**New York State Mental Hygiene Budget Hearing:**
**Testimony of Jack Beck for**
**The Correctional Association of New York**
Regarding the New York State Executive Budget Proposals
State Fiscal Year 2018-2019
February 13, 2018

I am Jack Beck and work for the Correctional Association of New York ("the CA"), which is an independent, non-profit organization founded by concerned citizens in 1844 and granted unique authority by the New York State Legislature to inspect prisons and report its findings and recommendations to the legislature, the public and the press. Through monitoring, research, public education and policy recommendations, the CA strives to make the administration of justice in NYS more fair, efficient and humane. Our unique access to prisons run by NYS Department of Corrections and Community Supervision (DOCCS) and the information garnered from incarcerated persons and prison staff, combined with our policy and legislative expertise, informs our perspective today. We have detailed information about mental health care in our state prison system and how the services provided by the Forensic Unit of the NYS Office of Mental Health (OMH) impact the prison population and the operation of the prison system. Moreover, as nearly everyone in our prisons and jails returns to his/her community, we are also concerned about continuity of care for those released from incarceration with mental health needs to obtain improved outcomes for these returning citizens and enhance the public health in the communities to which they return.

This testimony will focus on the following issues: (1) an overview of mental health services in DOCCS facilities and the areas of such services that require improvement; (2) an analysis of DOCCS and OMH response to patients experiencing mental health crises and mechanisms to improve this response; (3) decreases in the utilization of psychiatric hospitalization at Central New York Psychiatric Center and the need to expand such admissions; (4) an analysis of the excessive number of incidents of suicide and self-harm in the prisons and what OMH can do to reduce these incidents; (5) description of the excessively punitive responses by DOCCS to patients with mental health needs in DOCCS residential mental health programs; (6) DOCCS excessive use of solitary confinement in state prisons and the need to enact HALT, a bill to end the practice of long-term isolation for all DOCCS residents; and (7) analysis of the non-punitive residential mental health units in DOCCS and mental health services for patients in the general prison population; and (8) need to expand resources to the Justice Center for the Protection of People with Special Needs in its efforts to monitor prison mental health care and the implementation of the SHU Exclusion Law and for the Justice Center to modify its procedures to address systemic problems with mental health in the state prisons.

## A. Overview of Mental Health Services in DOCCS

There is a large and growing incarceration of people with mental health needs in the state prisons, and there has been a long history of inadequate care and problematic conditions for people with mental health needs. In the decade leading up to and including the full implementation of the SHU Exclusion Law in mid-2011, the provision of mental health services in New York prisons increased and, in many cases, improved. This expansion was in no small part due to intense scrutiny and demand for enhanced mental health services and improvements in care provided by DOCCS and OMH urged by the legislature, courts, prison and mental health advocates, and prison mental health patients and their families. State officials, including DOCCS and OMH employees, responded by providing more treatment beds, assessing more incarcerated persons for mental health needs and enhancing existing programs or creating new ones for patients with serious mental illness (SMI or S-designated). The CA regularly visits state prisons and surveys incarcerated persons about their treatment. Incarcerated persons continue to often rate mental health services somewhat better than other services provided in the prisons, including medical care. In addition, most patients in non-disciplinary residential treatment programs assert they feel safer on these units than in general population. When asked what they like most about these residential units, many patients point to the group or individual counseling they receive.

However, there continue to be problematic prison conditions that can create or exacerbate mental illness, and challenges with the provision of adequate mental health programs and services. Mental health care is not uniform across the system and more resources are needed to meet the needs of all persons with mental illness in DOCCS. At some facilities and in some treatment units, patients are much less satisfied with the mental health care they are receiving. Moreover, at many prisons, the relationship between mental health patients and security staff is problematic and can undermine the therapeutic environment and perpetuate an over-reliance on punishment instead of treatment in dealing with these individuals and their behavior. We are also concerned with the substantial decrease in the number of patients OMH has identified as suffering from serious mental illness, even while the OMH caseload is increasing. Additionally, there are many persons with mental illness, including those with serious mental illness, who remain in the general prison population with very limited services and treatment, and it is only when their condition significantly deteriorates, or they are determined to have violated prison rules, that they will be offered more appropriate care. Such delays in comprehensive care contribute to the deterioration of the mental status of these patients, expose them to increased risk of harm from themselves and others, and make the prisons less safe for the prison population and staff. We also believe that the overly punitive nature of our prisons for persons with mental health needs, the lack of adequate interventions for persons in a mental health crisis and the failure by DOCCS and OMH to adequately respond to acts of self-harm all have resulted in the unacceptably high numbers of suicide and self-harm in New York's prisons, which significantly exceeds the national average. More needs to be done by DOCCS and OMH to significantly reduce these incidents.

