



**TESTIMONY BEFORE THE
JOINT LEGISLATIVE HEARING
ON HEALTHCARE IN NYS CORRECTIONAL FACILITIES
CONDUCTED BY THE
ASSEMBLY COMMITTEES ON
CORRECTION AND HEALTH**

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**Karen L. Murtagh, Esq., PLS Executive Director
Betsy Hutchings, PLS Deputy Director
Michael Cassidy, PLS Litigation Coordinator
Prisoners' Legal Services of New York
41 State Street, Suite # M112
Albany, New York 12207
(518) 445-6050**

kmurtagh@plsnyc.org

INTRODUCTION

We would like to thank the members of the Correction and Health Committees for inviting Prisoners' Legal Services (PLS)¹ to testify about health care issues in state prisons. Our testimony today will identify critical issues in correctional health care that require immediate attention including adequacy of care (with a focus on delay in treatment and continuity of care), barriers to providing adequate care, treatment of communicable diseases and pain medication and chronic pain management. Our testimony will also focus on setting proposed standards for addressing these issues and developing a system of meaningful oversight that will help ensure that incarcerated New Yorkers are provided the medical care they need and to which they are entitled.

As many of you know, for over 40 years PLS has been responding to the grievances and concerns of incarcerated New Yorkers. Many of those concerns have involved issues of medical care and treatment. Each year, PLS receives, on average, 500 requests for assistance with matters involving general medical care issues. While we are not able to investigate all of these complaints due to our limited resources, the sheer number of requests demonstrates that the provision of adequate medical care continues to be a critical issue in our prisons.

By serving as the legal custodian of individuals in the custody of the Department of Corrections and Community Supervision (DOCCS or the Department), the Department is responsible for the physical well-being of every state prisoner. New York State regulations require that incarcerated individuals receive "adequate health care and health services [...] to protect their physical and mental well-being."² The state is also legally obligated to provide adequate medical care to those in its care and custody under our Federal Constitution.³ Unfortunately, however, legal mandates do not guarantee that reasonably adequate care always will be afforded.

To help further ensure that departments of correction meet the federal constitutional standards in providing medical care to prisoners, in 2010, the American Bar Association (ABA) adopted the ABA Criminal Justice Standards on the Treatment of Prisoners. These standards include

¹Created in 1976, following the uprising at Attica Prison, PLS provides a voice for incarcerated New Yorkers. Our mission is to provide high quality, effective legal representation and assistance to indigent prisoners, to help them secure their civil and human rights and to advocate for more humane prisons and for a more humane criminal justice system.

² New York Code Rules and Regulations Title 9 NYCRR § 7651.1.

³ *Estelle v. Gamble*, 429 U.S. 1066, 97 S.Ct. 798 (1976).

a section on health care.⁴ The ABA Standards governing health care for incarcerated people mandate that “prisoners are provided necessary health care, including preventive, routine, urgent and emergency care” and that “such care is consistent with community health care standards.”⁵

Today, to both foster the provision of appropriate and necessary care in our prisons and to help assess whether and when care that is provided is reasonably adequate, we encourage adoption of the ABA Standards. We also urge New York to embrace “The Standard Minimum Rules for the Treatment of Prisoners,” adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders in 1955, most recently amended in 2015. Both the ABA Standards and the United Nations rules should serve as our guideposts.⁶

The revised United Nations rules are commonly referred to as “the Nelson Mandela Rules,” in honor of the late-President of South Africa, Nelson Mandela, who spent 27 years in prison during his struggle for human rights, democracy and the promotion of a culture of peace.⁷ Rules 24 thru 35 set forth detailed guidance for health-care services in prisons. These rules are considered a “truly updated blueprint for prison management in the twenty-first century.”⁸

Rule 24 of the Nelson Mandela Rules states:

1. The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.
2. Health-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence.⁹

⁴ American Bar Association, *Proposed ABA Criminal Justice Standards on the Treatment of Prisoners*, Adopted February 2010. Hereinafter referred to as “ABA Standards.”

⁵ *Id.* at p. 30.

⁶ The Standard Minimum Rules for the Treatment of Prisoners were adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, in 1955, and approved by the Economic and Social Council in its resolutions 663 C (XXIV) of 31 July and 2076 (LXII) of 13 May 1977.

⁷ General Assembly resolution 70/175 entitled “United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)”.

⁸ United Nations Office on Drug and Crimes, *Assessing compliance with the Nelson Mandela Rules A checklist for internal inspection mechanisms*. August 2017. https://www.unodc.org/documents/justice-and-prison-reform/E_ebook_interactive.pdf p. 1.

⁹ <https://cdn.penalreform.org/wp-content/uploads/1957/06/ENG.pdf>.

I. MEDICAL CARE IN NEW YORK STATE PRISONS

A. ADEQUACY OF CARE

Forty years ago, the United States Supreme Court held that the state has an obligation to provide medical care to those whom it incarcerates.¹⁰ “An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical ‘torture or a lingering death.’ ”¹¹

In 2017, the Department’s health care budget was \$395,196,000, with a projected health care staff of 1,651.¹² Despite a budget of almost \$400 million, a staff that would provide a ratio of approximately one health care provider to every 30 prisoners, and a declining prison population, PLS continues to receive over 500 complaints annually regarding inadequate medical care in New York State prisons. While these complaints cover a myriad of issues, the majority of the complaints center on delays in treatment and the failure to provide continuity of care.

