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Testimony for the
Assembly Standing Committee on Correction
Assembly Standing Committee on Mental Health

Public Hearing
Mental Illness in Correctional Settings

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We commend the Assembly mental health and correction committees for convening this hearing and thank you for inviting us to testify.

The Urban Justice Center Mental Health Project (UJC) has focused on the needs of people with mental illness in the criminal justice system for more than fifteen years. We are deeply familiar with the difficulties people with mental illness have within correctional facilities and in accessing essential mental health services, housing, and benefits upon release.

As a member of the Mental Health Alternatives to Solitary Confinement (MHASC) coalition since its inception, we have collaborated with other organizations, family members, and formerly incarcerated individuals in opposing the placement of people with mental illness in solitary confinement in the New York State (NYS) prisons. During the last three years, we have campaigned against the expanded use of solitary confinement in the New York City (NYC) jails. We support the efforts of the Campaign for Alternatives to Isolated Confinement (CAIC) to have comprehensive solitary confinement legislation enacted and the NYC Jails Action Coalition (JAC) in improving conditions in the NYC jails.

We urge the State to confront through a major shift in public policy the problem of the staggering number of people with mental illness prosecuted in the criminal courts and warehoused in jails and prisons. Ultimate responsibility for addressing mental health, addiction, homelessness, and poverty should be given to agencies with expertise in addressing these problems. We must stop relying on police, criminal courts, jails, and prisons to absorb the people whose needs are not met by our social safety net.

The current problems providing mental health treatment in NYC jails and NYS prisons make clear the need for systemic reform.

Mental Illness in NYC Jails

Mental Health Treatment

The City has a constitutional obligation to provide mental health treatment to the people it incarcerates. The recent deaths of people with mental illness who were in jail mental health units suggest that the fundamental needs of people with mental illness are neglected and that the City currently lacks the capacity to provide adequate treatment.[1]

Jerome Murdough's death illustrates this inadequacy. He was placed in a mental observation unit in Anna M. Kross Center (AMKC), the jail at Rikers Island with the most intensive mental health resources, yet his needs were not met. He was reportedly placed on suicide watch, but he was not monitored every 15 minutes as required because there was apparently no one assigned to do this monitoring. The correction officer who was required to check on him every half hour reportedly did not do so for at least four hours. This unit, which houses people on psychotropic medication, was allowed to become exceedingly hot; the temperature in Mr. Murdough's cell was more than 100 degrees. Psychotropic medications can create extreme sensitivity to heat; thus people on such medications must be maintained in housing that takes this sensitivity into account. The City's neglect of this climate control issue in Mr. Murdough's housing area illustrates a disregard for people with the most severe mental health needs.

Mr. Murdough's is not the only recent death in a mental observation unit at AMKC. Bradley Ballard died there as well.[2] Correction officers confined him to his cell in violation of the Minimum Standards that require 14 hours of out-of-cell time daily and did so without a hearing to determine whether he merited confinement.[3] Correction staff unilaterally imposed that punishment, and no one stopped them. Mr. Ballard deteriorated before their eyes, yet not one of the uniformed staff, captains, or assistant deputy wardens who observed Mr. Ballard intervened. In fact, when his cell was finally opened after seven days of continuous confinement, it was not correction officers who took him out of the cell. Other people incarcerated on the unit were sent in to pull out his lifeless body.

Not only did correction staff fail Mr. Ballard, mental health staff did as well. Mental health staff are required to conduct rounds in the housing area twice daily. Yet no mental health staff intervened to evaluate or treat Mr. Ballard. Moreover, he was not provided with his prescribed psychiatric medication during most of the seven days he was locked in his cell. Mr. Ballard's need for treatment should have been apparent given that he was hospitalized at the Bellevue Hospital psychiatric prison ward for 38 days immediately before he was transferred to the mental health unit at AMKC.

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[1] The Department of Health and Mental Hygiene (DOHMH) is responsible for providing medical care, including mental health treatment, in the NYC jails. DOHMH contracts with Corizon Correctional Healthcare, a for-profit company, to provide these services.

[2] Pearson, *Inmate Died After 7 Days in NYC Cell*, Associated Press, May 22, 2014, available at http://news.msn.com/crime-justice/ap-exclusive-inmate-died-after-7-days-in-nyc-cell.

[3] DOC is permitted to lock individuals alone in their cell for 23 hours a day, but to do so, there must be an administrative hearing to determine whether a rule violation has occurred and the length of the sentence.

