



**BROOKLYN  
DEFENDER  
SERVICES**

**TESTIMONY OF:**

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BROOKLYN DEFENDER SERVICES**

*Written with: Riley Doyle Evans*

**Presented before**

**The New York State Assembly Committees on Health and Corrections**

**Hearing on Healthcare in New York State Prisons and Local Jails**

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My name is Kelsey DeAvila and I am the Jail Services Social Worker at Brooklyn Defender Services. BDS provides multi-disciplinary and client-centered criminal, family, and immigration defense, as well as civil legal services, social work support and advocacy in nearly 40,000 cases in Brooklyn every year. As part of our representation, BDS dedicates staff, including myself, to provide direct services and advocacy for our clients while they are incarcerated in New York City jails in pre-trial detention, serving sentences of less than a year, or returning from New York State Department of Corrections and Community Supervision (DOCCS) prisons upstate. I thank the New York State Assembly Committees on Health and Corrections, and in particular Chair Gottfried and Chair Weprin, for inviting us to testify regarding healthcare provision in New York State prisons and local jails.

I am providing upfront a list of recommendations that are explained in detail later in my testimony:

**Recommendation #1:** Invest in improvements to community-based health care, including mental health and addiction treatment, and ensure health equity across all communities.

**Recommendation #2:** Decarcerate by dramatically reducing pre-trial detention, reforming our criminal discovery laws, enacting sentencing reform, ending the Drug War and Broken Windows policing, and swiftly closing the most abusive prisons and jails.

**Recommendation #3:** Provide confidential and medically- and therapeutically-appropriate healthcare facilities in prisons and jails, and ensure access to care by more efficiently using existing security staff for medical escorts and removing all medical decision-making from the hands of correction officers.

**Recommendation #4:** Ensure continuity of care for people upon intake, while incarcerated, and upon release.

**Recommendation #5:** Provide destigmatized medication-assisted treatment for drug addiction in all prisons and jails.

**Recommendation #6:** Ensure timely access to medication and outside specialty appointments.

**Recommendation #7:** Coordinate collective purchasing of expensive medication for Hepatitis C and other chronic illnesses to ensure full access to treatment in state prisons and local jails.

**Recommendation #8:** Responsibly expand the use of Electronic Medical Records.

**Recommendation #9:** Ensure access to consistent transition-related care for transgender people in prisons and jails.

**Recommendation #10:** Ensure free access to quality feminine hygiene products as needed.

**Recommendation #11:** Offer female doctors and other medical staff to incarcerated women in all prisons and jails.

**Recommendation #12:** Streamline the process for expecting mothers to access nurseries or other appropriate housing and remove unnecessary obstacles.

**Recommendation #13:** End the use of private healthcare contractors across the state, as New York City has done.

**Recommendation #14:** End the torture of solitary confinement and replace it with more humane and effective alternatives by passing the Humane Alternatives to Long-Term (HALT) Solitary Confinement Act (S.4784-Parker/A.3080-Aubry).

**Recommendation #15:** Promote the axiom among correctional healthcare staff that #BlackLivesMatter, as do the lives of other marginalized people in our prisons and jails.

## **Background**

Before focusing on specific issues related to healthcare delivery in correctional facilities, we wish to highlight that addressing the public health calamities associated with incarceration should not be considered in a vacuum. New Yorkers who pass through local jails and state

prisons each come from and will return to communities around the state. Mitigating the harm of incarceration therefore involves addressing disparities in healthcare and outcomes which disproportionately impact poor communities and communities of color. Before people enter the criminal legal system, inadequate healthcare results in disproportionately high rates of chronic conditions among these communities, which are only exacerbated in jails and prisons. Similarly, a dearth of adequate community-based mental health and drug treatment funnels people struggling with mental illness into handcuffs, jails, and prisons, where their conditions are met with violence and isolation rather than appropriate care.

At the end of the system, people who return from prison or jail to communities lacking adequate healthcare infrastructure and affordable and supportive housing are at serious risk of falling through the cracks. In the case of people with mental illness the result is too often a tragic, churning cycle of incarceration, lapses in treatment, homelessness, and recidivism. For people with chronic medical conditions – even with adequate treatment in prison – a poorly managed healthcare transition during re-entry can lead to interruptions in care followed by irreversible sickness and premature death.

In sum, as you take on the important issue of correctional health, we urge you to keep in mind how the challenges in question fit into a larger continuum. Ultimately, prisons and jails were never intended to serve as medical facilities and conditions inside are fundamentally inappropriate to delivering a high standard of care. Decarceration while investing in healthy *communities* must remain the primary goal. Ending unnecessary arrests and discriminatory bail practices, adopting sentencing and discovery reform, and establishing a robust framework to divert people in need of treatment would all contribute to this end.

