NEW YORK CITY
BOARD OF CORRECTION

March 11, 2014

MEMBERS PRESENT
Gordon Campbell, Esq., Chair
Alexander Rovt, Ph.D., Vice-Chair
Greg Berman
Robert L. Cohen, M.D.
Honorable Bryanne Hamill
Michael J. Regan

Excused absence was noted for Catherine Abate, Esq. (present via telephone).

DEPARTMENT OF CORRECTION
Evelyn A. Mirabal, Chief of Department
Mark Cranston, First Deputy Commissioner
Ari Wax, Sr., Deputy Commissioner
Thomas Bergdall, Esq., Deputy Commissioner and General Counsel
Erik Berliner, Deputy Commissioner
Florence Finkle, Esq., Deputy Commissioner
Sara Taylor, Chief of Staff
Martin Murphy, Deputy Chief of Staff
Eldin L. Villafane, Press Secretary
Carleen McLaughlin, Legislative Affairs Associate
Ana Billingsley, Urban Fellow

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Homer Venters, M.D., Assistant Commissioner, Correctional Health Services
Daniel Selling, Psy. D., Executive Director of Mental Health/Substance Abuse Treatment
George Axelrod, Chief Risk Officer
Jasmine Graves, Research Coordinator to the Medical Director
Patrick Alberts, Agency Counsel

OTHERS IN ATTENDANCE
Dahianna Castillo, Office of Management and Budget (OMB)
Laurie Davidson, Doctors Council
Allan Feinblum, Jails Action Coalition (JAC)
Hadley Fitzgerald, JAC
Leah Gitter, JAC
Susana Guerrero, State Commission of Correction
Terry Hubbard, JAC
Elias Husamudeen, Correction Officers Benevolent Association (COBA)
Farzaan Ijaz, New York University School of Law Student
Martha King, Office of the Mayor
Lucas Koehler, OMB
Neil Leibowitz, M.D., Director of Mental Health, Corizon

Barbie Melendez, BOC
Jennifer Parish, Urban Justice Center (UJC)/JAC
Daniel Pearlstein, City Council
Jake Pearson, Associated Press
Shaquana Pearson, BOC
Julie Pennington, JAC
Jessica Prince, UJC/JAC
Anokhi Shah, JAC
S. Shapiro, Office of Mental Health (OMH)
Marc Steier, COBA
Mike Winesip, New York Times
Sallina Yung, OMB
Michael Zuckerman, M.D., Vice President of Operations, Corizon

Chair Gordon Campbell called the meeting to order at 9:05 a.m. A motion to adopt the minutes from the Board's January 14, 2014 meeting was approved without objection. The Chair announced the unfortunate resignation of former Board Member Pamela Silverblatt, who was a great asset to the Board.

Chair Campbell stated that the Board has instituted quarterly meetings with the Department of Correction (DOC), Department of Health and Mental Hygiene (DOHMH), Corizon, several Board members, and Board staff to discuss recent deaths and problematic use of force incidents. He went on to state that the December meeting was very productive, and it focused on the lessons that all parties can learn from a particular incident.

Chair Campbell reported that Acting Commissioner Mark Cranston has decided not to request renewal of the Temporary Cell Restriction (TCR) variance. The Chair noted that on Wednesday the Board was provided metrics for all of the Restricted Housing Units (RHUs), which he had requested from DOC and DOHMH at the January Board meeting.

Executive Director Cathy Potler gave the following report:

- Doctors Council has discussed with Board staff their concerns about non-compliance with the Health Care Minimum Standards, in areas such as inadequate staffing levels, especially on the midnight tour; long waits for patients to be seen by physicians at some clinics; and workplace safety issues. Doctors Council invited Board members and staff to join them on a walk-through of several clinics. At the January meeting, Chair Campbell agreed to the tour and invited DOC and DOHMH to join us. Dr. Venters organized a meeting with all interested parties on January 29th. Board staff attended, along with representatives from DOHMH, DOC, Corizon, NYS Nurses Association, 1199, Doctors Council, and the Correction Officers Benevolent Association (COBA). It was a productive meeting with open and frank conversations about the problems. A follow-up meeting is planned in the next month or so.