### *1. Description of DOCCS Patients on the Mental Health Caseload and DOCCS Mental Health Programs*

In DOCCS prisons, mental health services are provided by OMH in both an out-patient setting and in residential units in the prisons that confine persons with significant mental health needs.

During the past two decades, the number and percentage of incarcerated persons in our prisons has substantially increased. As of January 31, 2017, there were 10,397 patients on the OMH caseload in DOCCS, representing more than 20% of the prison population. By comparison, in January 2010, there were only 7,836 persons on the OMH caseload, representing just 13.4% of the DOCCS census at that time. Over this seven-year period, the percentage of DOCCS population receiving mental health care rose by more than 50%. **Table 1 – DOCCS OMH Caseload – 2011 – 2016** summarizes the total OMH caseload and patients assigned to each diagnostic category.

**Table 1 - DOCCS OMH Caseload - 2011 - 2016**

| Date | OMH Caseload | MHL 1 | % MHL 1 | MHL 2 | % MHL 2 | MHL 3 | % MHL 3 | MHL 4 | S-Desig | % S-Desig |
|---|---|---|---|---|---|---|---|---|---|---|
| 1/1/2008 | 8,567 | 1,821 | 21.27% | 2,631 | 30.6% | 3,705 | 43.1% | 438 | 3,412 | 39.8% |
| 1/1/2009 | 8,696 | 1,975 | 22.8% | 2,595 | 30.0% | 3,567 | 41.2% | 522 | 3,005 | 34.6% |
| 1/1/2010 | 7,836 | 1,836 | 23.5% | 2,768 | 35.2% | 2,958 | 37.6% | 306 | | |
| 1/31/2011 | 7,944 | 1,866 | 23.5% | 2,927 | 36.8% | 2,881 | 36.3% | 270 | 2,677 | 33.7% |
| 1/31/2012 | 8,234 | 1,942 | 23.6% | 2,968 | 36.0% | 2,986 | 36.3% | 338 | 2,429 | 29.5% |
| 1/1/2013 | 8,190 | 1,872 | 22.9% | 2,895 | 35.3% | 3,124 | 38.1% | 299 | 2,200 | 26.9% |
| 1/31/2014 | 8,504 | 1,998 | 23.5% | 3,047 | 35.8% | 3,123 | 36.7% | 336 | 2,091 | 24.6% |
| 1/30/2015 | 9,312 | 2,351 | 25.2% | 3,019 | 32.4% | 3,509 | 37.7% | 433 | 2,198 | 23.6% |
| 6/30/2015 | 9,555 | 2,453 | 25.7% | 3,002 | 31.4% | 3,712 | 38.8% | 388 | 2,270 | 23.8% |
| 1/29/2016 | 9,994 | 2,590 | 25.9% | 3,007 | 30.1% | 3,929 | 39.3% | 468 | 2,365 | 23.7% |
| 6/30/2016 | 10,309 | 2,653 | 25.7% | 2,935 | 28.5% | 4,202 | 40.8% | 519 | 2,498 | 24.2% |
| 1/31/2017 | 10,397 | 2,754 | 25.5% | 3,013 | 29.0% | 4,101 | 39.4% | 529 | 2,571 | 24.7% |

When someone is transferred to DOCCS, OMH conducts an initial mental health assessment and assigns the patient an OMH Level from 1-6. Level 1 indicates the patient has the most significant mental health needs and consequently, will likely receive the most robust treatment regimen, and level 6 indicates the incarcerated person does have any need for mental health treatment. There is no Level 5. The OMH caseload, as of January 31, 2017, consisted of 2,754 patients (26.5% of the OMH caseload) as Level 1, 3,012 patients (29.0%) as Level 2, 4,101 patients (39.4%) as Level 3 and 529 patients (5.1%) as Level 4. The percentage of patients in 2017 assessed as Level 1 and Level 3 has each increased by 3% since 2011, while those assigned Level 2 has dropped by 8%. In addition to the OMH Levels, OMH may assign a patient as an S-designation, indicating a mental illness that is considered Seriously Mentally Ill (SMI), encompassing severe disorders like Schizophrenia and other psychotic illnesses, signifying that the patient cannot generally be placed into solitary confinement. Patients' OMH Level, diagnosis and S-designation can be altered at any time during their incarceration. In 2016, approximately, 8,100 patients were discharged from the OMH caseload. Although we do not have a breakdown for 2016, based upon prior years' data, approximately 40% of these discharges are for patients still in DOCCS and 60% were released from custody. We are concerned about the removal of more than 3,000 patients from OMH monitoring while they are still inside, and many patients report to us that they have been discharged from DOCCS even though they still have mental health issues because they are not accepting the medications being prescribed by their OMH provider or are dissatisfied with the individual therapy they are receiving.