Selmin Feratovic died at the age of 28 while detained at Otis Bantum Correctional Center on Rikers Island less than two weeks ago, on October 19, 2017. He had been in pre-trial detention for nearly seven months, presumed innocent but locked in a cage because the local prosecutor, who alleged he had tried to steal from a laundromat coin machine, requested an absurdly high bail and the judge granted it. Specifically, a man accused of stealing coins was suddenly asked to cover \$50,000 bail or sit in jail for the remainder of his case. The Bronx District Attorney overcharged the case as a violent felony and refused to make a reasonable plea offer, leaving Mr. Feratovic in jail at an approximate cost of \$140,756 over the seven months.<sup>1</sup> Imagine what that money could have done to help him in the community. According to his attorney at the Bronx Defenders, he had struggled with opioid addiction after receiving a prescription for oxycodone while recovering from a serious motorcycle accident. Drug treatment in the community was inadequate. “Police sources” have told the press that he died of an apparent overdose, but the investigation is ongoing and, as his attorney wrote in a *New York Daily News* op-ed, the cause of his death is, more broadly, systemic injustice. That is why we say criminal justice reform is a matter of life and death.

In the meantime, because people with mental illness and chronic medical conditions are overrepresented in our criminal legal system, it is essential that healthcare in prisons and jails be

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<sup>1</sup> The Independent Commission on New York City Criminal Justice and Incarceration Reform, or “Lippman Commission,” estimated the annual price of locking a person in a New York City jail to be \$247,000. Mr. Feratovic was detained there for 208 days.

as compassionate, accessible and appropriately resourced as possible. In addition to the moral and legal obligations to provide treatment, public health stands to benefit if our prisons successfully diagnose and treat conditions which may have been undetected or mismanaged in the community. Ensuring continuity of care in re-entry has the potential to reduce recidivism, improve public safety, and most importantly, to improve health outcomes in communities across the state. To this end, I would like to share some specific insights drawn from the experiences of our clients and staff, which I hope will be useful in your efforts to improve healthcare in New York's jails and prisons. I also lend support for the comments of certain other organizations testifying today, such as the Correctional Association, who offer tremendous insight and expertise regarding the current state of affairs in our prisons.

### **Access to Care**

Access to care has long been and remains a fundamental concern for our clients in city jails and state prisons. Access to care in correctional settings is hamstrung by several distinct, but interconnected issues. Despite the significant healthcare needs of the population they house, jails and prisons are not constructed like hospitals, which prioritize clinical space and access to providers.

For instance, the Anna M. Kross Center – a 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. Healthcare staff on Rikers Island have taken the initiative to establish “mini-clinics” closer to housing units, which serve as a stop gap. However, these spaces are often cramped, sometimes lack necessary infrastructure to maintain hygiene, and may not allow for confidentiality.

More broadly, jails and prisons lack adequate confidential treatment spaces. A dearth of dedicated treatment spaces near housing units is particularly detrimental to effective mental healthcare delivery. Many, if not most, people are uncomfortable candidly reflecting on their struggles within earshot of other incarcerated people and custody staff, especially as members of the latter group are known to prey on vulnerable incarcerated people. 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.

### **Delivering Healthcare in a Security-Driven Environment**

Compounding physical plant limitations, the predominance of security in correctional institutions further inhibits access to healthcare. For example, when a facility goes on lockdown for security reasons, all movement may be halted, sometimes for extended periods. This means no one is able to go to the clinic, leading to delays care. Even when facilities are operating as designed, security interference in access to care and treatment decisions is a common occurrence.

In New York City jails, every incarcerated person must be escorted by a correctional officer to and from the clinic. As uniformed staff are often occupied with other tasks, or otherwise unwilling to help, escort shortages frequently result in missed appointments and treatment delays. **One sensible fix to overcoming the inevitable competing demands on correctional staff is to more wisely balance staffing to include roving medical escort posts during day-shifts** who are not assigned to other tasks. We believe 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.

Beyond their role as escorts, **correctional officers serve in many respects as gatekeepers to medical care, which poses serious dangers to the well-being of people in custody.** For instance, in New York City jails, an individual seeks medical care by submitting a “sick call” request to the officers in their housing unit. The officers are then responsible for forwarding the requests to medical staff who schedule an appointment. Under this arrangement, correctional staff can and do refrain from forwarding sick call requests to the clinic, or falsely claim that an individual “refused” to be brought to their appointment, as a tool of control or punishment.

One BDS client who had filed complaints against correctional staff was repeatedly denied sick call as well as escorts to the clinic, and was documented as having “refused” care. As a result of being denied timely medical treatment for a cut, the client developed gangrene which nearly required amputation. As this case illustrates, denying access to medical care is a particularly cruel form of punishment. It is also used to conceal injuries sustained from officer brutality.