- At our January meeting public forum, Ms. Myra Hutchinson reported that her godson, while housed at Rikers Island, was admitted to Bellevue Hospital, and that when he was discharged from Bellevue and returned to Rikers Island, he learned that his property had been either lost or stolen. She said that he did not have any clothes, his eyeglasses, soap, and other items, and that she had to purchase clothing for him. According to our staff, the situation she had described is not uncommon, and there does not seem to be a process in place to address this issue consistently throughout the system. At NIC Infirmary, Board staff receives similar complaints from inmates who were sent to the hospital, admitted at the hospital, and then sent to NIC Infirmary upon discharge, for closer medical supervision. They are unable to locate their property from the sending facility. An inmate is really stuck if he does not have family who can bring him clothes, he cannot borrow clothes from other inmates, or he is unable to find clothing in the facility's clothes box. This problem does not exist at Rose M. Singer Center because the women are housed in only one facility. Both BOC and DOC staff spend significant time tracking down lost property.

- The Mental Health Minimum Standards established an Observation Aide (OA) program whereby inmates work as suicide prevention aides in new admission, mental observation and punitive segregation housing areas. OAs are required to apply for the job. If DOC deems them eligible and they pass a written test, they are trained to monitor inmates who have been identified as potential suicide risks and to recognize the warning signs of

> suicidal behavior in other inmates. Over the years, it has been a successful program. Recently, however, our staff has observed that the OA program is not operating properly at many facilities. For instance, they are being used as sanitation workers, locked in the pantry whenever punitive segregation inmates are brought out of their cells, or are not assigned at all to the required housing areas. This problem was particularly striking in two most recent deaths. In one, the OA was assisting in the clean-up of a plumbing problem several cells from where an inmate committed suicide in punitive segregation, and in another, no OA was assigned to the Mental Observation Unit (MOU).

Chair Campbell stated that DOC should report back to the Board at the May meeting on the OA program and the property issue.

Board Member Catherine Abate asked if an aftercare appointment is made when an inmate comes back from Bellevue Hospital. DOHMH Correctional Health Services (CHS) Assistant Commissioner Homer Venters, M.D. responded that all hospital returns pass through a medical clinic before they are housed, to enable medical staff to assess the patients' medical needs and schedule new appointments.

Board Member Robert Cohen, M.D., expressed his disappointment over the Department's decision not to renew the TCR variance as a way to limit the use of punitive segregation. In response to Dr. Cohen's remarks, Acting Commissioner Mark Cranston stated that there are many aspects of TCR that discourage its use by staff, including the following: the amount of paperwork TCR requires, the requirement that a captain respond to the scene, and the fact that officers already have the authority to lock someone in if there is an incident or violence without having to resort to the TCR process. Acting Commissioner Cranston added that the Department would reconsider the possibility of having a temporary lock-in. Dr. Cohen stated that it need not be TCR, per se, but it is important to have available alternatives to punitive segregation.

Chair Campbell reported on the Board's rulemaking process. He stated that the Board is in the fact-finding stage. By the end of May, the Board should have completed its tours of the jails and meeting with and learning from a variety of stakeholders and experts. The Board will hold two public forums: one in mid-June to hear from experts across the country about their experience in reducing the use of punitive segregation and its effects on safety and security, and the second forum in September on whether to separately house inmates between the ages 18 to 21 or 18 to 24. Board staff is in the process of analyzing data to gain a better understanding of the different cohorts and identifying promising best practices, both nationally and internationally. The Board will begin drafting the proposed regulation in the fall. In conclusion, Chair Campbell stated that the Board needs to move quickly, but that "we also understand that we need to make sure that we get it right." He thanked Dr. Cohen and Ms. Hamill, chairs of the adult and adolescent rulemaking committees, respectively, for their hard work and leadership, and asked them to report on their committees' work.

Dr. Cohen emphasized that the Board should move rapidly and that DOC does not need to wait for the Board to promulgate rules; it can move in parallel or ahead of the Board. He referred to the dramatic changes implemented in the last year by the Director of the Federal Bureau of Prisons, as described in the Director's recent testimony during United States Senator Durban's hearing on solitary confinement.