In addition to the basic disregard for human life that these tragedies suggest, there appear to be systemic problems in providing mental health treatment in the jails. According to the Executive Director of the Board of Correction, only one of the 53 officers who worked on the mental health unit during the time Mr. Ballard was incarcerated there was a steady officer and none of the 11 captains were steady – even though the Mental Health Minimum Standards require that only steady correction officers be assigned to the mental health units. None of the uniformed staff had received the annual mental health training enhancement required by the Mental Health Minimum Standards.

We also have concerns that mental health staff does not have a greater presence on the units and that significant monitoring responsibilities are delegated to correction staff and incarcerated suicide prevention aides. Interactions between mental health staff and the people they treat seem to be quite limited, raising concerns about the adequacy of staffing. We also question whether there is sufficient capacity in the psychiatric prison wards to treat all of the people who require that level of care.

To gain a better understanding of the mental health treatment provided in the jails, we gathered information from people receiving mental health treatment at AMKC as well as the jails where adolescents and women are confined. With the help of students in Lori McNeil's Advanced Advocacy class at Columbia University School of Social Work, we surveyed people receiving treatment and learned the following:

• More individual therapy was the single most common suggestion for improving the quality of mental health services, with 70% of respondents indicating that this was important.

• The cursory nature of the mental health encounters is cause for concern. Over 60% of individuals stated that their sessions lasted from five to 15 minutes. One person commented: "*Sometimes they rush me out and don't listen carefully.*" Another individual highlighted the importance of quality services to prevent recidivism. *"Staff members should have more concern regarding treatment, rather than just providing a patient medication, asking the patient 3 to 5 standard questions and rushing them out the session to see the next patient. Mental health needs change in the jail system and should be treated as priority to assist people with their problems to refrain from coming back to jail, to correct as implied not punish as the system operates now."*

• The overuse of medication as treatment was an important concern. Most respondents (64%) were taking medication for their mental health condition prior to entering jail; 79% were on medication prescribed while in jail. Although part of the increase in these numbers may represent increased access to needed services, 27% said the only service they received was medication. Of those taking medication, only 62% reported seeing a counselor or therapist, 7% attended a substance abuse treatment group, and 20% attended a therapy group led by a counselor. This shows a very significant gap in the services provided, as it indicates that the only treatment some individuals are receiving is medication, and for those who also see a counselor, as noted above, these sessions tend to be too short to accomplish any therapeutic goals. One respondent explained, "*Often times mental health staff believe the correct way to treat a patient is by increasing the medication. Due to the lack of experienced treatment I have stopped taking my medication and refuse the services because [of] the fast food atmosphere and lack of therapy.*"

• The vast majority, 71%, of respondents, did not have or did not know they had a treatment plan. Only 8% reported having a lot of input into the development of their treatment plan and 54% reported having a little or no input at all. The experience was similar for discharge planning, where 59% reported not having or not knowing if they had a discharge plan.

• The importance of comprehensive discharge planning was highlighted by several respondents. One person said: "*I am terrified of leaving prison. I don't think I can remain free. Don't know how to assimilate. I've spent ½ of my life in prison.*" Lack of housing upon release was a particularly common concern for many, 59% citing it in their top three most important discharge services.

"This jail belongs to us. It does not belong to the department of mental health." – Norman Seabrook, President of the NYC Correction Officers' Benevolent Association (COBA)[4]

NYC Department of Correction (DOC) staff create an environment that is not conducive to effective mental health treatment. Some DOC staff present an overt danger to the safety of people with mental illness. People with mental illness in the NYC jails are more likely to be victims of DOC staff violence. An 11-month study conducted by the Department of Health and Mental Hygiene (DOHMH) found that 129 incarcerated people experienced serious injuries in altercations with DOC staff. [5] Seventy-seven percent of those injured had a mental health diagnosis.

The Department of Justice's (DOJ) careful investigation of the adolescent jails at Rikers Island revealed that DOC staff engaged in the "rampant use of unnecessary and excessive force."[6] The DOJ identified systemic deficiencies that are "largely responsible for the excessive and unnecessary use of force by DOC staff."[7]

DOC staff are hostile to the needs of people with mental illness and present obstacles to their receiving needed care. Mental illness is simply dismissed, frequently leading to tragic consequences. Ensuring that people with mental illness are escorted to their appointments with mental health staff is not prioritized, and medication distribution is inconsistent. In some jails lockdowns are frequent and have significant repercussions on treatment. The jails also lack an effective system for tracking people as they are moved from one facility to another which results in individuals missing their medication.

