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Correctional Association OF NEW YORK

2090 Adam Clayton Powell, Jr. Boulevard, Suite 200 New York, NY 10027
tel (212) 254-5700 fax (212) 473-2807 www.correctionalassociation.org

Testimony by Jack Beck, Director, Prison Visiting Project
The Correctional Association of New York
Before the Joint Legislative Hearings on the 2014-15 Proposed Budget for Public Protection
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I am Jack Beck, Director of the Prison Visiting Project of the Correctional Association of New York (CA), and I want to thank the Joint Legislative Committees for this opportunity to provide written testimony detailing our observations and concerns about the Governor's Fiscal Year (FY) 2014-15 Proposed Budget for public protection, with a particular focus on the impact it will have on the incarcerated population in Department of Corrections and Community Supervision (DOCCS) prisons. I will focus on four issues: (1) funding for prison healthcare; (2) reductions in staffing and resources for essential prison-based programs; (3) the Governor's proposal for a Re-entry Council; and (4) changes in DOCCS policies for solitary confinement. As many of you may know, the Correctional Association has had statutory authority since 1846 to visit New York's prisons and to report to the legislature, other state policymakers, and the public about conditions of confinement. Our access provides us with a unique opportunity to observe and document actual prison practices and to learn from incarcerated persons and staff what they believe to be the strengths and weaknesses of a facility's operation.

FUNDING FOR PRISON HEALTHCARE

The Governor's budget for DOCCS prison healthcare represents further reductions in medical staffing but also includes some modest increases in funding for medical supplies and outside contract services, including specialty care services. Overall, the healthcare budget is shrinking as a percentage of the entire DOCCS budget, continuing a disturbing trend spanning the past four fiscal years.

Providing quality medical care in prison is good public health policy because so long as our criminal justice policies criminalize rather than treat behaviors that place people at risk of many medical conditions and target poor minority communities most at risk for many diseases, prisons will provide a significant opportunity to diagnose and treat individuals with chronic medical conditions that often go untreated in the population at large. New York prisons remain the epicenter of HIV in the U.S. prison system, representing almost 17% of all HIV-infected state incarcerated persons in the country. New York State prisons also incarcerate approximately 6,300 patients infected with hepatitis C, and many others who suffer from other chronic diseases such as hypertension (8,270), diabetes (3,260), and asthma (8,720). More than 95% of these patients will return to their communities, and the effectiveness of DOCCS's efforts to provide meaningful patient education, adequate testing and care, broader prevention programs, and improved discharge planning and linkages to community health care will determine not only the individual patients' medical future but also the health of their communities.

Although the prison population decreased by less than 1% during 2013 and by 7.3% since January 2010, medical staffing for FY 2014-2015 will be reduced by 14.8% over the past four years, which is double the prison population decline. Although the FY 2013-14 budget authorized 1,678 health employees, DOCCS only employed 1664 staff and has budgeted for the same number in FY2014-15. This pattern can be seen over the last several years, starting from 2011-12 when DOCCS was authorized to fill over 2,000 FTE health positions. Essentially, the Department is downsizing medical staff by not filling authorized positions, and then making these cuts permanent by incorporating these staffing reductions in the upcoming fiscal year. The reductions each year have been imposed without adequate legislative oversight, and the new DOCCS budget again obscures the reductions in health staff being made. We are particularly concerned because healthcare staffing is taking a greater reduction than other DOCCS operations. Overall, security staff reductions for the past four budget years, including all the prison closures, will result in a total reduction of only 6.8%, which is less than half the rate of medical staff losses.

This 15% reduction in healthcare staffing during the last four years is unacceptable and potentially dangerous for the prison population and the public. The majority of healthcare providers in the prisons are nurses, doctors, other clinic providers or pharmacists, and they are directly responsible for patient care for more than 54,000 persons. If the already overtaxed medical staff have to provide services to an increasingly older and sicker population, delayed and inadequate care is inevitable. It should be noted that in the last decade, the percentage of people in prison 50 and older has increased by two-thirds to 16% of the prison population, the cost of their care can be two to four times that of other incarcerated persons, and providing healthcare to this population places increasing demands on the medical staff. It has been well documented that older incarcerated individuals often exhibit physical and mental conditions of persons in the community who are 10 to 15 years older than their chronological age. Unfortunately, many elderly persons in prison have been repeatedly denied parole, despite exemplary prison records and little public risk if released, and DOCCS must fund their escalating healthcare costs.