Board Member Honorable Bryanne Hamill reported the following:

> We did tour RNDC on January 30th, and at that time we had an opportunity to

> observe the new admission dorm, the RHU, the general population youth who had signed out of the educational programming, the Punitive Segregation Units, Mental Observation Unit . . . . We had a number of very productive meetings . . . with the DOHMH Deputy Director and a big chunk of the mental health staff that works with the adolescents . . . Department of Correction staff, [and] the Deputy Wardens of Operations and Security for RNDC. . . . [I]n general, there seems to be agreement that our youth at Rikers are very much in need of much more programming, art, music . . . more recreation . . . more therapy, and more therapeutic interventions, and not just for those in CAPS or RHU or punitive segregation, but in the general population, to reduce idleness. . . . We will be returning to tour some other parts of the facility, to see the CPSU where there are some adolescents, and to see the female adolescents at Rose M. Singer Center.
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> We will also be joining the tour with the rest of the Board when we go to the Bellevue Hospital Prison Ward later this month.
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> We have a number of fact-finding meetings . . . with adolescent psychiatric and psychological experts . . . with the Jails Action Coalition on the adolescent issues . . . with the Legal Aid Society's Adolescent Intervention Practice . . . the Department of Health and Mental Hygiene . . . and others. . . . [I]f there's anybody present that would like to meet with us, that's not included in the scheduling . . . please feel free to contact our Executive Director. . . . We want this to be open, transparent, [and to] give everybody an opportunity to speak to us. . . .
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> [W]e plan to hold a public forum in the fall with advocates, with experts, really focusing on better understanding and better defining the age cohort for juveniles and for young adults, given the variation in proposals and recommendations. . . . It would be very beneficial to hold a public forum with respect to that issue. . . . I look forward to working with all of you as we move forward to try to improve the outcomes for our incarcerated youth.

Chair Campbell asked Acting Commissioner Cranston to report on the "short-lived life" of the Central Intake Facility. Mr. Cranston responded that Central Intake was a well-intended plan to centralize and streamline the new admissions intake process. After the plan was implemented, however, they learned that (1) although it had a capacity of 150 inmates at peak time, courts sent new admission inmates in clusters exceeding 150, and not in a steady stream, which exceeded the maximum number of inmates who could be processed in a timely fashion, regardless of how hard DOC and medical staff worked; (2) Central Intake was not funded and turned out to be a very expensive operation; and (3) the heating and HVAC systems could not accommodate cold weather in the winter or high temperatures in the summer. For these reasons, Acting Commissioner Cranston stated that the Department will go back to providing new admission processing at multiple jail locations.

Chair Campbell requested that Dr. Venters report on the Clinical Alternative to Punitive Segregation unit (CAPS). Dr. Venters reported that CAPS continues to function very well. He explained that at the moment at AMKC one CAPS unit is a cell housing area and the other is a dormitory He went on to state, however, that one change will be made to one of the CAPS units: the one dorm unit will be replaced with another cell housing area. While patients in both units are engaged in programs throughout the day, those in the big, open dormitory area do not feel secure at night when the lights are shut off. Board Member Alex Rovt asked how many inmates

live in the dormitory. Dr. Venters replied approximately six to ten patients, and he went on to explain that it is a large dormitory with beds very close to each other, housing people with a serious mental illness. More patients could benefit from this program if the dormitory, which is under-utilized, were replaced with cell housing.

Ms. Potler asked what the average daily census would be once CAPS is comprised of two cell housing areas. Dr. Venters replied that it would increase by 20.

Chair Campbell stated that while everyone would agree that CAPS is a success, the RHUs have been very problematic because of the lack of steady and trained correctional staff, limited clinical programming, lack of an operating manual, uses of force and splashing, and physical plant limitations. The Chair reported that last week the Board finally received DOC's draft RHU directive and DOHMH's operating manual. He asked that Acting Commissioner Cranston report on why the directive only requires that two officers and one captain, rather than all staff who work in the RHUs, be steady and trained, and that Dr. Venters discuss why there are no substantive changes in the clinical programs and no added incentives for good behavior.