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[4] *See* Winerip and Schwirtz, *Rikers: Where Mental Illness Meets Brutality in Jail*, The New York Times, July 14, 2014, available at: http://www.nytimes.com/2014/07/14/nyregion/rikers-study-finds-prisoners-injured-by-employees.html?src=xps.

[5] *Id.*

[6] CRIPA Investigation of the NYC DOC Jails on Rikers Island, U.S. Department of Justice, August 4, 2014, p. 3.

[7] CRIPA Report, p. 4.

Discharge Planning

As a provider of mental health treatment in the jails, the City is obligated to provide discharge planning services to those who are released from jail. Discharge planning is universally recognized as an essential part of adequate mental health care. The settlement agreement in *Brad H. v. City of New York*[8] requires the City to provide discharge planning to individuals who receive mental health treatment in jail so that they have appropriate treatment and services when they are released.

We are disappointed to report that more than a decade after the case was settled the City remains out of compliance with its obligations to provide discharge planning services. In fact, the most recent report on the City's compliance shows little improvement in the provisions of services, and for measures related to Medicaid, medication and prescriptions on release, appointments and referrals for continued treatment, and public assistance and supportive housing applications, the City's performance remains abysmally low.

On April 18, 2014, the court extended the *Brad H.* settlement agreement for another two years and ordered the City to take actions that will hopefully result in its coming into compliance.

Solitary Confinement

DOC uses solitary confinement to punish any violation of jail rules. DOC expanded its solitary confinement capacity from 614 to 998 beds – a 61.5% increase – between 2007 and June 30, 2013.[9] Although the vast majority of people incarcerated in the City jails are awaiting trial (about 75%), anyone in DOC custody can be subjected to solitary confinement. This population includes adolescents as young as 16 years old and people with mental illness. In fact, almost 27% of the 16 to 18 year olds incarcerated in the City jails were in solitary confinement in fall 2013, and 71% of those were diagnosed as having a mental illness.[10] An expert report issued in September 2013 revealed that more than 40% of the individuals held in solitary confinement had a mental illness and that the incidence of mental illness among women and girls in solitary was 84%.[11]

DOC's use of solitary confinement has come under scrutiny during the last three years and is undergoing some changes. As a result of advocacy by the NYC Jails Action Coalition, the NYC Board of Correction, which regulates conditions of confinement in the NYC jails, has decided to adopt rules regarding DOC's use of solitary confinement. In the face of mounting public

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[8] In August 1999, the Urban Justice Center, New York Lawyers for the Public Interest, and Debevoise & Plimpton, LLP, filed *Brad H. v. City of New York*, a class action lawsuit challenging the City's failure to provide discharge planning for people with mental illness in the City jails. On January 8, 2003, the parties settled the case with an agreement that the City would provide class members with discharge planning services, including continued mental health care, case management, and assistance in accessing public benefits and housing.

[9] Gilligan and Lee, *Report to the New York City Board of Correction* (Sept. 2013).

[10] *Staff Report: Three Adolescents with Mental Illness in Punitive Segregation at Rikers Island*, CITY OF NEW YORK BD. OF CORRECTION (Oct. 2013), available at http://www.nyc.gov/html/boc/downloads/pdf/reports/Three_Adolescents_BOC_staff_report.pdf.

[11] Gilligan and Lee, *supra* note 8 at p. 3.

pressure, the DOC pulled back from its planned expansion of solitary confinement. In collaboration with the DOHMH, the DOC made some changes to its response to people with mental illness who violate jail rules. DOC and DOHMH developed units where clinical staff can provide a therapeutic response to individuals with serious mental illness who engage in problematic behavior. Most people with mental illness sentenced to solitary confinement, however, are still held in 23-hour lockdown; the new solitary confinement units for this population provide some opportunity to participate in behavioral programming that may lead to additional out-of-cell time and a reduction in length of solitary confinement sentence. Unfortunately these units remain primarily punitive and have been acknowledged as a failure by both DOC and DOHMH. DOC has pledged to stop placing 16 and 17 year olds in solitary confinement by the end of the year.

Mental Illness in NYS Prisons

Inadequate mental health treatment and services

Only about half of the people who are identified as having a serious mental illness in prison receive treatment in a specialized mental health unit. The others remain in general population and receive minimal services. The NYS Office of Mental Health (OMH) must work to ensure that each person receives the necessary level of care.

OMH must do more to prepare people for release and to advocate for their release with the Parole Board. OMH does not present the Parole Board with a plan for how the person will receive treatment and services in the community. OMH needs to provide individual attention and treatment with a focus on each person's eventual release into the community and a plan to get them out of prison at the earliest point possible.