During our prison monitoring visits, we continue to find instances where prisons had vacant medical staff positions that went unfilled. Vacancy rates for physicians as of 2012, the most recent year for which such data is available, were 28% and for nurses, 18%. As a result of inadequate medical staff allocations and staff vacancies, many prisons have clinic provider-to-patient ratios in the range of 1:600 to as high as 1:1,156, in contrast to the system-wide ratio of 1:450. Similarly, some prisons have nurse-to-patient ratios as high as 1:185 patients, significantly higher than the system-wide average of 1:100. Limitations on staffing resources are correlated with delays in care and can result in degradation in the quality of the care provided by overtaxed staff. Similarly, DOCCS has a 39% vacancy rate for pharmacists and has closed DOCCS pharmacies at several prisons in the last two decades because the pay rate for pharmacists is insufficient to compete with rates in the community. Consequently, 20 prisons must rely on community pharmacy services, which are more expensive and limit the prisons' ability to monitor their patients' medications. Under the current budget proposal, we suspect that more of these temporary vacancies will become permanent staff reductions.

Some positive health-related action should also be noted. We want to commend the Governor for including in the health budget $5 million to establish coordination between the health homes created by the Medicaid Redesign Program and the criminal justice system. This initiative is designed to facilitate enrollment of persons with serious health issues leaving state

prisons and jails into community-based health home programs. The task force created to develop the connection between health homes and the criminal justice system, along with the six pilot programs currently being implemented, demonstrate both the opportunities for improved care and cost savings that could result from promptly integrating formerly incarcerated persons in health homes, and the challenges that exist in making this process efficient and effective. The $5 million is needed to create the infrastructure necessary to share information among the many state and private agencies engaged in this process and to fund the expansion of the pilot programs throughout the state. Given the legislature's long-term interest and support for improving health outcomes for those involved in the criminal justice process, we believe it is crucial that this initiative facilitating the transition from incarceration to community-based care for persons with serious health issues needs your support.

We also note positively that there are no budget cuts proposed in non-personal services for prison healthcare; more specifically, we see an overall 4.6% increase from FY 2013-14. Most of this increase is in supplies and materials (a category used to pay for medications), an increase of 9.98%; however, over the last four years the funds available in this category have actually declined by 6.1%. Although this decline is slightly less than the decline in prison population, we are concerned that the funds are not sufficient given the increase in medication costs generally, the inclusion of new medications in the prison formulary, and the changing demographics of the population that include the increased medical needs of aging incarcerated persons. The recent approval of new, more effective, but expensive medications for the treatment of hepatitis C (HCV) suggests that significant additional expenditures will be necessary for this patient population. Although about 6,300 persons have HCV, as of April 2012 only 89 patients were receiving HCV therapy. With cure rates that may exceed 90% with the new medications, it will no longer be acceptable or legal to treat such a small percentage of the chronically infected HCV prison population. The latest medications can cost $66,000 to $84,000 per patient, and thus the DOCCS medication budget will be significantly impacted by these welcomed, but expensive new treatments. Similarly, the growth of the aging prison population, which has increased by two-thirds in a decade and now represents 16% of the prison population, means that much greater expenses will be associated with the continued incarceration of these elderly individuals.

The FY 2014-15 budget also includes a very slight (1%) increase in healthcare contract services, a category reserved for expenses relating to specialist care. Unfortunately, this increase has very little impact on the 17% decline over the past four years in this same category. Particularly given that much of the healthcare budget allocations in this area are used for patients with serious medical conditions, the continued funding limitations for these services will necessarily limit the ability of DOCCS to provide essential care. Overall, we are concerned that DOCCS will not be able to meet the essential medical needs of a prison population that suffers from serious medical problems.