We have documented that the number and percentage of patients diagnosed as having a serious mental illness has declined 38% from levels in 2008 to 2017, despite an increase of 4% in the percentage of patients assigned the highest mental health levels (Level 1 and 2) during this period. We are very concerned that patients considered to have a serious mental illness, as defined by the SHU Exclusion Law, and assigned an "S" designation by OMH, have consistently declined during the period 2008 to the present, a time coincident with the passage and implementation of the SHU Law. This decline is particularly troubling when the number of 2017 patients in Level 1 is more than 900 patients higher than in 2008, but those assigned an S-designation is 830 lower in 2017 than in 2008. The implications of failing to designate a patient as suffering from a serious mental illness is to make the person ineligible for the enhanced mental health services required by the SHU Exclusion Law.

Our review of OMH patient profile data also reveals that the primary diagnoses of prison OMH patients has changed significantly in the past nine years, with a significant drop in those with the diagnosis of schizophrenia or other psychotic disorders and a commensurate increase in those diagnosed as having a personality or adjustment disorders. Between January 2008 and 2017, the percentage of patients diagnosed with schizophrenia or psychosis dropped from 19.3% to 13.2%, representing a **decline of 52%**. In contrast, there has been an increase in the diagnoses of adjustment and personality disorders from 16.8% in 2008 to 35.2% in 2017, a **110% increase** in the percentage of patients with these diagnoses. It is unreasonable to assume that the patient population has changed so dramatically during this period to justify such a significant shift in diagnoses. A summary of the patient population in DOCCS and those in Central New York Psychiatric Center, along with the patient diagnostic profiles is attached as **Exhibit A CNYPC Patient Demographics and Profile 2008-17**. The impact of this change, however, is significant because most patients with a personality or adjustment disorder are not assigned an S-designation and therefore, they are not eligible to be removed from solitary confinement and placed in a residential treatment program.

DOCCS and OMH provide a range of mental health services to the state prison population in many locations and specialized housing units. 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 16 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 can be placed who are experiencing suicidal thoughts or significant mental health deterioration for assessment. As of January 2016, 7,113 patients were in these Level 1 prisons. There are 13 OMH Level 2 prisons serving 2,379 patients with Level 2 and below OMH assignments. These facilities usually have some full-time staff but no residential treatments units, so all mental health care is done as an out-patient. Finally there are seven Level 3 prisons and two Level 4 prisons that only have part-time OMH staff and treat 905 patients.

In order to understand this system, **Table 2 – Summary of Mental Health Services for DOCCS Patients** defines many of the terms and acronyms used to delineate these areas and services.

**Table 2 – Summary of Mental Health Services for DOCCS Patients**

| Unit | Title | Beds | Prisons | Description |
|---|---|---|---|---|
| Behavior Health Unit | BHU | 38 | Great Meadow | DOCCS/OMH residential treatment unit for persons with serious mental illness (SMI) being disciplined |
| 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 room in SHU with six treatment cubicles for SHU residents with SMI |
| 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 |
| Intermediate Care Program | ICP | 743 | 13 prisons | Non-disciplinary DOCCS/OMH residential treatment program for persons with serious mental illness |
| Residential Crisis Treatment Program | RCTP | 116<br>91 | 14 prisons | DOCCS/OMH unit consisting of observation cells and a dorm for patients who are suicidal or in psychiatric crisis |
| Residential Mental Health Treatment 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 |
| Therapeutic Behavioral Unit | TBU | 16 | Bedford Hills | DOCCS/OMH residential treatment unit for women with serious mental illness and a disciplinary sanction |
| 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 |

We urge that DOCCS and OMH increase mental health services in the prisons to address the expanding mental health needs of the prison population. Residential programs, OMH treatment staff, which are designated to remain static for the upcoming year, and expanded services for general population patients on the OMH caseload are needed.

