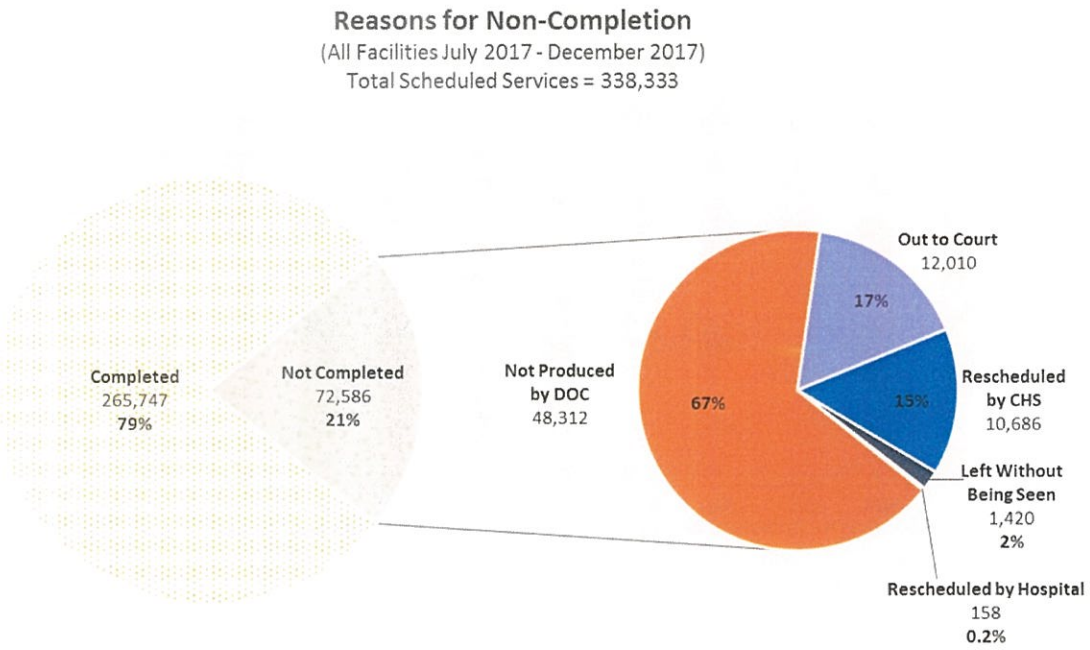
- 79% of health and mental health care services scheduled in the NYC jails were "completed."
- 72% of appointments included a patient seeing a clinician, and 6% of scheduled services included a patient refusing services.



Source: CHS Access Reports July - December 2017

Service Non-Completion

- Just over one-fifth (21%) of all scheduled services were not completed from July – December 2017.
- Sixty-seven percent (67%) of appointments were not completed due to non-production by DOC, followed by 17% due to the patient being out to court, and 15% due to rescheduling by CHS.

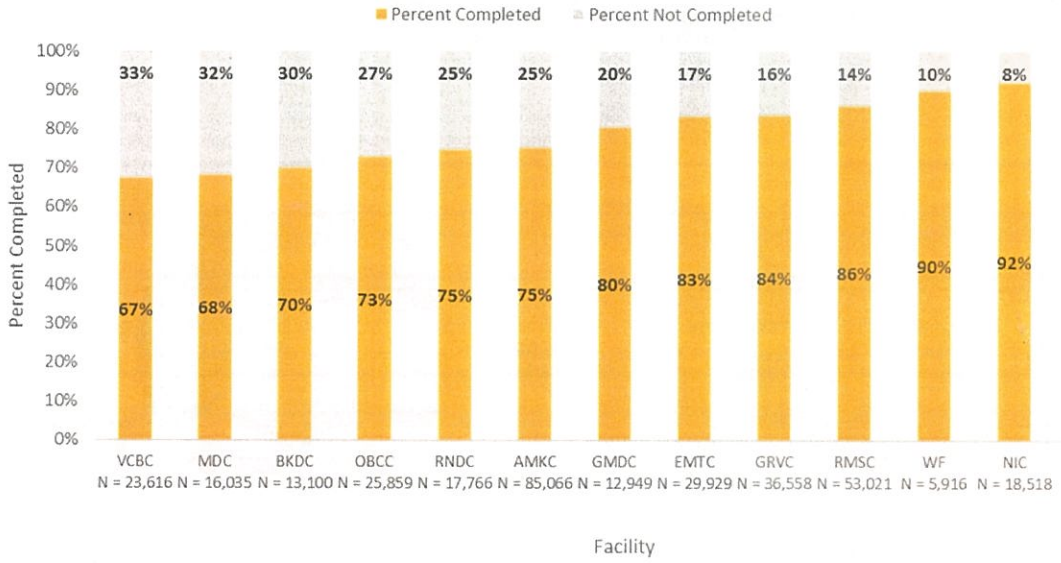


Source: CHS Access Reports July - December 2017
Note: Does not include appointments 'No Longer Indicated'

Completion By Facility

(July – December 2017)

- Appointment completion rates varied by facility, ranging from a 67% overall completion rate at VCBC to a 92% completion rate at NIC.
- NIC, WF, and RMSC had consistently higher rates of production and completed appointments. These facilities combined have less than 10% of DOC's total Average Daily Population.

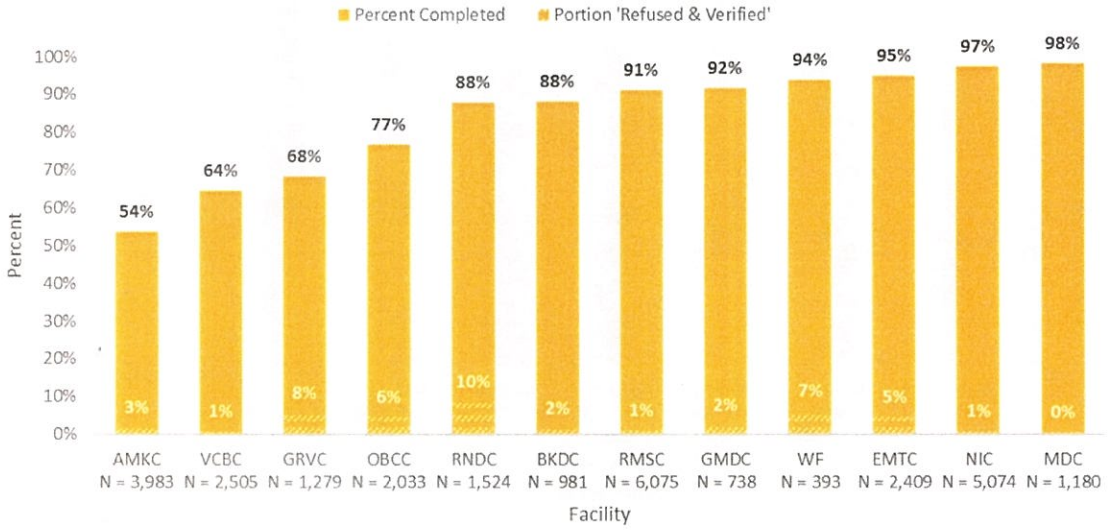


Source: CHS Access Reports July - December 2017
N = Total Number of Scheduled Services within Each Service Category – 'No Longer Indicated'
Total Scheduled Services Overall – 'No Longer Indicated' = 338,333

Medical Services Completed with Refused & Verified

(July – December 2017)

- Medical was the service category with the most variability in completion rates across facilities--with a 54% completion rate at AMKC to a 98% completion rate at MDC.

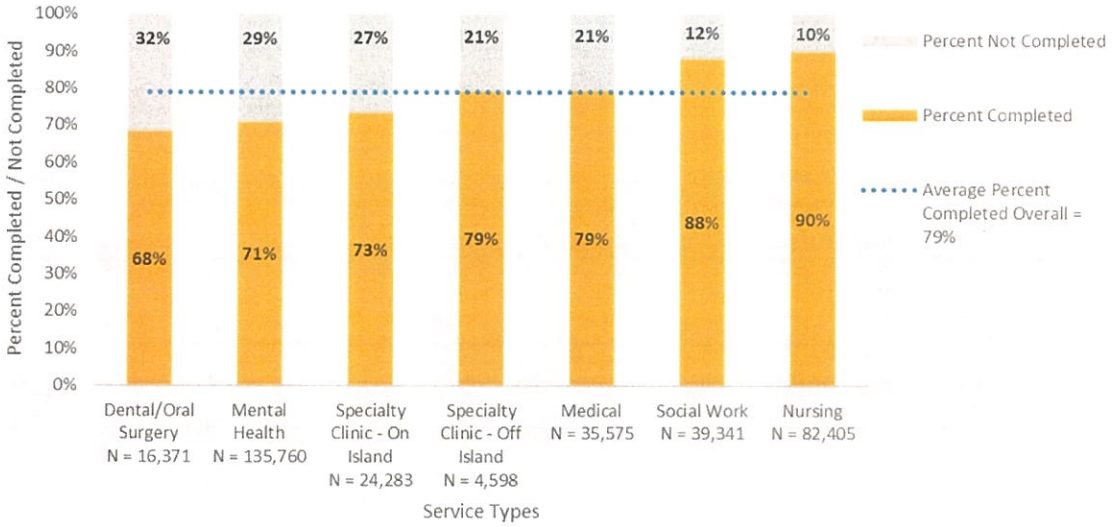


Source: CHS Access Reports July - December 2017

Completion by Service Type

(July – December 2017)

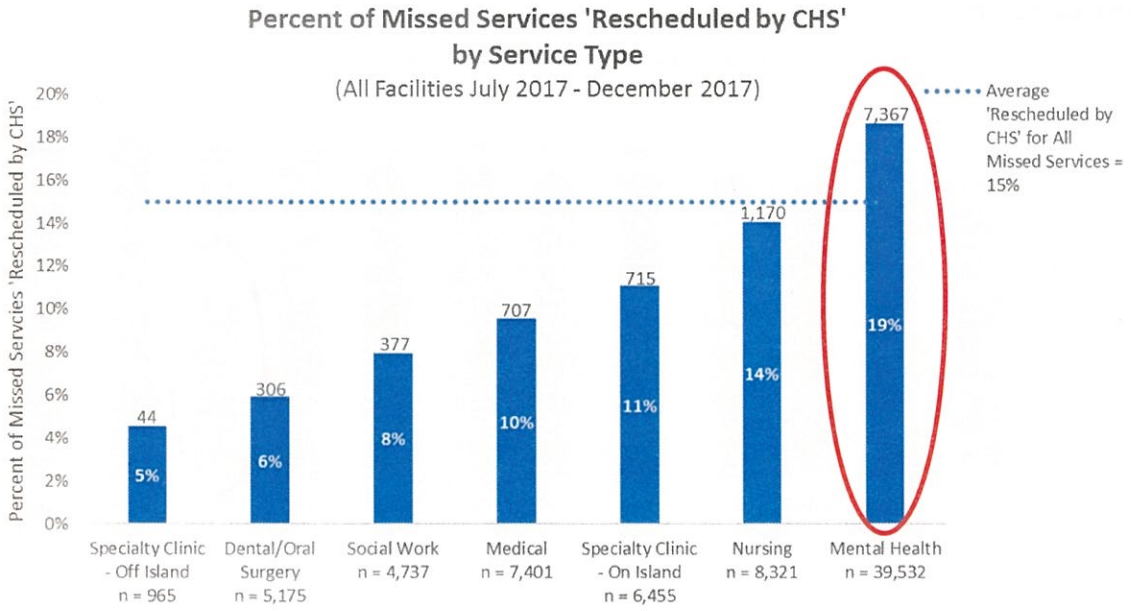
- Mental health appointments had a non-completion rate of 29% and was the service with the highest number of missed appointments (N=39,352).
- The next category most likely to be missed was on-island specialty clinics. Twenty-seven percent (27%; N=6,455) of these appointments were missed.



Source: CHS Access Reports July - December 2017
N = Total Number of Scheduled Services within Each Service Category – 'No Longer Indicated'
Total Scheduled Services Overall – 'No Longer Indicated' = 338,333

Mental Health Services Not Completed
(July – December 2017)

- For mental health appointments, an average of 64% of missed services were due to DOC non-production, and 19% were due to CHS staff rescheduling the appointment. This was the highest rate of rescheduling across all service types.

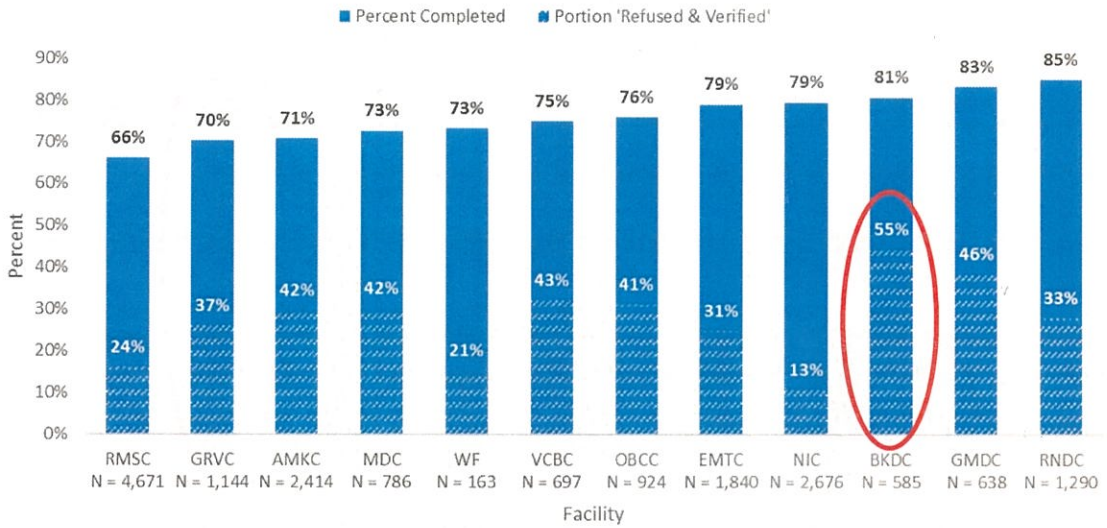


Source: CHS Access Reports July - December 2017

Specialty Clinic On-Island Completed with Refused & Verified

(July – December 2017)

- On average, 31% of "completed" on-island specialty clinic appointments involved a patient refusing care.
- Fifty-five percent (55%) of "completed" on-island specialty clinic appointments at BKDC were completed with a patient refusing care.