Mr. Cranston responded that most of the RHUs' physical layout could not provide the necessary security for the staff and made for a difficult living environment for inmates who are impulsive and have underlying mental health issues. He explained that the decision to move the RHUs to GRVC was made because it has the best physical plant, which would enable staff to make secure tours and speak face-to-face with each inmate without having anyone behind them. Acting Commissioner Cranston emphasized that basic programming for inmates cannot be provided unless the area is safe for DOC, health staff, and inmates. He added that just yesterday DOC moved 19 inmates from the RHU at GMDC to GRVC. As they were about to be transferred, five of the inmates tore up their cells, ripped out the toilets from the cinder block wall and got between the cells into the pipe chases. Mr. Cranston said that fortunately no force was used and the inmates complied with the officers' commands. He further noted that this incident reminds us why the move to GRVC is necessary.

The Acting Commissioner stated that about 52 officers and captains assigned to the GRVC RHU have been trained along with the mental health staff, and that he personally addressed the staff and made it clear to them that "this isn't MHAUII; this is the RHU." The goal is to have all staff be steady and trained—even the escort officers—and it is a point that can be made clear in the directive. He added that the Warden at GRVC is very innovative, "thinks outside the box, and that "she's not afraid to take chances." He went on to state that the new Deputy Warden overseeing the RHU at is experienced in working with this population and will be a huge asset.

Dr. Venters stated that this RHU move from GMDC to GRVC has been positive since the physical plant is better at GRVC and staff has been trained. He noted, however, that, a "fundamental reevaluation of the RHU model" must be undertaken, such as mixing punishment with clinical intervention and evaluating the data that have been collected since these units opened, to assess if these units promote behavioral change.

Dr. Cohen discussed his concerns about the RHU program: it still can take new inmates entering the RHU up to a week before they get out-of-cell time; inmates are in mechanical restraints during therapy, even at the end of their stay in RHU; and there was no change in the program in the DOC directive and DOHMH operating manual. In conclusion, Dr. Cohen stated that "the RHU is essentially solitary confinement and we have to do much better than that."

Ms. Hamill asked if there is any type of step-down unit from the RHU. Dr. Cohen replied that

they go back to general population or to mental health housing. Ms. Hamill stated that when the adolescent rulemaking committee visited the RNDC RHU, mental health staff and adolescents told them that they have to be discharged to the MOU Several of adolescents told them that they re-infracted in order stay in the RHU because there is such a strong stigma attached to going into a mental health unit.

Dr. Venters stated that a fundamental evaluation of the RHU program is needed, and that since the adolescent program has been running for several years, DOHMH has enough data to begin that process. He explained that there were a number of adolescents who went from the RHU to general population and ended up being re-infracted. For that reason, it was decided that a more supportive setting such as the MOU would be better. Dr. Venters said, "If we want to improve behaviors of people in jail, we also have to improve the environment of the jail itself."

Chair Campbell stated that DOC and DOHMH have just provided us with the RHU metrics that they will be looking at and that they will provide us with the data on a regular basis. These will be discussed at the May Board meeting.

The Chair then asked Dr. Cohen to discuss Building 12 Main at GRVC. Dr. Cohen reported on his tour of the unit about a month ago as follows:

- Each person housed in the unit had an average of 373 days in solitary confinement, and two persons out of the nine owed over 2,000 days in punitive segregation.
- About two-thirds were seriously mentally ill and had not received mental health services outside of their cell.
- No group activity is afforded these individuals because, according to DOC, they are likely to engage in violent behavior.
- There were frequent cell extractions.
- While on the unit, there was a prisoner screaming for about 30 minutes. A captain and several correction officers were speaking to him, trying to calm him down.
- He is concerned that prisoners were not getting to recreation.

Dr. Cohen asked the Department to speak about its plans for the unit.