DOCCS PROGRAM SERVICES

Programs inside of DOCCS prisons – including academic, vocational, substance abuse, transitional services, and other programs – can and do play an important role in the personal development, growth, empowerment, and self-actualization of incarcerated persons. These programs can help participants develop meaningful personal and professional life skills, address the underlying causes of the behavior that led to incarceration, increase opportunities for post-release employment, become stronger family members and community members, and otherwise

prepare for successful return to their communities. These programs can also help develop peer mentors and leaders in prisons and in communities of release, reduce violence and increase safety in prisons and in communities to where incarcerated persons will return, stop the cycle of incarceration, and ultimately save the State of New York money in the long run.

In order to realize the tremendous potential that programs can create, there needs to be, in addition to more effective utilization of resources and development of programs, a substantial *increase* in program resources. For example, although DOCCS' stated academic mission is for all people to obtain a GED prior to release, less than 7% of all people without a GED acquire one in a given year. Similarly, for higher education, while 58% of the DOCCS population has a high school diploma or GED and could benefit from college, only 3% have a college degree and only 3% are enrolled in any college at a given time. For vocational programs, the vast majority of people in prison are eligible for these programs and could greatly benefit from relevant job skills, and yet 44% leave prison without any vocational training. Looking at substance abuse treatment, while DOCCS estimates that roughly 80% of the population is in need of such treatment, only about one-third enroll in any substance abuse treatment in a given year. Similarly for transitional services, most of the facilities the Correctional Association visits, including recent visits to Five Points and Collins Correctional Facilities, have waiting lists for transitional services programs that are multiple times the number of people who complete the programs in a given year.

Despite the essential role programs play in terms of rehabilitation and despite the need for *increased* resources for programs, the Governor's proposed budget continues the trend of *reducing* program resources. Specifically, the current proposed budget's staffing level for programs represents a 13.25% decrease from staffing levels at the end of FY 2010-2011. As with medical staffing and as was done with budgets in at least the last two years, although the 2014-15 budget shows an increase in authorized staffing positions from 2,690 to 2,717, in fact the proposed number of positions represents a further decline in authorized program staffing. As with previous years' budgets, this decline took place during the current fiscal year, even though the budget for the current fiscal year did not authorize such a decline. Specifically, the FY 2013-2014 budget indicated there were 2,693 FTE positions in program services as of the end of 2011-2012 and specified that staffing levels would increase to 2,739 FTE positions in that fiscal year. However, in the current proposed FY 2014-15 budget, the agency presentation indicates there are only 2,690 FTE positions in program services and that the number of items will increase to 2,717 – both less than 2,739, the number of authorized positions from the last budget, and less than 2,772 the number authorized in the FY 2012-13 budget.

In other words, although the number of dollars allocated to personal services has remained relatively constant in the proposed budget, with a 0.04% increase over last year, and although the current proposed budget appears to show an increase in authorized program staffing, it actually represents a further decline in staff positions. Since FY 2010-11 the number of program staff positions has declined by 13.25%. Moreover, as the Correctional Association testified at the budget hearings last year, the executive budget used the same method during the last two years for institutionalizing reductions in program staff without transparency or legislative input.

During our prison visits we have observed the impact of inadequate funding for program services, resulting in high vacancy rates for program staff and long waiting lists for persons needing essential services. At Cayuga C.F., for example, between our visit in 2008 and our visit