1. Delays in Treatment

While we all have experienced delays in obtaining medical treatment, whether it be having to wait several hours in an emergency room or several months to see a specialist, those delays pale when compared to the delays in treatment faced by many incarcerated individuals. Below are a few examples of such delays we have seen:

- C.W. was suffering from kidney stones. C.W. was seen by a urologist on April 29, 2015, but despite the doctor’s recommendation that C.W. have the kidney stones removed as soon as possible, the stones were not removed until April 11, 2016, almost a year later and only after PLS advocated on his behalf.
- A.M. requires blood pressure medication but, despite his numerous requests, he did not receive any medication for over two months. In fact, it was not until A.M. wrote to PLS about his situation and we contacted the superintendent of the facility where AM resided that the issue was resolved. The superintendent admitted a mistake had been made, and A.M. was immediately placed on the appropriate medication.

¹⁰ *Estelle v. Gamble*, *supra* note 3.

¹¹ *Id.* at 103 (citations omitted).

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<https://www.budget.ny.gov/pubs/executive/eBudget1718/agencyPresentations/appropData/CorrectionsandCommunitySupervisionDepartmentof.html>.

- J.Q., an incarcerated individual whose disability requires him to use a wheelchair, spent months in prison without a shower chair. After PLS advocacy, he was given a shower chair; however, J.Q. advised PLS that the chair did not actually fit into the shower and that caused him to fall several times. After PLS advocated for a different chair that was the proper size, J.Q. was finally given an adequate shower chair.
- K.F. has no legs and upon entering prison was given a broken wheelchair, which was very uncomfortable and difficult to use. K.F. was also denied physical therapy and prosthetic legs. K.F. complained for months, but it was not until PLS sent an advocacy letter that K.F. was fitted with a new wheelchair and informed that she would be starting physical therapy in preparation for being fitted with prosthetic legs.

The complaints that PLS receives regarding delays in treatment involve all types of medical issues including serious complaints about delays in receiving dental care. The *ABA Standards on the Treatment of Prisoners* specifically address the issue of dental care in prisons, stating:

“Dental care should be provided to treat prisoners’ dental pain, eliminate dental pathology, and preserve and restore prisoners’ ability to chew. . . . [R]outine preventive dental care and education about oral health care should be provided to those prisoners whose confinement may exceed one year.”¹³

Nelson Mandela Rule 25(2) in part states: “The services of a qualified dentist shall be available to every prisoner.” Rule 32.1(d) states in part:

The relationship between the physician or other health-care professionals and the prisoners shall be governed by the same ethical and professional standards as those applicable to patients in the community, in particular:

(d) An absolute prohibition on engaging, actively or passively, in acts that may constitute torture or other cruel, inhuman or degrading treatment or punishment.

The complaints that we receive regarding poor dental care are extremely troubling. The following are just a few examples of the complaints about delays in the Department’s provision of dental care:

- J.M. needed to have a decayed tooth pulled. He was in excruciating pain for over 19 months and made numerous requests to be seen by a dentist to perform the extraction. Only after he contacted PLS and we advocated on his behalf, did a dentist finally extract the tooth.

¹³ ABA Standards *supra* note 4, at p. 30.

- M.C., an inmate at Fishkill C.F., was told in November 2014 that he needed oral surgery due to tooth decay. He was subsequently transferred to another prison. He did not get the surgery until July 2016, one and a-half years later, and again, only after PLS advocated on his behalf.
- C.M. lost a filling in March of 2016. By April 2016, he had put in six requests for dental care. In May, his teeth were cleaned and he was told he would be put on a list to have his filling replaced. C.M. continued to submit requests for care over the next 11 months and in February of 2017 he wrote to the Central office of DOCCS requesting to see a dentist. He received a response that he would be called in order of priority and staff availability. He then contacted PLS. We sent an advocacy letter in mid-April 2017 and by May 4, 2017, over a year after he had lost his filling, his filling was replaced.
- K.D. developed severe tooth pain on January 2, 2017. Waiting months for treatment, he developed an infection in his mouth and began spitting pus. K.D. wrote to PLS in April 2017 begging for help. On April 21, 2017, PLS advocated on his behalf and by May 3, 2017, K.D. had seen an oral surgeon who had removed the infected tooth.

2. Continuity Of Care

DOCCS incarcerates over 51,000 individuals and regularly transfers prisoners between the 54 prisons across New York State. For incarcerated individuals with medical conditions that require ongoing medical treatment, there are serious issues regarding continuity of care. The lack of continuity of care – particularly where an individual suffers from a chronic and debilitating illness, the treatment of which is acknowledged to have painful side effects – is medically unacceptable. Standard 23-6.5 of the ABA Standards for Treatment of Prisoners states:

- (a) A correctional agency should ensure each prisoner's continuity of care, including with respect to medication, upon entry into the correctional system, during confinement and transportation, during and after transfer between facilities, and upon release. A prisoner's health care records and medication should travel *with the prisoner* in the event of a transfer between facilities, including facilities operated by different agencies. (emphasis added)
- (b) Prisoners who are determined to be lawfully taking prescription drugs or receiving health care treatment when they enter a correctional facility directly from the community, or when they are transferred between correctional facilities – including facilities operated by different agencies – should be maintained on that course of medication or treatment or its equivalent until a qualified health care professional directs otherwise upon individualized consideration.