## B. DOCCS Patients with Mental Illness Admitted to a Psychiatric Hospital

Admissions of DOCCS patients to Central New York Psychiatric Center (CNYPC) for hospitalization have significantly diminished during the past nine years. During calendar year (CY) 2016, there were only 372 admissions to CNYPC, a **52% decrease** in CNYPC admissions from CY 2008 when 773 patients were admitted to the hospital. It is unclear why there has been such a dramatic change in CNYPC admissions, as the number of patients being referred to crisis intervention in the prisons has increased during this time period. The census as of December 31, 2016 at CNYPC was 141 even though the capacity of the unit is 209. The percentage of CNYPC patients with schizophrenia or other psychotic disorders was 70.7% of the patient population, an increase of 27% from the average percentage (55.6%) for these illnesses of CNYPC patients during 2009-11. Given the decrease of diagnoses of schizophrenia and other psychotic disorders in the DOCCS population, we question why the percentage is increasing in the CNYPC

population. This could represent an unwillingness to hospitalize patients with axis II diagnoses, such as adjustment, anxiety and personality disorders, even as these diagnoses are on the rise in the prisons.

### C. DOCCS Patients Experiencing Mental Health Crises

There has been a substantial increase in the number of admissions to the Residential Crisis Treatment Program (RCTP) throughout the past 10 years, even as CNYPC admissions have declined. RCTPs are located in the 15 OMH Level 1 facilities and the Marcy RMHU. Incarcerated persons who are suicidal or having a mental health crisis are taken to the RCTP for assessment and housing in an environment designed to ensure safety. These units usually contain several observation cells where patients are placed in clothing resistant to manipulation for the purpose of self-harm. RCTP patients in observation cells are provided no property or other items with which they could harm themselves. Patients generally remain in these observation cells for one to four days while the mental health staff evaluate what treatment should be provided and where the patients should be housed. This could include eventual psychiatric hospitalization, placement in a residential mental health unit in the prisons or a return to a general population bed or special housing unit in a prison. The RCTPs may also have a small dormitory unit for patients discharged from the cells or returning from another mental health unit. As indicated in **Table 3 – Annual Admissions to DOCCS RCTP – 2007-2016**, admissions to the RCTPs have risen from 5,226 in 2007 to 8,801 in 2016, representing a **68% increase**. In the last six years (2011 to 2016), there was a 15% increase. The rise in crisis interventions while the admissions to CNYPC has declined is particularly troubling and suggestive that OMH is not aggressively responding to the needs of patients in crisis.

**TABLE 3 - ANNUAL ADMISSIONS TO DOCCS RCTP - 2007-2016**

| Year | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|---|---|---|---|---|
| Admissions | 5,226 | 5,802 | 6,415 | 7,515 | 7,658 | 7,842 | 8,224 | 8,905 | 8,882 | 8,801 |

A few additional issues must be raised about the RCTP process. These units are intended to be a place where persons experiencing a mental health crisis and/or who are at serious risk of self-harm are encouraged to utilize to avoid further deterioration or physical injury. Unfortunately, too many incarcerated persons believe they do not offer this relief and instead inflict greater harm. The CA has interviewed and surveyed many persons who report that they or other incarcerated persons have been physically abused or otherwise mistreated by security staff for requesting transfer to these units.

At the same time, patients with significant mental health needs who believe they are deteriorating and need psychiatric hospitalization may request placement in the RCTP to prompt an evaluation for CNYPC admission. As the data previously presented illustrated, admissions to CNYPC have significantly declined and several patients have reported to us that it is nearly impossible to get transferred from the RCTP to CNYPC. With only 335 CNYPC admissions and more than 8,200 RCTP admissions in 2013, their fear of a non-response to their desire for psychiatric hospitalization is well founded. Between the fears of physical harm and non-response, many incarcerated persons will do whatever they can to avoid going to the RCTP. Worse still, some patients described how their fear of going to the RCTP will greatly inhibit their ability to have any meaningful discussions with OMH staff about their mental health symptoms or challenges. According to one survey respondent in the Five Points RMHU, "They use RCTP

as punishment and it makes someone like me, who struggles everyday with suicidal thoughts, [afraid] to discuss how I feel."