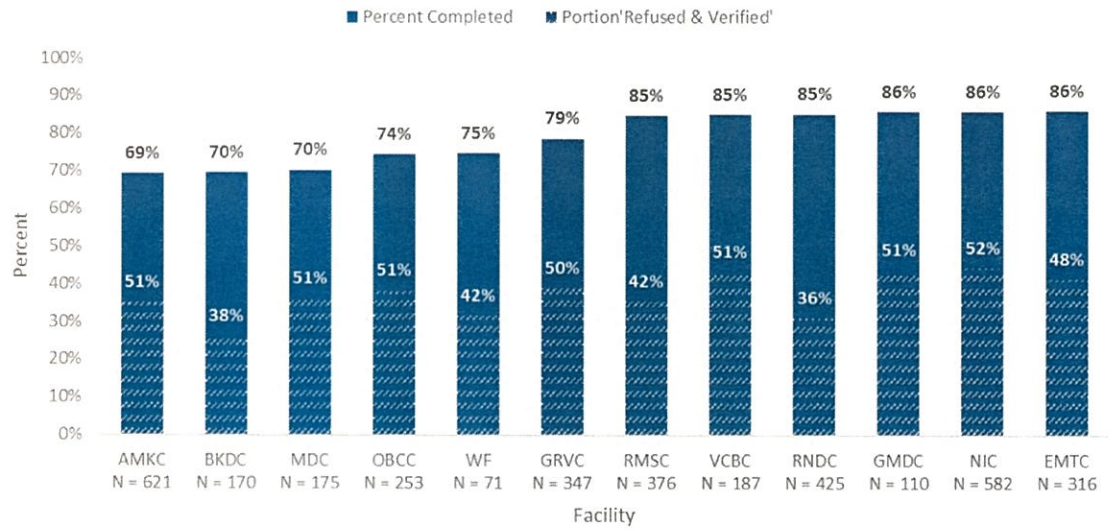


Source: CHS Access Reports July - December 2017

Specialty Clinic Off-Island Completed with Refused & Verified

(July – December 2017)

- Almost half (47%) of "completed" off-island specialty clinic appointments involved a patient refusing services.



Source: CHS Access Reports July - December 2017

URBAN JUSTICE CENTER

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

Oversight Hearing on Correctional Health

Thursday, November 15, 2018
Committee Room, City Hall
New York, NY

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

Prepared by Jennifer J. Parish
Director of Criminal Justice Advocacy
(646) 602-5644
jparish@urbanjustice.org

We appreciate the Council's commitment to ensuring quality health care for people incarcerated in the New York City jails. We hope that you will continue to support initiatives to improve access to care and enhance services while also advancing reforms to reduce the jail population.

Fundamentally, jails are not conducive to good health. The conditions of confinement exacerbate health problems. Incarceration can disrupt treatment, Medicaid coverage, and financial stability. To the greatest extent possible, individuals accused of committing crimes should not be detained pre-trial, and incarceration should be the penalty of last resort.

The Urban Justice Center Mental Health Project advocates for people with mental health issues involved in the criminal legal system. We represent the *Brad H.* Class, all incarcerated individuals who receive mental health treatment while in New York City jails. We are deeply familiar with the difficulties people with mental health issues have within correctional facilities and in accessing essential mental health services, housing, and benefits upon release.

Our perspective on correctional health care is grounded in more than 18 years representing people with mental health issues incarcerated in the City jails. Along with New York Lawyers for the Public Interest and Debevoise & Plimpton LLP, we monitor the City's compliance with the settlement agreement in *Brad H. v. City of New York*, which requires the City to provide discharge planning services to people who receive mental health treatment in jails. Our monitoring work involves visiting all the jails on Rikers Island, the borough facilities, and prison wards at Bellevue and Elmhurst Hospitals and meeting individually with as many as 40 *Brad H.* class members each week. The focus of these monitoring interviews is on determining whether class members' discharge planning needs are being met, but during these encounters, individuals routinely report complaints about accessing mental health and other health care.

At the outset, we must acknowledge the significance of the City appointing the NYC Health + Hospitals Correctional Health Services (CHS) to provide health care to people incarcerated in the City jails. Replacing Corizon, Inc., the for-profit company with which the City contracted for 14 years, with CHS was definite progress. As we describe below, many challenges remain, but CHS brings the necessary commitment to serving this population and demonstrates its dedication to improving patient care.

Providing health care to people incarcerated in the City jails is not only the responsibility of CHS but also of the Department of Correction (DOC). Without the DOC's cooperation and support, CHS cannot serve their patients. The DOC is responsible for the overall security of the jails. The DOC manages intake areas where individuals are processed into the facility, and delays in expediting medical care to people in crisis at intake can have grave consequences. The DOC is responsible for movement within the jails, which includes providing sufficient staff to escort patients to clinic appointments. How and whether care is provided during a facility lockdown is also within DOC's control. In addition, incarcerated individuals usually have to go through correction staff to meet with treatment providers. Thus, for incarcerated people to receive adequate health care, CHS and DOC must be working toward the same aim. This means that DOC must prioritize the health of the people in its custody.

Discharge Planning

The *Brad H.* settlement requires that the City provide comprehensive discharge planning services to the people receiving mental health treatment. All class members are entitled to referrals or appointments for mental health and substance use treatment in the community, assistance securing Medicaid coverage, medication and prescriptions upon release from jail, and referrals to shelter. People with serious mental illness are entitled to additional support, including assistance applying for public benefits, obtaining supportive housing, and receiving case management services as well as transportation upon release.

Correctional Health Services has made fundamental improvements to service delivery, yet the City remains noncompliant with key discharge planning responsibilities. (*See* compliance findings from the Thirty-ninth Regular Report of the Compliance Monitors (39th Report) issued October 31, 2018, and attached as Exhibit A.) The failure to provide initial mental health assessments, comprehensive treatment plans, and discharge plans in a timely manner results in class members being discharged from jail without vital services. When clinicians incorrectly assess whether a class member has a serious mental illness, the individual is not afforded access to enhanced services. Providing individualized, appropriate treatment referrals, supportive housing assistance, and case management services is central to ensuring that class members can successfully transition from jail to the community. Yet CHS's compliance with these performance measures, although improved, remains well below expectations. (See summary of appropriateness findings from the 39th Report attached as Exhibit B.) Providing these services appropriately requires communication with past treatment providers as well as coordination with services to which the class member is referred.

Although the City is required to assist class members in obtaining Supplemental Security Income (SSI) and Veterans benefits, they do not have a reliable system for identifying individuals eligible for these services. The City contracted with the EAC Network to provide post-release services to class members, but more than a year later has yet to establish an office in Manhattan as the settlement requires. All the City agencies required to provide data for monitoring performance have deficits in meeting this obligation.

The DOC must improve its performance producing class members for mental health and social work appointments, transmitting accurate information about class members released from jail so that their Medicaid can be activated or reinstated in a timely manner, and releasing class members incarcerated on alleged parole violations during daylight hours.

We will continue our advocacy for discharge planning services until the City has a system that operates effectively. The Council has been instrumental in our efforts to secure discharge planning services for individuals with mental health challenges. We urge the Council to pressure the City to make remedying discharge planning barriers a priority.

Mental Health Treatment

The most frequent complaint regarding mental health treatment we receive from class members concerns the lack of individual therapy. Some people report not receiving therapy on a regular basis; others describe their interactions with mental health clinicians as "drive-by," two-minute check-ins. This population experiences profound daily trauma, stress, anxiety, and depression, among other mental health concerns, and needs the opportunity to receive supportive therapy. This lack of support also relates directly to individuals' behavior and thus to the level of jail violence. The City has made significant progress in enriching services for people with the greatest mental health treatment needs by developing CAPS and PACE units and establishing treatment teams in the other mental observation units. Enhancing mental health treatment for individuals in general population should be part of the City's efforts to transform the jail culture.

Another common complaint is changes in the psychiatric medication prescribed. Individuals' experience with medication that has proven effective in managing their symptoms is often disregarded, and efforts to consult with previous treatment providers are lacking. This lack of communication with past providers impedes continuity of care.

Other Medical Treatment

Access to care remains a significant concern. Individuals regularly report signing up for sick call daily for weeks before they are seen by medical staff. The DOC and CHS share responsibility for sick call and should work together to improve its functioning. In *Access to Health and Mental*

Health Care (July - December 2017), the Board of Correction highlighted the need for CHS and DOC to implement a coordinated approach to reporting and tracking sick call.

Most of the substantive complaints we receive relate to the inadequacy of care at North Infirmary Command (NIC) where people with serious and/or chronic medical issues are housed. Although there are more services at NIC than at other facilities, they are often inadequate. For example:

- The physical therapy services in NIC are quite limited. Over the last six months, several people reported their mobility regressing since incarceration (i.e., moving from using a cane to needing a wheelchair). Although attentive, the physical therapist appears to have only general training. The equipment is outdated, and the availability is limited.
- Only continuous positive airway pressure (CPAP) therapy is available for the treatment of sleep apnea, and there can be a delay of several weeks in accessing this treatment. Two people who require BiPAP treatment for their sleep apnea reported that use of CPAP alone puts them at risk, yet it is the only therapy offered for this serious, potentially life-threatening condition.
- There is also a lack of specialty electronically controlled beds at NIC. People with circulation issues complained of being moved from an electronic bed to a stationary hospital bed, resulting in swollen, discolored legs.
- There does not seem to be capacity to provide adequate treatment for people who have serious mental health issues and other serious health conditions. NIC does not have a mental observation unit, and PACE and other mental observation units are not equipped to serve individuals with co-occurring chronic medical treatment needs.

Individuals with serious medical conditions are at risk of their health deteriorating, possibly permanently, while they wait for their case to be resolved.

Finally, the mattresses provided to incarcerated people are woefully inadequate. People with back injuries frequently complain that their conditions worsen while in jail due to the mattresses. Not only are the mattresses detrimental to people with preexisting medical conditions and elderly people, but they also affect incarcerated people's quality of sleep generally. Sleep deprivation can

weaken the immune system and contribute to a range of health problems. It also likely contributes to the stress and frustration that can lead to jail violence.

* * * * *

Thank you for the opportunity to testify. We appreciate the Council having this hearing and playing an active role in the oversight of the City jails.

Exhibit A

Index No. 117882/99

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

BRAD H., *et al.*,

Plaintiffs,

-against-

THE CITY OF NEW YORK, *et al.*,

Defendants.

THIRTY-NINTH REGULAR REPORT OF THE COMPLIANCE MONITORS

October 31, 2018

HENRY A. DLUGACZ
Compliance Monitor
99 Park Avenue
26th Floor/PH
New York, N.Y. 10016
(212) 490-0400
Fax: (212) 277-5880

ERIK ROSKES
Compliance Monitor
99 Park Avenue
26th Floor/PH
New York, N.Y. 10016
(212) 490-0400
Fax: (212) 277-5880

Compliance

Table 1: Compliance findings, Report 39

	Item		*Finding*[4]	*Section*
	Initiation of Prescreen at ANS	4.1.2	Compliant	IV.C
	Completion of Prescreen	4.2	Compliant	IV.C
	Submission of MA Application	5.1	Compliant	IV.C
	Provision of MGP Card at ANS	5.3.2	Compliant	IV.C
	Timely Activation of Medicaid	6.1	Compliant	IV.C
	Timely Unsuspension of Medicaid	6.2	Compliant	IV.C
	Provision of Medications and Prescriptions upon Release	7.1.1	Compliant	IV.C
	Provision of Medications by ANS-day of Release	7.1.2	Compliant	IV.C
	Provision of Medications by ANS-after day of release	7.1.3	Compliant	IV.C
	Provision of Appointments	8.1	Compliant	IV.C
	Provision of Appointments by ANS	8.2	Compliant	IV.C
	Forwarding of Supportive Housing Applications	10.2	Compliant	IV.C
	Provision of Transportation	11.1	Compliant	IV.C
	Provision of Transportation by ANS	11.2	Compliant	IV.C
	Follow-up contacts re: Referrals	**12.0.12**	**Compliant**	**IV.C**
	Follow up contacts re: Appointments by CTCM	12.1	Compliant	IV.C
	Follow up contacts re: Referrals by CTCM	12.2	Compliant	IV.C
	Follow up contacts re: Housing by CTCM	12.3	Compliant	IV.C
	Offer of assistance re: Housing by CTCM	12.4	Compliant	IV.C
	Direct Placement in Program Shelters		Compliant	IV.G
	Time of Release		Compliant	IV.H
	Submission of MA Application at ANS	5.2.2	0/0	IV.C
	Provision of Emergency Benefits	9.1	No Data	IV.C
	Processing and Pending of PA Applications	9.3	No Data	IV.C
	Parole Violator Releases		No Data	IV.I
	Timeliness of Initial Assessment	1.1	Noncompliant	IV.C
	Timeliness of CTP	3.1	Noncompliant	IV.C
	Timeliness of DCP	3.3	Noncompliant	IV.C
	Initiation of Medicaid Prescreen	4.1.1	Noncompliant	IV.C
	Provision of MGP Card on Release Date	5.3.1	Noncompliant	*IV.C*
	Provision of Referrals	*8.3*	*Noncompliant*	IV.C
	Submission of PA Application	9.2	Noncompliant	IV.C
	Submission of HRA 2010e Application	10.1	Noncompliant	IV.C
	Follow up contacts re: Appointments	12.0.1	Noncompliant	IV.C
	Follow up contacts re: Housing	12.0.2	Noncompliant	IV.C
	Offer of assistance re: Housing	12.0.3	Noncompliant	IV.C
Appropriateness	Appointment/referral	3.2	Noncompliant	IV.D
Appropriateness	SMI assessment	2.4	Noncompliant	IV.D
Appropriateness	Supportive housing	3.2	Noncompliant	IV.D
Appropriateness	Case management	3.2	Noncompliant	IV.D

[4] Findings in bold in this column indicate that performance for the given PI moved from noncompliant to compliant between the last reporting period to the current reporting period, while findings in italics indicate a move from compliance to noncompliance.