Nelson Mandela Rule 26 (2) and Rule 30 state:

Medical files shall be transferred to the health-care service of the receiving institution upon transfer of a prisoner and shall be subject to medical confidentiality. (Rule 26(2))

“A physician or other qualified health-care professionals, whether or not they are required to report to the physician, shall see, talk with and examine every prisoner as soon as possible following his or her admission and thereafter as necessary. (Rule 30)

PLS regularly receives complaints from incarcerated individuals that upon being transferred to a different prison, medications/treatments are interrupted or stopped completely, often before they have been examined by, or even talked to, a physician or other medical provider. This disruption and discontinuity of care appears to occur for several reasons: medical records have not followed the individual; the receiving prison does not carry the medication at issue; security issues trump the prescribed treatment; or the provider at the new facility has a different opinion as to the appropriate treatment. Below are a few examples:

- J.C. wrote to PLS at the end of Dec. 2016. He was diagnosed with Crohn's disease in 2014 and was being treated with Humira with good results. In Nov 2016, J.C. was transferred to a different prison and all treatment was terminated, apparently because he had not had a physical or seen a specialist in a long time. The termination of treatment led to a flare up which required his transfer to the prison infirmary. While he was in the infirmary, medical staff did nothing except check his vital signs. J.C. was told he would see a specialist in January. It was not until May 2017, after he contacted PLS and we advocated on his behalf, that he was finally given treatment.
- J.M. has been transferred roughly seven times since August of 2015 when he entered DOCCS custody. With one or two exceptions, each time the receiving facility discontinued the Ultram that he was prescribed for pain from the chemotherapy he was receiving for chronic myeloid leukemia.
- WB requires supportive boots for plantar fasciitis. He received them nine years ago at Great Meadow Correctional Facility and was allowed to keep them when he was transferred to Elmira Correctional Facility. However, on return to Great Meadow he was told there were "security issues" and he was not allowed the boots. W.B. went without the boots for several years, but the foot pain grew worse so he asked again and was denied for security issues. He then contacted PLS and we successfully advocated for restoration of the permit.

Significantly, it should be noted that DOCCS has long had a specific written procedure – Directive 4918, Inmate Health Care During Transfer – outlining what steps must be taken when a prisoner is transferred to another facility to avoid an interruption in the individual’s medical care. Clearly, however, adopting such written procedures did not eliminate this long-standing and chronic problem in the continuity of care. As just the above few examples demonstrate, the Department has failed to properly and consistently implement, monitor and enforce this policy. It is for this reason, as discussed below, that we strongly urge not only adoption of the ABA Standards and the Mandela Rules to reinvigorate the commitment to appropriate continuity of care, but also increased oversight of DOCCS’ provision of medical care by the State Department of Health.

B. BARRIERS TO PROVIDING ADEQUATE CARE

In addition to the issues of delay in providing treatment and discontinuity of care, there are also barriers, both external (language barriers) and self-imposed (DOCCS’ policy on treatment for substance abuse) that limit DOCCS’ ability to provide adequate health care to its population.

1. Language Barriers

PLS regularly receives medical complaints from incarcerated individuals for whom English is a second language. Patients for whom English is not their primary language often are unable to adequately communicate with or understand the DOCCS medical staff. Prisoners have advised PLS too that there are instances when untrained translators are used during medical visits, including other prisoners and security staff. Obviously, in light of the confidential nature of medical visits, such a practice is inappropriate and raises serious ethical concerns. As the Correctional Association of New York noted in its report on *Healthcare in New York Prisons 2004-2007*, this issue has plagued DOCCS for many years.¹⁴

¹⁴The Correctional Association of New York, *Healthcare in New York Prisons 2004-2007*. February 2009 p. 69.

2. DOCCS' Policy on Treatment for Substance Abuse

Many incarcerated individuals enter DOCCS' custody in need of substance abuse treatment.¹⁵ "Drug dependence is a chronic, relapsing disease. Drug users, both in and out of prison, have a right of access to health care that should include drug dependence treatment and harm reduction measures to reduce health risks such as transmission of HIV and hepatitis B and C."¹⁶ New York State prisoners often face lengthy delays in treatment, and such delays threaten "the fundamental right to health and may violate the protection against cruel, inhuman, and degrading treatment or punishment by subjecting drug dependent prisoners to unnecessary mental and physical suffering."¹⁷

The availability of drug treatment to drug dependent prisoners throughout the terms of their incarceration is both necessary and possible in the current prison system. The "failure to treat drug dependent prisoners is bad public policy, as failure to treat drug dependent prisoners increases the likelihood of return to prison."¹⁸ Aside from the usefulness of treatment, there is a legal mandate for it: "As is the case with people affected by other diseases, persons dependent on drugs – including prisoners – have a right of access to medical care for their condition, both under international human rights law and US law."¹⁹

While DOCCS does provide some substance abuse programs – Alcohol and Substance Abuse Treatment [ASAT] and Comprehensive Alcohol and Substance Abuse Treatment [CASAT] – there are limited beds available and thus long-waiting periods for entry into these programs. Many PLS clients tell us that they cannot get into ASAT programs, and when they do, the programs are often not useful to them. In addition, if a person is in such a program and is found guilty of relapsing and using drugs, typically he or she is immediately removed from the ASAT or CASAT program and punished with solitary confinement and the loss of all attendant basic privileges of prison life. For example, one individual reported to PLS that he had admitted to having a drug problem. He therefore was subjected to a drug test. When he tested positive for drugs and was issued a misbehavior report, the Hearing Office recommended ASAT. However, before he could take the course, he received a

¹⁵ The most recent published report by DOCCS on this issue is a 2007 report entitled, "Identified Substance Abusers" which indicates that 83% of prisoners need substance abuse services.

¹⁶ Human Rights Watch, "*Barred From Treatment*" p. 1 (March 2009) available at: https://www.hrw.org/sites/default/files/reports/nyprisons0309webwcover_0.pdf.

¹⁷ *Id.* at 28.

¹⁸ *Id.*

¹⁹ *Id.* at 16.

second misbehavior report for drug use and was given 80 days in solitary confinement and loss of privileges. Clearly, what this individual needed was intervention in the form of treatment, not deprivation and the rigors of punishment.