A pilot effort in certain New York City jails seeks to mitigate this issue by establishing confidential “sick call” boxes in common areas, which are only accessible to healthcare staff. This common-sense sick-call reform is a welcome first step which should be expanded in other institutions. However, situating access to treatment and medical decision-making as the exclusive domain of healthcare providers should be the ultimate goal.

A recent incident with another BDS client demonstrates the significant health risks that arise when security staff can simply override medical determinations. This client had a diagnosed seizure disorder, which was not appropriately managed with medications at Rikers. Despite written notification from medical staff outlining the specific medical dangers should he be placed alone in a cell, he spent numerous months in solitary confinement, over the repeated objections of healthcare staff. His isolation only exacerbated his medical condition, resulting in weekly seizures, one of which led to a broken tooth and shoulder injury. Our office advocated for his immediate transfer to a hospital or an open dorm. He was sent to Bellevue Hospital for a week of tests, but was ultimately sent back to Rikers to finish his time in solitary confinement.

### **Dual Loyalty and the Role of Healthcare Professionals**

Arising from the security concerns in jails and prisons, correctional healthcare staff face dual loyalty challenges, which can interfere with their providing compassionate and appropriate care. On the one hand, medical and mental health providers are ethically bound to treat patients. On the other hand, providers are pulled toward loyalty to correctional staff who are charged with ensuring 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 corrections officers. New York City Health and Hospitals Corporation, the healthcare provider in

NYC jails, trains their staff to manage dual loyalty. **While dual loyalty training is far from a complete solution, we believe it is a best practice which should be mandated in all jurisdictions.**

In addition to dual loyalty training, **jail and prison officials should welcome a culture shift which empowers healthcare officials to weigh in on management decisions and have unfettered authority with regard to treatment matters**, unless a genuine, immediate security emergency is at play. Simultaneously expanding de-escalation and mental health first aid training among corrections staff can help officers better understand how treatment interventions work and why they should be given priority.

These steps should be taken urgently to prevent the tragedies all too common in New York's prisons and jails. Perhaps such efforts would have spared Samuel Harrell who, instead of receiving compassionate mental health interventions, was reportedly beaten to death in Fishkill State Prison when he experienced an obvious Bipolar episode. The same may be said for Bradley Ballard and Jerome Murdough who died, neglected in their cells on Rikers Island, despite corrections and healthcare staff being aware of their dire conditions.

### **Continuity of Care**

Continuity of care is particularly important in correctional institutions owing to the high prevalence of people with chronic medical conditions (e.g. diabetes, hypertension), infectious diseases (e.g. Hepatitis C) and behavioral health and addiction issues – conditions for which lapses in care can have serious impacts on health outcomes. Death by overdose is particularly common upon release from incarceration.<sup>2</sup> Ensuring continuity of care requires that people have timely and consistent access to treatment upon arrest, during incarceration, and when they return to the community. In each phase, various challenges arise that impact our clients' wellbeing, and the health of their home communities.

On the front end, we reiterate that it is imperative that New York State do a better job providing equal access to compassionate healthcare to all communities. In addition to making our state more just, improved healthcare access in poor communities would likely reduce contacts with the criminal legal system. Moreover, better community healthcare would result in better and more cost-effective management of chronic health conditions when people are locked up in jails and prisons, thanks to more consistent diagnosis and treatment prior to detention. More robust community mental health and addiction management services would benefit public safety by reducing unnecessary arrests of people who require treatment interventions and support.

### **Substance Abuse and Addiction Management**

Continuity of care issues arising as people enter the New York City jail system are many and complex. Our clients' experiences suggest that Health and Hospitals Corporation and the Department of Corrections have addressed various challenges with mixed results. The agencies

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<sup>2</sup> See, e.g., Binswinger, I., Nowels, C., Corsi, K., Glanz, J., Long, J., Booth, R., Steiner, J. (2012). 'Return to drug use and overdose after release from prison: a qualitative study of risk and protective factors', *Addiction Science & Clinical Practice* 7(1), p. 3.

should be acknowledged for their efforts to safely manage substance abuse and addiction among people in custody. **Prompt screenings for alcohol withdrawal** appear to function well to avoid possibly fatal withdrawals. The **substance abuse program** “A Road Not Taken” offers people struggling with addiction an opportunity to be housed among peers and receive programming geared to support their efforts to get clean.<sup>3</sup> We believe there are **best practices to be gleaned from these programs which should be evaluated for use in other jurisdictions.**