in 2013, the ASAT program had been cut in half from a capacity of 120 to 60, and at the time of our visit, there were 60 people enrolled in ASAT, and more than seven times that number – 433 – on a waitlist. Also at Cayuga, transitional services programs – Thinking for a Change (T4C) and Aggression Replacement Training (ART) – had waitlists more than 50 times enrollment (771 waitlist, 15 enrolled for T4C) and 10 times enrollment (465 waitlist, 40 enrolled for ART), respectively. Similarly, Collins C.F. had a waitlist for ASAT (420 people) that was more than four times the number of people enrolled (104 people) at the time of our visit, and Thinking for a Change and ART had hundreds and hundreds of people on the waitlist (858 for T4C and 449 for ART). In addition, four vocational shops had closed at Collins between 2009 and April 2013, leaving nearly 55% of the people who require a vocational program without access to such programming. At Watertown C.F., half of the authorized academic teacher positions were vacant (three out of six) at the time of our visit, with one of the positions being vacant for more than eight months, and leaving more than 55% of people who need academic programming without access to such programming. At Sullivan, a staff vacancy in ASAT had left the entire program closed for nearly six months at the time of our 2013 visit, meaning that the facility was not even able to provide substance abuse treatment to the 20 people who had been enrolled in general population ASAT or the 40 people previously enrolled in ASAT for special populations in the Special Needs Unit or the Intermediate Care Program. At Five Points C.F., although there were nearly 700 persons without a GED at the facility, one-quarter of the educational positions were vacant and 450 individuals were in need of essential educational services.

In addition to problems caused by staff vacancies, non-personal services funds for programs will drop by another 1% in the current proposed budget, continuing a trend, albeit at a slower rate, that has led to a drastic reduction of nearly 30% of non-personal program services funding over the last four years. This rate of decline over the past four years is nearly two times higher than the rate of decline for non-personal services overall, and is nearly three times higher than the rate of decline for the entire DOCCS prison-based budget. Equipment, supplies and materials, and contract services are the non-personal service items that have seen the largest declines. Funding for equipment has dropped more than 66% in the last four years, with this year's budget decreasing the funding by 23% from last year. Contract services and travel also show further small declines in this year's proposed budget, for a total reduction of around 30% and 20%, respectively, over the past four years.

Positively, funds allocated to supplies and materials have increased by 24.6% from the previous year. Unfortunately, this increase does not undo the downward trend over the past four years. Since FY 2010-11, funds allocated to supplies and materials have decreased by 22%. On many of the CA's prison visits, vocational staff have lamented the decline in supplies and materials and the negative impact of such declines on the ability to provide meaningful vocational programming. It is positive that the proposed budget will at least allocate an increased level of funding for such supplies, though more will be needed to be allocated to undo the sharp decline over the past few years.

The continued decline in resources directed toward programs at DOCCS facilities is part of a larger trend across prisons in New York State away from a focus on programming and rehabilitation services and toward even greater emphasis on warehousing and punishment. The current proposed budget continues this negative trend away from programming, and does not take advantage of the tremendous opportunities that programs present to improve the lives and

life chances of participants, recognize the dignity and value of all incarcerated persons, and enhance opportunities released persons to be successful when they return home.

NEW YORK STATE COUNCIL on COMMUNITY RE-ENTRY and REINTEGRATION

We strongly endorse the Governor's proposal to create a Council on Community Re-Entry and Reintegration ("Re-Entry Council") that will assess the needs of the incarcerated population returning home and coordinate the activities of state agencies and community resources to ensure that those re-entering our communities are successful and that public safety is enhanced by supporting people coming home to be productive members of society.

We know that individuals who are educated, trained and provided skills while in prison and who are promptly connected to relevant community-based services upon release are more successful in reintegrating into their communities and less likely to be involved again in the criminal justice system. In order for this process to achieve optimal results, at least five factors must be in place: (1) an assessment must be made of each incarcerated individual to identify that person's needs for education, treatment, vocational skills and other interventions to address criminogenic factors that impede her/his ability to live a crime-free life; (2) the prison system must address those needs while the person is incarcerated; (3) a discharge plan must be developed for each person returning home that identifies additional needs to be addressed in the community and connects people to resources available in the community for jobs, training, services and additional support; (4) current legal barriers to successful reentry must be eliminated; and (5) agencies in the community must promptly connect with formerly incarcerated persons to engage them in the services they need and provide opportunities for employment, training, education and treatment.

