

Testimony of The Legal Aid Society
on
Physical Health Services in
New York City's Correctional Facilities

Presented before
The New York City Council
Committees on Health and
Fire and Criminal Justice Services

Presented by
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Thank you for the opportunity to testify concerning the future of the New York City jails' health care system. The Legal Aid Society's Prisoners' Rights Project has been dealing with the problems of the jail health care system for over 35 years. We have a record of helping to reform the City jail medical care system both through litigation and administrative advocacy. Our litigation efforts have led to the construction of new health care treatment facilities, including a Contagious Disease Unit for the quarantine of patients with tuberculosis and other diseases; to improved access to hospitals and specialty clinics; and to improved systems for infection control and medical clinic sanitation. We advocate on a near daily basis on behalf of City prisoners, including those suffering from chronic and acute problems, pregnant women, and the mentally ill. The Legal Aid Society is intensely interested in improving the quality of care for City prisoners, as well as in the City's plans for the future of health care services to constituents who are held in the City's jails.

Virtually every day, our office is contacted by prisoners or their families or attorneys with complaints about medical care issues such as denied access to sick call, failure to provide care that medical staff has ordered, psychiatric emergencies, the need for special diets, and so on. We regularly contact the medical provider, Prison Health Services (PHS), and Department of Health and Mental Hygiene (DOHMH) staff, both in the central office and on Rikers Island, on behalf of these prisoners. While we do not have the resources to compile statistics or issue reports on the medical care system's performance, there are clear patterns in the complaints we receive which we believe reflect ongoing deficiencies in the jail medical care system.

Treating the medical and mental health needs of inmates is essential to protecting not only their health, but the public's. Many of the City's prisoners are among the most seriously ill persons in our community. Every year over 100,000 persons are admitted to City jails. Thousands are discharged back into society.¹ Many do not stay in jail long.

The Board of Correction has promulgated detailed Minimum Standards for the provision of Health Care and Mental Health Care services to City jail prisoners. These Standards have been in effect since the early 1990s. If the Board of Correction enforced these Minimum Standards and the Department of Correction complied with them, we would see significantly fewer problems with the provision of medical and mental health care in the City jails. The Board earlier this year completed a revision of the 1973 Minimum Standards for the City jails, a process that met with significant resistance from the large community of prisoners, former prisoners, families, advocates (including former Board members and staff). We thank Chairman

¹ See DOC website: http://www.nyc.gov/html/doc/html/stats/doc_stats.shtml (last visited October 21, 2008).

Martinez and the Fire and Safety Committee for taking an active interest in opening up that process and ensuring greater public participation.

We do not know what plans, if any, the Board has to propose changes to the Health and Mental Health Standards. We do know that it would be a terrible mistake for the Board to weaken them. We urge the Council to maintain oversight of the Board's actions in this critical area.

The delivery of quality health care services to prisoners is not just a legal and constitutional obligation;² it is an essential part of good community health care. But there are some practical concerns that need to be kept in mind to see that it is done right for the health and safety of inmates, staff and the general public.

We will address major issues that have repeatedly been the subject of inmate complaints and will discuss the general themes which have been raised by them. On some topics we suggest questions which the Council can pose to the Departments of Health and Correction. At the end of our presentation we will suggest some legislative remedies to improve the quality of jail medical care, to lower its costs, and to increase accountability.

DEATHS IN CUSTODY

A number of deaths of inmates have been reported to have occurred in City jails, including at the jail infirmary. Some of these deaths appear to have been preventable, based on initial reports.³ Because the City Board of Correction no longer investigates the deaths of City inmates, we recommend that the Committee obtain and read the death review reports of the State Commission of Correction on a regular basis to gain a better understanding of how the jail medical care system may have failed and of the State Commission's recommendations for improvements to the jail health care system. The Council may also wish to consider taking steps to ensure that there is a public and transparent death review process by City officials, independent of the Department of Correction, since this function appears no longer to be exercised by the Board of Correction.

² In the case of *Estelle v. Gamble*, the United States Supreme Court ruled that government has a constitutional obligation to meet the serious medical needs of its prisoners. New York City's Charter requires that the Department of Health provide for the care and treatment of City inmates. The City Board of Correction has promulgated Minimum Health Care Standards for the City Departments of Health and Correction, and any medical service contractor, to follow.