Exhibit B

noncompliant in each of these four areas. The table below presents the numeric outcome of our reviews concerning the appropriateness of discharge planning.

Table 9: Summary of Appropriateness Findings

		Appointment/ Referral	SMI	Case Management	Supportive Housing
Eligible	Appropriate	62	64	40	16
	Inappropriate	15	16	20	21
Ineligible or Not Rated		3	0	20	43
Total cases		80	80	80	80
Defendants' compliance		81%	80%	67%	43%
Compliance threshold		90%	95%	90%	90%

All cases included in the data set are contained in Appendix 4.[28] Defendants' compliance increased in all areas, as follows:

- Appointment/referral — Increased by 9%
- SMI assessment — Increased by 12%
- Case management — Increased by 16%
- Supportive housing — Increased by 5%

While defendants have realized improved performance, they have yet to achieve compliance with any of the appropriateness measures.

Specific Reasons for Noncompliance: We assessed the reasons a given case was not compliant. Various factors accounted for the non-compliance of cases, as follows:

[28] The Court and class counsel are provided with a deidentified version of this appendix.

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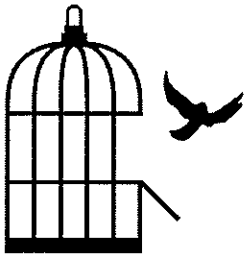

CORRECTIONS
ACCOUNTABILITY
PROJECT

New York City Council

Committee on Hospitals
Carlina Rivera, Chairperson

Committee on Criminal Justice
Keith Powers, Chairperson

Committee on Mental Health, Disabilities & Addiction
Diana Ayala, Chairperson

"Oversight Hearing – Correctional Health"

November 15, 2018
1:00 P.M.
New York, New York

Sade Dixon
Corrections Accountability Project
Urban Justice Center

URBAN JUSTICE CENTER

CORRECTIONS ACCOUNTABILITY PROJECT

Good afternoon. My name is Sade Nixon and I am here representing the Corrections Accountability Project at the Urban Justice Center. We are a non-profit, criminal justice advocacy organization committed to ending the financial exploitation of people involved in the criminal legal system.

I want to thank Chair Rivera, Chair Powers, and Chair Ayala, as well as the members of their committees, for the opportunity to speak to you today as part of your joint oversight hearing on correctional health.

I am here today to speak about my experiences accessing healthcare while incarcerated here in New York City. I spent 8 months incarcerated at Rikers Island between 2012 and 2013. During this time, there were two instances that I required medical attention, which both resulted in abuses and lack of care.

In one case, during an extreme summer heat wave, I became physically ill and was never given an opportunity to visit medical staff. Temperatures that summer rose to 105 degrees within the cinderblock walls of Rikers, with no fans or air conditioning to help with the heat. After days of living in these conditions, I finally fainted from heat exhaustion. I was discovered by a corrections officer who didn't even attempt to send me to the doctor and refused to give me water. Finally, a different corrections officer gave me the water out of her own lunch bag, but I remained in my cell without any sort of medical attention. Access to medical care when you really need it is entirely non-existent inside Rikers.

In another instance, my tooth was in severe pain and I urgently required dental care. I put in multiple sick calls and talked to several corrections officers, but I wasn't seen by the dentist until two and a half weeks later. I was never given a reason for their delays, and when I did finally get to the dentist, I was treated with subpar care that would not have been tolerated outside of jail. I would not have trusted them to put a needle in my mouth anyway, knowing what kind of medical treatment is given inside jail.

All of this happened while Corizon, a national correctional healthcare company based in Tennessee, managed healthcare on Rikers. During this period, Corizon was being sued on average every other nationally. But it's not surprising because their entire business model relies on treating people in jail at the lowest cost possible, which at times means not treating them at all.

In 2015, NYC Health and Hospitals assumed control of healthcare in city jails, but this does not mean that medical abuses no longer occur or that the commercialization of the system and financial exploitation of people involved no longer exists.

Even if you manage to get access to the subpar medical attention on Rikers, you and your loved ones may be forced to pay for treatment. Now, luckily, I had healthcare through my father, but most people are not as fortunate to be covered and their family and support networks outside must cover the high co-pays themselves. People inside are penalized if they have no one to pay, and their commissary accounts are garnished by the city. I know people this has happened to.

Finally, while not a critical issue for me, I want to bring your attention briefly to abuses within correctional healthcare of pharmaceuticals. Pharmaceutical companies like Alkermes make millions from selling opioid addiction treatment medication like Vivitrol to prisons and jails like Rikers. In fact, they make so much of incarcerated people that they are an annual corporate sponsor of the American Corrections Associations. I urge you to investigate the use of pharmaceuticals in New York City.

Regardless of who is exploiting you, at the end of the day, when you are in prison, you are nothing but a number. There is no quality of care because you do not have the same rights as someone outside. You are treated like you are nothing, you are denied healthcare, you are abused medically, and you are exploited financially.

The experiences I mentioned are far from unique. Every day, I heard from people about their inability to access healthcare and the costs they faced if they did. Going to jail is traumatic enough without worrying whether there would be anyone to care for you in the event of a medical emergency.

Thank you for your time in listening to my testimony, and I look forward to seeing concrete solutions from the Council that address the exploitation of so many people who cannot be here to testify today.

THE LEGAL AID SOCIETY

Testimony to City Council by the Prisoners' Rights Project

November 15, 2018

Thank you for giving me the opportunity to testify about issues regarding Correctional Health. My name is Julia McCarthy, and I am here on behalf of the Prisoners' Rights Project of the Legal Aid Society. As Paralegal Casehandler, I speak with upwards of 10 people each day, and hear about all types of issues facing those in custody. However, the vast majority of the calls we field are about medical care in city jails.

Our clients call us every day with a spectrum of medical complaints. Today, we'd like to highlight two trends: lack of access to sick call, and inadequate treatment for serious medical issues.

The Department of Correction's failure to provide sick call seems to be a pervasive problem across the city jails. Sick call is the gateway to all jail medical treatment, and Board of Correction Minimum Standards require that each facility offer sick call at least 5 days a week and within 24 hours of a request. Whether an individual is spitting up blood or attempting to renew a prescription, we receive reports of people being denied sick call on a regular basis. Last month, several incarcerated people from the same housing area in one city jail organized to reach out to us, each sharing their experiences of not having access to sick call. These individuals reported that they had informed multiple officers, captains, and deputies about their lack of access to services, but nothing changed. They told us that often, the only course of action that seemed to work was calling 311.

There are plenty of reasons that could contribute to a lack of access to sick call. Many incarcerated people tell us that officers seem to be acting as gatekeepers when it comes to deciding who gets access to sick call. The Minimum Standards require that "Correctional personnel shall never prohibit, delay, or cause to prohibit or delay an inmate's access to care or appropriate treatment. All decisions regarding need for medical attention shall be made by health care personnel." This section exists for very good reason: correction officers are not medical staff and are not equipped to make medical assessments. We also hear reports of retaliation. One client called us last month to tell us that he was the only one in his unit not called for sick call; he believes it is because he had reported DOC and medical staff misconduct. Consistent in all of these reports is a sense of desperation, that incarcerated people are at the mercy of uniformed staff for basic medical care.

Another common refrain from our clients is an apparent staffing issue: officers tell them that their housing area cannot attend certain services, such as sick call, because there are simply not enough staff to take them. This problem is pervasive, and not just in assigned housing areas. Clients tell us about waiting for hours or days in intake areas before being brought to sick call,

even if they are visibly in need of medical care. Several incarcerated people have reported to us that after being assaulted, they waited in intake areas for several hours while profusely bleeding before being seen by medical staff. Minimum Health Care Standards require adequate staffing for both medical and correctional personnel. Incarcerated individuals should not be subject to elongated waiting times or complete lack of care simply because staffing is low.

We also regularly hear from our clients that they cannot get adequate treatment for serious medical problems. In one instance, a client reported to us that his legs were bleeding and metal rods were protruding from his skin, a result of a surgery he underwent prior to his incarceration. He was scheduled for a 2016 surgery to remove the rods, but then he was arrested. After months of incarceration without any surgical intervention, the only relief given to our client was Ibuprofen and Naproxen. A Legal Aid paralegal saw the bleeding, visible rods in his legs and thought the wounds looked infected. Our client reported that the pain he was experiencing was so extreme, many days he was unable to walk. He told us that he repeatedly attempted to access a cane to help him ambulate, but was told by medical staff that a specialist would need to prescribe him this assistive mobility device—but they didn't schedule an appointment for him, and he didn't receive a cane.

Another one of our clients had a rare form of cancer and multiple other diagnoses of complications. He was wheelchair-bound, extremely ill and very susceptible to health hazards. His wife reached out to us when he was transferred from an infirmary setting at NIC to a general population dorm: a dorm covered in mold that did not provide either the medically-necessary bed nor the level of medical supervision that he required. He was told that his discharge was ordered by a doctor who had never examined him. His requests for transfer were ignored for months.

These individuals are experiencing semi-torturous circumstances on a daily basis. Despite reporting their concerns to officers and medical staff, it seems as if their concerns go unaddressed for weeks, months, or years before being released to the community. This means that improvements to medical and mental health care in the City jails are essential not only from a human rights standpoint, but as a public health measure.

We support the collection and reporting of the sick-call data named in Int. 1236-2018. Even further, we urge the Council to use its oversight powers to conduct a substantive audit about medical care in the city jails: not only of the treatment provided to incarcerated people by CHS, but also of the Department's duty to provide access to medical care.

Additionally, we support Resolution 0581-2018 calling for the passage of state legislation requiring that DOCCS facilities provide Medication Assisted Treatment to incarcerated people. We provided written testimony to the State Assembly on the topic, and are happy to provide it to the Council if it would be helpful.

We thank the Committees for the public forum on such a vital area of concern.

TESTIMONY OF:

Brooke Menschel
BROOKLYN DEFENDER SERVICES

Presented Before

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

Oversight Hearing on Correctional Health

November 15, 2018

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

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

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

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

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

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

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

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

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

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

Lisa Schreibersdorf
Executive Director

177 Livingston Street, 7th Floor
Brooklyn New York 11201

T (718) 254-0700
F (718) 254-0897

www.bds.org
@bklyndefender

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

Access to Care as a Linchpin to Improving Security

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

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

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

Correctional Staff as Gatekeepers

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

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

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

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

Lockdowns Preventing Care

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

Limitations on Treatment as a Punishment

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

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

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

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

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

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

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

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

Lisa Schreibersdorf
Executive Director
177 Livingston Street, 7th Floor
Brooklyn New York 11201
T (718) 254-0700
F (718) 254-0897
www.bds.org
@bklyndefender

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

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

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

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

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[8] Shalev, S. (2008), A sourcebook on solitary confinement. (London: Manheim Centre for Criminology, London School of Economics), p. 15.
[9] Haney, C. (2003) 'Mental health issues in long-term solitary and "Supermax" confinement', in: Crime & Delinquency, 49(1) pp. 133-136.
[10] Id.; Grassian, S. (1983), 'Psychopathological effects of solitary confinement', in: American Journal of Psychiatry, 140(11), p. 1452.
[11] Haney, 2003, p. 133; Grassian, 1983 p. 1453; Gilligan, J., Lee, B., (2013), 'Report to the [New York City] Board of Corrections', [online] (Available at http://solitarywatch.com/wp-content/uploads/2013/11/Gilligan-Report.-Final.pdf [accessed 11 August 2017]), p. 6.
[12] Venters, H., Kaba, F., Lewis, A., Glowa-Kollisch, S., Hadler, J., Lee, D., Alper, H., Selling, D., MacDonald, R., Solimo, A., Parsons, A. (2014), 'Solitary confinement and risk of self-harm among jail inmates', in: American Journal of Public Health, 104(3), p. 445.
[13] Statistics provided by DOCCS
[14] Gilligan and Lee, 2013, p. 6.