Acting Commissioner Cranston responded that these individuals are very difficult to manage. Time and again, the same eight to ten individuals have disrupted the Department's attempts to provide programs. Mr. Cranston stated that he has addressed the high incidence of cell extractions with the exceptional Warden at GRVC. She explained to him that there are five inmates who are compliant and five who are not. He discussed the incentives developed by the Warden for the five compliant inmates, and they include access to a television, DVR, and Wii system in an empty cell on the unit, as well as time in the gym.

Dr. Venters stated that the plan has been to get inmates in Building 12 Main out of GRVC and to the North Infirmary Command (NIC) Main [currently under renovation], which has much better cell configuration for patients with persistent behavioral problems. He further explained that staff can interact and engage with people better in a more open cell design, rather than in a closed-door room, so that there is a greater possibility that the outcomes will improve. Dr. Venters added that they have successfully moved some patients from 12 Main to CAPS.

Mr. Rovt asked Acting Commissioner Cranston if he ever considered separating the non-compliant inmates from compliant ones. He responded that once NIC Main is opened, it will give

them greater flexibility to transfer the inmates.

Chair Campbell asked Dr. Venters to discuss the DOHMH's recent publication in the American Journal of Public Health on self-harm in solitary confinement and provide an update on medical and mental health services at AMKC. Dr. Venters reported the following:

> We noticed . . . increases in acts of self-harm among our patients [from] 300 or 400 a year, and it has steadily marched up to 700 or 800 a year, and even more in the last year. . . . We then wanted to assess if there are variables associated with our patients or with the jail conditions that might predict this act. And, to be clear, self-harm could be something trivial, like scratching yourself with a plastic fork or spoon. It also could be lethal.
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> So we undertook an analysis from our electronic health record of about 250,000 jail admissions. We looked at variables associated with these 250,000 admissions over about three years, and what we found was that being an adolescent was highly predictive of self-harm; adolescents were 7.5 times more likely to be in self-harm cohort. Being seriously mentally ill was highly predictive; they were almost 8.5 times more likely to be in the self-harm cohort. And being in solitary confinement was highly predictive of self-harm; those in solitary confinement were about 6.9 times more likely to commit self-harm. And the serious mental illness and solitary confinement stay were also highly predictive of what we call high lethality self-harm—self-harm that could lead to death. . . . What it helps identify is that there are . . . characteristics associated with vulnerability that a person has when they come into jail, like serious mental illness, that may predict a bad outcome. . . . And so we need to work hard to think about all of these predictors as we try and mitigate bad outcomes in the jail settings.

Dr. Venters went on to discuss the update that he provided to Board regarding clinical encounters at AMKC, a jail with a high concentration of MOUs. The data update that Dr. Venters sent to the Board shows the number of inmates coming to the clinics for sick call and follow-up has remained low. He added that more and more people with serious mental illnesses have been placed at AMKC, and they have had to open more MOUs to provide these individuals intensive mental health care. As in the community, people with serious mental illness are sicker, medically, than everybody else. They need to reconsider ways to ensure the mental health patients get access to sick call and follow-up care. One way would be to use the old AMKC main clinic exclusively to treat patients in the MOUs. Dr. Venters went on to state that the problem has not been fixed and that they continue to work on it because of the urgency of this issue. Soon, he added, new admission processing will return to AMKC, which will add another thousand new admission intakes when Central Intake closes.

Dr. Cohen noted two contributing factors to this problem: (1) AMKC required escorted movement to medical and other programming several years ago, and (2) a Corizon contract metric for measuring whether patients are seen for sick call looks at whether someone from each housing area shows up in the clinic, and does not look at whether everyone who signed up for sick call made it to the clinic. Dr. Cohen asked Dr. Venters to respond.

Dr. Venters replied that the sick call access is a problem because there is no reportable or accountable way to know who wanted to go to sick call—they only know who showed up in the

clinic. He stated that it is not sufficient if only one or two people show up from a housing area. This is very different from medical follow-ups where patients are individually scheduled to be seen. In conclusion, Dr. Venters stated that until they know how many people want to go to sick call from each housing area each day, it cannot be enforceable as a performance indicator.