³ We say "initial report" because although the Board of Correction is required by the City Charter to investigate and report on inmate deaths in custody, it has stopped issuing Death Review Reports, apparently preferring to rely on the Department to investigate and report on itself.

SUICIDE RESPONSE

As the Committee knows, the downsizing of psychiatric hospitals has flooded jails and prisons with people who suffer from mental illnesses. Mentally ill prisoners frequently encounter difficulty abiding by the rules and regulations of jail, and often find themselves in confrontations with staff and other prisoners. Many then find themselves punished and confined to their cells for 23 hours a day—a regimen which often results in psychiatric deterioration and increased risk of self-injury and suicide.

We have received complaints from prisoners and advocates about inadequate responses to threats of suicide. For example, a defense attorney reported to us that, after he called DOC to report a client's threat of suicide, the report was ignored and nothing was done until the next day, after the client tried to kill himself. We regularly contact DOHMH and PHS to request immediate intervention for prisoners who contact us, or whose lawyers contact us, because of threats of self-harm.

Although the Department of Health and Mental Hygiene says that it is its policy to require psychiatric hospitalization of suicidal inmates, it does not appear that this is the actual practice.

Many inmates who express suicidal thoughts or attempt to kill themselves are not hospitalized, but instead are placed on a jail "suicide watch." In at least one instance, a prisoner deemed by a judge to warrant suicide watch was not even placed in that status, and hanged himself within his first twenty hour hours in custody. Inmates confined by themselves in cells for 23 hours per day, especially those with underlying psychiatric problems, are at particular risk of suicide or self injury. We know of at least two suicides in the close custody unit (where vulnerable inmates who require separation and protection are housed). One of these suicides was an adolescent boy.

If an inmate has broken the jail rules, but is mentally ill, DOC will in many instances keep the inmate in punitive segregation, *i.e.*, in solitary confinement, for weeks or months at a time in a cellblock known as the Mental Health Unit for Infracted Inmates or "MHAUII." We believe, based on the consensus of medical expert opinion, that solitary confinement can be, and often is, dangerously inappropriate for mentally ill inmates: it can literally cause them to become severely depressed, or suicidal. MHAUII was created by the prior administration at our request, after we identified a number of prisoners in the Central Punitive Segregation Unit (or "CPSU") who had decompensated under the harsh conditions of isolated confinement. MHAUII does have clinical staff on-site which provides enhanced mental health services; it is clearly a step above what we saw ten years ago. But, in our view, it does not sufficiently respond to the disastrous effects that prolonged solitary confinement can have on persons with mental illness. The consequences of such confinement can be physically as well as psychologically injurious. We know that a large number of use of force incidents in the jails involve mentally ill inmates in MHAUII or other punitive segregation areas for mentally ill inmates, such as 12 Main in GRVC.

We have encountered other instances of the inhumane treatment of prisoners with mental illness in the jails. Several years ago, the current Department of Correction administration authorized a policy to place diagnosed mentally ill patients into solitary lockdown because it

suspected that they were “faking” mental illness to get out of serving time in punitive segregation. These inmates were known to Correction as “bing beaters” because they were perceived to be trying to beat the “bing” or jail punishment system. As a result of this directive, PHS and DOHMH supervisors reviewed, and in many cases reversed, the decisions of mental health treatment staff and “cleared” these inmates for punitive segregation. However, the Department of Correction (and perhaps DOHMH officials) ordered that these inmates be stripped practically naked, with only adult paper diapers and a so-called suicide smock, allegedly so they could not use clothes to hang themselves just in case the inmates really were suicidal or would try to fake a suicide, but go too far. These prisoners were also denied reading materials and writing utensils, although some were given crayons. The Department of Correction called this “No Harm Housing.” To the outside observer, however, this treatment appeared clearly more punitive in nature than preventive, an effort to humiliate grown men by treating them like children.

After strenuous objections to this regimen were raised by this office and others, the policy was discontinued.