Lisa Schreibersdorf
Executive Director
177 Livingston Street, 7th Floor
Brooklyn New York 11201
T (718) 254-0700
F (718) 254-0897
www.bds.org
@bklyndefender

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

Physical Design and Inadequate Resources as Hurdles to Care

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

Physical Plant as a Barrier to Treatment

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

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

Inadequate or Inappropriate Staffing Prevents Access to Care

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

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

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

Lisa Schreibersdorf
Executive Director
177 Livingston Street, 7th Floor
Brooklyn New York 11201
T (718) 254-0700
F (718) 254-0897
www.bds.org
@bklyndefender

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

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

Inaccessible Medical and Mental Health Care During Intake

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

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

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

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

Lisa Schreibersdorf
Executive Director

177 Livingston Street, 7th Floor
Brooklyn New York 11201

T (718) 254-0700
F (718) 254-0897

www.bds.org
@bklyndefender

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

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

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

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

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

Lisa Schreibersdorf
Executive Director
177 Livingston Street, 7th Floor
Brooklyn New York 11201
T (718) 254-0700
F (718) 254-0897
www.bds.org
@bklyndefender

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

Administrative Barriers to Accessing Care

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

Logistical Complications Prevent Mandated Treatment

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

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

Forced Choices Between Safe Housing and Necessary Treatment

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

Lisa Schreibersdorf
Executive Director

177 Livingston Street, 7th Floor
Brooklyn New York 11201

T (718) 254-0700
F (718) 254-0897

www.bds.org
@bklyndefender

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

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

Conclusion

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

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

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

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

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

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

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

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

Lisa Schreibersdorf
Executive Director

177 Livingston Street, 7th Floor
Brooklyn New York 11201

T (718) 254-0700
F (718) 254-0897

www.bds.org
@bklyndefender

November 14th, 2018

We are the Drug Policy Alliance.

New York City Council's
Committee on Criminal Justice
Committee on Hospitals
Committee on Mental Health, Disabilities and Addiction

Subject: Examining the Effectiveness of Medication-Assisted Treatment Programs in State and Local Correctional Facilities in the State.

Testimony of the Drug Policy Alliance

The Drug Policy Alliance appreciates the opportunity to submit testimony to this joint hearing on correctional health. The Drug Policy Alliance is the nation's leading organization working to advance policies and attitudes to best reduce the harms of both drug use and drug prohibition and to promote the sovereignty of individuals over their minds and bodies.

This morning I would like to focus on treatment for substance use disorder in New York City Jails. New York and the nation is in the midst of an opioid epidemic. In 2017, there were 1,487 unintentional drug overdose deaths in New York City - 82% of recorded overdose deaths involved an opioid. The rate of overdose deaths are declining in New York's wealthier neighborhoods, however the fatal overdose rate is steadily increasing in New York's high poverty neighborhoods. New York City is the largest city with residentially concentrated poverty and has the greatest number of opioid abusers with past estimates ranging from 92,000 to 200,000 –a moderate percentage of that population initiates treatment.[i] The lack of an adequate treatment and harm reduction infrastructure to meet the needs of low-income communities leads many into the criminal justice system - wherein existing chronic health conditions and diseases are likely to worsen.

A 2018 national study on criminal justice involvement among adults with varying levels of opioid use indicated more than half of individuals with a prescription opioid use disorder or heroin use in the past year reported contact with the criminal justice system.[ii] Further individuals with any level opioid use have a higher prevalence of chronic disease, including hepatitis B or C and disability – so there is a need for correctional facilities to provide healthcare for a range of conditions. Researchers and practitioners often call on public health and criminal justice policy makers to take advantage of the container of incarceration to reach medically underserved populations. This argument is problematic as it negates the health consequences of incarceration and justice involvement overall. [iii] Any positive health outcomes achieved while incarcerated, only served to illuminate the lack of comparable health care options in the community setting. So while this hearing is focused on improving correctional healthcare, perhaps the focus should be on keeping people in need of care for SUD and mental illness out of correctional settings.

Treating People with Substance Use Disorder

Most incarcerated people with substance use disorder, and primarily opioid use disorder (OUD), don't have receive adequate treatment using medications commonly used to treatment opioid addiction. To its credit, New York City has operated The Key Extended Entry Program at Rikers Island, better known as KEEP. The KEEP program, established in 1987, is one of the longest running jail-based opioid treatment program in the country.

KEEP has matured into a model jail-based treatment program, so much so that the New York office of DPA is encouraging the State Department of Corrections and Community Supervision and the State Commission of Correction to emulate KEEP, and provide medication for the treatment of opioid use disorder to those incarcerated in state and county correction facilities. While KEEP is viable and serviceable model that has connected thousands of New York City resident to care since its inception, there are improvements that can be made to ensure that patients can be retained in a treatment program following a period of incarceration.

To begin, the existing research on the KEEP program is limited. The two most comprehensive evaluations of KEEP were published by Mount Sinai in 2001. The lack of data on programmatic outcomes make it difficult to assess areas of improvement, especially in the realm of program retention. The most recent report indicated that there are declines in treatment retention following release from Rikers, the report indicates that Medicaid enrollment is a significant indicator of whether patients remain in care, patients who were not enrolled in Medicaid and still did not have Medicaid at discharge were less likely to remain in the program and tended to be re-incarcerated or lost to contact. Since 2001, tremendous efforts have been made to re-enroll reentrants on to Medicaid prior to release in order to maintain the continuum of care, but more can be done to prevent interruption in healthcare and treatment services.

DPA firmly believes that people should not be incarcerated as a response to substance use or crimes related to substance use. New York City should continue to invest in harm reduction and community based treatment that is not administered via the criminal legal system. Until we reach the point of full decriminalization of substance use and develop of health and treatment infrastructure to support the needs of New Yorkers who experience substance use disorder, treatment offered in corrections must be centered on the needs of the patient. To that end, DPA suggest the following recommendations to improve treatment for substance use disorder in New York City Corrections.

- Currently, KEEP patients are offered referral to community based treatment programs upon release so that they can maintain care. The American Society of Addiction Medicine and the American Correctional Association issued a joint policy statement on OUD treatment in the justice system. A key pillar was strengthening reentry and community supervision which emphasized the importance of warm hand offs. Currently, patients are referred to community based treatment settings, but there are limited or burgeoning proactive supports for patients. In response to the challenges of reentry care, NYC Health and Hospitals is partnering with Fortune Society to improve transitional care services but more can be done to improve treatment retention – such as offering peer recovery support pre-release and to make referrals to SEPs and harm reduction service providers.

- The failure of NYS DOCCS to implement a system wide medication assisted treatment program places limitations on KEEP when determining patient ineligibility. Patients with felony arraignment charges are ineligible for KEEP but there are errors in the predictive model used by correctional health staff. In 2016, 8,200 patients were admitted into Rikers with OUD, of that population 46% were considered KEEP Eligible and 4,405 potential patients or 54% were deemed ineligible due to felony arraignments – of that total population of patients deemed ineligible 3,139 individuals actually stayed in an NYC jail or were discharged. Physicians are operating with information providing by courts during the screening and assessment and can't control the outcomes of a disposition, but they are taking strides to get better information regarding a patient's sentence in order to reach as many patients as possible. To better serve all patients in need of care – NYC Council and the BOC can advocate that MAT be used in all state prisons so that all patients can remain in treatment.

- Finally, BOCS and the New York City Council should provide updated information about the efficacy of the KEEP program to the public as a resource. The KEEP program is increasingly referenced as a model program for states wishing to respond to the opioid crisis, however there are few reports that illustrate how the program is currently administered and the outcomes of treatment. This information is valuable to those who need instruction on clinical best practices, addressing regulatory barriers and reentry services.

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[i] Hansen, Helena B., et al. "Variation in Use of Buprenorphine and Methadone Treatment by Racial, Ethnic, and Income Characteristics of Residential Social Areas in New York City." *The Journal of Behavioral Health Services & Research*, vol. 40, no. 3, 24 May 2013, pp. 367--377, https://link-springer-com.ezproxy.cul.columbia.edu/article/10.1007%2Fs11414-013-9341-3#Sec5, 10.1007/s11414-013-9341-3. Accessed 9 Nov. 2018.

[ii] Winkelman TN, Chang VW, Binswanger IA. Health, Polysubstance Use, and Criminal Justice Involvement Among Adults With Varying Levels of Opioid Use. JAMA Netw Open. 2018;1(3):e180558. doi:10.1001/jamanetworkopen.2018.0558

[iii] Dumont, Dora M. & Allen, Scott A. & Brockmann, Bradley W. & Alexander, Nicole E. & Rich, Josiah D."Incarceration, Community Health, and Racial Disparities." Journal of Health Care for the Poor and Underserved, vol. 24 no. 1, 2013, pp. 78-88. Project MUSE, doi:10.1353/hpu.2013.0000

SYLVIA RIVERA LAW PROJECT

TESTIMONY OF:

Mik Kinkead, Esq. - Director of Prisoner Justice Project
Sylvia Rivera Law Project
147 W 24th St., 5th Floor
New York, NY 10011
212-337-8550 x302
mik@srlp.org

PRESENTED BEFORE:

the Committee on Hospitals jointly with the Committee on Committee on Mental Health, Disabilities and Addiction and the Committee on Criminal Justice

Oversight - Correctional Health

November 15, 2018

Members of the Committees,

Thank you for the invitation to testify before you all today on the issue of healthcare in correctional settings. My name is Mik Kinkead and I am a staff attorney and the Director of the Prisoner Justice Project at the Sylvia Rivera Law Project ("SRLP"). SRLP is one of the oldest non-profits in New York City offering legal services to transgender, gender non-conforming, and intersex people (TGNCI people) by TGNCI people. We specifically focus on working with TGNCI people who are low-income and/or people of color at the intersection of transphobia, sexism, racism, and classism.

We offer direct legal services to people in the New York City area, including those held by the NYC Department of Correction (NYC DOC) and people incarcerated by New York State's Department of Correction and Community Supervision (NYS DOCCS). Not only do we serve TGNCI people in the city jails broadly, since August 2015, SRLP has provided legal and cultural programming twice a month to individuals housed in the Transgender Housing Unit (THU). Since that time, I have personally served close to 100 TGNCI individuals in the NYC DOC. We are, to our knowledge, the only TGNCI-lead and specialist organization currently in the NYC DOC.

SRLP has been involved for over a decade in the issues of housing, sexual and physical violence, access to necessities of daily living, and healthcare for TGNCI people held in NYC DOC custody. We have commented extensively at Board of Corrections hearings on these issues, and I am pleased to be able to speak now on the specific issue of healthcare for TGNCI people.

OVERVIEW

Since healthcare operations were turned over to the NYC Health & Hospitals Corporation, the governing policy on transgender medical care has been Policy #MED 24B. This policy, which was revised in July 2015, relies on healthcare practices that are outdated and fail to see the healthcare needs of transgender and gender non-conforming people (TGNC people) as real and necessary.

As a general overview, TGNC people require the same care as our cisgender counterparts. In addition, some of us need care specific to our transitions. Transitions are highly individualized and they require individualized care. Every TGNC person's experiences of gender dysphoria, and the steps we must take to thrive with that dysphoria, are different. There can be no cookie-cutter approach to our healthcare, as indeed, there can be no cookie-cutter approach to *most* healthcare. Transition-related care can range from knowledgable counseling, Hormone Replacement Therapy (HRT), and various different surgeries which reduce feelings of gender dysphoria allowing us to thrive and survive. In addition, we also need the care specific to our bodies regardless of our gender identities - trans men like myself need to continue to receive pap smears and chest exams, transgender women need to receive prostate exams - and all of us continue to need the birth control, STI treatment, and other examinations and care specific to our bodies.

Despite the fact that any TGNC person could stand here and share these basic needs, they continue to overwhelm and confuse medical providers who are not properly trained.

This confusion, in general, leads TGNC people to avoid accessing healthcare. We don't want to explain again and again that we are real. We do not want to deal with being in a vulnerable situation and being misgendered, denied services, laughed at, or worse by those sworn to do no harm. TGNC people have long learned - and passed along to each other - that healthcare in any non-LGBT-specific setting is not a safe option. We at SRLP are trying to change this reality, but it is near impossible when policies like this exist which blatantly write our very real needs out of existence.

THE EXISTING POLICY

There is *significant*, case law stating that - and I hate that I still find myself saying this - transgender people's healthcare needs are real and necessary. One need only look at the 2017 decision in *Cruz v. Zucker,* a case that prompted Governor Cuomo to issue an executive order disallowing private healthcare companies to operate transgender care bans in New York State, to see that there is compelling and recent information on the life-saving effect of comprehensive and individualized care for TGNC people.

Policy #MED 24B, however, states right at the beginning under the title "purpose" that the policy is meant to "minimize the use of non-standard or high dose regimens which may be appropriate under the direct supervision of expert community providers, but may also confer undue risk in the jail environment." No further explanation is offered. Without any context, one surmises that the "risk" individualized HRT care resent, is the risk of us having successful transitions. What this means in practice, is that all TGNC people's medical regimes are changed from whatever was considered to be correct and optimal for their health in the outside, to one universal standard. The policy states it should be twice-daily oral tablets of 3 milligrams of Estradiol and 25 milligrams of Spironolactone daily for women and 200 milligrams of testosterone for men via injection every two weeks.