We have also analyzed where RCTP patients are located prior to their admissions and where they are sent when discharged from the RCTP. **Table 4 - 2011-15 RCTP Observation Cells/Dorm Admissions & Releases by Location** summarizes the locations from which patients were sent to the RCTP and where they returned after their RCTP stay. This data reveals several disturbing observations. First, the number of admissions to the RCTP has increased by 16% since 2011 from 7,658 to 8,882 in 2015. Although we do not have a breakdown of the locations for 2016 RCTP admissions, the total number of RCTP admissions in 2016 remained high at 8,801. The increase in RCTP admissions has been ongoing for the past decade. Given there were only 5,302 RCTP admissions in 2007, the 2016 admissions represent a **66% increase** during a time period when the DOCCS population declined by 17%.

More importantly, the number and percentage of RCTP admissions from the SHU and other restrictive mental health housing units are extraordinarily high. During 2011-15, 6,352 persons from the SHU were admitted to the RCTP, representing 15.3% of all admissions. Averaging 1,270 persons per year coming from the SHU, this annual admission rate represents having approximately one RCTP admission for every three SHU residents. In contrast, there were only 7,640 admissions from general population (GP) for this five-year period, an annual admission rate of one patient for every 30 GP residents, a rate one-tenth the SHU rate. Even more problematic is the high RCTP admission rates from the BHU/RMHU/TBU. During the five-year period, there were 2,892 admissions from these RMHTUs, with an annual rate of 578 patients. Given that the average census of the RMHTUs during this time was 197 patients, this annual admission rate represents three admissions to the RCTP for every RMHTU patient. The ICP and TrICP admissions to the RCTP were also significant, totaling 4,671 patients during 2011-15. Given the census of these non-punitive mental health units, the annual admission rate represents one admission for every patient bed in the ICP/TrICP. Clearly many mental health patients are experiencing significant crises that appear to be on the increase in the Department. With such high rates, it is unclear what DOCCS and OMH are doing to reduce recurring events by patients or assisting their patients before they experience a mental health crisis.