We have encountered many people who are released without adequate discharge planning. OMH has a specialized unit at Sing Sing to provide comprehensive discharge planning services, but the unit serves only 30 people at a time – about 100 people per year. The program at Sing Sing has not been expanded or replicated at other prisons, so only a small fraction of the people who need comprehensive discharge planning services receive them. OMH has pre-release coordinators at many prisons but does not have sufficient staffing to address appropriately the needs of most people with mental illness who are about to be released to the community. Consequently people receive inadequate discharge plans that are little more than a paper referral to an outpatient program and directions to a shelter.

SHU Exclusion Law

Some people are being diverted from solitary confinement to residential mental health treatment units as a result of the SHU Exclusion Law. The training for the New York State Department of Corrections and Community Supervision (DOCCS) staff required by this law has provided an opening for DOCCS staff to see people with mental health issues differently and gain a better understanding of them. The more that we can infuse corrections with an understanding that the people they house are not merely "prisoners" but people, the better chance we have of changing their approach from punishment to rehabilitation. The more that people who provide a treatment approach are put in leadership positions and can make decisions that advance that view, the

closer we will come toward turning these warehouses into places that actually provide potential for change.

Unfortunately even with the SHU Exclusion Law, many people with serious mental health issues remain in solitary confinement. The law provided for a process through which people who become ill due to the effects of solitary confinement could be removed from that toxic environment. Unfortunately this rarely seems to happen. Consequently SHU remains an incubator for self-harm, and people with mental illness still cycle between SHU and the Residential Crisis Treatment Programs (RCTP).

Although the law sets forth the criteria for determining "Serious Mental Illness," referred to as an "S" designation, in practice the law has failed to improve OMH's limited view of self-harm and does not address underlying issues.

The experience of one of our clients who is currently in SHU at Elmira Correctional Facility illustrates the problem. His circumstances are not only troubling as they relate to his mental and physical wellbeing, but also exemplify the systemic deficiencies in the mental health care of incarcerated people.

In 2008, this man was designated as an OMH level 1S – a designation reserved for individuals with the most serious mental health needs – and was treated for several months at Central New York Psychiatric Center. He was then transferred to a Behavioral Health Unit (BHU), an alternative to SHU. After an incident with security staff, his OMH level was drastically reduced – from 1S to 3.

Once his OMH level was changed, he was transferred out of the BHU and placed in SHU at Southport Correctional Facility. He remains in solitary confinement today, nearly six years later.

This summer he was in such crisis that he bit flesh from his own arm. He has cycled in and out of the RCTP many times for cutting his wrist and neck. In correspondence with us, he describes his plans and intentions to end his life. His outreach for help, as well as his frequent trips between SHU and the RCTP, should be glaring indicators that he is in danger of seriously injuring himself. Despite these frightening warning signs, he is continually placed back into isolation without receiving an appropriate mental health intervention.

The OMH unit chief has told us that these acts of self-harm are "superficial." She suggests that these gestures towards self-inflicted violence are ways for this individual to "take a break" from the destructiveness of solitary confinement and assures us that he does not have a serious and persistent mental illness.

Despite these reassurances, we continue to receive letters from a man who says that his mental health is deteriorating due to the experience of isolation and that he is not getting the treatment that he needs. And that he doesn't know how much more he can take.

Ending Solitary Confinement in New York

In enacting the SHU Exclusion Law in 2008, New York became a leader in addressing the issue of solitary confinement. As discussed above, the law has not adequately addressed the problem in the state prison system, and no legislation currently limits placing people with mental illness in solitary confinement in the City jails.

The harms of solitary confinement are made plain by a study published in the *American Journal of Public Health* earlier this year.[12] The authors of the study are all DOHMH staff, the agency responsible for providing healthcare to people incarcerated in NYC jails. The researchers analyzed data from 244,699 incarcerations in the NYC jail system from January 1, 2010, through January 31, 2013. This wide-ranging study was praised as the "largest, most comprehensive" look at the use of solitary confinement.[13]

The researchers found that incarcerated individuals "punished by solitary confinement were approximately 6.9 times as likely to commit acts of self-harm."[14] Only 7.3% of jail admissions included any solitary confinement sentence, yet "53.3% of acts of self-harm and 45% of acts of potentially fatal self-harm occurred within this group."[15] These findings are an indictment of the use of solitary confinement. To continue with this practice knowing full well that it causes people to engage in violence against their own bodies is inexcusable in a civilized society.