According to trans health care experts - such as Dr. Amy Bourns who wrote the 2016 *Guidelines and Protocols For Hormone Therapy and Primary Health Care for Trans Clients* or The Endocrine Society's recently updated 2017 *Clinical Practice Guideline on Gender Dysphoria/Gender Incongruence* - recommended dosages of Estradiol may range between 1 and 4 milligrams and Spironolactone should be, at a minimum, 50 milligrams and range up to 200 milligrams twice daily. The generic Spironolactone amount that all transgender women are placed on is below the recommended starting dosage and way below the maximum. Spironolactone is a key part of HRT which allows for the suppression of testosterone. Without it, even on Estradiol alone, women experience mentally horrific physical occurrences which exacerbate any mental healthcare needs. That every woman is placed on this regime - allegedly for their safety - simply because they are in jail, is inexcusable.

There can be no excuse, in New York City, for the NYC Health & Hospitals Corporation to not have or partner with an expert allowing them to continue individualized and correct dosages. There are over five different LGBT-specialist clinics in the city, not to mention entire hospital units, where doctors, nurses, and other medial specialists regularly administer and supervise hormones. For anyone held in the Manhattan Detention Complex, APICHA's Community Healthcare Center is literally only five blocks away. It is astounding that someone's healthcare would be compromised simply due to a lack of specialists in a city that is known for its TGNC healthcare.

It must be shared that, in *general*, the individuals I work with do not experience outright denials of HRT and do not report that NYC Health & Hospitals Corporation employees misgender them or make them feel uncared for. The resounding issue that is reported to me is that the dosages are simply far too low to be effective. In addition, employees don't seem to have answers to larger healthcare questions such as connecting to care upon re-entry or what care looks like upon transfer to NYS DOCCS.

Perhaps explaining the lack of answers to these questions, Policy #MED 24B does not mention anything beyond HRT. Our other medical needs relating to transition care are not provided for under this policy. Nor are there any explicit instructions on working with TGNC people who are recovering from surgeries. Recently, I worked with a woman who had been held in a jail outside of NYC where she wasn't allowed access to her post-surgical needs. Some surgeries that TGNC people have require care for multiple years afterwards. The jail she was held in simply stated that they were unable to determine the medical necessity of her post-surgical care and so had denied it. Given that, again, New York City is a hub for TGNC people and contains many experts on our medical care, having written policies for healthcare workers regarding post-surgical care seems prudent - and lifesaving.

CONCLUSION

In light of all this, NYC Health & Hospitals Corporation must work with TGNCI providers and TGNCI community members to update their existing policy on care and bring it into this century. It is not sufficient to tell individuals with a particular diagnosis that treatment for that diagnosis will be diminished due to them being in jail. It seems unthinkable that healthcare providers would say to any other similarly situated people: "now that you are in jail, your healthcare needs are not real."

SRLP would be happy to continue to work with these committees and the NYC Health & Hospitals Corporation on updating these policies, and we look forward to continuing this work.

SUBJECT: TRANSGENDER CARE POLICY #: MED 24B

POLICY:

All transgender patients will receive appropriate care, education, therapy and medical follow-up as described in this policy.

PURPOSE:

The purpose of this policy is to:

- Remove potential barriers to transgender therapy by providing an appropriate standard regimen, which, in most cases, can be initiated prior to obtaining collateral information or specialist consultation.
- Minimize the use of non-standard or high dose regimens which may be appropriate under the direct supervision of expert community providers, but may also confer undue risk in the jail environment.
- Improve patient understanding of the risks and benefits associated with transgender hormone and anti-androgen therapy.

PROCEDURE:

A. **Patients on feminizing hormone therapy (estrogen) prior to incarceration [Hormone Experienced - Male to Female]**

1. History and Physical Examination: Perform comprehensive history and physical. Screen for coronary artery disease, deep vein thrombosis, embolic stroke, liver disease, pituitary adenoma, hypertension, diabetes, psychosis, cognitive impairment, dementia, suicidal/homicidal ideations/attempts.

2. Laboratory Testing: Order baseline laboratory tests including CBC, chemistries, liver function tests, lipids, hepatitis A, B and C serology, thyroid stimulating hormone (TSH), prolactin, RPR, rapid HIV test and other tests as clinically indicated..

3. Enter diagnosis of Transsexualism NOS – ICD 302.50

4. Evaluate any contraindications to hormone therapy - See Appendix 1.

5. Patient education and informed consent: Review attached patient education information with the patient, answer any questions and then obtain informed consent – See Appendix 2.
Note: Parental consent is required for unemancipated minors under age 18.

6. Therapy: See attached table of Feminizing Hormones and Anti-Androgens for dosage and their effects - Appendix 4.
Order the following for one month pending admission labs:

a) Estradiol 3 mg p.o., b.i.d.

b) Spironolactone 25 mg p.o. b.i.d.

Note:

- Spironolactone should be avoided in patients with a history of hyperkalemia, low blood pressure or renal failure.
- Spironolactone is not indicated for post-orchiectomy patients.
- Do not order 2 different forms of estrogen (e.g., Estradiol and Premarin, or any other combination)
- Estradiol is the first-line estrogen to order, unless the patient is allergic to it or there are other contraindications that should be documented in the patient's record.
- Do not order IM and PO estrogen together.
- IM estrogen is not recommended in our setting. Order PO estrogen (Estradiol).
- Provera or other progesterone preparation is not indicated in our setting.
- Standard Estradiol dosing of 3 mg BID can be increased to 4 mg BID, provided lab work returns without concerning findings.

7. Schedule patient for a follow-up visit in 1 month. (Follow-up may need to be sooner based on initial labs results.)

8. Follow-up Visit:

a) Obtain pertinent HPI relating to transgender therapy.
b) Perform pertinent physical exam, as clinically indicated.
c) Reevaluate initial laboratory test results and address any abnormal results – See Appendix 6, management of abnormal laboratory results.
d) Adjust estrogen and other therapy based on laboratory and clinical findings.
e) Order appropriate laboratory tests. (LFTs and electrolytes are recommended at least every 3 months.)
f) Order medications for 3 months.
g) Re-schedule patient for follow-up in 3 months or sooner if clinically indicated.

B. **Patients who are not on feminizing hormone therapy (estrogen) [No Hormone Experience]**

Patients with no hormone experience who wish to initiate feminization should be referred to Mental Health and Bellevue Hospital Center Endocrine Clinic prior to initiating transgender therapy.

C. **Patients on masculinizing hormone (testosterone) prior to incarceration [Hormone-Experienced – Female to Male]**

1. History and Physical Examination: Perform comprehensive admission history and physical. Screen for coronary artery disease, liver disease, hypertension, diabetes, psychosis, weight gain, increased cholesterol, cognitive impairment, dementia, suicidal/homicidal ideations/attempts.

2. Laboratory Testing: Order baseline laboratory tests including CBC, chemistries, liver function tests, lipids, hepatitis A, B and C serology, RPR, rapid HIV test and other tests as clinically indicated.

3. Enter diagnosis of Transsexualism NOS – ICD 302.50.

4. Evaluate any contraindications to hormone therapy – See Appendix 1.

5. Patient education and informed consent: Review attached patient education information with the patient, answer any questions and then obtain informed consent – See Appendix 3.
   Note: Parental consent is required for unemancipated minors under age 18.

6. Therapy: See attached table of masculinizing hormones for dosage and effects - Appendix 5.
   Order one of the following for one month pending initial labs:

   a) Testosterone 200 mg (1.0 cc) Intramuscular (IM) Q 2 weeks (every 2 weeks)

   b) **Post-oophorectomy**: Testosterone 100 mg (0.5 cc) Intramuscular (IM) Q 2 weeks (every 2 weeks).

7. Schedule patient for follow-up visit in 1 month. (Follow-up may need to be sooner based on initial labs results.)

8. Follow-up Visit:

   a) Obtain pertinent HIP relating to transgender therapy.
   b) Perform pertinent physical exam, as clinically indicated.
   c) Reevaluate initial laboratory test results and address any abnormal results – See Appendix 6, management of abnormal laboratory results.
   d) Adjust testosterone and other therapy based on laboratory and clinical findings.
   e) Order appropriate laboratory tests as clinically indicated.
   f) Order medications for 1 month.

g) Re-schedule patient for follow-up in 1 month or sooner if clinically indicated.

D. Patients who are <u>not</u> on masculinizing hormone therapy (testosterone) [No Hormone Experience]

Patients with no hormone experience who wish to initiate masculinization should be referred to Mental Health and Elmhurst Hospital Center Endocrine Clinic prior to the initiating transgender therapy.

Approved by:	Original Issue Date	Date(s) Reviewed	Date(s) of Revision
Ross MacDonald, M.D. Medical Director Correctional Health Services	May 11, 1994	March 2000 June 2005 March 2008 June 2012 March 2015 June 2015	April 1, 2000 March 19, 2008 June 2012 March 27, 2015 July 1, 2015

Managing Contraindications

Active Psychosis

- Active psychosis is defined here as loss of contact with reality and a decline in general functioning
- If a patient presents with active psychosis, refer to Mental Health on a stat basis
- Do not initiate hormone therapy until the Psychiatrist confirms the patient's ability to consent to treatment at the time hormone therapy is initiated
- The treatment plan should include a lesser initial dose with gradual increases to be determined by the patient's medical and mental health providers.

Cigarette Smoking

- While patients who smoke can begin hormone therapy, it should be made abundantly clear that for both women and men of transgender experience, smoking in the presence of hormones greatly increases the risk of adverse events
- For patients on feminizing hormones, cigarette smoking increases the likelihood of thrombus formation
- For patients on masculinizing hormones, it increases the potential for coronary artery disease.
- For both, smoking while on hormone therapy places them at higher risk for atherosclerosis if they develop hyperlipidemia
- At every visit, the provider should actively engage the patient in negotiation around smoking cessation.

Coronary Artery Disease

- Estrogens appear to have a mixed effect on coronary artery disease, on one hand lowering risk stratification but on the other, potentially increasing lipids
- Testosterone has only deleterious effects, including increasing risk stratification and worsening lipid profiles (increasing LDL and decreasing HDL)
- While hormone therapy is not contraindicated in the presence of coronary artery disease, the patient should be aware of the risks
- The provider should intervene to reduce all other risk factors for coronary artery disease.

Dementia

- Hormone therapy should not be provided to a patient who is unable to give informed consent
- Psychiatrist must make this determination at the time hormone therapy is initiated
- Psychiatrist should also be consulted if there are any questions about a patient's ability to provide informed consent.

History of Deep Venous Thrombosis, Pulmonary Embolism or Embolic Stroke

- This is only a concern for patients using exogenous estrogen
- There is no management that will diminish the possibility of future thrombotic/ embolic events.
- In patients with this history, only anti-androgens should be used

Homicidal/Suicidal Ideation/Attempts

- Patients with active homicidal ideation/ attempts should be engaged in mental health care
- Mental health provider has to confirm the patient's ability to consent to treatment
- The treatment plan may include a lesser initial dose with gradual increases to be determined by the patient's medical and mental health providers.

Liver Disease

- If the patient has a self-limited hepatic infection, such as acute Hepatitis A or B, hormone therapy should be delayed until the patient is in the convalescent stage and transaminases have returned to normal
- If the patient has chronic hepatitis for which treatment is available, such as Hepatitis C with elevated transaminases, treatment of this should be pursued before hormone therapy is started
- If the patient has chronic disease, such as alcohol-induced cirrhosis or Hepatitis C that did not respond to treatment, hormone therapy should only be started if the patient has normal liver synthetic functions (normal PT, albumin and cholesterol). In this case, the patient should be cautioned that he/she is at potentially increased risk for progression of liver disease if he/she initiates hormone therapy.
- Other liver diseases such as autoimmune hepatitis should be co-managed with a hepatologist
- For all patients with chronic disease, the primary care provider should minimize the risk of further liver injury with appropriate immunizations and behavioral interventions.

Pituitary Adenoma

- If the patient has a history of pituitary adenoma, hormone therapy should be delayed until the patient has had a full evaluation and clearance from an endocrinologist.

Uncontrolled Diabetes

- There is no clear evidence on the relationship between hormone therapy and glycemic control in diabetics
- It is clear that people on hormone therapy are at greater risk for lipid abnormalities. These facts should be communicated to the patient
- Diabetes should be managed independent of hormone therapy. If however, the patient has a glycosylated hemoglobin greater than 10 after one year of hormone therapy, it should be stopped until better diabetes control is achieved.

Uncontrolled Hypertension

- Management should be based on the risk category of the patient
- The patient should be informed that there might be greater difficulty in controlling his/her blood pressure while on hormones
- If the patient has Stage 1 hypertension (<160/<100) and is without diabetes or end organ damage, hormone therapy can be initiated
- At the same time, blood pressures should be closely followed and lifestyle modification initiated
-

- If the patient's blood pressure is not well controlled after six months, anti-hypertensive medication should be started
- If the patient has Stage II/III hypertension (>160/>100) or Stage 1 hypertension with diabetes or end organ damage, anti-hypertensive medication and lifestyle modification should be started in conjunction with hormone therapy (e.g. Spironolactone).
- If the patient's blood pressure is still poorly controlled after six months, hormones should be discontinued until proper control is achieved. Adequate control is defined as <130/<85 in patients with diabetes or proteinuria, and as <140/<90 in all other patients.

Informed Consent and Patient Education Form for Feminizing (Estrogen) Therapy [Transgender]

This form refers to the use of Estrogen and/or Androgen Antagonists by persons in the male-to-female spectrum who wish to become feminized to reduce gender dysphoria.

