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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 Joint Legislative Public Hearing on 2016-2017 Executive Budget Proposal
Mental Hygiene – February 3, 2016

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 the CA's observations and concerns about two agencies included in the Governor's Fiscal Year (FY) 2016-17 Proposed Budget: (1) resources for mental health care as provided by the Division of Forensic Services of the Office of Mental Health (OMH), with a particular focus on the impact it will have on the incarcerated population with mental health needs in Department of Corrections and Community Supervision (DOCCS) prisons and (2) resources for the NYS Justice Center for the Protection of People with Special Needs (Justice Center) concerning its legal obligation to monitor mental health care in the prisons. After providing a background overview of mental health services in DOCCS prisons, I will focus on six issues: (1) increased funding for OMH Forensic Services staffing; (2) mental health services for 16- and 17-year old persons in DOCCS custody who will be sent to a prison designated by the Governor to house these youth; (3) expansion of OMH resources for discharge planning for persons with mental illness being released from prison and the resources in the community to provide services and housing for these individuals; (4) objections to the FY 2016-17 Executive Budget Part K proposal to amend Criminal Procedure Law (CPL) § 730 to permit restoration of capacity in prison or jail facilities; (5) other needs of the incarcerated population with mental health needs which are not being adequately addressed by current resources; and (6) need for more resources for the oversight of mental health services in NYS prisons by the Justice Center pursuant to the SHU Exclusion Law.

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 mental health care provided in our state prisons.

The FY 2016-17 budget for Forensic Services (FS) for the Office of Mental Health (OMH) includes a significant increase in FS staffing, new initiatives focused on more effective discharge planning for individuals returning home from prison, and the expansion of programs and housing for persons recently released from prison with serious mental health needs. So long as the state continues to incarcerate large and growing numbers of people with mental health needs, these expanded resources are welcomed and reflect the expanding need for services for those with mental illness in NYS prisons. More resources and major improvements, however, are required to address the needs

of incarcerated persons with mental illness in the general prison population and such patients residing in disciplinary segregation in the prisons' Special Housing Units (SHUs) and Residential Mental Health Treatment Units (RMHTUs). The prisons are overcrowded with mentally ill patients because of the over-criminalization of behavioral manifestations of mental illness, and a lack of community-based mental health services and alternatives to incarceration programs for these patients. The prison population could be decreased if police forces, community-based mental health response teams, and other community mental health resources could facilitate treatment, diversion, and recovery rather than imprisonment. Moreover, so long as people with mental illnesses remain incarcerated, substantial improvements and expansion in care must take place to provide for these individual's needs, as well as increase the safety and well-being for all in the prisons and in outside communities.

Overview of Mental Health Services in DOCCS Prisons

With the growing population of people with mental health needs in the state prisons, the CA has observed during the last decade that prison mental health services have expanded and improved in several respects. These improvements have resulted in part due to intense scrutiny and demand for enhanced services by prison mental health patients, their families, the legislature, courts, and prison and mental health advocates. For example, the number of patients in residential mental health treatment units in the prisons has increased, and more and varied programs are offered to these patients. Most significantly, the Special Housing Unit (SHU) Exclusion Law, passed by the NYS legislature in 2008 and fully implemented in July 2011, requires the diversion of people with the most serious mental illness (SMI or S-designation) from solitary confinement. As a result of this law, approximately 200 persons have been placed in disciplinary Residential Mental Health Treatment Units (RMHTUs). Pursuant to the SHU Exclusion Law, the NYS Justice Center for the Protection of People with Special Needs (Justice Center) has been monitoring mental health care in the prisons and OMH and DOCCS compliance with the SHU Law. As a result of this process, deficiencies in care have been identified by the Justice Center, and OMH and DOCCS have made efforts to rectify some identified problems and improve care. We commend all these state agencies for these efforts, but find that deficiencies in care remain, and additional measures and resources are needed to provide appropriate care to the many persons in our prisons with mental health needs.

DOCCS and OMH provide a range of mental health services to the state prison population in many locations and specialized housing units. In order to understand this system, **Table 1 – Summary of Mental Health Services for DOCCS Patients** defines many of the terms and acronyms used to delineate these areas and services. Each prison is designated by an OMH level representing the extent to which that facility can provide mental health services and therefore is authorized to house patients who are classified according to their mental health needs. The 15 OMH Level 1 prisons provide the most intense services, including a residential mental health unit in the prison for patients with serious mental illness and a residential crisis intervention unit where patients who are experiencing suicidal thoughts or significant mental health deterioration can be placed for

assessment. There are 13 OMH Level 2 prisons providing care to patients with major mental illness but without as significant active symptoms; these facilities have full-time OMH staff but do not have a residential treatment unit or crisis center. There are 10 prisons designated as OMH Levels 3 or 4 facilities in which persons with less serious mental health needs are housed and serviced by part-time OMH staff.