**Table 4 - 2011-15 RCTP Observation Cells/Dorm Admissions & Discharges by Location**

| Housing Location | Transferred From Location to RCTP | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2011 | | 2012 | | 2013 | | 2014 | | 2015 | | 2011-15 | |
| | # RCTP | % of Totl | # RCTP | % of Totl | # RCTP | % of Totl | # RCTP | % of Totl | # RCTP | % of Totl | Total | % of Total |
| Special Housing U. | 1015 | 13.3% | 1220 | 15.6% | 1326 | 16.1% | 1409 | 15.8% | 1382 | 15.6% | 6352 | **15.3%** |
| Special Needs U. | 33 | 0.4% | 33 | 0.4% | 48 | 0.6% | 62 | 0.7% | 76 | 0.9% | 252 | **0.6%** |
| Infirmary | 363 | 4.7% | 405 | 5.2% | 352 | 4.3% | 680 | 7.6% | 553 | 6.2% | 2353 | **5.7%** |
| Other | 133 | 1.7% | 166 | 2.1% | 133 | 1.6% | 220 | 2.5% | 277 | 3.1% | 929 | **2.2%** |
| BHU/TBU | 173 | 2.3% | 167 | 2.1% | 133 | 1.6% | 123 | 1.4% | 169 | 1.9% | 765 | **1.8%** |
| Willard DTC | 57 | 0.7% | 27 | 0.3% | 40 | 0.5% | 36 | 0.4% | 56 | 0.6% | 216 | **0.5%** |
| TrICP | 153 | 2.0% | 138 | 1.8% | 128 | 1.6% | 159 | 1.8% | 193 | 2.2% | 771 | **1.9%** |
| GTP | 8 | 0.1% | 5 | 0.1% | 4 | 0.0% | 10 | 0.1% | 4 | 0.0% | 31 | **0.1%** |
| IICP | 35 | 0.5% | 20 | 0.3% | 36 | 0.4% | 26 | 0.3% | 12 | 0.1% | 129 | **0.3%** |
| ICP | 754 | 9.8% | 758 | 9.7% | 791 | 9.6% | 730 | 8.2% | 738 | 8.3% | 3771 | **9.1%** |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RMHU | 348 | 4.5% | 369 | 4.7% | 420 | 5.1% | 522 | 5.9% | 468 | 5.3% | 2127 | 5.1% |
| CNYPC | 184 | 2.4% | 139 | 1.8% | 127 | 1.5% | 158 | 1.8% | 154 | 1.7% | 762 | 1.8% |
| General Pop. | 1558 | 20.3% | 1409 | 18.0% | 1450 | 17.6% | 1567 | 17.6% | 1656 | 18.6% | 7640 | 18.4% |
| Other facility | 1564 | 20.4% | 1843 | 23.5% | 1903 | 23.1% | 1889 | 21.2% | 1945 | 21.9% | 9144 | 22.0% |
| Reception | 482 | 6.3% | 437 | 5.6% | 592 | 7.2% | 495 | 5.6% | 407 | 4.6% | 2413 | 5.8% |
| Observation cell | 641 | 8.4% | 590 | 7.5% | 605 | 7.4% | 689 | 7.7% | 658 | 7.4% | 3183 | 7.7% |
| Dorm bed | 122 | 1.6% | 116 | 1.5% | 132 | 1.6% | 127 | 1.4% | 133 | 1.5% | 630 | 1.5% |
| Released/Prison | 0 | 0.0% | 0 | 0.0% | 4 | 0.0% | 2 | 0.0% | 1 | 0.0% | 7 | 0.0% |
| **Total** | **7658** | | **7842** | | **8224** | | **8905** | | **8882** | | **41511** | |
| | **Transferred From RCTP to Location** | | | | | | | | | | | |
| | **2011** | | **2012** | | **2013** | | **2014** | | **2015** | | **2011-15** | |
| Special Housing U | 1103 | 14.4% | 1423 | 18.1% | 1508 | 18.3% | 1762 | 19.8% | 1676 | 18.9% | 7472 | 18.0% |
| Special Needs U. | 41 | 0.5% | 39 | 0.5% | 53 | 0.6% | 67 | 0.8% | 101 | 1.1% | 301 | 0.7% |
| Infirmary | 175 | 2.3% | 188 | 2.4% | 159 | 1.9% | 191 | 2.1% | 156 | 1.8% | 869 | 2.1% |
| Other | 208 | 2.7% | 197 | 2.5% | 196 | 2.4% | 287 | 3.2% | 361 | 4.1% | 1249 | 3.0% |
| BHU/TBU | 183 | 2.4% | 198 | 2.5% | 164 | 2.0% | 137 | 1.5% | 190 | 2.1% | 872 | 2.1% |
| Willard DTC | 47 | 0.6% | 19 | 0.2% | 36 | 0.4% | 34 | 0.4% | 57 | 0.6% | 193 | 0.5% |
| TrICP | 161 | 2.1% | 161 | 2.1% | 144 | 1.8% | 188 | 2.1% | 235 | 2.6% | 889 | 2.1% |
| GTP | 3 | 0.0% | 2 | 0.0% | 2 | 0.0% | 13 | 0.1% | 8 | 0.1% | 28 | 0.1% |
| IICP | 24 | 0.3% | 16 | 0.2% | 26 | 0.3% | 29 | 0.3% | 11 | 0.1% | 106 | 0.3% |
| ICP | 876 | 11.4% | 841 | 10.7% | 860 | 10.5% | 788 | 8.8% | 822 | 9.3% | 4187 | 10.1% |
| RMHU | 325 | 4.2% | 334 | 4.3% | 389 | 4.7% | 495 | 5.6% | 459 | 5.2% | 2002 | 4.8% |
| CNYPC | 268 | 3.5% | 223 | 2.8% | 180 | 2.2% | 227 | 2.5% | 204 | 2.3% | 1102 | 2.7% |
| General Pop. | 1655 | 21.6% | 1537 | 19.6% | 1548 | 18.8% | 1797 | 20.2% | 1812 | 20.4% | 8349 | 20.1% |
| Other facility | 1548 | 20.2% | 1669 | 21.3% | 1707 | 20.8% | 1664 | 18.7% | 1712 | 19.3% | 8300 | 20.0% |
| Reception | 233 | 3.0% | 256 | 3.3% | 479 | 5.8% | 407 | 4.6% | 302 | 3.4% | 1677 | 4.0% |
| Observation cell | 108 | 1.4% | 134 | 1.7% | 184 | 2.2% | 174 | 2.0% | 157 | 1.8% | 757 | 1.8% |
| Dorm bed | 650 | 8.5% | 591 | 7.5% | 568 | 6.9% | 609 | 6.8% | 577 | 6.5% | 2995 | 7.2% |
| Released/Prison | 14 | 0.2% | 14 | 0.2% | 20 | 0.2% | 11 | 0.1% | 42 | 0.5% | 101 | 0.2% |
| **Total** | **7658** | | **7842** | | **8223** | | **8905** | | **8882** | | **41510** | |