The high incidence of addiction among those in DOCCS facilities, the policy decision to limit treatment until a person is within a few years of release and the need for more effective and evidence-based drug treatment has resulted in the denial of adequate medical care and treatment for thousands of incarcerated individuals in New York State.

Delays in such treatment create and foster a vicious and endless cycle for individuals suffering from addiction and substance abuse. Punishing people for their addiction before they are permitted to receive treatment effectively denies them treatment. This failure to provide treatment in a timely manner to those suffering from addiction and substance abuse only serves to subject them to years of unnecessary suffering – not just from their disease, but also from the collateral consequences of that disease, such as placement in solitary confinement and the consequent loss of opportunity to engage in other substantive and meaningful programming aimed at enhancing the likelihood of successful reentry upon release. Allowing a person who acknowledges having an addiction to be unnecessarily deprived of treatment also places the security of DOCCS' facilities and the safety of the public at risk.

Conversely, the timely provision of effective drug treatment to prisoners with substance addiction is not only in DOCCS' best interest but is also part of its legal obligation to ensure the mental and physical health of those in its custody. Disregarding a person's addiction and disease serves only to encourage the continued use – and abuse – of drugs for the foreseeable future. If DOCCS fails to provide drug treatment to a person in need for years, DOCCS should expect the drug use to escalate in frequency, and, inevitably in some cases, result in death. This is not safe for the individual or for DOCCS and its staff. As such, it is imperative that DOCCS focus on providing effective and timely treatment, not punishment, for those individuals in its custody who are in need of substance abuse treatment.

The United States Surgeon General recognizes that addiction to opioids has become a crisis in the United States, noting that close to two million people meet the diagnostic criteria for substance abuse disorders involving prescription opioids. Thousands of incarcerated New Yorkers are part of

this epidemic. Many of them have made clear to DOCCS that they are struggling with a problem they cannot address on their own. However, DOCCS insists on repeatedly punishing them for their addiction in direct contravention of the U.S. Surgeon General, who has described addiction as “a chronic disease that must be treated with urgency and compassion.”²⁰

For those addicted to opioids, medication-assisted therapy (MAT) has been endorsed by the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS).²¹ However, when individuals in DOCCS’ custody ask for medically supervised detox or opioid blockers, they are told by medical staff that DOCCS does not provide such treatment and, more often than not, given a misbehavior report and confined in solitary confinement for having disclosed that they have a drug problem.

- M.M. met with his treating physician to request treatment for his addiction. The treating physician contacted the Facility Health Services Director (FHSD) as to how to proceed. The FHSD contacted the DOCCS’ Chief Medical Officer who instructed the FHSD to provide detoxification to M.M. The FHSD also contacted DOCCS’ Counsel’s Office, and spoke to an attorney there who advised him that M.M. should be given detoxification treatment, that the situation should be reported to security staff, and that M.M., should not be penalized or receive a misbehavior report for drug use because he came forward on his own to request treatment. The FHSD followed these instructions and when he reported the situation to the Deputy Superintendent of Security (DSS), the DSS stated that security staff was unaware of M.M.’s drug use, and that M.M. would be ordered to submit a specimen for urinalysis.

M.M.’s urinalysis specimen was positive for Buprenorphine (a/k/a Suboxone). The positive urinalysis led to a misbehavior report, which led, in turn, to a disciplinary hearing. At his hearing, M.M. testified that he had become addicted to opioid pain killers and had tried to quit using drugs, but was unable to do so because withdrawal was too difficult. The FHSD also testified at M.M.’s hearing, completely supporting M. M.’s version of events. Notwithstanding the testimony of the FHSD or M.M.’s plea for help, M. M. was found guilty of drug use, was sentenced to 30 days cell confinement *and was removed from drug treatment.*

M.M. was soon thereafter subjected to a second urinalysis, which also tested positive, and for which he received an additional misbehavior report, a second disciplinary hearing and 45 days in solitary confinement.

²⁰ Remarks by Surgeon General Vivek Murthy at the Unite to Face Addiction Rally, October 4, 2015, Washington, DC available at <https://www.surgeongeneral.gov/news/2015/10/unite-to-face-addiction-remarks.html>.

²¹ Human Rights Watch, “Barred From Treatment,” *supra* note16, at p. 13.

After PLS filed an Article 78 challenge to the first hearing, DOCCS agreed to administratively reverse the first hearing. PLS then successfully advocated for the administrative reversal of the second hearing.

- AB's experience was similar to M.M.'s. A.B. has struggled with addiction for decades. He was released from his last sentence "with a habit" in 2015, and was returned to DOCCS within five months following a conviction for criminal possession of a controlled substance. In May 2017, A.B. went to the facility nurse to ask for medically supervised detox. In response to the nurse's question about when he had last used, he told her the prior night, whereupon she immediately called a security officer to supervise urinalysis testing. A.B. tested positive and was given a disciplinary ticket, found guilty and given a suspended sentence. He wrote to PLS in June 2017, after he requested injections of Vivitrol, an opioid antagonist that is used in the outside medical community, and was again required to submit to a drug test. When the urine was positive to opioids, he was given a second disciplinary ticket.

As the above examples demonstrate, DOCCS appears to be unwilling to use opioid-replacement therapy such as Suboxone or Vivitrol and punishes people for seeking help for their drug addiction. This is entirely out of step with acceptable medical treatment for drug addiction in the community.