Table 1 – Summary of Mental Health Services for DOCCS Patients

Unit	Title	Beds	Prisons	Description
Behavioral Health Unit	BHU	38	Great Meadow	DOCCS/OMH residential treatment unit for persons with serious mental illness (SMI) being disciplined
Therapeutic Behavioral Unit	TBU	16	Bedford Hills	DOCCS/OMH residential treatment unit for women with serious mental illness and a disciplinary sanction
Central New York Psychiatric Center	CNYPC	209	Separate OMH facility	Inpatient psychiatric hospital operated by OMH for DOCCS patients with SMI
Group Therapy Program	GTP	24	Elmira Wende	A program in group treatment rooms in SHU with six treatment cubicles for SHU residents with SMI
Intermediate Care Program	ICP	743	13 prisons	Non-disciplinary DOCCS/OMH residential treatment program for persons with serious mental illness
Intensive Intermediate Care Program	IICP	38	Wende	DOCCS/OMH residential treatment unit for persons with SMI who need more intensive supervision than those in ICP
Transitional Intermediate Care Program	TrICP	253	11 prisons	DOCCS/OMH residential program for patients with mental illness who have less service needs than ICP patients
Residential Crisis Treatment Program	RCTP	112 102*	14 prisons	DOCCS/OMH unit consisting of observation cells and a dorm for patients who are suicidal or in psychiatric crises
Residential Mental Health Unit	RMHU	170	Attica, Five Points, Marcy	DOCCS/OMH residential treatment program for persons with serious mental illness who have a disciplinary sentence
Special Housing Unit	SHU	4,952	41 prisons	Disciplinary housing units in prisons

* RCTPs have a total of 112 observation cells and 102 dorm beds.

1) Expansion of OMH Forensic Services Staffing

The Governor's budget indicates that in FY 2016-17 the staffing for FS will increase from an estimated 2,548 FTE positions as of March 2016, 50 more staff than the FY 2015-16 budget projected, to 2,567 positions by the end of the upcoming Fiscal Year. This increase of 19 positions is in addition to the projected 270 increase and actual 320 increase in FS staff during FY 2015-16. Since March 2011, the FS staff has been augmented by 618 positions, representing a 24% increase in staff. These additions have occurred during a period in which the other divisions of OMH have been losing staff, including a 15% and 22% decline, respectively, in staffing for adult services and

for children and youth services during this same period. It must be noted, however, that it is unclear how these increases in Forensic Services staffing are being funded; the budget for personal services for FS staff has remained fixed at $191.3M during the past four fiscal years (FY 2013-14 through FY 2016-17). We urge the legislature to have OMH identify the funding for these additional FS positions to ensure that the items can be filled in a timely manner.

To the extent that the increase in OMH FS staff will include increased staff within NYS prisons, the increase is justified for several reasons. First, since January 2011 to August 31, 2015, the OMH prison caseload has increased from 7,944, to 9,584 patients, representing a 21% increase in patients. Second, in July 2011, the SHU Exclusion Law was fully implemented, requiring significant expansion of services to be provided by FS staff. Specifically, the Law requires that DOCCS and OMH utilize residential mental health treatment units (RMHTUs) for any incarcerated person with serious mental illness who is given a disciplinary sanction of 30 days or more in place of sending that patient to solitary confinement.

Five facilities house approximately 200 patients in these units daily, numbers that have been increasing since implementation of the SHU Exclusion Law. Most patients in these RMHTUs must receive at least four hours per day of programming, five days per week. Much of this programming is supplied by OMH staff. Moreover, the SHU Exclusion Law requires initial and periodic assessments of all persons being sent to disciplinary confinement to determine if they qualify for RMHU placement and/or whether their mental health status has deteriorated while in the SHU.

An estimated 13,000 persons are sent to SHU each year by DOCCS with the vast majority of these persons receiving an initial assessment, and many will be eligible for multiple OMH assessments while in the SHU. As of June 30, 2015, 4,561 individuals with a mental health diagnosis were placed in the SHU since the start of the year, resulting in an estimated 9,000 annual reviews. Third, the number of persons in DOCCS who have experienced a mental health crisis requiring admission to the Residential Crisis Treatment Program (RCTP) units in the prisons has risen to 4,623 admissions as of June 30, 2015, projecting an annual admission number of 9,264 by the end of 2015. The admissions to the RCTP have significantly increased during the last five years. In 2010 there were 7,515 admissions, and the estimate for 2015 would represent a 23% increase from 2010 and a 13% increase from 2013. Each person in the RCTP has to be seen at least daily by OMH staff while on the unit. Fourth, over the last several years DOCCS and OMH have intensified the program opportunities for persons with serious mental illness housed in the non-punitive mental health residential units, Intermediate Care Programs (ICP), throughout DOCCS. These programs involve 20 hours per week of educational and treatment services for each patient. The average census on these residential units in 2015 was 710-740 patients, and annually approximately 700 patients are admitted to these treatment programs. These units require intense OMH staff providing both group sessions and individual counseling. Overall, the need for mental health services in our state prisons has significantly expanded during the past few years, and the proposed increases for

FY 2016-17 are essential if the prison patient population is going to receive constitutionally required mental health care.

2) Expanded OMH Resources for Discharge Planning and Community-Based Programs for Persons with Mental Illness Being Released from Prison

The OMH FY 2016-17 Forensic Services budget also addresses enhancing transitional support for incarcerated people upon release, particularly during the first six months of reentry, when people are experiencing the greatest challenges in reintegration to their community and in accessing appropriate services and care. The Executive proposal invests $1 million to expand the County Re-Entry Task Forces to provide enhanced supports for this sub-population. The three-point plan enacts transitional housing assistance, connections to employment, and continuity of care.