The Key Extended Entry Program (KEEP) in New York City jails facilitates detox and **manages methadone treatment for opiate-dependent individuals.** Unfortunately, people facing state prison time are excluded from KEEP because state prisons do not offer methadone management. Many people face state prison time “on paper” although there is little real chance they will be sent to state prison. As cases proceed through plea bargaining, prosecutors wait until pleas are entered to withdraw the most serious charges, despite all parties involved being aware that prison time is not a likely outcome. 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. Likewise, the state prisons system should offer methadone treatment and other medication assisted treatment (MAT), particularly 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.<sup>4</sup> **MAT in jails and prisons and other public health approaches to tackling 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.** Although the drug claims to block an individual’s opioid receptors in long-lasting doses, we are dubious about the drug’s effectiveness in treating addiction *sustainably*. It is our position that tackling addiction must address 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.**<sup>5</sup>

### **Medication Delivery**

Despite some strengths, New York City jails fall short in the realm of continuity of care in several important respects. One of the most common complaints I receive is about the **failure to consistently deliver medications in a timely manner.** It is not uncommon for our clients to wait several days after being taken into custody before they receive crucial medicines. Often, they do not receive their medications until I advocate on their behalf. Lapses may also occur

<sup>3</sup> 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

<sup>4</sup> 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>.

<sup>5</sup> 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.

when individuals travel between jails. Whether high blood pressure medicines, inhalers, or anti-psychotic medications, these lapses can have devastating consequences.

### **Specialty Appointments**

Another persistent shortcoming involves appointments with outside specialty providers. By design, prisons and jails cannot staff a full range of specialists full-time. However, for a variety of sometimes elusive reasons, **outside specialty appointments and follow up visits are frequently delayed or missed altogether**. Quite often, at the time of their arrest, clients have upcoming follow-up appointments scheduled with specialists. For unknown reasons, Health and Hospitals Corporation too often fails to promptly schedule and deliver follow-up visits, despite being informed of the situation by the patient and our office.

In one recent case, our client had 2 stents around his kidneys which were due 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, and the specialty appointment to remove the stents had not been ordered. Eventually, the client developed an infection which had to be treated, further delaying the operation to remove the stents. Meanwhile, our client suffered a great deal of pain and when urinating, he became lightheaded. Over time, his appearance declined; his skin became pale, and he was eventually transferred to a hospital where he finally received treatment.

In other cases, the 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. I often receive reports of people waiting hours in the jail intake for their escort. If they ever leave, they arrive late for their appointment, waiting several more hours at the specialty clinic, before eventually being told that they arrived too late to be seen that day. Rescheduling missed appointments only compounds delays in treatment. In light of these circumstances in New York City, where a vast public hospital system is relatively accessible, we surmise the challenges are even greater in rural communities. **Sufficient escorts and dedicated specialty schedulers who interface between correctional staff and specialty clinics are fundamental to address specialty care delays.**

### **Chronic Care**

Improving treatment of chronic medical conditions is also relevant to continuity of care. Individuals who have initiated a course of effective but costly Hepatitis C treatment in the community should be continued on this treatment when in custody. Local jurisdictions can seek reimbursement waivers from the federal Centers for Medicare and Medicaid Services (CMS) for this treatment.<sup>6</sup> More broadly, despite their significant up-front cost, sound public health policies require treating Hepatitis C in correctional settings to improve health outcomes among

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<sup>6</sup> See Venters, H. (2016), 'A three dimensional action plan to raise the quality of care in US correctional health and promote alternatives to incarceration', in: American Journal of Public Health, 106(4), pp. 613-614

individuals and avoid longer term costs associated with cirrhosis and other related conditions.<sup>7</sup> Unfortunately, considerable barriers are foreseeable during the present administration toward securing more general waivers for federal reimbursement for chronic care delivered in prisons, but DOCCS should collaborate with local jail administrators and others, perhaps across the country, in advocating for funding.

While we support advocacy to reform Medicare and Medicaid law to expand federal funding for correctional health, we encourage the state to be proactive in other ways in the meantime. As noted in a 2016 Yale study, reducing costs is one way to expand availability of Hepatitis C treatment. The study describes cost-reduction strategy including **coordination between state agencies, for example Medicaid and DOCCS, along with county agencies, to purchase drugs collectively and with greater buying power. Alternatively, while prisons are excluded from the federal 340B Drug Discount Program, partnering with outside providers which are eligible, may offer cost savings.** However, securing treatment through outside providers can give rise to additional challenges, as mentioned previously.<sup>8</sup>

### Re-Entry

Others testifying today will certainly offer more comprehensive recommendations to improve continuity of care during re-entry. Nevertheless, I would like to highlight a few of the recurrent issues handled by our Re-Entry Unit, some of which could be relatively easily addressed. In addition to a 30-day supply of medications, we believe **DOCCS should make a greater effort to discharge people with a copy of their essential medical records**, which would help to avoid delays in securing treatment in the community. At present, people must have the wherewithal to request a copy before they are discharged, and are not prompted to do so during pre-release counseling. Predictably, many do not.