Ms. Potler asked Dr. Venters when the old main clinic will be available to provide medical and mental health services to inmates in the MOUs. DOC Deputy Commissioner Erik Berliner responded that April 11th is the target date. Over the last couple of years, he explained, AMKC has shifted to an escort facility for most services, but the MOU housing areas have always been an escort-only area. Mr. Berliner added that sufficient escort officers will be provided once the old main clinic is opened and that DOC would do a more complete job of tracking patients.

Ms. Potler requested that both DOC and DOHMH report on the tragic death of a 58-year old man who was housed in the MOU at AMKC. She added that the Board was very fortunate to have two of our field representatives working that weekend, and that they did an excellent job investigating his death. Acting Commissioner Cranston stated that the 58-year old inmate was admitted to DOC custody on February 8th and transferred to the MOU on February 10th. He added that this was all he could say in a public forum.

Board Member Dr. Cohen stated that the decedent was homeless, and that he had been discharged from DOC custody the day before his arrest for trespassing—a misdemeanor. He died while in custody with bail set at $2,500. Dr. Cohen added that it is very distressing that this person would end up back on Rikers Island. Ms. Abate added that the court should have referred him to psychiatric care, rather than send him to Rikers.

Chair Campbell commenced the public forum part of the meeting.

Anokhi Shah, a member of the New York University Jails Action Coalition (JAC), read a statement from Michael Ellison, an inmate who is incarcerated at the Otis Bantum Correctional Center (OBCC). The statement is attached hereto as Appendix A.

Lea Gitter is the godmother of a person incarcerated at GRVC. She discussed three concerns: (1) correction officers disrespect visitors and treat them in a degrading manner, and have visitors sniffed out by dogs on the assumption that every visitor is in possession of contraband; (2) long visit wait times, from three to five hours, for a one-hour visit; and (3) family members of inmates with mental illness do not have any way to communicate with mental health providers to check on their loved ones and to provide them input on their loved ones' psychiatric histories.

Terry Hubbard, a member of JAC and the Milk Not Jails Coalition, has visited the City jail system for the last five years as both a parent and advocate. She discussed an incident that occurred two weeks ago involving her son who has mental illness. Her son told her that he had chest pain and that he had coughed up blood at AMKC. He told her that he was not given access to medical care. Ms. Hubbard said that she spoke with correction staff and she was told that he had been given medical attention. Ms. Hubbard also expressed concern that her son had been transferred to three different housing areas within the span of a week, which she stated is very unusual for a person with a mental illness. She added that he has since been transferred to Downstate prison, but will be returning to DOC custody. Ms. Hubbard stated that she wants to ensure that he will get proper health care.

Allen Feinblum expressed hope that the Mayor will appoint a DOC Commissioner from a jurisdiction outside of New York City, where alternatives to solitary confinement are used. Mr. Feinblum stated that he communicates by mail with 26 inmates with mental illness. They have

reported that they do not receive treatment and that they have been beaten by correction staff. Mr. Feinblum asked, “How many suicides is it going to take before anything is done?” He added, “The status quo is unacceptable.”

Jennifer Parish stated that she hopes that DOC and the Board would take into consideration her comments when considering the changes that must be made. Ms. Parish referred to comments made by Dr. Venters regarding the distinction between environmental and individual factors. She stated that it is always the incarcerated who are viewed by DOC as the one to blame, and that it is the incarcerated who suffers. Ms. Parish provided several examples of how environmental factors affect the way that individuals respond. Referring to Dr. Venters’s article on self-harm in solitary, she said, “We have created a situation where people will take physical action against themselves to hurt themselves if they are put in solitary confinement.” She went on to say, “ I encourage . . . before rulemaking even happens, to really change the way that solitary confinement is being used, because the government is doing something that’s causing people harm, and we are not taking responsibility of it.” In conclusion, she discussed how the Central Intake Facility was exalted as being the fix to new admission processing, but it did not work, and there were no repercussions for DOC when it failed.

Chair Campbell adjourned the meeting at 10:52 a.m.

Appendix A

NYC Board of Correction
Public Meeting

March 11, 2014

Statement of Michael Ellison

I am 27 years old. I was incarcerated on September 7, 2012, and was placed in the Restrictive Housing Unit on December 18, 2013. I was released from the RHU in early January for "excessive behavior," and was placed back in regular solitary confinement. I was in solitary before, and was released on September 4, 2013. I stayed in the general jail population from September to December.