We urge the Re-Entry Council to evaluate the reintegration process in the context of each of these five components. The new assessment tool, COMPAS, used by DOCCS to evaluate newly admitted persons to the system is a good beginning in identifying incarcerated person's needs. Similarly, the case plan process being employed by DOCCS to continuously reassess the progress being made by persons inside in reaching their goals to address identified needs is also a potential improvement in preparing people for re-entry. It will be important, however, to evaluate whether these new instruments and processes are effective in identifying the most essential needs and engaging the prison population in setting short- and long-term goals.

We are less optimistic that DOCCS is capable of meeting all the needs of the prison population in their preparation for release. As noted above concerning funding for programming, DOCCS has continuously reduced the program staff and other resources for programs during the past four years. We have identified critical staff shortages in education, vocational training and substance abuse treatment. As a result of these vacancies and reductions in authorized staff, some essential prison programs, such as substance abuse treatment have been closed or substantially reduced in size. Moreover, there are substantial concerns about whether the programs being provided are offering people meaningful skills that will help them be successful upon returning home. For example, the lack of college and other academic program opportunities, limited access to computer training, substance abuse treatment programs that are often criticized by participants as failing to provide a therapeutic environment, limited medical and mental health services, and vocational programs that often do not match the needs of the current employment opportunities in the community all should be assessed and addressed by the

Re-Entry Council. There is no value in identifying needs if the person is not afforded an opportunity to adequately address them before release.

Discharge planning for re-entry in also a problematic area that needs attention by the Re-entry Council. Much of the preparation for returning home currently occurs in Phase III of Transitional Services in DOCCS. This program is limited in that it is facilitated primarily by peers and has very limited input from outside agencies or resources. Although the course addresses job-related issues, such as resume preparation and job interviewing techniques, it does not include any component specifically identifying community resources that a soon-to-be-released individual should contact. Simply put, there is no concrete re-entry plan for each person. Moreover, there is very little contact between community-based programs and the re-entering population. Very few community providers interview or even correspond with soon-to-be-released individuals unless that person on their own has written to the outside agency. The Re-Entry Council should focus on mechanisms to get community-based programs, including in such areas as housing, medical care, mental health services, substance use treatment, education, and employment, to engage with incarcerated persons before their release to improve the likelihood that the recently released individual will contact the outside agency when s/he is home.

It is also important to distinguish among the different categories of individuals being released from DOCCS facilities in determining the support they will need and the likelihood that assistance will be available to them. In 2012, 27,541 persons were discharged from a DOCCS facility, including 24,934 who were sentenced individuals and 2,607 who were incarcerated parolees released from specialized programs such as Willard Drug Treatment Campus, Edgecombe residential treatment program and the parole diversion programs at Hudson and Orleans Correctional Facilities. The incarcerated parolees have much shorter stays and may have different re-entry issues than the sentenced population. Of the nearly 25,000 incarcerated persons returning from regular prison programs, their situation also needs differentiation. Of this group 3,280 are being released without any community supervision because they have completed their maximum sentence or are being released for other reasons. These persons will not have assistance from parole staff in identifying community resources and will also be getting less attention from DOCCS Offender Rehabilitation Coordinators, since they will not be appearing before the Parole Board. It is important that these individuals get assistance in planning for release because many have spent a long time inside, may not have significant family or friends in the community to help them, and will have some of the greatest challenges in adjusting to the changes in the community after being incarcerated for many years or decades. There are also other special populations that need enhanced assistance. These include persons with significant mental health needs, those who are developmentally disabled, individuals with significant medical problems requiring specialized care and/or medical residence and persons being discharged directly from solitary confinement. Many of the people in these special categories will not have participated in Transitional Services, will need enhanced community support and will have greater difficulties in re-entry due to long-term challenges. We urge the Re-entry Council to explore the special needs of these populations to both identify how they can be adequately assessed while incarcerated and how community-based resources can be identified to meet their needs.

Once people are released, there needs to be an elimination of current barriers that make it very difficult for people to be successful. People with felony convictions currently face myriad legal barriers that undermine their ability to build healthy and productive lives for themselves

and their families after prison. These barriers include, for example, legal impediments to: securing educational opportunities or living-wage employment, living with family members who reside in public housing, and regaining custody of children and thus reunifying with families. Such barriers are completely contradictory to the purported goals of helping people to reintegrate into their communities, and removing them often does not require any additional resources. The Re-Entry Council should assess the various barriers currently existing and call for their removal.