Furthermore, bureaucratic missteps can inhibit access to care upon discharge and should be prevented. Despite welcome efforts to enroll people in Medicaid prior to discharge, people are frequently released on inpatient Medicaid status, rather than outpatient status. In practical terms, this limits the range of services available to hospital care. Our re-entry specialists find it takes days to weeks to correct this relatively straightforward error. In the meantime, people are unable to access the full range of services available through the health-home system, relying instead on emergency rooms, thereby further draining public health resources.

Additionally, our clients' experience suggests that DOCCS does not do enough to educate people to navigate the complex and intimidating healthcare system awaiting them in the community. A first step to resolve this issue would be to **better incorporate healthcare staff and navigators into the pre-release process.** This process should offer opportunities for people close to discharge to ask questions of healthcare providers who can provide guidance on managing their health conditions once out of prison.

This is especially important for the large proportion of aging people in New York State prisons

<sup>7</sup> Beckman, A., Bilinski, A., Boyko, R., Camp, G., Wall, A.T., Lim J., Wang, E., Bruce, R.D., Gonsalves, G. (2016), 'New Hepatitis C drugs are very costly and unavailable to many state prisoners', in: Health Affairs 35(10) pp. 1893-1901

<sup>8</sup> Id., p. 1899

who are more likely to have higher healthcare needs, and at the same time, be less familiar with an evolving healthcare landscape. More than 10,100 people aged 50 or older are currently incarcerated in New York, according to the latest available data. Even as the total prison population in this state has gradually decreased, the number of individuals in this older adult category has jumped by 46 percent.<sup>9</sup>

Advocates like the Release Aging People in Prison (RAPP) Campaign, Parole Justice New York, Citizen Action and the Challenging Incarceration collective are pushing Governor Cuomo and the Legislature to adopt reforms that would allow for many incarcerated older adults, who have the lowest recidivism rates, to be released. We support these efforts – prisons are not well suited to handle the complex and expensive healthcare needs of older adults, and are simply not humane institutions to house aging people. In addition to securing release for these individuals, it is imperative that state and local officials take steps to bolster the quality and range of healthcare services to meet their unique needs.

Currently, in New York City there is a broad slate of programs and services for older New Yorkers, and a growing network of re-entry resources, but very little overlap between the two. Older adults endure unique hardships in prisons and jails, as the facilities and staff are not adequately equipped to support them. Crucially, family members and others in the home and community who would traditionally serve as caretakers are prevented from doing so. Likewise, few community-based organizations that serve older New Yorkers specialize in meeting the needs of returning citizens. In sum, **dedicating adequate study and resources to address shortcomings in service provision at the intersection of aging and reentry will become increasingly urgent in the coming years.**

Parole also has a role to play in continuity of care. Barring certain exceptional cases, our clients report that parole officers have adopted an increasingly punitive orientation over the years, and they do little to assist them to navigate the healthcare system after they arrive home. Because parole offices are situated locally, they are better positioned than upstate prisons to assist people to access care in their communities. In addition to making information about area providers available, parole officers should take initiative to build relationships with health-home networks and help returning citizens resolve bureaucratic issues with Medicaid and other agencies. More broadly, keeping people healthy improves public safety and should be a high priority in the agency's mission.

### **Quality Control: Electronic Medical Records**

There is certainly more to say regarding quality control strategies, but my remarks will be limited to lending **support for expanding the use of Electronic Medical Records (EMRs)**, which may be funded through CMS “Meaningful Use” funds. When used properly, EMRs have potential to assist healthcare management identify and resolve problems, balance staffing with demand, and

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<sup>9</sup> NYS Comptroller Thomas P. DiNapoli (2017), ‘New York State’s Aging Prison Population’, The Office of Budget & Policy Analysis 2017, [online] (available at: <http://osc.state.ny.us/reports/aging-inmates.pdf> [accessed 20 October 2017])

deliver evidence-based care. In the case of individual patients, those who transfer or reenter a facility are less likely to experience serious lapses in care, and schedulers can be alerted when chronic care follow-up deadlines are missed or specialty care is delayed. At the system-wide level, EMRs can help identify trends, bolster quality improvement, and improve transparency regarding health outcomes.<sup>10</sup>

## Gender and Gender Identity and Expression

### *Transition-Related Care*

The difficulty surrounding a transgender person's ability to access hormones while incarcerated in our jails and prisons is not uncommon. In order for a person to receive transition-related medication they will first need a diagnosis of Gender Dysphoria. This can be problematic to many people who do not have access to safe and affordable healthcare in the community prior to arrest and will only delay their necessary treatment once detained. Transgender clients frequently report delays in accessing sick call and scheduling an appointment for a diagnosis evaluation. **It is important to note that those who do need medical treatment related to their transition often do not receive consistent treatment.** We know that abrupt and extended halts in hormone replacement therapy can have serious and irreversible effects on one's physical and mental health, yet such interruptions are sadly common.