The need for continuity of care for patients with mental health needs also requires that these persons promptly have health insurance when they return home and are referred to appropriate community-based services. The Executive budget specifically endorses continuity of care through the use of Medicaid interventions for recently released individuals with addiction, mental health needs, or chronic medical conditions. The current budget proposes using $5 million of existing Department of Health (DOH) funds to bridge newly released individuals with placement in Health Homes to help facilitate continuity of care upon community reentry.

During the testimony of OMH Commissioner Sullivan at the February 3, 2016 Joint Budget Hearing, she confirmed that OMH will continue to fund the initiative started in the OMH FY 2015-16 budget involving enhanced discharge planning for persons with mental health needs leaving state prisons and expanding the resources in the community to assist their reentry, including programming and housing. The FY 2015-16 $19.56M initiative had three components: $5.45M to support additional assessment of incarcerated persons with mental illness, enhanced discharge reviews, and staff training; $6.71M to support discharge planning and placement in OMH facilities outside DOCCS; and $7.8M to support 200 assertive community treatment slots and 400 housing units for persons leaving prison. It is our understanding that these funds were used to support the hiring of approximately 50 new OMH positions for treatment, assessment and discharge planning in the prisons. We support the inclusion of similar funding in the FY 2016-17 budget but recommend that the legislature obtain more details as to how these funds have been used and to clarify (1) the number of staff assigned to these duties; (2) the number of patients provided assistance; (3) the number of patients receiving assistance in the community; (4) the number of beds created and used by formerly incarcerated patients; and (5) how effective the programs have been for providing needed support to people returning home.

We agree with OMH that enhanced resources are needed for incarcerated persons for discharge planning and their placement in appropriate mental health settings in the community. Continuation of the funding for the 2015-16 initiative and funding for the new 2016-17 programs are crucial

because these funds will enhance the ability of OMH staff to assess what the mental health needs are for persons about to be released from prison, help these persons prepare for the often difficult transition to the community, and increase the likelihood that they will succeed when they return home by expanding the resources that will be available for housing and support, better preparing them for their reintegration into their communities, and providing enhanced support during the early period of their reintegration.

These added resources for discharge planning and reentry for persons with mental illness in prison are sorely needed. OMH is responsible for discharge planning for patients with mental health needs leaving the state prisons. In 2013, 3,661 patients on the OMH caseload were discharged from our state prisons, 103 of whom were placed in a psychiatric hospital. During the first two quarters of 2015, the number of patients being discharged from DOCCS has increased. Using those two quarters to project for the entire calendar year 2015, there would be 4,068 discharges to community services, including 224 to state hospitals, representing an 11% increase in discharges from 2013. Providing discharge planning and assistance once these patients return home will significantly enhance their ability to reintegrate into their communities and decrease the likelihood that they will return to prison.

3) Mental Health Resources for Youth Confined to Newly Created Youth Prison

Another initiative in the OMH FY 2016-17 budget relates to providing mental health care to children still being held in DOCCS prisons. The Governor issued Executive Order Number 150, mandating the transfer of 16- and 17-year-old male youth with a minimum- and medium-security classification and all 16- and 17-year-old female youth to a separate DOCCS prison at Hudson C. F. by August 2016. The proposed OMH budget allocates $1M to support nine OMH FTE positions to provide residential crisis treatment, residential day treatment, medication monitoring by psychiatric nursing staff, and potential commitment to Central New York Psychiatric Center as required. We strongly support the Governor's renewed call for raising the age of criminal responsibility for all 16- and 17-year-old persons and ensuring that no 16- or 17-year-olds should be incarcerated in DOCCS prisons at all. At the same time, until that legislation is passed and implemented, it is crucial that youth remaining in DOCCS facilities receive adequate mental health care. Consequently, we urge the Legislature to support the additional funds for mental health services for those youth sent to the newly renovated Hudson C.F. We are concerned, however, that maximum-security male youth will be sent to Coxsackie C.F., a maximum security facility classified as an OMH level 2 prison, where there does not appear to be any additional mental health staffing or a proposal to create a youth-oriented treatment plan for youth assigned to that prison. We urge the Legislature to pass the comprehensive Raise the Age legislation and finally remove all youth from all state prisons.

4) Executive Budget 2016 Part K Proposal to Amend CPL § 730 to Permit Patients Found to be Incapacitated to be Placed in Prison or Jail Facilities for Restoration to Capacity

We strongly oppose the 2016-17 Executive Budget Part K proposal that would amend CPL § 730 to authorize patients who have been determined to be incapacitated to be removed from the Department of Mental Hygiene facilities and placed in local jails or state prisons to be restored to capacity. Currently under the law, persons accused of crimes who are suffering mental illness or cognitive impairments so severe that they are unable to participate in their own defense are transferred to state facilities operated by the Office of Mental Health (OMH) or the Office for People with Developmental Disabilities (OPWDD), where they receive comprehensive treatment in a therapeutic environment. Patients are evaluated by a clinical team, and when they are found to be healthy enough to proceed with their criminal cases, they are returned to local jurisdictions. These patients are among those with the most significant mental health needs in the state and generally require extensive mental health treatment to improve.

Under the Part K proposal, OMH would be permitted to restore individuals to fitness inside county jail facilities in "volunteering counties" or state prisons. The bill text does not address conditions or staffing in any specialized correctional unit, what treatment modalities would be available on these units, or if and how a determination would be made to transfer patients to a state hospital if treatment in the correctional facility is unsuccessful.