This form explains the risks, benefits and changes that may occur from taking feminizing medications.

If you have any questions or concerns about any information below, please discuss them with your with your healthcare clinician prior to signing this consent form so you can make a fully informed decisions about your treatment.

Risks of Feminizing Medications

The medical effects and safety of these medications are not fully understood, and there may be long term risks that are not yet known

It is important that a patient not take more medication than he/she is prescribed, as this increases health risks. Taking more medication than prescribed will not make feminization happen more quickly. Extra estrogen can actually slow or reverse feminization.

A patient is more likely to have dangerous side effects from estrogens if he/she smokes cigarettes, is overweight, is over the age of 40 years old, or has a history of blood clots, high blood pressure or a family history of breast cancer

Risks Associated with taking Estrogen

- Increased risk of cancers, including breast cancer.
- Potential damage to the liver, possibly leading to liver disease. Patients are advised to be monitored for possible liver damage as long as they take these medications.
- Increased the risk of blood clots. Patients are advised to stop smoking cigarettes completely because the danger of blood clots is much higher if they smoke. Blood clots in the lungs (pulmonary emboli) can cause permanent lung damage or death. Blood clots in the brain (stroke) can cause permanent brain damage or death. Blood clots in the heart can cause a heart attack or death. Blood clots in the leg veins can lead to a stroke, blood clot in the lung or heart attack.
- Increased blood pressure.
- Feminine pattern of fat deposits and weight gain.
- Headaches or migraines. Patients should go to the clinic if the pain is prolonged or severe.

Informed Consent and Patient Education Form for Feminizing (Estrogen) Therapy [Transgender]

- Increased risks of non-cancerous tumors of the pituitary gland (prolactinoma) which can cause changes in vision and headaches.
- Production of breast milk.
- Emotional side effects including mood swings, increased sensitivity, crying and sadness.
- Other risks include liver and gall bladder damage requiring periodic blood tests to monitor possible liver damage. Patients should go to the Clinic for prolonged or severe abdominal pain.

Risks associated with Androgen Antagonists (Spironolactone)

- Affects the balance of water and salts in the kidneys.
- Increase in the amount of urine produced and the frequency of urination.
- Increased thirst.
- Increase in the level of potassium in blood, which can cause changes in heart rhythm and may be life threatening.

Prevention of Medical Complications

- Take medications as prescribed and go to the clinic if you are unhappy with the treatment or are experiencing any problems.
- The right dose or type of medication prescribed for you may not be the same as for someone else and you should not take anyone else's medication.
- Physical examination and blood tests are needed on a regular basis to check for negative side effects.
- Feminizing medications can interact with other medications, dietary supplements, herbs, alcohol and street drugs. Being honest with the healthcare clinician about these medications and drugs may prevent medical complications that could be life threatening.
- Some medical conditions can make it dangerous to take feminizing medications and the healthcare clinician may suggest to reduce or stop taking feminizing medications

Informed Consent and Patient Education Form for Feminizing (Estrogen) Therapy [Transgender]

My signature below confirms that my healthcare clinician has discussed the risks and benefits of feminizing medications and that I understand these risks.

I had sufficient opportunity to ask questions and all my questions have been answered to my satisfaction.

I understand that this form covers known effects and risks and that there may be other long term effects and risks that are not yet known

I believe that I have adequate knowledge to make an informed decision to consent to feminizing medications which are not FDA-Approved for this use.

Patient's signature _____ Date _____

Clinician's signature _____ Date _____

Informed Consent and Patient Education for Masculinizing (Testosterone) Therapy (Transgender)

This form refers to the use of testosterone by persons in the female-to-male spectrum who wish to become more masculine.

This form explains the risks, benefits and changes that may occur from taking testosterone.

If you have any questions or concerns about any information below, please discuss them with your with your healthcare clinician prior to signing this consent form so you can make a fully informed decisions about your treatment.

Risks of Masculinizing Medications

The medical effects and safety of testosterone are not fully understood, and there may be long term risks that are not yet known.

It is important that a patient not take more medication than he/she is prescribed, as this increases health risks. Taking more medication than prescribed will not make masculinization happen more quickly. Extra testosterone can be converted to estrogen (feminizing hormone) which can slow or stop masculinization.

Patients may develop dangerous side effects from taking testosterone, as explained below.

Risks Associated with Taking Testosterone

- Increase risk of cancers.
- Heart disease:
    - Decreased good cholesterol (HDL), increased bad cholesterol (LDL).
    - Increased blood pressure.
    - Increased deposits of fat around internal organs.
    - The risks of heart disease are greater if a patient has a family history of heart disease, is overweight or smokes.
    - Heart health check-ups, including monitoring a patient's weight and cholesterol levels will be done periodically as long as the patient is taking testosterone.
- Liver damage and possible liver disease. Patients have to be monitored for possible liver damage as long as they are taking Testosterone

Informed Consent and Patient Education for Masculinizing (Testosterone) Therapy (Transgender)

- Increased red blood cells and hemoglobin, usually to the normal male level. A further increase is possible, which can cause potentially life-threatening problems such as stroke and heart attack. Patients' blood levels will be monitored while they are taking testosterone.
- Increased risk of weight gain, especially around the abdomen, which may pre-dispose a patient to diabetes and heart disease. Patients' blood sugar will be monitored while they are taking testosterone.
- Testosterone can make my cervix and the walls of the vagina more fragile, which can lead to tears and abrasions that increase the risks of sexually transmitted diseases (including HIV) if a patient has vaginal sex -- regardless of the gender of the partner. Safe sex, including the use of condoms is advisable.
- Headaches or migraines. Patients should go to the clinic for prolonged or severe headaches.
- Emotional changes, including increased irritability, frustration and anger.

Prevention of Medical Complications

- Take medications as prescribed and go to the clinic if unhappy with the treatment or experiencing any problems.
- The right dose of testosterone prescribed for a patient may not be the same as for someone else and a patient should not take anyone else's medication.
- Physical examination and blood tests are needed on a regular basis to check for negative side effects of testosterone.
- Testosterone can interact with other medications, dietary supplements, herbs, alcohol and street drugs. Being honest with the healthcare clinician about these medications and drugs may prevent medical complications that could be life threatening.
- Some medical conditions can make it dangerous to take testosterone and the healthcare clinician may suggest to reduce or stop taking masculinizing medications.

Informed Consent and Patient Education for Masculinizing (Testosterone) Therapy [Transgender]

My signature below confirms that my healthcare clinician has discussed the risks and benefits of testosterone and that I understand these risks

I had sufficient opportunity to ask questions and all my questions have been answered to my satisfaction.

I understand that this form covers known effects and risks and that there may be other long term effects and risks that are not yet known.

I believe that I have adequate knowledge to make an informed decision to consent to testosterone medication which is not FDA-Approved for this use.

Patient's signature _____ Date _____

Clinician's signature _____ Date _____

Appendix 4: Feminizing Treatment – Estrogen and Anti-Androgen

Medication	Dose	Intended Effects	Possible Side Effects	Labs to Draw
Standard Recommended Regimen				
Estradiol -1st Line	3 mg PO BID	Breast Hypertrophy Impotence Fat redistribution Testicular atrophy	CVA, DVT, PE Depression, Gall Bladder Disease, GI Upset, Headache, Hepatitis, Hypercalcemia, Hyperlipidemia, Hypertension, Impotence, Loss of libido, Mood changes, Pituitary Adenoma, Sterilization	Lipids LFT Prolactin Other as clinically indicated
Spironolactone -1st Line (not needed in post-orchiectomy patients)	25 mg PO BID	Decrease of androgenic alopecia Impotence Thinning and decrease of facial hair	Ataxia Gastric ulcer GI upset Headache Hirsutism Hyperkalemia Hyponatremia Hypotension Mood changes	Electrolytes Other as clinically indicated
Alternative Agents				
Conjugated Estrogen (Premarin) – 2nd Line	1.25 mg PO BID	Same as estradiol	Same as estradiol	Same as estradiol
Finasteride (Proscar)- 2nd Line	5 mg PO QD (once/day)	Same as spironolactone Breast hypertrophy		

Anti-Androgen

- Spironolactone should be the first line Anti-Androgen as it is both safe and cost effective It should be avoided only in patients who have a history of hyperkalemia, low blood pressure, or renal failure
- Finasteride (Proscar) can be used if above conditions are present
- Anti-Androgens (Spiranolactone or Proscar) are not needed and should **not** be ordered for patients who have undergone orchiectomy (surgical castration).

Appendix 5: Masculinizing Hormone

Medication	Dose	Intended Effects	Possible Side Effects	Labs to Draw
Testosterone Enanthate	200 mg (1.0 cc) IM Every 2 Weeks 100 mg (0.5 cc) IM Q 2 weeks (every 2 weeks) for **post-Oophorectomy** patients	Clitoral hypertrophy Growth of facial and body hair Increase in muscle mass and definition Increase of androgenic alopecia Lowering of vocal pitch	Acne Amenorrhea Androgenic alopecia Depression GI upset Headache Hepatitis Hyperlipidemia Hypertension Mood changes Polycythemia	CBC Lipids Liver functions Prolactin Other as clinically indicated

Managing Laboratory Abnormalities

Elevated LDL

- This result should be based on a fasting lipid profile
- The approach to this should be based on pre-existing cardiac risk factors (age, hypertension, smoking, diabetes mellitus, family history of cardiovascular disease and HDL,<35mg/dL)
- If the patient has none or one of these risk factors, dietary therapy should be started at LDL>160 mg/dL and drug therapy should be started at LDL>190mg/dL
- If the patient has two or more risk factors, the thresholds go down to 130 mg/dL and 160 mg/dL respectively
- If the patient has cardiovascular disease, the numbers are even lower, at 100mg/dL and 130 mg/dL respectively
- In addition to dietary therapy, patient should be advised that a half hour of aerobic exercise 4 times a week may directly or indirectly help reduce LDL
- If drug therapy is necessary, an HMG-CoA reductase inhibitor (statin) should be started at the lowest dose and titrated up to desired response
- Patient should be informed that among other side effects, statins might cause liver irritation
- Transaminases should be followed and if they exceed three times the normal limits, the dose of statin should be reduced (see also section on elevated transaminases below)
- If maximum dose of statin is reached and the patient has still not reached target LDL, hormone therapy should be stopped for three months, and LDL should be rechecked to determine if hormones played a role in elevated LDL

Elevated Prolactin Level

- Patient with a Prolactin level between 20-49 should be followed with history (focusing on visual field deficits) and physical exam (blood pressure, fundoscopic exam and gross visual field assessment)
- If Prolactin level is greater than 50, in addition to above, hormone therapy should be discontinued, an endocrine consult should be generated, and the level should be rechecked one month later
- If it remains over 100, an MRI of the pituitary should be obtained to rule out pituitary adenoma
- MRI results and the decision to restart hormones should be discussed with Bellevue endocrinology

Elevated Transaminases (LFTs)

- Elevated Transaminases to two times the upper limit of normal or twice baseline (if chronically elevated) should prompt a halving of the hormone dose.
- Elevated Transaminases to three times the upper limit of normal or three times baseline (if chronically elevated) should prompt discontinuation of hormone therapy.
- Blood should also be sent for hepatitis A and B studies (if not already done at initial visit) and liver function tests should be repeated at periodic intervals (3 months sooner as clinically indicated).
- If history of heavy acetaminophen use is identified, it should be addressed immediately.

- If acute viral hepatitis is diagnosed, hormone therapy should be withheld until the patient is in the convalescent stage and transaminases have returned to normal
- If history and blood work are negative, further blood work should be done for hepatitis C, ANA and anti-smooth muscle antibody (the latter two to rule out autoimmune hepatitis) and referral should be made to Bellevue Hospital GI
- If the patient is diagnosed with hepatitis C, he or she should be discussed with the site Medical Director (evaluation and other work up such as sonogram, viral load and referral to Bellevue ID)
- If the evaluation remains negative, transaminases should be drawn two months after stopping hormone therapy
- If normal, it can be concluded that hormones were causing the liver irritation, and they can either be restarted and maintained at a lower dose or a different medication can be tried – (See Appendix 1)
- Other potentially hepatotoxic medications to consider include acetaminophen, phenytoin, valproic acid, sulfonamides, nitrofurantoin, isoniazid and rifampin

Hyperkalemia

- Patient has potassium over 6.0 must be evaluated immediately (EKG, etc) and Spironolactone should be discontinued
- If the EKG is abnormal (peaked T-waves, wide or flattened P waves, or prolonged QRS intervals) the patient should be sent to the emergency room after discussion with Urgicare Physician and site Medical Director
- If the EKG and clinical evaluation is normal, electrolytes should be repeated on a stat basis via Urgicare (i-stat machine) and followed weekly until they return to normal and Spironolactone should not be restarted.

Elevated Thyroid Stimulating Hormone (TSH)

- For abnormal TSH in a patient taking transgender hormones, consultation with Bellevue endocrinology should precede hormone treatment.

References

1. Knopp, R.H. Drug Treatment of Lipid Disorders. *New England Journal of Medicine, 1999; 341:498-511.*
2. Abramowicz, M. Choice of Lipid-Lowering Drugs. *The Medical Letter,* 1998; 40: 117-22.