Finally, there must be sufficient resources in the community to meet the needs of the returning population from prison. It is well known that a person returning home from prison faces numerous obstacles including housing, employment, treatment needs, educational and/or vocational limitations and difficulties reintegrating with their families and their community. If there is not a coordinated approach to these many challenges, it is more likely that the person will not be successful. Placement in temporary housing in shelters often frustrates recently released persons in their ability to stabilize their situation and focus on finding employment and treatment programs. Substance abuse treatment is often a requirement for parole, but in many areas of the state it is difficult to locate a program in which a person can enroll and many parolees cannot afford such treatment until they are qualified for federal health insurance such as Medicaid, which most persons do not have when released from DOCCS. The Re-entry Council should evaluate whether there are sufficient resources throughout the state and assess how providing these resources can be coordinated so that returning citizens can be quickly enrolled in comprehensive services; obtain employment, education, and stable housing; and become integrated into family and community networks of support.

ISOLATED CONFINEMENT

The Governor's proposed budget has allocated additional funding for the purposes of changing some aspects of the way in which people are subjected to isolated confinement in NYS prisons, although much more reform is needed. Specifically, the proposed budget has indicated an allocation of $3.8 million for DOCCS, including a recommended additional 66 full time equivalent staff, "in support of updated policies and programs regarding supervision of [incarcerated persons] in Special Housing Units" (SHUs). To the extent that these additional resources are meant to provide additional programs, services, out-of-cell time, and meaningful human interaction for people who are placed in SHU, these changes are a necessary and welcome development.

Although it is not clear what changed policies and procedures these funds will be used to implement, the new funds should be used to, and additional steps will need to be taken to, end the inhumane and counterproductive use of isolated confinement. Whether for disciplinary confinement, administrative segregation, or protective custody reasons, people in either SHU or keeplock currently spend 22 to 24 hours per day locked in a cell, generally without any meaningful human interaction, programming, therapy, or even the ability to make phone calls. The sensory deprivation, lack of normal human interaction, and extreme idleness can lead to intense suffering and psychological damage. Although there appear to have been some decreases in the use of SHU in NYS prisons in the last year, there are still far too many people who are subjected to isolated confinement – with more than 3,800 people in SHU on any given day, according to the latest available data, in addition to the many others who are subjected to keeplock. Contrary to popular belief, isolated confinement is not used to address chronically violent behavior or serious safety or security concerns, but more often comes in response to non-

violent prison rule violations, or even retaliation for questioning authority, talking back to staff, or filing grievances. Although the United Nations Special Rapporteur on Torture has concluded that isolated confinement beyond 15 days amounts to cruel, inhuman, or degrading treatment, or torture, people in NYS prisons regularly remain in isolated confinement for months and years, and sometimes even decades. The people subjected to isolated confinement are disproportionately African Americans, representing 60% of the people in SHU compared to the already vastly disproportionate 50% of people in NYS prisons and 18% of the total NYS population. The people subjected to isolated confinement also include people particularly vulnerable to either the effects of isolation itself or additional abuse while in isolation, including young and elderly people, people with addiction and mental health needs and medical and other disabilities, pregnant women, and members of the LGBTI community.