I am not sure how long I am supposed to be in the box. I am apparently serving time owed from a previous infraction, plus a new infraction. The last time I was placed in the box, it was for being disrespectful to staff and refusing to obey orders. I did not do anything violent. I pleaded guilty with an explanation, but I was still sentenced to time in the box. I think that my sentence now is due to something I did in 2009, back when I was in Rikers for a few months.

When I was first placed in RHU, everything was for the worse. I felt terrible. I felt like I wasn't working towards anything. I read, tried to stay focused, and stuck to a daily schedule. However, I had limited control over this because I lost track of time and external forces, like the COs, frustrated my goals. I tried to avoid the COs, but sometimes that proved impossible.

My emotions varied when I was caged. It felt like a dream state. I liked to pretend that I was in a dream, but that made coming back to reality so much worse. I never experienced hallucinations, but I did drift off a lot. Sometimes I felt like I was somewhere else. I haven't had a visitor in about 2 months. I felt my communication and social skills deteriorating. It felt weird to come back to society.

I think the main problem with RHU is that DOC and the mental health people don't cooperate. There is some sort of power struggle between the two. DOC doesn't see eye-to-eye with the mental health board. I think that mental health board has an decent agenda. When DOC intervenes with patients, however, this presents a huge concern.

I don't think that the RHU program is going to succeed as long as this battle is ongoing. The COs aren't educated about mental health. The COs antagonize us, and we are deprived of our phone access, and food. We learn skills like anger management from the mental health treatment, but we can't practice these skills because the COs antagonize us. I get pushed around by the COs on a daily basis, and so do others. The COs beat people up. I see them reacting to provocation from inmates (verbal and physical provocation), but I also see them acting in the face of zero provocation. We are put back in cages immediately after an incident between an inmate and a CO, and we have no way to express our stress. We keep our emotions bottled up. Sometimes, the

COs even stand in the way of us receiving our mental health treatment. I don't think the problems we encounter with the COs are healthy for any of the people going through the program.

Another problem with RHU is the mental health treatment itself. The providers in RHU only wanted to talk about how we feel about mistreatment; our reaction. The problem is that the mistreatment is a cause of our current emotional state, and it's generally at the hands of the COs. However, the mental health providers don't what to hear us talk about the COs (unless we are physically hurt by them), so we are left without anyone to talk to about our problems.

I was prescribed medication, but I never took it. The COs don't make us take our medication. They are largely uneducated about mental health and mental health treatment. My meds were changed about seven times over six months. There is a lack of consistency with the medication. I would be prescribed something within half an hour of meeting with a mental health provider. Then, I would talk to a different doctor and they would prescribe me something else. Sometimes the second doctor's prescription would replace the first. Other times, they just added something else to my medication list.

I think the structure of solitary also prevents RHU from reaching its full potential. For example, our recreational time is once a day, but we are in cages outside in a row. I can see and talk to people during this period, but there is absolutely no physical contact. It feels like a dog kennel. We could get the best mental health treatment possible, but it is ineffective because we are in solitary, and because we have to constantly deal with DOC's antics.

Additionally, I think that there needs to be a greater incentive for people to enroll in RHU. Right now, it's a 60-day program. The time you have left after completing the program is slashed in half. I think that there needs to be a greater concession given for those who complete the program. However, the main problem is definitely the power struggle between DOC and mental health. If DOC wouldn't frustrate the goals of the mental health board, I think that RHU would be able to accomplish a lot more.

I have other complaints about life at Rikers. The food I receive is always cold, and disgusting. We also have limited portion sizes. The weight loss I have experienced since being here has been dramatic. Additionally, there is almost no access to the law library. We get copied papers out of the books but this is distributed at random. A guy comes around and distributes copies of pages of books. I think that the law library access should be taken a lot more seriously. I've thought about filing grievances before, but I did not because I thought nothing would come of it. I think that DOC has the power to sweep anything under the table that it doesn't want to deal with.