We assert this provision is ill-advised as it would place patients with serious mental illness in settings that are primarily focused on security and punitive confinement, have a well-documented history of failures to provide appropriate care, and would expand the number of persons with significant mental health needs in correctional institutions that are already overwhelmed with this patient population. Jails and prisons were never designed or intended to be mental health facilities, but reluctantly have become the largest mental health institutions in our state, even though experts, advocates, and even many government officials acknowledge that these are ill-suited to serve this patient population.[1] It is both foolhardy and somewhat callous to assume that these punitive environments can somehow be transformed into caring institutions focused on restoring the mental health of these patients.

Commissioner Sullivan testified that the primary motivation for this proposal is the possibility that the counties and state could save money with these transfers. The savings, however, seem speculative since no evidence was presented demonstrating what the actual costs will be in a

[1] See James Gilligan and Bandy Lee, *Report to the New York City Board of Correction*, (2013), available at http://solitarywatch.com/wp-content/uploads/2013/11/Gilligan-Report.-Final.pdf; Testimony of Dr. Daniel Selling, former Executive Director of Mental Health at New York City Department of Health and Mental Hygiene (DOHMH) to the Board of Corrections Hearing on Enhanced Supervision Units and Punitive Segregation, December 19, 2014, available at http://www.nyc.gov/html/boc/downloads/pdf/Variance_Comments/RuleMaking_201412/BOC%20Testimony%20Dr%20Selling.pdf; Doris James and Lauren Glaze, *Mental Health Problems of Prison and Jail Inmates*, Department of Justice, Bureau of Justice Statistics Special Report, 213600, 1 (2006), available at http://www.bjs.gov/content/pub/pdf/mhppji.pdf.

correctional setting or how the counties are better suited to provide care comparable to that in the state mental health hospitals at less than one-half the current costs. We believe it is much more likely, given the lack of any meaningful guidelines for the requirements of these units and the desire for cost savings, that these units will be grossly underfunded and therefore inadequate to meet the needs of the patients. In contrast to this proposal, the thrust of reform in addressing the needs of patients with mental health needs who have contact with the criminal justice system is to facilitate diversion from criminal justice facilities. It seems entirely inappropriate to reverse that trend in a situation where there is no legal or logistical reason to have patients desperately in need of mental health services confined in a correctional setting.

5) Other Needs Not Adequately Addressed with Current Resources[2]

While it is positive that the FY 2016-2017 budget includes the above additional funds for increased FS mental health staff and increased discharge planning services, the following serious needs regarding mental health care remain unaddressed under current projected initiatives and resources.

a) Mental Health Services for Persons in the Prisons' General Population

The OMH caseload in DOCCS facilities has continued to grow for the past three years. In 2013, there were 8,190 mental health patients in DOCCS, representing 14.9% of the prison population. As of August 2015, there were 9,584 patients, representing 18.2% of the current prison population, the highest rate ever recorded, and it is our understanding that the caseload has grown since then. Unfortunately, there are only limited mental health services for patients on the OMH caseload who reside in the prisons' general population housing units. With only around 1,200 total disciplinary and non-disciplinary residential mental health beds in the system and nearly 9,600 patients, the vast majority of people with mental health needs, including many of those with serious mental illness, remain in the general prison population. At some prisons, such as Albion, Collins or Groveland, the number of people on the OMH caseload represents about half of all people incarcerated at the prisons. Also, many OMH Level 1 facilities have 400-600 people in general population with significant mental health needs, including Level 1 and 2 patients and those with an S-designation.

Even the current OMH caseload does not reflect the scope of the need for mental health services for this population. During our prison visits, we have identified many persons who are not currently receiving mental health care even though prior to their incarceration or at some point earlier in their prison sentence they had received mental health care. For example, at Collins C.F., in addition to the 55% of all persons surveyed by the CA who reported being currently on the OMH caseload, an additional 23.5% of surveyed persons reported that they previously had been on the caseload. The large percentage of incarcerated persons with mental health needs can have a major impact on the

[2] For a more extensive analysis of the mental health services provided in NYS prisons, please see Jack Beck, Correctional Association of NY, Testimony before the NYS Assembly's Corrections and Mental Health Committees, Nov. 13, 2014, available at: http://www.correctionalassociation.org/wp-content/uploads/2014/11/Testimony-by-Jack-Beck-11-13-2014-re-Mental-Health-Services-FINAL.pdf.

entire prison, where program and security staff, as well as other incarcerated persons, are not adequately trained on how to effectively interact with people with mental health needs.

In the general prison population there typically are very limited mental health services provided other than medications and short check-in meetings once per month lasting around 15 to 30 minutes with a mental health provider who is usually a mental health social worker. In addition, these patients may see a psychiatrist through a telemedicine video conference once every three months for medication renewals. Even when these patients experience a mental health crisis, they are often sent back to their cells without substantially augmenting their mental health care. At only a few prisons and only with very few patients, OMH has started to experiment with group sessions for mental health patients. For example, at Sing Sing there is a weekly group for 10-12 patients. These efforts are commendable but minimal, and OMH has failed to assign staff to establish meaningful group programs for this population. We urge OMH to develop group counseling programs for general population patients at more facilities with large OMH caseloads, but this will require increases in staffing which does not appear to be part of the staff augmentation included in the FY 2016-17 budget.