### *Feminine Hygiene Products*

Access to feminine hygiene products is critical for women's health. Doctors recommend changing sanitary napkins or tampons every four to eight hours to prevent bacterial and fungal infections that may lead to serious health problems. **All women who are incarcerated should have access to feminine hygiene products in sufficient quantities to meet their individual needs.**

According to a recent survey by the Correctional Association, 54 percent of respondents in New York prisons said they did not get enough sanitary napkins each month. This is consistent with the experience of our attorneys and social workers supporting our clients detained at Rikers. Some clients tell us that they are given only 12 sanitary napkins at a time. In other blocks, pads are left out in a bucket or box in the bathroom. This supply is sometimes insufficient for women with heavier flows. Women without a sufficient supply must then request additional napkins from guards, who often use the request as a way to control women and assert their authority over her. Our clients tell us that they have to beg officers for more free pads only to be treated with disrespect that make them feel ashamed. Furthermore, the free napkins provided at Rikers are of very poor quality and most of our clients will go to great lengths to purchase name brand napkins from the Commissary. Our clients report that the free napkins are not properly absorbent and thus easily lead to staining of their uniforms.

Renee's story is a perfect example of how Rikers current policy on feminine hygiene products affects poor New Yorkers. Renee, a 24-year-old BDS client, spent nine months detained on Rikers. She asked her BDS social worker not to visit her while she was on her period because

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<sup>10</sup> Venters, 2016.

she was worried about leaking through her uniform and having to walk the halls of the jail with a bloodstain. Renee had to choose between the shame of leaking blood while on her period and meeting with her legal team. Renee comes from a low-income family and worked overtime in the jail to pay for her basic needs including deodorant, soap and sanitary napkins. She shared that she did not have enough sanitary napkins and she would try to wear the same napkin for as long as possible to ration the supply she was able to purchase from the Commissary because the free pads were of such low quality.

### *Staffing Female Providers*

Many of our female clients have a history of physical and sexual abuse prior to incarceration. For many of these women, their trauma has never been processed. It is essential for medical staff to be trained on how to treat women with a history of trauma because pelvic and breast exams can be re-traumatizing. In addition, women should be allowed to choose female doctors for gynecological care. At the Rose M. Singer Center, the female facility on Rikers Island, many of our female clients have reported feeling unsafe visiting a male doctor. This becomes a barrier and our clients will not seek medical attention, even during urgent and critical situations due to the fear of being assessed by a male staffer. Though the policy in our New York City jails allows for a female to be present when a male doctor is examining a woman, it does not negate the feelings many of our clients' experience.

### *Access to Nursery for Expecting Mothers*

In a recent case, a BDS client was 7 months pregnant when she was sentenced to Bedford Hills Correctional Facility. Prior to her sentence, she was held in the Pregnant Mother's Unit on Rikers Island and, with the help of Riker's Nursery Manager, applied to the Bedford Hills Nursery in the hopes that there would be a smooth transition into the unit once transferred. Unfortunately, our client waited several months to hear if she had been approved to the nursery and was sent to the General Population Unit at Bedford Hills upon transfer. Our client had a high risk pregnancy and needed a setting that would allow a stable and orderly environment. Being in General Population only increased her stress levels, putting her unborn child at greater risk. **It is important for there to be a streamlined process for expecting mothers in our jails, awaiting transfer to a state facility, so there is no gap in care or appropriate housing.** This will contribute not only to the mother's health, but to the safety of the child.

### **For Profit Providers**

**We urge an end to the use of private healthcare contractors in correctional facilities across New York.** Following several jail deaths and other tragedies, New York City ended its contract with Corizon at the end of 2015 and incorporated Correctional Health Services into the city hospital network, NYC Health and Hospitals Corporation. It is too early to assess the full impact of the change; however, certain improvements are apparent. More generally, we believe there are several strong arguments for replacing private companies who are primarily concerned with their bottom line, with mission-driven and public health oriented providers.

The most obvious concern is that private companies will aim to cut costs by providing substandard care. After many years with Corizon in New York City jails, we believe this is a legitimate concern. Moreover, it is our experience that the contracting relationship with for-profit

companies only exacerbates issues of dual loyalty. When healthcare providers feel beholden to corrections officials to retain their contracts, managers and line-staff alike are less willing to raise objections in the face of abuse or neglect.