**Table 4** reveals another issue that raises concerns about the connection between the RCTP and the SHU. In comparing the number of patients who came to the RCTP from SHU during 2011-15 to those who are discharged to the SHU, there were 1,120 additional discharges to the SHU than admissions from those units. It appears that patients arriving from other areas in the prison system are being sent to the SHU directly from RCTP. This raises several concerns. First, it would appear many of these patients may have pending disciplinary charges, but even under these circumstances, we question whether these patients are being adequately assessed for possible diversion from the SHU due to their mental health status while the charges are pending. Second, do DOCCS and OMH consult on determining an appropriate placement for patients with significant mental health issues during the period they are being processed for rules violations? What precautions, if any, are taken in monitoring patients discharged from RCTP to SHU, particularly if the SHU staff and mental health staff assigned to the SHU are not familiar with the patient? The practice of returning patients who just experienced a mental health crisis to disciplinary confinement, which happened annually on average 1,648 times during 2013-15, is fraught with significant risks to those individuals and the persons with whom they come in contact. We believe the Justice Center, DOCCS and OMH should discuss developing more rigorous procedures to both consider avoiding such transfers and, for those that must be sent to the SHU, adequate safeguards to closely monitor these patients.

Related to the issue of increasingly high utilization of the RCTP is the decline that has occurred during the past seven years in the number of admissions to Central New York Psychiatric Center (CNYPC). The CA has been monitoring this issue since the DAI settlement mandated the expansion of the capacity at CNYPC. As **Table 5: Comparison of NYCPC Admits to Population, OMH Caseload and RCTP - 2010-16** illustrates, the number and, more significantly, the percentage of OMH patients being sent to the hospital has dramatically declined. In particular, the rate of admissions compared to OMH caseload and RCTP admissions is down 46% and 41%, respectively.

**Table 5: Comparison of CNYCP Admits to Population, OMH Caseload & RCTP - 2010-16**

| Year | CNYPC Admits | DOCCS Pop | % of DOCCS | OMH Caseload | % of Caseload | RCTP Admits | % of RCTP |
|---|---|---|---|---|---|---|---|
| 2010 | 314 | 58,378 | 0.54% | 7,816 | 4.02% | 7,515 | 4.18% |
| 2011 | 268 | 56,315 | 0.48% | 7,944 | 3.37% | 7,658 | 3.50% |
| 2012 | 223 | 55,195 | 0.40% | 8,234 | 2.71% | 7,842 | 2.84% |
| 2013 | 180 | 54,865 | 0.33% | 8,306 | 2.17% | 8,224 | 2.19% |
| 2014 | 226 | 52,643 | 0.43% | 8,504 | 2.66% | 8,904 | 2.54% |
| 2015 | 204 | 51,890 | 0.39% | 9,312 | 2.19% | 8,882 | 2.30% |
| 2016 | 216 | 51,080 | 0.42% | 9,994 | 2.16% | 8,801 | 2.45% |

We have consistently expressed our concern about this pattern of declining admissions to CNYPC for DOCCS patients with significant mental health needs. Anecdotally, we have learned from several patients that they have been refused a transfer to CNYPC even when they have repeatedly experienced a mental health crisis and have requested such transfer. We urge DOCCS, OMH, and the Justice Center to develop plans to respond more effectively to patients with serious mental health needs whose mental status has deteriorated while in DOCCS, particularly those in restrictive housing.

D. **Suicide, Suicide Attempts and Self-Harm in DOCCS with Focus on Rates during 2014-16**

The CA has analyzed records from OMH and the State Commission of Corrections detailing the number of suicides, suicide attempts and incidents of self-harm that occurred during 2014-2016. We analyzed the suicides for 2014 through 2016 and the suicide attempts and self-harm incidents in 2015 and 2016 and found the results very disturbing. In addition, we have analyzed DOCCS Unusual Incident Report (UIR) data for 2015-2017, which contains additional information about suicide and suicide attempts in our prison system; it too raises significant concerns.