b) Expansion of the ICP as a Model

A positive development in the last decade has been the expansion in capacity of the non-disciplinary residential Intermediate Care Program (ICP) by more than a third between 2007 and 2009. The ICP offers 20-hours per week of intensive therapeutic programming, mostly on the unit but at times off the unit, to patients with a serious mental illness. A Transitional ICP (TrICP) also aims to help people leaving residential mental health treatment units to be reintegrated into general population. Of all mental health units and programs within DOCCS, the ICP receives relatively positive assessments from our survey participants. Around 70% of ICP residents reported feeling safer in the ICP than in general population. Also, most ICP residents had relatively positive ratings of group therapy, with between 80% to 90% of ICP survey respondents rating individual program groups they were in as either good or fair. ICP residents did raise some substantial concerns, including insufficient time for individual therapy (15 minutes once per month), staff harassment, and excessive use of disciplinary tickets and imposition of keeplock. However, there were less reported problems, abuse, and punishment than in most general population or disciplinary mental health units. The ICP, despite its limitations, could serve as a model for providing a relatively safer and more therapeutic environment for people with mental health needs so long as they are incarcerated. Yet, its capacity has remained stagnant in the past five years while the OMH caseload has dramatically increased. Moreover, during the past two years the ICPs have between 40 and 70 empty beds. Given that the full capacity of the ICP represents only one-third of all S-designated patients and 9% of all OMH patients, many more people with mental health needs could benefit from ICP placement. OMH and DOCCS should fully utilize existing capacity and provide funds to expand the number and capacity of the ICPs to place a much greater percentage of the patients with serious mental illness in a residential treatment program that has demonstrated its effectiveness.

It is our understanding that in 2016, DOCCS and OMH will be introducing new programs in the ICP to address the needs of patients with significant mental health conditions who also have a history of violence or other problematic behaviors. Although this new initiative has not been implemented, and therefore the CA has not had an opportunity to examine its curriculum or interview participants, we support the efforts of DOCCS and OMH to proactively address the needs of these patients to hopefully reduce problematic behaviors in prison and avoid the placement of these patients in disciplinary confinement.

c) Mental Health Services for People Currently in Solitary Confinement

New York must stop placing people with mental health needs in solitary confinement and must end the torture of solitary confinement for all people. The total number of people in solitary in NY prisons and the number of people with mental health needs in solitary has grown over the last year. On any given day, over 4,000 total people (or 7.84% of the DOCCS population) and over 800 people on the OMH caseload – the highest number of mental health patients ever in DOCCS – remain in a Special Housing Unit (SHU) each day, even while around 200 people with the most serious mental illness are diverted from solitary to a residential mental health treatment unit (RMHTU) under the SHU Exclusion Law. In addition, around 1,000 other people, some of whom are on the OMH caseload, are held in keeplock – another form of solitary confinement.

People in solitary confinement in New York prisons, in SHU or keeplock, spend 23 to 24 hours per day locked in a cell, with generally no meaningful human interaction, programs, jobs, therapy, group interactions, or the ability to make phone calls. People in solitary do not participate in any group therapy and receive very limited mental health services. This lack of mental health support is particularly problematic given that solitary can exacerbate pre-existing mental illness and create new mental health challenges for any person. The sensory deprivation, lack of normal human interaction, and extreme idleness have long been proven to lead to intense suffering and physical and psychological damage for any person. While President Obama, Supreme Court Justice Kennedy, and the Pope have all strongly denounced the use of solitary confinement,[3] and while the Mandela Rules – recently adopted by the entire UN General Assembly, including the US – place an

[3] *See, e.g.*, https://www.washingtonpost.com/opinions/barack-obama-why-we-must-rethink-solitary-confinement/2016/01/25/29a361f2-c384-11e5-8965-0607e0e265ce_story.html; http://www.justice.gov/restrictivehousing; http://solitarywatch.com/2015/07/14/obama-in-criminal-justice-speech-denounces-the-overuse-of-solitary-confinement-in-u-s-prisons/; http://solitarywatch.com/2015/06/23/supreme-court-justice-kennedy-denounces-human-toll-of-solitary-confinement-and-invites-constitutional-challenge/; http://solitarywatch.com/2014/10/26/pope-francis-denounces-solitary-confinement-calls-for-prison-conditions-that-respect-human-dignity/.

absolute prohibition of solitary confinement beyond 15 consecutive days,[4] thousands of people in NYS spend months and years in solitary, and even decades, including upwards of 30 years.[5]

The legislature and Governor should pass the Humane Alternatives to Long Term (HALT) Solitary Confinement Act, A. 4401 / S. 2659 so that people with any mental illness – whether they are S-designated or not – are removed from isolation, no person is subjected to the torture of solitary confinement, and more humane and effective alternatives are utilized.[6] In addition, the Senate should pass A. 1346A / S. 5900, which has already passed the Assembly and would, among other limitations, prohibit solitary for all people with any mental illness and any person under the age of 21. Similarly, A. 1347 / 5729, which also already passed the Assembly, would prohibit solitary confinement for women who are pregnant, have recently given birth, or who have infants in the prison nursery program. In the meantime, so long as people, including people with mental illness, continue to remain in solitary confinement, we urge that FY 2016-17 budget include allocations for the operation of out-of-cell congregate mental health group programming for people held in SHU.