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New York City Council
Committee on Hospitals, Committee on Mental Health, Disabilities, and Addiction &
Committee on Criminal Justice
Joint Oversight Hearing on
Correctional Health
November 15, 2018
Testimony of The Bronx Defenders
By Julia Solomons

Good afternoon, Chair Rivera, Chair Ayala, Chair Powers and committee members. My name is Julia Solomons and I am a social worker in the Criminal Defense Practice at The Bronx Defenders. Thank you for the opportunity to testify before you today on this important matter.

The Bronx Defenders is a community-based and nationally recognized holistic public defender office dedicated to serving the people of the Bronx. The Bronx Defenders provides innovative, holistic, client-centered criminal defense, family defense, immigration representation, civil legal services, social work support, and other advocacy to indigent people of the Bronx. Our staff of over 300 represents approximately 28,000 individuals each year. In the Bronx and beyond, The Bronx Defenders promotes criminal justice reform to dismantle the culture of mass incarceration.

I am here today to speak about the experiences of incarcerated individuals receiving medical and mental health care while in the custody of the Department of Corrections.

As a social worker in our Criminal Defense Practice, my role, though varied from case to case, often involves providing extra support and advocacy to clients who are incarcerated, many of whom are battling physical or mental health challenges, drug and alcohol addiction, or some combination thereof. This is not an aberration: as the Mayor's Office of Criminal Justice recently found, 40% of people in the city's jails have a mental health designation.[1]

[1] Mayor's Office of Criminal Justice, "Smaller, safer, fairer: Monthly progress on New York City's roadmap to closing Rikers Island" (March, 2018) *available at* https://rikers.wpengine.com/wp-content/uploads/Rikers-scorecard_March_final.pdf.

When first meeting new clients who have recently been sent to Rikers, it is routine for me to ask them if they have any chronic health conditions, whether or not they have been seen by Correctional Health yet, and if so, whether they receiving the care that they need to maintain their physical health and mental stability while incarcerated. Unfortunately, the responses I get from clients about the care they receive within their first few days or weeks of incarceration are alarming, to put it mildly.

Clients often speak of the delay they experience between their initial arrest and the first time they see a doctor at Rikers Island. The process of being arrested, processed through Central Bookings, arraigned and transported to Rikers Island alone can often take up to 36 hours. Once a person arrives at Rikers, they begin an intake process that takes several days. Only once they reach the facility where they will be housed throughout the duration of their incarceration do they finally have the opportunity to see a doctor. This means that now this person has likely been without medical attention and, at times, critical medication, for 4-5 days.

Now, imagine you are a person battling a chronic illness, relying on daily medication to manage your symptoms or even just to stay alive. Five days without medication can be a matter of life or death, and, unfortunately, we have witnessed the gravity of this delay firsthand. We have seen lapses in access medical care result in consequences as grave as death.

Even more alarming, however, is that even once clients have seen a doctor three or four times they still report receiving inadequate care.

One such example is that of Kevin[2]. Kevin is still a young man, but has experienced more trauma and suffering than many of us will experience in our lifetimes. After facing a great deal of insurmountable loss, Kevin found himself turning to opiates to numb the pain. His heroin habit eventually cost him his physical health, first with the diagnoses of several chronic health conditions and, ultimately, Kevin's heart became severely compromised. As a result, he began taking several cardiac and blood pressure medications to support his cardiovascular functioning.

Despite efforts by our staff and Kevin's own advocacy to receive his medication through Correctional Health, he was still not receiving any of his necessary heart medications two weeks into his detention at Rikers. Kevin ran into a problem we see often; clients with serious health issues communicate their condition to doctors immediately, but doctors may not trust the information they receive from the client's report alone.

[2] Client names have been changed in order to protect clients' privacy and keep their identities confidential

Doctors often require documentation to validate clients' self-reported needs, documentation that can be very difficult and time consuming to obtain. Kevin spent weeks without critical medications because of a fundamental lack of trust between the medical staff and the clients they serve. While waiting for hospital medical records to wind their way to Rikers, Kevin's physical health hung in the balance.

While Kevin's healthcare was compromised by a lack of documentation, other clients are not being escorted to the clinic by correctional officers because of a particular security classification or housing area. One example of this is Ron,[3] a client who suffers from chronic knee issues and walks with a cane. He followed protocol by signing up to see the doctor on several occasions but when his appointment time came, no officer was made available escort him. As a result, his knee pain went unaddressed for several weeks. When his advocates contacted Correctional Health about this issue, we were told that Correctional Health has no oversight over the necessary escort to the clinic by the Department of Corrections. This illustrates that the gaps in healthcare on Rikers not only reflect a need for change within Correctional Health but also a lack of effective collaboration between Correctional Health and the Department of Corrections.

Lastly, delays in receiving care are not the only threat to our clients' well-being while incarcerated. Some of our clients have not been able to access critical medication because of a "street value" that suggests medication could be bartered among inmates. This means that Correctional Health's concern about a "black market" developing out of inmates misusing their prescribed medication ends up creating a barrier to our clients receiving the medication that they desperately need. For example, clients who are prescribed controlled substances such as Xanax or Ambien in the community may find themselves unable to receive that medication while incarcerated because of the addictive qualities of those particular drugs and subsequent concerns that they may be abused. Instead, a common alternative offered by Correctional Health for inmates who struggle with sleep disorders is a prescription of Benadryl, an allergy medication with side effects of drowsiness, to help them sleep. As a result of these often inadequate substitutions, clients regularly report unmanaged anxiety and continued difficulty sleeping.

It is understood by the majority of our clients that the mere fact of their incarceration means they lose the right to adequate healthcare. As advocates for our incarcerated clients, we at The Bronx Defenders refuse to accept this standard. Rikers Island houses a diverse cross section of people presenting with often very complicated physical and mental health needs, and Correctional Health has a responsibility to provide them with sufficient care while they are being held in the custody of the Department of Corrections. We find encouraging the committees' joint inquiry into this important issue and we urge you, as members of these committees, to exercise greater

[3] Client names have been changed in order to protect clients' privacy and keep their identities confidential

oversight of the care being provided to our incarcerated clients, and to ensure a certain standard of care that is currently lacking. We would welcome the creation of a system that allows for greater accountability on the part of Correctional Health and allows inmates and their advocates to submit complaints when they are not receiving adequate healthcare. These complaints would then be tracked and managed to identify patterns and recurrent gaps in care, helping to uphold our clients' right to access adequate healthcare.

Thank you for the opportunity to be heard on this matter today, and for your continued consideration of our clients' healthcare while incarcerated.

Jonas Caballero
DIN# 18A3369
Greene Corr. Facility
P.O. Box 975
Coxsackie, NY 12051-0975

November 1, 2018

To Whom it May Concern:

Hello and good day. My brother, Scott Moffat, recently told me that your office was collecting evidence and testimony to present to a Board of Correction and City Council panel regarding problems that NYC inmates currently face with NYC Correctional Health Services.

Attached, you will find a letter dated October 6, 2018 which addresses the many incidents in which my specialty appointments at outside clinics were cancelled while I was incarcerated at the Brooklyn Detention Complex. Ten appointments altogether were cancelled with a heart and a cancer/G.I. specialist between the months of March and September 2018. The last two appointments that were cancelled were a result of my being transferred to Greene Correctional Facility.

Attached you will also find an artcle which appeared in The Gothamist on July 11, 2018, entitled, "NYC Inmates Call 311 to Report Mistreatment, But is Anyone Listening?" The article addresses the dysfunctional grievance procedures in NYC jails, and also calls to light the numerous times that I have attempted to utilize the administrative remedies theoretically available to grievants. Most of the grievances that I've filed are related to inadequate medical care at the BKDC.

Because medical complaints are referred to CorrectionalHealth Services, filing a grievance at BKDC did not necessarily trigger the formal grievance process, and thus almost all of my medical complaints were ignored, forcing me to contact a wide range of prisoners' rights groups and members of Congress, in an attempt to have my voice heard. Though I received some moral support from Senators like Sean Patrick Maloney and Carolyn Maloney, and NYC Councilman Corey Johnson, I was left with no real remedies for my growing list of complaints about the correctional health system, and thus was forced to file two Section 1983 civil rights actions in the US District Court for the Eastern District of New York.

The docket numbers for these two civil actions are:

*Caballero v. Nurse Shayna, et al. 18-CV-1627-PKC-RML; and
*Caballero v. City of New York, et al. 18-CV-2397-PKC-RML

In these Section 1983 prisoners rights cases, I addresses numeous issues related to what I consider to be a dysfunctional correctional health services, at least with regard to my experiences with CHS at the BKDC. Some of the allegations in these federal district court cases include:

1. Denial of access to emergency medical care (when I was having chest pain for three days in 11/2017; I was denied medical attention for three days, despite having a history of CHF and cardiogenic shock, HTN, tracheotomy, HIV, ischemia;

2. Doctors at the BKDC clinic misdiagnosing a bump under my armpit and instructing me to use a shaving razor to self-lance it, causing the infection, which was later properly diagnosed as herpes, to spread;

3. Despite it being clear in the NYC BOC Correctional Health Care Minimum Standards, I was illegal shackled to my hospital bed for 24 hours a day for nearly six days after I was transferred to Brooklyn Hospital in Nov. 2017 after having three days of chest pain; the Minimum Standards specifically states that an inmate shall not be shackled for the convenience of the medical staff while 24 hour escort officers are assigned to security escort posts. Despite my numerous pleas to be unrestrained and for the medical staff and escort officers to contact my medicalproxy, my mother, the medical staff instead conspired with and acted jointly to deprive me of my constitutional rights;

4. During another incident, I provided my confidential medical records to Dr. Amanda Harris, the BKDC medical director, after another physician, Dr. Lesly Jean Gilles, promptly lost the copy that I provided to him somewhere in the medical clinic; I feared that another inmate might find these records and read the confidential and sensitive medical information and put me at risk;

5. During another sick-call related consult with Dr. Gilles, I informed him that I was experiencing nosebleeds and headaches after being forced to inhale tar fumes that were continuously wafting into my housing unit (6D) from a construction project happening below at the BKDC; Dr. Gilles said that I would need to file a lawsuit and that the nosebleeds were most likely due to a scratch of the nasal tissue (i.e. from picking my nose)

These and other CHS-related complaints are detailed further in my Section 1983 civil actions filed in the US District Court-EDNY.

By way of background, I received a Bachelor of Philosophy in International and Area Studies and a B.Phil in Media and Professional Communications from the University of Pittsburgh from which I graduated summa cum laude in 2010. I went on to obtain a Master of Philosophy in Middle Eastern Studies from the University of Cambridge in the UK where I studied as a Fulbright Scholar. I have previously worked as an emergency medical technician in Pittsburgh and in Palestine, where I also worked as a journalist and media relations coordinator for an Israeli-Palestinian human rights organization. I am currently working on a memoir, entitled The Book of Jonas.

You can reach me at the above address, or by contacting my brother, Detective Scott Moffat, of the Allegheny County Police Dept., at (412)977-7478.

Thank you and I look forward to hearing from you soon!

Very Truly Yours,

Jonas X. Caballero, M.Phil
Fulbright Scholar, Univ. of Cambridge

Jonas Caballero
DIN# 18A0369
Greene Corr. Facility
P.O.Box 975
Coxsackie, NY 12051-0975

October 6, 2018

To Whom it May Concern:

Hello and good day. My name is Jonas Caballero and I am currently incarcerated at Greene Corr. Facility. I recently sent you a letter detailing my ongoing battle to receive the appropriate life-saving medical care which has been denied to me for more than six months while incarcerated in NY State.

As I mentioned previously, I was diagnosed with congestive heart failure (CHF) in 2015 and, as a result, was hospitalized that same year for nearly two months after my ejection fraction (EF), which measures the health-strength of the heart, plummeted to 5%. To put this into perspective, a healthy EF is situated around 50%-60%. During my hospitalization at Mt. Sinai West, I was given an emergency tracheotomy and placed on a ventillator. Miraculously, I survived and managed to make a full recovery.

Howver, since my incarceration began on 11/03/17, my EF again plummeted to 30% while incarcerated at the Brooklyn Detention Complex (BKDC). On March 16, 2018, I was due to receive an echo-cardiogram at Bellevue Hospital to determine whether or not I would need to have a defibrillator surgically implanted. That appoiintment, however, was cancelled without warning. Since then, three more appts. with a cardiologist have been cancelled, the most recent being on Sept. 18, 2018, during which I was to receive an Echo but which I did not receive due to my transfer Upstate.

In my prvious letter, I also discussed my pre-anal cancer dys-plasia with which I was diagnosed in 2015. Prior to my arrest, I was receiving treatment from Dr. Eric Ganz at Mt. Sinai West. These treatments involved anal pap smears and surgical procedures called an ablation, which helps to prevent a patient from pro-gressing into full-fledged anal cancer. A total of six appts. with a cancer specialist were cancelled without warning, the most recent being on Sept. 4, 2018, the date I was to receive the results of my latest pap smear to determine the next plan of action for the pre-anal cancer dysplasia.

This makes ten cancelled appts on the following dates: March 27, 2018; April 19, 2018; April 24, 2018; May 16, 2018; June 5, 2018; June 22, 2018; July 3, 2018; July 31, 2018; Sept. 4, 2018; and Sept. 18, 2018.

I was transferred from the BKDC on Aug. 28, 2018. I was first sent to Downstate Corr. Facility, then to Ulster, then to Greene, and at each facility I informed the medical staff of my

urgent need for both an Echo and for an appt. with a cancer specialist. At each facility I was told, "Sorry, we cannot help you with that; you are going to have to tell them at the next facility." When I arrived at Greene, I was shocked to learn from the nurse that they had no records describing either illness nor any pending orders for any diagnostic or surgical procedures. This was a shock because I was under the impression that my medical records were to follow me wherever I went so as to avoid any preventable medical catastrophe.