I dealt extensively with an acutely mentally ill prisoner, who is no longer in City custody, who jail and health officials kept for months in solitary confinement 23 hours per day in punitive segregation despite his obvious mental illness.

When I saw him he had deteriorated to a primordial state of being; he was completely non-communicative, curled in a fetal position in a far corner of his bed. He had smeared his own feces around the cell but was kept locked in that filth. The stench could be smelled from outside the locked door. Staff told me that he had been seen eating his own waste. Nonetheless jail medical and guard staff had stripped him naked and kept him for months on end in a punitive segregation isolation cell without mental health care. While he was in the segregation area, a member of the staff of the Office of Compliance Consultants, which assists the federal court in monitoring conditions in the jails, visited this prisoner and observed the following:

[The prisoner] was observed nude and asleep (fetal position) on the bed frame with the mattress folded at his feet. The cell was littered with three partially eaten paper food trays on the bed, one partially eaten food tray on the floor and dirty/soiled bed sheets on the floor. There was what looked and smelled like feces on the bed and on the paper on the desk and floor. A strong odor, akin to feces and urine, emanated from the cell. [We] discussed the matter with the area captain and Assistant Deputy Warden, who informed us that [the inmate] would be moved from [the cell] to facilitate cleaning.

After this visit, and after we continued to complain, the prisoner was transferred to a jail mental health unit and placed in lockdown isolation cell in a remote corner of the cellblock. DOHMH officials initially told us he was put in “the most intensive treatment area on Rikers.” However, they did not tell us, as a doctor later revealed, that he was not getting any treatment in the intensive treatment unit because his condition was so severe that it was beyond their ability to treat on Rikers. But they did not admit him to a hospital, where a higher level of treatment was available, until we complained again. Instead DOHMH, its contractor PHS, and HHC sent him back and forth between Bellevue and Rikers, in a process of patient “dumping” known in the

system as “ping pong.” Eventually the relevant officials were persuaded to keep him hospitalized at Bellevue for inpatient psychiatric treatment until he was released from City custody.

We think the treatment we have described in the preceding paragraphs is unjustified. However, when persons with mental illness are jailed, conflict between their psychiatric condition and even the legitimate needs of jail security is difficult to avoid; it is far better to avoid keeping them in the jail setting. **We think that the City Council can help by funding community treatment and housing programs to keep as many mentally ill persons out of jail as possible and to allow them to become healthy in an appropriate treatment environment. Jails simply are not that place.**

SICK CALL ACCESS

Inmates consistently report difficulty getting seen by medical staff at both daily and emergency sick call. Obviously, preventing access to sick call can be a dangerous failing if an inmate is seriously ill or injured and cannot get prompt treatment.

Board of Correction Minimum Health Care Standards require that :

Sick-call shall be available at each facility to all inmates at a minimum of five days per week within 24 hours of a request or at the next regularly scheduled sick-call. Standard 302.c.1.

Sick-call is to be conducted by a physician or under the supervision of a physician.

(i) correctional personnel shall not prevent or delay, or cause to prevent or delay an inmate's access to medical or dental services.

(ii) correctional personnel will not diagnose any illness or injury, prescribe treatment, administer medication . . . or screen sick-call requests.

Standard 302.c.2.

Emergency Services. All inmate requests for emergency medical or dental attention shall be responded to promptly by medical personnel. This shall include a face to face encounter between the inmate requesting attention and appropriate health care personnel. Standard 302.d.1.

Regular sick call

Despite the Board's rules, inmates have consistently complained to us over a period of years about restrictions on seeing a doctor at one of the largest Rikers jails, the Anna M. Kross Center, or AMKC. We have received many complaints that some housing areas simply are not called for sick call, sometimes for days on end. In other instances, inmates are taken to sick call, but sit in uncomfortable and crowded waiting rooms for hours on end, often late into the night; correctional staff then offer to return them to their housing areas, and many are so exhausted or frustrated that they do so, foregoing their right to medical attention. Some of the recent complaints describe what amounts to a crude quota system. Inmates have reported that only a

fixed number of those wanting to go to sick call will be taken there by correction staff (*e.g.* 4 out of 12). Then inmates are told to choose among themselves who needs to go the most. The rest are left behind and denied treatment.