Furthermore, utilizing private companies only deepens the challenge to recruit qualified and enthusiastic providers to work in correctional settings. It is unlikely that young healthcare professionals, eager to contribute to health justice, will be inspired join a private company with misaligned values. On the other hand, public health systems or mission-driven non-profits may attract more talent. As mass incarceration continues to garner the widespread attention across the country, it should be possible to recruit passionate healthcare providers to work in prisons in much the same way humanitarian organizations recruit doctors to treat patients in warzones and refugee camps.<sup>11</sup>

### **Solitary Confinement**

To close, I would like to address the issue of solitary confinement; as this practice represents the coalescence of all the issues discussed already and is of grave concern to our office. As you probably already know, solitary confinement entails locking a person in a cell 23-24 hours per day, with one hour of recreation alone in what amounts to a slightly larger cell. The health impacts of solitary confinement are significant and well documented.

As Health Committee Chair Gottfried has said in a press release by the Campaign for Alternatives to Isolated Confinement, “Solitary confinement has catastrophic long-term effects on physical and mental health. No responsible medical professional could stand for this, and New York State shouldn’t either.”

Physiological conditions brought on by solitary confinement include gastrointestinal and urinary issues, deterioration of eyesight, lethargy, chronic exhaustion, headaches and heart palpitations among others.<sup>12</sup> Solitary is further shown to cause psychological trauma including severe depression, anxiety, insomnia, confusion, emotional deterioration, and fear of impending emotional breakdown.<sup>13</sup> In addition to hallucinations and delusions,<sup>14</sup> studies consistently find that prolonged solitary induces bouts of irrational anger and diminished impulse control, leading to violent outbursts;<sup>15</sup> invoking the very behavior it purports to manage.

Scientific and legal understandings of the harm of solitary confinement are not new. In fact, recognition that solitary confinement is inhumane and ineffective dates back to 1890, when the

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<sup>11</sup> Id.

<sup>12</sup> Shalev, S. (2008), A sourcebook on solitary confinement. (London: Manheim Centre for Criminology, London School of Economics), p. 15.

<sup>13</sup> Haney, C. (2003) ‘Mental health issues in long-term solitary and “Supermax” confinement’, in: *Crime & Delinquency*, 49(1) pp. 133-136.

<sup>14</sup> Id.; Grassian, S. (1983), ‘Psychopathological effects of solitary confinement’, in: *American Journal of Psychiatry*, 140(11), p. 1452.

<sup>15</sup> 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.

US Supreme Court found in *In Re Medley* that placement in solitary confinement caused extreme and long-term harm, writing that a “considerable number of the [people in solitary] fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.” In 1993, Correctional psychiatry expert Dr. Stuart Grassian identified what has been called SHU Syndrome, which includes the aforementioned symptoms.

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.**<sup>16</sup> **The suicide rate in DOCCS’ Special Housing Units (SHU) is nearly six times higher than that of the General Population (GP).**<sup>17</sup> 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.”<sup>18</sup> In fact, one man who has been held in solitary confinement at Elmira prison for approximately thirty years, William Blake, described his long-term isolation as a “sentence worse than death.”

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. Nevertheless, New York State prisons hold a disturbing number of people in solitary confinement, at a much higher rate than the national average with more subjected to the practice in county jails across the state.<sup>19</sup>

Contrary to clear direction from the National Commission on Correctional Health,<sup>20</sup> **healthcare staff in prisons and jails are generally complicit in subjecting people to the harms of solitary confinement. Worse, healthcare staff are too often complicit in cases where solitary is clearly being used to cover up brutality. Once someone is placed in solitary confinement, the problems with access to care are exacerbated. Officers have even more control over access to sick call, and securing escorts from high security units to appointments is increasingly difficult.**

Equally troubling, a recent report by Disability Rights New York uncovered rampant abuse of people with mental illness in Residential Mental Health Units (RMHU) at Attica State Prison. These units were intended to protect people with serious mental illness from the harms of solitary confinement under the SHU Exclusion Law. Instead people in RMHU were subjected to the same kind of punitive isolation without input from mental health staff, and in direct violation

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<sup>16</sup> 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.

<sup>17</sup> Statistics provided by DOCCS

<sup>18</sup> Gilligan and Lee, 2013, p. 6.

<sup>19</sup> The Liman Program, Yale Law School & of State Corr. Administrators, *Time-In-Cell: The ASCA-Liman 2014 National Survey of Administrative Segregation in Prison* (2015), [https://law.yale.edu/system/files/area/center/liman/document/asca-liman\\_administrativesegregationreport.pdf](https://law.yale.edu/system/files/area/center/liman/document/asca-liman_administrativesegregationreport.pdf).