d) Mental Health Services for People in Disciplinary Mental Health Units

The RMHTUs need to be improved and expanded, to allow for increased out-of-cell programming for current residents and allow diversion of a larger number of people from the SHU. For some people who were suffering the worst impacts of the SHU, the RMHTUs – particularly at Marcy, but to a lesser extent at Five Points, Bedford Hills, Great Meadow, and Attica – provide a relatively more humane and effective environment than SHU. Simply the ability to come out of their cells, have some individual therapy, and participate in group programming for multiple hours a day is having a positive impact for many people, and some residents at Marcy and to a lesser extent at Five Points praised the group programs and OMH staff as being relatively supportive and helpful to deal with their mental health issues. Also positively, there is a growing number and percentage of discharges of RMHU and BHU patients to non-punitive housing, including general population, the ICP, and TrICP. While many patients have benefited from being in an RMHU or BHU, many others have faced an overly punitive and abusive environment, particularly at Great Meadow, Attica, and Five Points, and to a lesser extent at Marcy. Although it is positive that people are diverted from the SHU to the RMHTUs, these units remain disciplinary confinement units and hold people for months and even years. Roughly half of all persons on these units received a disciplinary ticket on the unit over a less than four year period and 115 people received 10 tickets or more (up to 60 tickets for a single person). In turn, subtracting out time cuts, over 300 people received a cumulative six months or more additional SHU time, 148 received one year or more, 35 received five years or more, and

[4] *See* http://www.penalreform.org/news/10071/; Rules 43-44, http://www.penalreform.org/wp-content/uploads/2015/05/MANDELA-RULES.pdf.
[5] *See, e.g.*, William Blake, *Voices from Solitary: A Sentence Worse than Death*, Solitary Watch, Dec. 24, 2014, *available at*: http://solitarywatch.com/2014/12/25/voices-from-solitary-a-sentence-worse-than-death-2/.
[6] We also support passage of other legislation that would substantially restrict the use of solitary, including A. 1346A, which among other limitations would prohibit solitary for all people with mental illness and any person under the age of 21, and A. 1347, which would prohibit solitary confinement for women who are pregnant, have recently given birth, or who have infants in the prison nursery program.

eight people received *10 years or more* of additional SHU time while on a mental health unit. In addition to this formal punishment, many RMHTU residents, at Five Points and Great Meadow in particular, reported physical abuse, verbal harassment, and threats by security staff. Respondents described horrific examples of confrontations in which security staff brutally beat them or taunted them specifically about their mental health issues or self-harm. Numerous RMHU and BHU residents also reported that staff utilize deprivation orders, including cell shields, basic service denials, and exposure suits, all of which are inhumane, to inflict even additional punishment.

In addition, while some patients benefited from programs on these units, overall residents in the RMHTUs gave a mixed assessment of the quality of group and individual care, and some were highly critical. Many patients, particularly at the Great Meadow BHU and to a lesser extent at the Five Points' RMHU, felt that the programs did not offer meaningful treatment opportunities to address their mental health issues, and that some staff appeared disinterested if not antagonistic, or repeatedly played outdated videos. Many others felt that the punitive nature of the security staff on the unit dominates even the group and individual treatment, exemplified by the use of individually caged cubicles for group therapy, and information told confidentially by patients to therapists leading to disciplinary tickets or security staff harassment. Worse still, DOCCS is too often denying some patients the opportunity to come out of their cell or participate in programming due to "exceptional circumstances" signifying a patient presents an unacceptable safety risk. Three-quarters of Five Points survey respondents and 42% of respondents at Marcy reported to us that they had been denied programs at some point. Past denials, security staff abuses, and excessive use of disciplinary tickets, also lead many people to refuse to come out of their cell for programs.

We urge that the FY 2016-17 budget include allocations to expand and improve the RMHTUs, including to increase the number of people who are diverted from SHU to the RMHTUs, provide more and improved programs to people already in the RMHTUs, enhance the qualifications and number of mental health staff, increase mental health training for all mental health, program, and security staff in the RMHTUs, and utilize responses and interventions focused on de-escalation, communication, mutual respect, treatment, and growth, rather than discipline and punishment.

e) Concerns about Diagnoses

Related to patients in the SHU, there has been a major shift in diagnoses of all DOCCS mental health patients in the last six years of available data from schizophrenia and psychoses (35% drop) to adjustment, anxiety, and personality disorders (72% rise). In the annual summaries for calendar years 2010 through 2013, the percentage of patients diagnosed with schizophrenia and psychoses dropped 21%, while the percentage for adjustment disorders rose 49%. In just the last two years for which data is available (2011 to 2013), the schizophrenia and psychoses diagnoses dropped 13.5% and adjustment disorder diagnoses rose 19%.