C. COMMUNICABLE DISEASES

Up until August 2016, DOCCS had a policy that denied Hepatitis C (HCV) treatment to any prisoner who had tested positive for drugs in the preceding six months. This policy was not based on current medical standards of care for patients with HCV. PLS had a client who was suffering from advanced stage liver disease from HCV, with cirrhosis of the liver, and yet was being continuously denied HCV treatment due solely to positive urinalysis drug tests. Our client's health continued to deteriorate and he continued to needlessly suffer from the painful and debilitating symptoms of the disease, including profuse sweating, dramatic changes in body temperature, chronic headaches, diarrhea, dizziness, and black outs. For months PLS advocated for this client, to no avail. As a result, we were forced to file a federal §1983 action alleging that DOCCS had been deliberately indifferent to our client's serious medical needs.

Shortly after filing, DOCCS agreed to promptly commence HCV treatment for our client and expressed interest in resolving the broader policy issues in the case. In the end, DOCCS agreed to change its HCV policy so that evidence of substance use is no longer an automatic exclusion from HCV treatment and all patients who otherwise qualify for HCV treatment are now seen by an

infectious disease doctor regardless of drug use.

While we had hoped that we could effect this change without resorting to litigation, we commend DOCCS for its change in policy which brings the Department into line with community standards regarding the treatment of HVC. Notably, our client in this case also experienced virtually a full recovery once treatment was commenced. After the 12-week course of medication therapy, his disease had essentially been cured, his greatly increased risk of developing liver cancer lessened, and the chronic physical symptoms from which he had been suffering for over a year subsided.

More recently, however, we heard from another individual who needs HCV treatment but to whom DOCCS has not yet provided the treatment.

A.P. was informed that he had HCV in 2004 (during a prior incarceration) and tried to get treatment for years. As recently as April 2017, DOCCS was continuing to deny treatment on the ground that A.P. did not (yet) have cirrhosis of the liver and thus did not need HCV treatment. This was despite the fact that a community-based liver specialist had also recommended the treatment. Upon review of A.P.'s medical records and DOCCS policy for HCV treatment, PLS sent a letter to the DOCCS' Chief Medical Officer citing portions of the Hepatitis C Primary Care Practice Guidelines that supported treatment of A.P. in light of his worsening symptoms and quality of life. PLS asked that DOCCS' provide A.P. with HVC treatment or, alternatively, provide an explanation as to why treatment was being denied. We were recently informed that DOCCS has made a request for an expedited evaluation of A.P.

As the above-cited examples demonstrate, the Department's response to our advocacy is often to provide the individual with the treatment that he or she seeks and needs. The problem is that, without our advocacy, the person most likely would not have received the treatment or would have experienced even greater delays in treatment. And even with our advocacy there can be a significant delay in the provision of necessary care. While we applaud the Department's receptivity to our advocacy and arguments, we suggest that DOCCS needs to adopt a policy that assumes that treatment for communicable diseases will be provided and only denied where medically warranted after consideration by the DOCCS chief medical director.

D. PAIN MEDICATION AND CHRONIC PAIN MANAGEMENT

The need for adequate management of chronic pain is not uncommon among the prison population, a segment of society that all too often suffers very poor health. PLS has long advocated on behalf of individuals suffering from very serious and legitimate debilitating chronic pain. A common complaint for many years has been that a prisoner who had long been prescribed certain pain medications, including narcotics, would summarily and inexplicably have those medications discontinued upon transfer to a new facility. Through advocacy by PLS, such individuals would often have their pain medications restored, but not until after needlessly suffering a prolonged interruption and delay.

This situation has recently taken a very different turn, one which we fear may result in widespread denial and disruption of adequate pain management, and one which we believe warrants close monitoring. As noted earlier in our testimony, there is growing recognition that there is an epidemic of pharmaceutical opioid abuse in society and this crisis has extended to our prisons. Accordingly, just as measures must be taken in the wider society to combat this growing problem, so too must efforts be made to address the issue among the prison population. The concern, however, in our view and based upon our experience with the systemic inadequacies of prison health care, is that many individuals suffering from very real, legitimate and significant chronic pain may not receive appropriate pain care management and will suffer horribly and unnecessarily.

In June 2017, DOCCS implemented a new health care policy entitled “Medications with Abuse Potential (MWAP).” This is set forth in the DOCCS Health Services Policy Manual (HSPM), denominated Policy No. 1.24. This policy provides for a centralized review and approval process relating to any prescription medications that have a recognized potential for abuse (i.e. likelihood of causing dependence, addiction and misuse). The policy sets forth a designated list of such medications with abuse potential. In brief, the policy requires the review of all prescriptions of MWAP’s within DOCCS. It also creates a procedure under which all MWAP requests from facility medical providers to prescribe an MWAP require approval by the Regional Medical Director (RMD). The facility medical provider who seeks to prescribe an MWAP must complete the MWAP Request Form. This form is provided as an appendix to the policy, along with the list of MWAP’s. This form is to be completed by the provider and then sent to the RMD for consideration and either

approval or denial of the request.

Among other things, the policy also expressly contemplates that alternative pain management modalities to treat both acute and chronic pain should be used. Section IV(J) of the policy provides, “As an alternative to the use of medications with abuse potential, safer treatment modalities to treat acute and chronic pain and chronic medical/psychiatric and or neurological issues will be strongly encouraged by facility medical providers and specialty care consultants like pain specialists, neurologists, and psychologists.” Thus, not only should any denial of an MWAP entail perhaps prescribing other medications that do not have a recognized potential for abuse, but other alternative means of helping treat and manage pain are “strongly encouraged.” For instance, it would seem that more use of physical therapy and other medical interventions should be made available, and thus are something those who are denied an MWAP should actively seek from their providers.

On its face, this policy appears entirely reasonable and appropriate. The concern, however, is that too often DOCCS medical care policies run afoul of their stated goals or are simply not properly followed or implemented. Examples are the above-noted Directive 4918 (see page 8), which is supposed to ensure continuity of care upon transfer (but which seems to fail far too often) and the HCV policy which has too often worked to deprive prisoners of the care they need.