We have requested that DOC and DOHMH enforce the rules against staff interference with daily sick call. The BOC Minimum Standards state that “correctional personnel shall not prevent or delay, or cause to prevent or delay an inmate's access to medical or dental services and that (ii) correctional personnel will not diagnose any illness or injury, prescribe treatment, administer medication . . . or screen sick-call requests.” Standard 302.c.2.

Nothing has occurred to our knowledge in response to those requests, despite our numerous reports and demands to that effect. A simple request to post the rules in the housing areas about letting inmates see a doctor (*i.e.*, the Minimum Standards requirements) has been ignored by DOHMH and DOC for years.

Emergency sick call

We receive frequent complaints that access to emergency care is also denied, or an inmate’s request for help is second guessed, particularly by untrained DOC staff, in violation of BOC Minimum Standards. For example, inmates say they are frequently told by officers, “you must be bleeding or dying or unconscious” to get emergency care, contrary to the above quoted Minimum Standard 302.d.1, which requires prompt response to *all* requests for emergency care.

These complaints are not just about correction staff, but are directed at to PHS health care staff as well. For example, an asthmatic with an acute breathing attack during the night complained to us that PHS told DOC staff to tell him to wait until morning when the clinic opened, instead of treating him in a nearby infirmary that was open all night.

Bureaucratic obstacles: No treatment without forms

Inmates frequently complain to us that PHS staff will not see or treat them in the jail clinics for injuries without a DOC “injury to inmate report.” We know that a number of inmates are struck and injured in incidents that are not reported, and hence there is no “injury to inmate” form filled out. In some cases, the inmate is threatened by Correction staff not to report the use of force. It is only after the inmate contacts us, and we in turn contact DOHMH Risk Management, that these patients will be seen, examined, and treated.

Dental sick call

We still see long delays of days, weeks and months for complaints of dental pain, which in some instances no doubt represent true emergencies.

DOHMH has told us that part of the problem is a lack a sufficient number of dentists to meet the demand for care.

CONTINUITY OF CARE

We have received complaints that PHS does not continue medicines prescribed for AIDS patients, persons with heart disease or other chronic conditions before they were arrested.

We have had many complaints about treatment orders, either existing orders for chronic care from personal physicians or City hospitals, or even HHC specialist orders, that are not being followed by PHS or are changed without explanation to the patient.

SPECIAL MEDICAL DIETS

When a doctor orders a restricted medical diet it is because the patient cannot safely eat the regular jail diet served by the jail kitchens. High salt food can be dangerous to an inmate with high blood pressure or heart disease. Sugary sweet food can be dangerous to a diabetic.

Inmates regularly complain to us that these important medical diet orders from jail doctors are not maintained in place if an inmate is transferred to a different DOC jail. Often, special diet orders are not implemented by the kitchen in the first place, until we intervene and contact DOC and the DOHMH.

DISABLED / HANDICAPPED INMATES AND ORTHOPEDIC CARE

Many inmates are admitted to the jails with severe injuries or handicaps requiring intensive care and physical therapy to prevent permanently disabling conditions. Yet, to our knowledge, there is no organized system of treatment oversight or appropriate housing for physically disabled inmates, though many of them are housed in the North Infirmary Command on Rikers Island. We have long advocated that this care be placed under the supervision of a qualified orthopedist. Disabled inmates are housed in large dormitories with poor facilities. Physical therapy, when it is offered, is held in a cramped, poorly equipped room at the men's infirmary. Bathroom areas are deteriorated and have barriers that prevent handicapped inmates from safely using toilets, sinks and showers.

Patients complain that they do not get the early treatment or therapy that is critical to preventing loss of function or range of motion. We have repeatedly received complaints from prisoners that they are not being provided the physical therapy that is prescribed for them.

Just last Friday, October 24, seven prisoners held at the North Infirmary Command called our office to request assistance in obtaining functioning wheelchairs, follow-up ordered care for prosthetic limbs, pain medication and appropriate medical equipment, such as a foam mattress. One of these inmates, who is blind, told us that he had been required to go to court on a regular DOC bus, not the van in which he is ordinarily transported, and in trying to enter the bus had fallen, sustaining injuries which required his treatment at Bellevue.