We have also observed similar declines in the percentage of patients diagnosed with serious mental illness pursuant to the SHU Exclusion Law. From 2008 to 2015, the percentage of OMH patients given an "S-designation," signifying under the SHU Exclusion Law that the patient suffers from SMI, has dropped from 40% to 24%, respectively. This drop raises serious concerns about whether the SHU Exclusion Law's provision of a sharp line above which people receive intensive services and below which people receive none and remain in the SHU, are leading to improper diagnoses. These concerns are even more stark given that the percentage of the total OMH caseload designated as Level 1 has risen in recent years.

f) Crises and Problematic Crisis Intervention

The most visible and disturbing outcomes of many of the challenges identified – incarceration of large numbers of people with mental health needs, limited residential mental health beds and insufficient services in general population, continued and pervasive use of solitary confinement, and overly punitive nature of the RMHTUs – include people going into mental health crisis and/or committing suicide or self-harm. Incarcerated persons who are suicidal or having a mental health crisis are taken to the Residential Crisis treatment Program (RCTP) for assessment and housing in an environment intended to ensure safety and provide an opportunity for evaluation. Admissions to the RCTPs have risen 75% from 5,302 in 2007 to an estimated 9,264 in 2015. Although data is not available for the past fiscal year, historically, the disciplinary mental health units have had RCTP admission rates multiple times higher than the rate of the general prison population, and three times the rate of the non-disciplinary mental health units even though patients' mental health acuity is comparable. Also, historically the SHUs have had admission rates several times greater than the rate of the general prison population, even though nearly all S-designated patients have been removed from the SHUs.

Unfortunately, the RCTP often fails to address the underlying mental health issues leading to the crisis, and fails to examine the living conditions and/or experiences of patients that contributed to the deterioration of their mental health status or intention to harm themselves. Instead, the mental health response is limited to assessing only the immediate risk of serious self-harm, and generally after a few days people are returned to the very environment that led to the crisis or self-harm, including to solitary confinement. Indicative of the lack of an appropriately therapeutic response to crises, as RCTP admissions have dramatically increased, admissions to the Central New York Psychiatric Center (CNYPC) – where people in crisis can receive intensive in-patient care – have decreased more than 70% since 2008. In addition to the failure to address people's mental health issues, many incarcerated persons view the RCTP as an ineffective, punitive, and abusive response. For a unit intended to provide people experiencing a mental health crisis a safe environment to avoid further deterioration or physical injury, patients repeatedly report that they are physically abused or otherwise mistreated by security staff during transfer to, or in, the RCTP. OMH must intensify its resources to more comprehensively respond to the needs of patients being sent to the RCTP. In addition, it should re-examine its process for determining whether DOCCS patients

would benefit from admission to CNYPC. If resource limitations at CNYPC are deterring placement at the hospital, these should be adjusted. But whether resource driven or a result of policies and practices, OMH must expanded its response to incarcerated persons who are experiencing mental health crises in the prisons, including placement in a psychiatric hospital when needed.

g) High Rates of Suicide and Self-Harm

Most distressingly, too often mental health crises in the prisons lead to self-harm and suicide. During the past decade, NYS prisons have had a suicide rate 50%-70% higher than the national average for state prisons, and roughly two times the suicide rate in the outside community. Suicides also have been concentrated at a select few prisons. From 2011 through mid-2014, 54% of all suicides occurred at just five prisons: Auburn, Attica, Clinton, Elmira, and Great Meadow. These facilities had a suicide rate three times the DOCCS average and nearly five times the national rate for state prisons. Nearly a quarter of all suicides have taken place in the SHU – a rate more than three times the percentage of people in the SHU represent of the entire prison system. Fortunately, during the period July 2014 through December 2015, the numbers of suicides have declined to a rate lower than it has been during the past three years. We hope that this decline will continue and the reduced rate sustained in the future.

OMH is one of several state agencies that review all suicides. Unfortunately, OMH plays a much less significant role in responding to suicides and serious acts of self-injury concerning the impact these acts have on the incarcerated persons and staff who live or work in the locations in which these events occur. Moreover, we are unaware of any detailed analysis of why so many suicides are occurring in a few prisons and what actions should be taken to reduce these incidents. We urge OMH to expand its efforts to prevent self-harm and to partner with DOCCS, the State Commission of Corrections and the Justice Center to develop more comprehensive approaches to this issue.

6) Need for More Resources for the Oversight of Mental Health Services in NYS Prisons by the NYS Justice Center for the Protection of Persons with Special Needs

In FY 2016-17 budget there is no increase in funding for the staff of the Justice Center assigned to oversight of mental health care in the prisons and monitor DOCCS and OMH compliance with the SHU Exclusion Law. Greater oversight is needed over the provision of mental health services in NYS prisons and the legislature and Governor should adequately fund the Justice Center's SHU Exclusion Law oversight responsibilities and ensure the Justice Center publicly reports its findings and recommendations, as mandated under existing law. Pursuant to the SHU Exclusion Law (Correction Law §§ 137, 401 and 40-a) the Justice Center is mandated to assess whether DOCCS and OMH are in compliance with the law concerning the treatment of persons with serious mental illness who are sentenced to long-term disciplinary confinement and OMH's periodic assessments of the mental health status of all persons placed in disciplinary confinement. In addition, the Justice

Center has more general jurisdiction to monitor "the quality of mental health care provided to" incarcerated persons throughout the prisons. Throughout the period from 2008 to the present, both the Justice Center's precursor agency – Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC) – and the Justice Center have *not* had sufficient staff to fully perform their duties under the SHU Law and have had much less staff than the 14 staff members budgeted to perform these duties in the first fiscal budget (FY 2008-09) after the law's enactment.

Even with the limited resources, since the SHU Exclusion Law was enacted, this oversight function has produced some meaningful assessments of mental health care in the prisons. Specifically, CQC and the Justice Center have produced reports about (1) persons who experienced mental health crisis, (2) analysis of the screening process for determining whether a person should be on the mental health caseload; (3) reviews of care in the non-disciplinary prison residential mental health treatment units; and (4) assessments of the services provided to people in the SHUs to determine whether OMH is promptly and regularly evaluating individuals to determine if they should be transferred to an RMHU or need mental health services.