The jury is still out on the MWAP policy, as it is far too soon to tell how it will be implemented in practice. However, PLS can attest that we have been inundated with complaints from numerous individuals whose long-term pain medications have been abruptly halted. We are guiding these individuals in navigating the new policy’s review process, in seeking restoration of their pain medications and approval and implementation of alternative modalities of pain care management.

That same knowledge and experience also leads us to urge both committees to take heightened interest in this issue and to monitor this new policy’s implementation and development. It also further compels us to encourage you to mandate extra-Departmental oversight of this and all other aspects of DOCCS medical care by the State Department of Health.

E. LACK OF COMPASSION, CALLOUSNESS, AND NEGLECT

Finally, as dismaying as it may be, a number of the complaints that PLS receives from prisoners about difficulties accessing medical and dental care include allegations that medical care providers often evince a lack of compassion and display callous attitudes. This may be surprising and perhaps unexpected, possibly because it is so incongruous to the common perception that we have of health care professionals. We certainly hear such surprise, disappointment and dismay in our clients' letters when recounting the negative experiences they have had with health care professionals. They often had hoped for, and expected, a greater measure of compassion and sympathy from health care personnel than perhaps they would from security staff, in an environment where such human emotions are expressed too infrequently.

For whatever reason, even health care professionals can suffer the dehumanizing effects of the well-recognized complex dynamic that results from incarcerating other human beings. It should be no real surprise though that seeking to provide care in a prison environment may erode almost anyone's reserves for providing patient and compassionate care to a fellow human being. Undoubtedly too, not all prisoners are respectful, tactful, or appreciative patients. As with any extreme and difficult environment, prisons can nurture both the best and the worst in people. This is true of prisoners and staff alike, and prison health care staff certainly is not immune to such effects.

So, for whatever the complex reasons, such failures and lapses in compassion and care and otherwise respectful patience by DOCCS medical personnel seems to play a significant role in many of the problems in the delivery of prison medical care. Indeed, most of the complaints we receive unfortunately entail at least some account of how a provider – be it a nurse, a physician's assistant, a doctor or a dentist – demonstrated to one degree or another, a lack of care and compassion, patience, or basic human respect for his or her prisoner-patient. These accounts run the gamut from dismissive, discourteous, and disrespectful behavior, to outright callous and even openly hostile behavior, including threats to punish prisoners for continuing to voice medical complaints and request treatment or to complain about them to superiors.

By no means do we suggest that all DOCCS providers lack compassion or are uncaring, let alone hostile and threatening, either all the time or occasionally. In fact, many DOCCS health care providers are caring and committed to their roles and profession and are able to reflect such qualities

in their behavior. Indeed, prisoners have shared with us the names of providers whom they like and who treat them well. And we too have certainly had many positive interactions with DOCCS medical staff, including those caregivers who have intervened and been responsive to our advocacy on behalf of our clients.

Nonetheless, the difficult truth – and one we are compelled to share and emphasize – is that a great many of the hundreds of complaints PLS receives each year about medical and dental problems include allegations of very unpleasant and negative encounters with the health care staff. Such negative interactions can also involve security personnel who are often present as well.

Accordingly, it is important to be mindful that a good deal of what lies behind the denial of care, delay in care, and lack of continuity of care, including those examples recounted throughout this testimony, are not only or simply honest mistakes, oversights, or glitches in the system that can be corrected and are unlikely to be repeated. Rather, many of the above and similar instances where we have successfully advocated have included complaints that not only was care denied, but that the medical care provider was abusive, hostile and/or lacked compassion.

It is these widespread complaints of disrespectful, uncaring and other negative attitudes by medical providers that drive our concern that the DOCCS medical staff may not implement the new MWAP policy in a manner that ensures that prisoners receive the care that they need and to which they are entitled. We worry that prisoners with genuine chronic pain and a legitimate medical need for on-going treatment with potent and even potentially addicting pain medications may be wrongfully deprived of such necessary and appropriate pain care management.

II. RECOMMENDATIONS TO IMPROVE MEDICAL CARE IN NEW YORK STATE PRISONS

Given all the above, how can we improve the delivery of health care in our prisons? We have shown that advocacy can improve the care that is provided to particular individuals. We have also shown how litigation can sometimes enhance the quality of care, not only for individuals, but also for the prison population as a whole, e.g., the Hep C lawsuit that DOCCS finally settled in recognition of the desirability of amending its eligibility guidelines for such treatment. However, these solutions have their limitations.

As an initial matter, PLS cannot begin to effectively address all of the individual complaints we receive with either advocacy or litigation. The number of people needing help with obtaining adequate medical care is overwhelming, and speaks to the great need for systemic and structural change to the delivery of medical care. The successes where we have intervened and obtained care for many individuals also demonstrate the difficulty and often futility many prisoners confront when they try to advocate for themselves. In a word, they are often ignored.

Secondly, while litigation and the threat of litigation can have their benefits in effecting change, in the context of prison medical care, meaningful judicial remedies are often absent or severely constrained. Judicial remedies for medical care entail a number of significant and often insurmountable legal as well as financial obstacles. This is not only true for often significantly uneducated and/or undereducated, indigent and incarcerated lay persons, but also for under-resourced legal services organizations like PLS. Indeed, it is even true of the private bar, members of which rightly see prison medical cases as too difficult and/or too costly in relation to the potential recovery.

In short, litigation is too blunt and imprecise an instrument; more often than not litigation is largely limited to seeking compensation for individual harm that already has been caused by substandard care and treatment, as opposed to proactively effecting broader change. The reasons for this are several fold.