<sup>20</sup> See United States National Commission on Correctional Health Care (2016), *Position Statement: Solitary Confinement (Isolation)*, [online] (available at: <http://www.ncchc.org/solitary-confinement> [accessed 25 October 2017]).

of the law. Horrifying accounts of verbal and physical abuse in the unit make the report even more disturbing.<sup>21</sup> This report reaffirms that **New York must adopt comprehensive legislation prohibiting prolonged solitary confinement in any form.**

BDS supports the efforts of New York State legislators and our grassroots partners in the Campaign for Alternatives to Isolated Confinement to **enact the Humane Alternatives to Long Term (HALT) Solitary Confinement Act (S.4784-Parker/A.3080-Aubry)** and bring an end to the torture of solitary confinement in New York State. The Corrections Commissioner in Colorado, Rick Raemisch, has already successfully implemented solitary reforms that mirror HALT.<sup>22</sup> These reforms include: A hard limit of 15 consecutive days in solitary confinement, with most serving far less; the use of therapy to address seriously problematic behavior; and a dramatic reduction in the overall use of solitary. In 2011, 1,500 people in Colorado prisons, or 7% of the prison population, were held in solitary; the state's prison commissioner now reports that number has dropped to 18 people, or far less than 1%. These reforms mark a new era of compliance with the UN's Nelson Mandela Rules for the Treatment of Prisoners. It is not only possible, it is absolutely and urgently necessary that we in New York follow suit.

For comparison, there are approximately 3,000 people in SHU in New York's state prisons, at least hundreds more in keeplock (another form of solitary whose census DOCCS will not disclose), and likely hundreds more in local jails.

The New York Times conducted an investigation last year and found Black people to be far more likely to be subject to solitary confinement in New York State prisons, which, in addition to the aforementioned effects, exacerbates disparities in release determinations, as people in SHU are far less likely to be granted parole.<sup>23</sup>

We have ample client stories that illustrate the immense and often irreparable harm of solitary confinement, but by now you likely know what happened to Kalief Browder and others like him. This issue is beyond debate; action to pass HALT is needed now.

## **Conclusion**

To improve healthcare in prisons and jails, it is necessary consider the broader context and circumstances that allow for substandard healthcare and outcomes to be the norm.

In a landmark article published in the New England Journal of Medicine, entitled *#BlackLivesMatter – A Challenge to the Medical and Public Health Communities*, Dr. Mary T. Bassett, M.D., M.P.H. writes that “the rate of premature death is 50% higher among black men than among white men.” Dr. Bassett, who is Commissioner of the New York City Department of

<sup>21</sup> Disability Rights New York (2017), ‘Report and Recommendations Concerning Attica Correctional Facility’s Residential Mental Health Unit’, [online] (available at: <http://new.drny.org/docs/reports/attica-rmhu-report-9-12-2017.pdf> [accessed 24 October 2017])

<sup>22</sup> Raemisch, R., ‘Why we ended long term solitary confinement in Colorado’, The New York Times, 12 October 2017.

<sup>23</sup> Schwirtz, M., Winerip, M., and Gebeloff, R., ‘The Scourge of Racial Bias in New York State’s Prisons’, The New York Times, 3 December 2016.

Health and Mental Hygiene, was citing her own department’s vital statistics. She also writes that “Black women in New York City are still more than 10 times as likely as white women to die in childbirth.” The article asks – and answers – this question: “Should health professionals 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?”<sup>24</sup>

The article does not explicitly address healthcare in prisons and jails, or correctional healthcare providers, but the author cites as her inspiration another matter of the criminal legal system: police killings of unarmed Black people – with no legal sanctions – and the public uprisings that followed. Just as racism afflicts law enforcement in myriad ways in the community, it also underlies many of the healthcare deficiencies in our prisons and jails, which are disproportionately populated by people of color and poor people. DOCCS, the New York State Department of Health, and local jail and correctional health providers should view Dr. Bassett’s article as a wake-up call and reevaluate the ways in which race impacts the care that is needed, and that which is delivered, in their facilities. For example, Upstate prisons confine predominately people of color in the custody of predominately white security staff and this undoubtedly impacts access to care.

At a New York City Council hearing on violence in City jails last week, the new Commissioner of the Department of Correction, Cynthia Brann, described her agency’s new approach to people with mental illness, treating them as “patients” and not “inmates.” In fact, DOC supervisors regularly refer to our clients as packages, at best, or animals, expletives, or racial slurs.

Of course, the disparities and biases are not limited to matters of race, but intersect with other aspects of oppression, including sexual orientation and gender identity or expression. Our clients 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. Our state and city continue to treat non-conforming identities and substance use and abuse as pathological behaviors. On the contrary, 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 also focus on decarceration – including by closing some of the most abusive facilities identified by the Correctional Association, such as Attica and Clinton, as well as Supermax facilities Upstate and Southport – and the promotion of quality community healthcare as you seek to reform and improve specific aspects of jail and prison healthcare.

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<sup>24</sup> 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>.

BDS is immensely grateful to the Assembly 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 Advocacy Specialist, at 718-254-0700 ext. 382 or [jchausow@bds.org](mailto:jchausow@bds.org).