These findings reflect the desperation of people condemned to solitary confinement – they are driven to hurt themselves in an effort to escape the painful environment of deprivation and isolation to which they have been sentenced. The most common methods for doing so included laceration, ligature, swallowing a foreign body, and overdose.[16] The researchers observed that some types of self-harm occur exclusively in solitary confinement settings, such as setting fire to one's cell or smearing feces.[17]

Incredibly these acts of self-harm frequently result in additional time in solitary confinement.[18] For instance, one of our clients received an infraction and was sentenced to additional time in solitary confinement for refusing to obey a direct order after she was told to stop cutting her wrist and continued to do so. This young woman has repeatedly attempted to hurt or kill herself

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[12] *See* Kaba, Lewis, Glowa-Kollisch, Hadler, Lee, Alper, Selling, MacDonald, Solimo, Parsons, and Venters, *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 AM. J. PUBLIC HEALTH 442 (Mar. 2014) (hereinafter "Venters et al.") available at http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2013.301742.

[13] Pearson, *Study of NYC Jails Shows Inmates in Solitary Confinement Are More Likely to Harm Themselves*, Associated Press, February 12, 2014, available at http://www.startribune.com/lifestyle/health/245257751.html.

[14] Venters et al., *supra* note 11 at p. 445.

[15] *Id.* at p. 442.

[16] *Id.* at p. 444.

[17] *Id.* at p. 446.

[18] *Id.*

by eating soap, drinking bleach, taking pills, cutting her wrists – at times with glass – and attempting to hang herself. She has been taken from solitary confinement to the hospital on multiple occasions only to be returned to solitary confinement. She has spent most of the last two years in solitary confinement as she awaits trial.

Some who act in desperation may not intend to end their own lives, yet that is certainly a risk. During the period of the study, seven acts of self-harm were fatal.[19] One example is a young man who swallowed a toxic soap ball in August 2012 while in the solitary confinement unit for people with mental illness. Correction staff recognized that he was in distress but failed to provide medical attention. He died as a result, and the medical examiner ruled his death a homicide due to the denial of medical care.[20]

The mental torment that drives individuals to commit acts of self-harm is damaging to the individuals who experience it. These acts of self-harm also tax jail resources. The study evaluated the response to self-harm which includes medical and mental health evaluations, correction officer escorts, and possibly local emergency medical services, hospital emergency departments, and inpatient units. Based on these data, the researchers estimated that "every 100 acts of self-harm result in 36 transfers to a higher level of care and 10 hospital admissions. Every 100 acts of self-harm conservatively represent approximately 3760 hours of additional time by correction officers (for hospital transport and suicide watch) and approximately 450 excess clinical encounters in the jail system."[21]

As mentioned above, New York City has moved toward creating alternative therapeutic units for people with serious mental illness sentenced to solitary confinement. However, maintaining a regime of solitary confinement as the first line of punishment and exempting those with serious mental illness will not adequately address the problem of self-harm. According to this research, "[s]elf-harm is significantly correlated with patients who were in solitary confinement, irrespective of [serious mental illness] status or age."[22]

Certainly we should not place adolescents or people with serious mental illness in solitary confinement – the effects on their development and disabilities respectively are apparent. But this study reveals that anyone placed in solitary confinement is significantly more likely to take the extreme action of harming him- or herself in response to this punitive environment.

Therefore, solitary confinement cannot remain a legitimate form of correctional management.

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[19] *Id.* at p. 442.

[20] Blau, *Bronx DA Will Not Prosecute Jail Guards in Inmate's Death Caused By 'Neglect and Denial of Medical Care' After Eating Soap*," N. Y. Daily News, March 24, 2013, available at http://www.nydailynews.com/new-york/bronx/bronx-da-charged-jailers-inmate-soap-death-article-1.1298034.

[21] Venters et al., S*olitary Confinement and Risk of Self-Harm Among Jail Inmates*, *supra* note 11 at p. 446.

[22] *Id.* at pp. 444-45.

The Urban Justice Center endorses the approach advanced by the Campaign for Alternatives to Isolated Confinement and set forth in the Humane Alternatives to Long-Term (HALT) Solitary Confinement Act (A08588A / S06466A).[23]

The HALT Solitary Confinement Act is a blueprint for transforming the punitive, ineffective environment of punishment into one of rehabilitation. Ultimately we will not eliminate violence from our jails and prisons through the violence that solitary confinement incites. Instead we must look to the causes of behavior and address them.

[23] The Humane Alternatives to Long-Term (HALT) Solitary Confinement Act is available at http://open.nysenate.gov/legislation/bill/A8588-2013.