As a general matter, the Constitution requires prison officials to provide prisoners with “reasonably adequate care.”²² Reasonably adequate care has been characterized as “services at a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards.”²³

Secondly, the legal standard for a federal claim, both for damages and for injunctive relief, is that the plaintiff must prove that the defendant provider was “deliberately indifferent to a serious medical need” in order to establish an 8th Amendment violation.²⁴ Deliberate indifference is also the standard that must be proven in a state court action seeking injunctive (prospective) relief.²⁵ Needless

²² *Newman v. Alabama*, 559 F.2d 283, 291 (5th Cir. 1978). See also *Langley v. Coughlin*, 888 F.2d 252, 254 (2nd Cir. 1989) (officials must provide “reasonably necessary medical care . . . which would be available to [the prisoner] if not incarcerated.”)

²³ *Newman v. Alabama*, supra note 22.

²⁴ *Estelle v. Gamble*, supra note 3, at p. 104.

²⁵ *Matter of Wooley v. NYS Dept. of Correctional Services*, 15 N.Y.3d 275 (2010).

to say, and without exploring the legal intricacies here, deliberate indifference is a tremendously complex and very high and difficult standard to meet. It also necessarily excludes many quite significant and important health care issues that are not deemed to rise to a sufficiently “serious” level. The deliberate indifference to a serious medical need has been largely circumscribed by the courts to require proof of a “condition of urgency, one that may produce death, degeneration or extreme pain.”²⁶

Similar problems are present in state tort claims for negligent care and malpractice. To prove negligence, a prisoner must demonstrate a departure from accepted standards of ordinary and reasonable care within the community. Malpractice, a form of negligence, requires that the plaintiff prove that the provider failed to use ordinary and reasonable care or to exercise his or her best judgment in applying the knowledge and skill ordinarily possessed by practitioners in the field.²⁷ While negligence and malpractice are more forgiving standards of proof than “deliberate indifference,” such claims are also strictly limited to seeking after-the-fact monetary compensation for inadequate care; injunctive or prospective relief is not available.

Moreover, and perhaps the most significant and practical hurdle of all, is that both federal and state medical care claims require the use of expert medical opinion and testimony. There are no provisions in either state or federal court for the appointment of experts, and thus on this point alone these claims are prohibitively expensive and unavailable to most incarcerated individuals. Almost all *pro se* medical care claims in both state and federal court are regularly dismissed for lack of expert medical opinion, irrespective of the merits and strength of those claims; without evidence of either the applicable standard of care within the given medical field and community or the expert’s opinion as to the quality of services provided, the prisoner is simply unable to establish a claim. And, of course, as with most litigation, those cases which do seek injunctive and prospective relief and where medical experts can be retained are complex such that relief may not be available for years.

In sum, advocacy and litigation are indispensable and important tools that can bring a measure of significant relief in what are typically individual circumstances. However, they are not and should not be seen as a fundamental solution to the prolonged, persistent and continuing prison health care crises we all face here in New York.

²⁶ *Hathaway v. Coughlin*, 37 F.3d 63, 66 (2d Cir. 1994).

So, again, what is to be done? What can these committees and our legislative branch do to implement and effect the change that we know is so desperately needed? As touched upon above, we have two principal recommendations for action: (1) the adoption and imposition of new, heightened general state expectations and standards of care; and (2) the imposition of genuinely independent and outside (of DOCCS) oversight – oversight empowered with enforcement authority.

A. ADOPTING STANDARDS AND ASSESSING COMPLIANCE

To ensure that medical care in NYS’s prisons is uniform and consistent with health care in the community, DOCCS should not only adopt standards that govern the provision of medical care throughout its facilities, but also adopt a procedure to assess compliance with those standards.

As noted, both the ABA Criminal Justice Standards on the Treatment of Prisoners and the Nelson Mandela Rules give us guidance on setting standards for medical care in our prisons. On October 16, 2017, the United Nations Office on Drugs and Crime issued a manual that also gives guidance on assessing compliance with standards.²⁸ In its manual, the U.N. Office on Drugs and Crime notes: “The provision of health care in prisons is a crucial element of prison management for various reasons.” First, it is not only the legal duty of the State to provide adequate health care to those it confines, but it is also a human rights and civil rights obligation. Second, incarcerated individuals are typically a marginalized section of the population and present higher incidences of mental illness, substance abuse and infectious diseases than are found in the wider community. Third, failure to properly address health issues in prison often results in the transfer of those health issues to the community at large upon an individual’s release from prison. “In that context it has been acknowledged that the lack of adequate health-care services in prisons not only significantly hinders the social reintegration of prisoners, but also risks leading to the spread of transmissible and life-threatening diseases in prisons and the community.”²⁹

The manual sets forth the rationale for setting standards for health care in our prisons by noting: “As the primary duty of health-care services is to treat prisoners as patients, they have a

²⁷ *Jackson v. State of New York*, Claim No. 98848 (Ct. Cl. 2001).

²⁸ United Nations Office on Drugs and Crime, “*Assessing compliance with the Nelson Mandela Rules*,” *supra*, note 8.