We urge the Council to require that DOHMH establish a treatment unit for the physically disabled that is competently administered, handicapped accessible and that is under the direction of an orthopedist, with enough staff to provide assistance with daily living and the physical

therapy equipment and services necessary to allow patients to recover or regain as much function as possible.

Handicap and Wheelchair Transport

Disabled inmates who cannot walk need to be transported to and from court and medical appointments in appropriate vehicles. Until recently, DOC used converted vans without proper restraints to prevent patients, including those in wheelchairs, from being thrown about the cabin. The use of these jerry-rigged vans frequently resulted in serious injury to inmates during outside trips to court or to medical clinics. The City has had to pay thousands of dollars in lawsuits brought by inmates injured in these vans.

We are pleased to report that, under a settlement agreement with the U.S. Department of Justice, following our request for an investigation by Justice, DOC has recently purchased several specially manufactured wheelchair ambulettes for the transport of handicapped inmates.

DOC INTERFERENCE WITH MEDICAL ORDERS FOR DISABLED INMATES

The jails have many handicapped and disabled inmates, some of whom are paralyzed from gunshot wounds, falls, motor vehicle collisions or other types of accidents or diseases. Some are temporarily suffering from broken legs or arms or back injuries that prevent them from walking normally. Some of these inmates are confined to wheelchairs or must use canes or crutches or braces to get around. Inmates will come to jail with these aids and jail doctors will write permission slips to allow the disabled inmate to use them while in jail.

However, we are frequently called by prisoners and their families after DOC uniformed staff have confiscated medically ordered canes, wheelchairs, crutches, braces, or orthopedic shoes without first checking with medical staff to find out if the inmate has a doctor's order. We have complained to DOC, DOHMH and BOC officials about this practice for years with no apparent change.

The DOC and BOC have failed to address this issue or even reply to our repeated complaints over the past several years. As a result, we have requested an investigation by the Department of Justice of this apparent pattern and practice violation under the federal disability discrimination law.

In addition, various other DOC actions are reported by patients. For example, despite a federal court order prohibiting the practice, we learned of repeated instances of rear-cuffing of an asthmatic inmate who needed to be able to use his inhaler pump in an emergency on the way to court. A Deputy Warden ignored medical orders not to rear cuff the inmate, but to use instead the Department alternative of front cuffing the inmate to a secure to a waist chain that would still allow the inmate to use his inhaler. We complained to DOC Central Office but our complaints were ignored, and the asthmatic inmate continued to be rear-cuffed, until we said we would go to court and seek contempt sanctions.

PREGNANT WOMEN AND INFANT CARE

A significant number of pregnant women are jailed each year and require competent prenatal and obstetrical care to insure a safe and healthy delivery.

Still, pregnant women's health care at the jail for women on Rikers is often deficient. One of the most egregious incidents we dealt with was witnessed by one of Legal Aid's parole attorneys: a pregnant inmate with HIV was brought to court for a parole hearing *while in labor*. Because she had HIV it was extremely important that her pregnancy be closely monitored so that when she gave birth, the HIV virus was not transmitted to the baby during delivery. Long before the incident, at the beginning of her pregnancy, we told PHS about this woman's need for special delivery precautions.

We do not know why jail doctors cleared her for court in this condition, but apparently this incident is not unique to PHS at Rikers. The *New York Times* reported several similar instances in other jails run by PHS where women gave birth in their cells, not a hospital, and were ignored by PHS staff.

We recommend that the Council investigate if there is a systemic PHS practice that delays hospitalization for near-term, high risk pregnancies

PHS STAFF RETALIATION

A number of complaints have been lodged against PHS staff at the jail infirmary at NIC and at other jails that inmates are called names, or threatened with discharge from the infirmary, or with disciplinary action for questioning their treatment or complaining to Legal Aid about their medical care.

Other inmates complain that when they ask for stronger pain medicine, PHS staff have called them names, like "junkies." The *New York Times* reported similar behavior by a PHS doctor in an Illinois correctional facility. Inmates complain to us that PHS staff even deny or reduce pain medicine doses, sometimes in retaliation for perceived insolence or making complaints to their attorneys.