Given the current situation, there needs to be a fundamental transformation in how DOCCS responds to people's needs and/or alleged problematic behaviors inside prison. People who have the most severe needs and/or engage in the most egregious conduct should not be subjected to inhumane and counterproductive isolation and deprivation that will only exacerbate their needs or behaviors. Rather, these individuals need additional support, programs, and therapy that are both humane and effective. Thus, if there are people who are such a risk to others that they need to be removed from the general prison population, they should be separated, rather than isolated, into safe, secure residential rehabilitation units that have substantial out-of-cell time and meaningful human interaction, programs, and therapy. Hopefully, the Governor's proposed budgetary allocations will move a step in that direction, but it is likely that more of a fundamental transformation will need to take place. In addition, DOCCS must end the use of long-term isolated confinement, such that no person remains in SHU or keeplock or any form of isolation beyond the 15-day limit established by the UN Special Rapporteur, and members of the particularly vulnerable categories described above should never spend any time in isolated confinement. Moreover, DOCCS should restrict the criteria that could result in isolated confinement or any separation from general population, in order to drastically reduce the number of people subjected to isolated confinement and ensure that separation to alternative rehabilitative units can be focused on those individuals who need such intensive interventions. The Humane Alternatives to Long-Term (HALT) Solitary Confinement Act (A08588/S06466) would achieve these ends of creating effective and humane alternatives, limiting the length of time people can spend in isolated confinement, banning the isolation of particularly vulnerable people, and restricting the criteria of what conduct can result in isolated confinement or separation. The legislature should pass the HALT Solitary Confinement Act without delay to ensure these changes take place.

These changes in the use of isolated confinement will not only bring about more humane conditions for people who are separated from general population and provide more effective mechanisms to address people's needs and behaviors, but will also reduce the state budget for DOCCS in the short, medium, and long term. In the short term, by restricting the criteria for the conduct that can result in isolated confinement or alternative rehabilitative units to the most egregious acts, DOCCS can dramatically reduce the number of people who are separated from the general population. Rather than thousands of people who are currently in isolated confinement, there could be hundreds of people who are separated. Although much more analysis would be needed to assess the specific impact, even using the latest available data that indicates that five out of six SHU sentences are for non-violent conduct as a rough bench mark, then the current SHU population could potentially shrink from approximately 3,800 people to

approximately 600 people. In turn, some of the eight free standing 200-bed S-block units or free standing SHU units within a prison could potentially be closed, thereby substantially reducing costs. Although additional resources will be needed for the more intensive alternative rehabilitative units and thus there will need to be a shifting of resources, these resources would only be needed for a relatively small number of persons and overall the costs saved through the drastic reduction in the population of people separated and closure of lockdown facilities would likely outweigh the additional resources required.

In the medium term, the reduction in the use of isolated confinement would likely increase the number of people who are able to be released on parole by the Parole Board. People who go before the Board while they are in SHU are often denied parole, both because (1) they may be viewed as having engaged in serious misconduct simply by virtue of being in the SHU, when, in fact, they have not violated serious prison rules, and (2) while in SHU they are not able to be engaging in productive activities to prepare themselves for release. As such, the changes outlined above would reduce the length of time that people spend in *prison* and thereby save the state substantial resources, given that it costs an average of $60,000 per year to incarcerate one person in NYS prisons and people denied parole are generally given an additional two years of incarceration before they will be reviewed again. As an example, Upstate C.F. – which is a facility used solely for purposes of SHU confinement – had the lowest release rates for any DOCCS prison in the latest year of available data, with a release rate of initial appearances of two percent and a release rate for all reappearances of 12%. Similarly, Southport – another complete disciplinary lockdown facility – had some of the lowest release rates of any prison with only 7% of initial appearance applicants released and only 11% of people reappearing before the Board released while at Southport.

Finally, in the long term, reducing the use of isolated confinement and creating more effective alternatives will reduce the number of people who return to prison after being released by better preparing people to be successful upon release. According to the latest available data, around 2,000 people are released directly from isolated confinement to the community, without any meaningful transitional services. Thousands of others have been subjected to isolated confinement at some point prior to being released. Given the well-known and long-term damaging effects of isolation, the current policies are doing the exact opposite of the purported goals of incarceration, and the goals of the Re-Entry Council described above, to better prepare people to return to their communities.

Most importantly, regardless of the financial costs associated with the use of isolated confinement, the human costs are exponential and thus making the changes described above would help the state move more in line with our fundamental human values. The Governor's proposed budgetary allocations appear to be a step in the right direction, the funds should be used toward the ends described throughout this section, and ultimately the state must end the counterproductive, costly, and inhumane practice of isolated confinement.