²⁹ United Nations Office on Drugs and Crime, “*Assessing compliance with the Nelson Mandela Rules*” *supra* note 8, at p. 15.

distinct role in prison settings which is not always straightforward to fulfill. Beyond challenges related to the infrastructure of [,] and equipment and medical supplies available in [,] prison clinics, the complex nature of their task may also relate to the need to uphold principles of medical ethics. These include, for example, the clinical independence of health-care professionals regarding health-related decisions and the confidentiality of medical information, but exclude their involvement in security matters, except insofar as those [security matters] concern the health needs of prisoners. The Nelson Mandela Rules include detailed provisions on the above in order to ensure that healthcare professionals: (a) positively impact the quality of life in prisons; (b) protect or improve prisoners' physical and mental health, paying particular attention to prisoners with special health-care needs; (c) contribute to their prospects of a successful social reintegration; and (d) are guided on how to document and/or report cases of torture or ill treatment.”³⁰

The detailed assessment process set forth by the U.N. Office on Drugs and Crime mandates that prisons be evaluated for compliance with the below expected outcomes:

1. A health-care service is in place which takes professional care of the physical and mental health of prisoners.
2. Prisoners have access to health-care services according to their health needs.
3. Health-care services are being offered in line with professional ethical standards.
4. Health-care staff professionally respond to their potential involvement in disciplinary regimes as well as to allegations or signs of ill treatment.
5. The physical and mental health of prisoners is professionally examined upon admission, and appropriate measures are taken.

We recommend that the Legislature mandate that DOCCS adopt both the ABA Standards for the Treatment of Prisoners and the Nelson Mandela Rules regarding health care in prisons together with the assessment process set forth by the U.N. Office of Drugs and Crime.

³⁰United Nations Office on Drugs and Crime, “*Assessing compliance with the Nelson Mandela Rules*” *supra* note 8, at p. 15.

B. EXPAND DEPARTMENT OF HEALTH OVERSIGHT

As alluded to several times above, PLS strongly urges that the Department of Health be given authority to oversee and monitor the quality control of DOCCS medical care. In its 2004-2007 report on *Healthcare in New York State Prisons*, the Correctional Association made a number of recommendations including the enactment of “legislation to require the New York State Department of Health (DOH) to monitor and evaluate prison medical care. Alternatively, accomplishment of this goal could be achieved through a directive from the governor, who could, without additional statutory authority, order DOH to act pursuant to its authority under Public Health Law Article 28.” We make that same recommendation here today.

DOCCS spends almost \$400 million dollars on the provision of health care for approximately 51,000 individuals, but outside monitoring and independent oversight of that care by the DOH is currently limited to cases involving HIV and Hepatitis C treatment.³¹ While HIV and Hepatitis C raise serious health concerns, so too do many other health related issues that arise in prison. External oversight of healthcare is essential to ensure compliance with community and ethical standards and enhance quality control. By its very nature, DOH is best suited to provide that oversight within DOCCS.

As part of this oversight, DOH should also be charged with addressing the issues of negative and ill-mannered behavior by health staff that greatly contribute to and amplify the problems in the delivery of prison health care. We would urge more training and support for medical and dental staff in helping to foster and maintain compassionate and caring attitudes and behavior, and otherwise in navigating with equanimity the often dehumanizing environment of prison. We also urge that you require more rigorous training and support, as well as monitoring and oversight on these issues, not only by DOH, but also directly by DOCCS’ authorities. This would include the DOCCS Office of Special Investigations (OSI) which must seriously investigate allegations of medical neglect and callous and abusive behavior by the Department’s health care providers.

³¹ In 2009, then-Governor Patterson signed a law, referred to as the DOH Oversight Law, mandating DOH assess the quality of HIV and Hepatitis C care in New York State prisons.

C. ADOPT “BARRED FROM TREATMENT” REPORT RECOMMENDATIONS

In March of 2009, Human Rights Watch issued a report entitled “Barred from Treatment: Punishment of Drug Users in New York State Prisons.”³² In that comprehensive report, Human Rights Watch found that DOCCS failed to provide adequate health services to prisoners who used drugs and made a number of recommendations. We urge the Legislature to adopt those recommendations as set forth below:

- Provide oversight and review to ensure evidence-based substance abuse treatment for New York State prisoners;
- Take immediate steps to ensure that the Department of Correctional Services provides timely access to evidence-based drug treatment and HIV prevention services to drug users and reforms disciplinary policies related to substance use;
- Require an independent review of Department of Correctional Services’ substance abuse programming to evaluate its availability, accessibility, appropriateness, quality and conformance to evidence-based practices;
- Support ongoing efforts to increase the involvement of the Office of Alcohol and Substance Abuse Services (OASAS) in programs operated in the Department of Correctional Services; and
- Support legislation:
 - Promoting expansion of evidence-based substance abuse treatment programming in New York State prisons.
 - Promoting expansion of health and harm reduction services in New York State prisons, including Medication-Assisted Therapy for opioid dependence.
 - Ensuring that disciplinary sanctions for substance use are proportionate and do not undermine prisoners’ access to essential health and harm reduction services.

³² Human Rights Watch, “*Barred From Treatment*” *supra* note 16.

CONCLUSION

The provision of medical care in accordance with the federal constitution to the 51,000 individuals in DOCCS' custody is a massive undertaking for the State of New York. DOCCS has the funding and the staff to provide medical care that meets the mandate of the Nelson Mandela Rules and the American Bar Association. The Department's responses to PLS advocacy and litigation is strong evidence of not only the Department's willingness to provide that care when alerted to shortcomings by a reputable outside agency, but also its ability to provide that care. Because PLS has fewer than twenty attorneys to handle the some 500 requests for assistance with medical care issues alone, the State of New York cannot rely solely on PLS and the small number of other advocacy groups to identify and report all of the problems in its medical care delivery system. Further, there is no reason to assume that there are not more medical service delivery issues that are not reported to PLS. For these reasons, and because of the State's responsibility to ensure the provision of medical care to incarcerated individuals, we ask that this committee give serious consideration to the above proposals.

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Karen L. Murtagh, Esq.
Prisoners' Legal Services, Executive Director
Michael Cassidy, Esq.
Betsy Hutchings, Esq.
41 State Street, Suite #M112
Albany, NY 12207
(518) 445-6050
kmurtagh@plsnny.org