Prior to my arrest I was steadfast in my fight to stay alive and well, by being "religious" about my medical appts. During my ten months at the BKDC, I was also steadfast in my fight to receive adequate medical care, despite being repeatedly denied access to life-saving diagnostic and surgical procedures. When I was transferred into the custosy of the NYS DOCCS, I mistakingly believed that all of my medical worries would be eased. Instead, my fears were exacerbated. To find out that there is no record of the very medical needs for which I have been fighting fuels my fear that no one cares about this inmate's dire medical predicament, that no one is listening, and that I may die in jail at the age of 36.

I have written extensively to city and state politicians, prisoners' right groups, and legal organizations. Though I have achieved some media attention (See: "NYC Inmates Call 311 to Report Mistreatment" in The Gothamist), and have received some moral support from US Senators, House Representatives, amd city council members, the fact remains: I am still in desperate need of an Echo and a possible ablation procedure. I am doubly concerned because I am in a race against time as I am also afflicted with a troubled immune system, which seeks to aggravate these other illnesses and further complicate my body's ability to fight them. All the while, the clock keeps ticking as I continue my hurdled quest to stay alive, well, and optimistic that one day my plea will fall into the hands of a sympathetic soul with the power to amplify my voice.

Thank you for your attention to this very serious matter. You can reach me at the above address or by contacting my brother, Det. Scott Moffat of the Allegheny County Police, at (412)977-7478.

Very Truly Yours,

Jonas Caballero

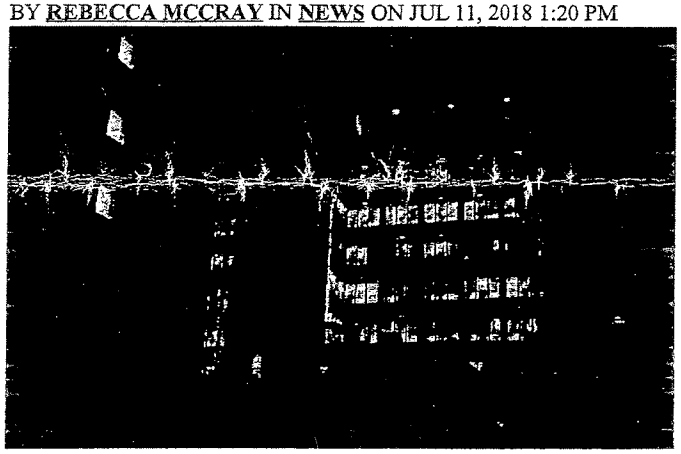
Jonas Caballero, M. Phil
Fulbright Scholar, Univ. of Cambridge

PS: I am also pursuing legal action in the US District Court (EDNY) in an effort to find relief. The docket numbers for these two Section 1983 pro se civil actions are:

18-CV-1627-PKC-RML and 18-CV-2397-PKC-RML

NYC Inmates Call 311 To Report Mistreatment, But Is Anyone Listening?

BY REBECCA MCCRAY IN NEWS ON JUL 11, 2018 1:20 PM



The Brooklyn Detention Center (Bebeto Matthews / AP / Shutterstock)

Over the course of eight months in jail, Jonas Caballero has earned an unusual nickname: "Mr. 311." Caballero, 36, tells Gothamist that corrections officers at the Brooklyn Detention Complex on Atlantic Avenue call him this because he files so many grievances, both through the jail's formal written complaint system, and more often, by calling 311, the city's 24-hour helpline.

"I've easily filed about 40 complaints with 311" while incarcerated says Caballero, who is facing charges for a first-time nonviolent felony drug offense.

Caballero has filed grievances about a wide range of issues. In one instance after being hospitalized for a heart procedure, he returned to find all of his personal belongings—books, clothing, and items from the commissary—had been removed from his cell. He filed written grievances and called 311 more than once, but says he hasn't received a response, or his stuff. He lodged another complaint when tar fumes from construction nearby the jail wafted continuously into his cell while the jail was on lockdown, causing nosebleeds and headaches—again, no response.

Many of Caballero's complaints are related to repeated failures by the City's Department of Correction to transfer him to a facility with a doctor on days he has appointments. Because of Caballero's frequent missed appointments and his history of heart disease, as well as a precancer diagnosis—as of June 22 he had missed six—he fears he will die in jail before his trial date in August.

After missing his sixth appointment, Caballero approached the deputy warden of the jail to tell her what happened. "Instead of investigating, they told me 'That sounds like a 311 call. We can't help you with that,'" he said in an interview at the jail.

In 2015, the Department of Correction made 311 calls free for people in the city's custody, waiving the 50 cent call initiation fee, plus the 5 cents per minute fee after that. Between FY 2016 and FY 2017, the number of complaints about the city's jails made via 311 increased by 49 percent, according to a report released last month from the New York City Board of Correction, a jail oversight body run by the city government. During that time period the helpline received almost 30,000 jail-related calls from people in custody, as well as from family members and loved ones on the outside. (The report notes it is unclear how many of these calls are duplicative.) Meanwhile over the same period, the number of written grievances dropped by 15 percent.

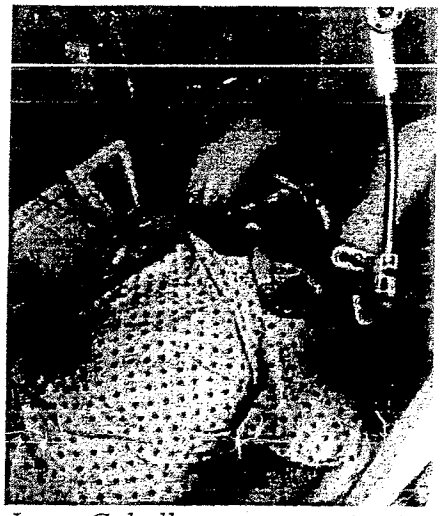
The DOC made 311 calls free, Office of Constituent and Grievance Services (OCGS) director James Boyd says, "to show the department's commitment that inmates have a credible outlet to file their complaints Monday through Sunday."

But calling 311 doesn't technically trigger the formal grievance process. The person taking the call must communicate the complaint to the OCGS, and then a staff member must follow up with the person who lodged the complaint to assist them in filing a grievance. In part, the problem is that the DOC hasn't effectively informed people in custody about this process, leading people to believe calling 311 is the same as dropping a written grievance form in a box at the jail, according to people in custody, the Board of Correction, and advocates. That confusion extends to all parts of the grievance system, according to the Board's report, which states that it is unclear how many of the prisoners' 311 calls are actually addressed.

"People in custody are not told when they can expect a response, or how the investigation process works," said Emily Turner, the Board's deputy executive director of research at the BOC's June 12 public meeting.

Caballero has also filed dozens of written grievances, a process he says is just as fruitless. And medical complaints are referred to the Correctional Health Services, not OCGS. Between FY 2016 and 2017, the total number of complaints rose by 51 percent, and 86 percent of those health-related complaints were made via 311 and Legal Aid, according to the report.

"There really is no such thing as a grievance procedure—it exists on paper, but in practice it's a joke," Caballero said.



Jonas Caballero recuperating in the ICU after a heart procedure a few years ago (courtesy the Caballero family)

In its intended form, the jail grievance system is more than just a way for people in custody to be heard and for staff to catalogue and ameliorate problems in the jails. First established by the Board of Correction and the DOC in the 1980s, following uprisings in New York prisons and jails in the '70s, the system was developed partly to better maintain order and to prevent violence. When the federal Prison Litigation Reform Act (PLRA) was enacted in 1996 as a response to the rising numbers of lawsuits filed by inmates, the grievance system became a requisite obstacle course for those seeking relief in the courts. Under the PLRA, inmates must exhaust all administrative remedies (i.e. the grievance system) before they are allowed to file a viable lawsuit.

"Before the PLRA interjected, it didn't matter if you used the grievance system or not," says Dale Wilker, a Legal Aid attorney who has worked with the organization's Prisoner's Rights Program for 34 years. "[The PLRA] exists specifically to try to suppress the rights of inmates, and there's no pretense about that."

That the grievance system is a necessary hurdle for people like Caballero to overcome before they can be heard in court makes its current dysfunction all the more problematic. In particular, the Board's report notes that for those who do receive a grievance resolution from OCGS, the process to appeal a denial of their complaint is unclear. At the bottom of the resolution document is a space where inmates are supposed to indicate that they accept or reject the decision. Wilker describes this text as "like the fine print on a loan document."

The DOC "problematically considers a complaint informally resolved if grievants do not indicate on the form" whether or not they accept the outcome, according to the Board's report—making the department's designation of 95 percent of all grievable complaints filed in FY 2017 "informally resolved" questionable. Of 262 complaint resolution forms reviewed by the Board, 58 percent "appeared incomplete."

Boyd, the OCGS director, says the report mostly "reflects a system we're working away from," and doesn't represent some of the updated systems being implemented to improve the response process. One of those systems is an electronic service desk for tracking complaints, which was

introduced in 2017. Previously, the system was largely paper-based. Boyd says that between May 2017 and May 2018, since introducing the electronic system, "response times have increased by 70 percent across facilities." (Data backing this claim up is not currently publicly available.)

Yet that improved response time doesn't seem to comport with the reality on the ground for those seeking recourse through their complaints. Kelsey De Avila, a jail services social worker for Brooklyn Defender Services who spends multiple days a week at Rikers, says that while she has seen slightly more confirmations from OCGS that they have received grievances over the last year, follow up after that hasn't improved. "Under the current [grievance] system, the city is only contributing to the harm it so boldly tries to deny, De Avila says.

While Boyd claims that grievance forms "are accessible to all inmates," 37-year-old Erika Walker of Brooklyn says that's not the case for her husband, who was recently transferred from Rikers Island to a prison upstate.

Walker's husband has paraplegia, and uses a wheelchair. Because of this, she says he relies on corrections officers to both bring him grievance forms and file them, which rarely seems to happen. On one occasion, she says an officer at Rikers ripped up the form in front of him after he filled it out. She says she does her best to advocate for him on the outside by calling 311 and filing written grievances, but never hears back.

"I just keep on calling, keep on talking, and hopefully they get tired of hearing from me and do something," Walker tells Gothamist. "I feel like they don't care. If your system is for us to call and make a complaint, at least have the decency to contact someone back."

Boyd concedes the system is imperfect: "We agree with the Board that there's a lot more that needs to be done." One such project is a plan to put up posters all over the jails that better explain the byzantine complaint system and appeal process. As for when that might happen, Boyd said OCGS is "looking at designs right now," but didn't offer a timeline.

After not receiving responses to complaints during his first few months in jail, Caballero began tracking each grievance he filed. He now has tracking numbers for at least 19 calls to 311 that he says haven't been resolved. (OCGS did not respond to a request for the status of those specific grievances, for which Gothamist provided tracking numbers.)

Caballero says he did receive a response to one grievance he filed after being assaulted by a correction officer. (Complaints about DOC staff are not considered one of the 29 grievable offenses handled by OCGS, and are handled separately.) "That one was transferred to an investigative unit—it got where it needed to go," he says.

Still, Caballero fears for the worst, as he continues to make calls and file grievances into an unresponsive void. "It's a lot of work and it's tedious, but I'm trying to stay alive," he says. "My mom shouldn't have to bury me."

Rebecca McCray is a Brooklyn-based journalist. Follow her @rebeccakmccray.

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: 11/15/18

(PLEASE PRINT)

Name: Robert Cohen

Address: 1 Centre St

I represent: Board of Correction

Address: 1 Centre

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: Allegra Schorr

Address: 121 W 36 St

I represent: COMPA

Address: 121 W 36 # 201 NYNY 10018

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: 11/15/18

(PLEASE PRINT)

Name: Fazal Yussuff

Address: NYC Dept. of Correction

I represent: Asst. Commissioner of Health Affairs

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: 11/15/18

(PLEASE PRINT)

Name: Sade Dixon

Address: 220 Baintridge St Brooklyn NY 11233

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☑ in favor ☐ in opposition

Date: 11/15/18

(PLEASE PRINT)

Name: Jordyn Rosenthal

Address: _____

I represent: College + Community Fellowship

Address: 475 Riverside Drive 1626

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: 11/15/18

(PLEASE PRINT)

Name: Jennifer Parish

Address: 40 Rector St., 9th fl.

I represent: Urban Justice Center

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: _____

Address: _____

I represent: _____

Address: 177 Livingston Street Brooklyn

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: 11/15/2018

(PLEASE PRINT)

Name: Julia Solomons

Address: 360 E 161st St. Bronx, NY 10451

I represent: The Bronx Defenders

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: 11/15/2018

(PLEASE PRINT)

Name: Mik Kinkead / Sylvia Rivera Law Project

Address: 147 W. 24th St. 5th Floor NY, NY 10011

I represent: Sylvia Rivera Law Project

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: Martha King

Address: ~~Centre Street~~ 149 Gillmore Ave

I represent: NYC Board of Correction

Address: 1 Centre Street

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: 11/15/18

(PLEASE PRINT)

Name: Julia McCarthy

Address: 199 Water St.

I represent: Prisoners' Rights Project Legal Aid Society

Address: 199 Water St.

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: 11.15.18

(PLEASE PRINT)

Name: Dionne King

Address: D 330 7th Ave

I represent: Drug Policy Alliance

Address: _____

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