Although the assigned staff are working hard to meet the Justice Center's statutory duties, the current allocation of staff is insufficient to accomplish all needed tasks in a timely manner. As noted above, there are more than 9,500 patients on the OMH caseload in the prisons at any one time, representing 18% of the entire prison population, and estimates range up to 40% of persons incarcerated in our prisons at some point during their incarceration may need mental health care. There are more than 4,000 persons in disciplinary confinement in 47 different prison units and about 13,500 persons are sentenced to the SHU each year. With only five staff members, it is impossible for the Justice Center to perform its duties in a timely manner. Family members of persons with mental illness inside have been pressing the Justice Center to investigate allegations of improper care of their loved ones. It appears that the limited resources available make it practically impossible for the Center to be responsive to these complaints, even in situations that present dire circumstances for the affected patients. In addition, the scope of the Justice Center's reviews of the SHUs has been relatively limited, focusing primarily on procedural aspects of care and compliance with the law, including whether assessments are done in mandatory time frames and whether documentation of patient reviews and treatment plans is completed fully and appropriately.[7] Also, the Justice Center has yet to report on the disciplinary Residential Mental Health Treatment Units – one of the key components of the SHU Exclusion Law as the sites of diversion from SHU.

In addition to the need for adequate resources, the Justice Center is failing to meet its statutory obligation to make public its reports and findings. Advocates and family members have waited patiently for more than a year for the Center to post its work product, but Justice Center documents have not been made available despite repeated requests to the agency leadership. Moreover, advocates waited over eight months and had to engage in repeated advocacy simply to receive

[7] The Justice Center has done relatively more extensive substantive reviews in incidents where incarcerated people have committed suicide within DOCCS custody.

documents requested under the Freedom of Information Law (FOIL) on the Justice Center's basic monitoring of SHUs. The Justice Center's credibility is being threatened by this failure to make public its activities, and the lack of transparency raises the concern that state officials are attempting to cover up potential negative findings about the care of mental health patients in our prisons. The legislature must ensure that the Justice Center publicly reports its findings in a timely manner as already required under the SHU Exclusion Law. Overall, it is crucial for the Justice Center unit dedicated to monitoring the SHU Exclusion Law and prison mental health services to have adequate resources to evaluate the mental health care being provided in our prisons and to make those evaluations public. Only through independent monitoring can the state identify where resources are needed, evaluate the effectiveness of the SHU Exclusion Law and assess the impact these new programs are having on the care of incarcerated individuals with serious mental illnesses.

Recommendations

Dramatic reform is needed to address these myriad issues and better serve the people in New York State who have mental health needs. Specifically:

- New York must de-criminalize behavioral manifestations of mental illness, and provide greater community mental health care, diversion, and alternatives to incarceration so that prisons and jails are no longer the dumping ground for people with mental illness.

- Inside prisons, DOCCS and OMH must expand the ICPs and mental health programs and services for people in general population so that as long as people with mental illness are incarcerated, they are able to receive the treatment and environment they need to cope with their mental illness and prepare to return home.

- The legislature and Governor should pass the Humane Alternatives to Long Term (HALT) Solitary Confinement Act, A. 4401 / S. 2659, so that people with any mental illness – whether they are S-designated or not – are removed from isolation, no person is subjected to the torture of solitary confinement, and more humane and effective alternatives are utilized. The Senate and Governor should also pass bills already passed by the Assembly: A. 1346A / S. 5900, which, among other limitations, would prohibit solitary for all people with mental illness and any person under the age of 21; and A. 1347 / 5729, which would prohibit solitary for women who are pregnant, have recently given birth, or who have infants in the prison nursery program

- All current and future alternative units to SHU, including the RMHUs, BHU, and TBU, must be more therapeutic and rehabilitative, and all staff abuse, disciplinary tickets, additional SHU time, and program denials must cease.

- DOCCS and OMH must enhance assessments, diagnoses, and individualized treatment for all people with mental health needs, including by relying on family input and past mental health history and treatment, and by creating a full time dedicated family liaison.

- OMH should re-evaluate its processes for diagnosing patients to ensure that persons who have a history of serious mental illness are appropriately diagnosed and that patients who experience deterioration of their mental health status or a mental health crisis while in prison are carefully reassessed to determine whether their diagnoses and treatment plans should be changed.

- OMH must expand its capacity to provide comprehensive services to persons experiencing a mental health crisis in prison and reassess its policies and practices concerning transfer of patients to Central NY Psychiatric Center to increase access for persons who would benefit from psychiatric hospitalization.

- There must be greater suicide, self-harm, and crises prevention and therapeutic responses, including through counseling, treatment, and transfers to an RMHTU or CNYPC.

- Resources for the Justice Center must be increased so that it can adequately monitor implementation of the SHU Exclusion Law and more generally monitor mental health services for persons in our state prisons.

- To ensure that the public remains aware of what is happening behind the walls, DOCCS, OMH, and the Justice Center that oversees prison mental health services, must have greater public reporting, transparency, and in turn accountability.

At its core, in the prison system as well as in jails and the outside community, there must be a fundamental shift in the culture, philosophy, and approach to people with mental health needs from one of punishment, control, and abuse to one of treatment, recovery, and empowerment.