We have passed on many such complaints over the years but have almost never received substantive responses to them. We think it would be helpful for the Council to inquire into what DOHMH has done about such behavior, both as a general preventive matter and in response to specific complaints or incidents.

The repeated complaints which we have heard about PHS health care staff calling names and making threats of retaliation also raises the issue of how PHS screens its applicants for professional temperament, what the PHS staff qualifications are, and what PHS senior staff do to enforce appropriate standards of behavior towards inmate patients. We know, for example, that PHS has hired in one case a doctor whose medical license was suspended in two states, including New York, after patients died under his care because of "gross negligence," as the Court described his conduct.

We brought this to the attention of PHS and DOHMH years ago but to our knowledge the doctor is still working in the jails for PHS and treating inmates.

We note that under the former not-for-profit medical provider in the jails, Montefiore Hospital and Medical Center, it was extremely rare for our office to receive complaints of this sort of abusive treatment from medical personnel. We think that was because the strong message from the top at Montefiore was to treat patients in jail with the courtesy and respect that patients in any other setting would receive. It does not appear that the present provider is sending or reinforcing that message.

LACK OF ACCOUNTABILITY

Since this March, because of the loss of staff, DOHMH has stopped providing written answers to our complaints or requests for information when we present medical releases.

The Board of Correction hardly ever responds to our investigation requests. Hundreds of requests for enforcement of the Board's Minimum Standards for Health Care have gone without any reply from the BOC. We understand that the BOC has a severe shortage of staff that impedes their ability to investigate medical care complaints, either individual complaints or complaints that suggest patterns of mistreatment.

We also understand that Board members are not provided with our email complaints about medical care, which are copied to BOC staff. This might help explain why the BOC's monthly public meetings have never, to our knowledge, ever discussed a single patient complaint forwarded from our office for BOC investigation. Beyond that, the BOC has never, to our knowledge, undertaken any investigation of patterns of violations of their own Minimum Health Care Standards, much less produced written reports to the public about compliance with the Standards.

CONCLUSION AND LEGISLATIVE RECOMMENDATIONS

Some history: for over 20 years, between 1975 and 1997, most jail medical care was provided by a local non-profit teaching hospital. Since 1997, the City has relied, unwisely we think, on for-profit contractor providers. Since then inmate complaints to us about medical care have increased dramatically. As you know, periodic exposes have appeared in the newspapers about poor care and preventable deaths.

Yet the City continues to issue contracts based on the for-profit model.

To address this problem, the City Council can enact legislation that creates a preference for local teaching hospitals in the contract bidding process for the provision of jail medical care.

The federal courts are increasingly limiting their scrutiny of human rights in local jails and prisons. A federal statute has allowed local governments, including New York City's, to roll back the judicial protection of constitutional and other human rights in jails. At present, the City is seeking to terminate the court order that sets minimum standards for humane treatment of

prisoners who are held in the City's psychiatric hospital wards—at Bellevue and Elmhurst Hospitals—because the level of care they need is not available in the jails. The City Council is in a position now to take the lead to demonstrate that New York City is serious about maintaining humane conditions in its jails. To this end, the City Council can enact legislation that authorizes the Board of Correction or aggrieved persons—the prisoners who were intended to benefit from their protections—to enforce its Minimum Standards in local courts.

Another measure that is likely to provide increased oversight of the delivery of medical care in the jails would be a requirement that the jail health services be subject to review and accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO). It is not a coincidence that the delivery of psychiatric care to hospitalized prisoners in New York City improved markedly after the Joint Commission indicated in 1987 that it would not accredit Bellevue Hospital unless it made significant, long term improvements on the forensic psychiatric ward.

Finally, the North Infirmery Command, the medical infirmary on Rikers Island for the care of male inmates, has limped along for two decades in a decrepit building that was converted from an old garage. The City had plans, known as the C-133 Project, to build a permanent medical center on Rikers Island to provide infirmary care (*not* hospital care) in an acceptable clinical environment and to attract quality staff to work there. This plan was defunded during the Giuliani Administration. We urge City Council to restore funding for this long overdue and necessary project.

Thank you for this opportunity to express our perspective on the oversight of City jail medical care.