As we have previously reported in the CA's testimony to the legislature in 2014, DOCCS has an extensive history of high suicide rates, particularly in solitary confinement units. As summarized in **Table 6 - Summary of DOCCS Suicides 2000-2016,** we have identified a trend of increasing suicides in DOCCS during the past decade, at a time when mental health services have also been increasing. The suicide rate in 2010 was the highest rate not only for this decade, but also for the past 30 years, according to research by Mary Beth Pfeiffer, an independent reporter who has

been investigating suicides in DOCCS for several years.[1] Moreover, in the 12 year period 2005 - 2016, DOCCS has experienced its six highest suicide rates over the same 30+-year period. For the last seven years (2010-16), as summarized in **Table 6**, the average annual suicide rate is 24.98 incidents per 100,000 incarcerated persons, a rate **56% higher** than the national average of 16 suicides per 100,000 persons as reported by US Department of Justice, Bureau of Justice Statistics.[2]

**Table 6 – Summary of DOCCS Suicides 2000 – 2016**

| Year | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pop. | 71,172 | 69,157 | 67,117 | 66,050 | 64,659 | 63,698 | 62,732 | 63,304 | 62,599 | 60,081 | 58,378 | 56,315 | 55,195 | 54,865 | 52,643 | 51,890 | 51,080 |
| Suicides | 16 | 7 | 12 | 14 | 8 | 18 | 8 | 18 | 10 | 10 | 20 | 10 | 14 | 13 | 12 | 10 | 16 |
| Rate* | 22.5 | 10.1 | 17.9 | 21.2 | 12.4 | 28.3 | 12.8 | 28.4 | 16. | 16.6 | 34.3 | 17.8 | 25.4 | 23.7 | 22.8 | 19.3 | 31.3 |

* Rate is the number of suicides per 100,000 incarcerated persons.

Even more disturbing than the rate of suicides are the locations where these incidents are occurring. As the CA has shown in its 2000-2004 reports about disciplinary confinement and mental health care and as found in Ms. Pfeiffer's 2010 analysis, far too many of the individuals committing suicide are confined in the SHU or keeplock, and many of them suffer from mental illness. Between 1998 and April 2004, 34% of prison suicides occurred in disciplinary confinement, although incarcerated persons in these units comprised less than 7% of the total prison population.[3] That rate only declined slightly to 29%, for the period 1998 to 2009, according to the research from Ms. Pfeiffer.

We evaluated the location of suicides for the period from 2014 through 2016 and summarized these results in **Table 7 – Summary of DOCCS Suicides during 2014-2016.** It includes the number of suicides in special populations and the general prison units, as well as suicides in specific prisons. Concerning the housing areas where these suicides occurred, during the three-year period 2014-16, 32% happened in a SHU or keeplock cell, a rate that was **nine times** the rate in the remainder of the prison. Equally disturbing, patients in the ICP and TrICP had a suicide rate that was **23 times** the rate in the remainder of the prison system. As we will discuss below, we are concerned with the lack of appropriate responses to persons in DOCCS who express or exhibit self-harm actions, revealed by a failure to send patients to a Residential Crisis Treatment Unit (RCTP), to appropriately respond to the patients' concerns when they are on these units, or to send the patients to appropriate residential treatment, including the Central New York Psychiatric Center (CNYPC).

We also found, as we did in our 2014 testimony to the NYS Assembly, that suicides are concentrated in a small group of prisons. During the three-year period 2014-16, 53% of all suicides occurred in five prisons (Auburn, Clinton, Coxsackie, Elmira and Wende) and an additional 16% happened in Fishkill and Great Meadow. As noted in **Table 6,** the rates for suicide at these prisons were **five to 16 times greater** than that for all DOCCS facilities. This list is very similar to the one we noted in 2014 for suicides during 2011-14 (Attica, Auburn, Clinton, Elmira, and Great Meadow), which accounted for 54% of all suicides during that four-

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[1] Pfeiffer, M., *Prison Suicides Rise; Officials Deny Trend*, Poughkeepsie Journal, 12/26/2010 (available at http://www.nyaprs.org/e-news-bulletins/2011/2011-01-04-PJ-Prison-Suicides-Rise-Officials-Deny-Trend.cfm).

[2] BJS,US DOJ, *Mortality in Local Jails and State Prisons, 2000-2011 – Statistical Tables*, at Table 26, p. 27 (2013).

[3] Correction Association, *Mental Health in the House of Corrections* at 57 (2004).

year period. We are unaware of any specific measures taken at these prisons to significantly reduce suicides, despite the long history of high suicide rates.

**Table 7 - Summary of DOCCS Suicides during 2014 - 2016**

| Location/Facility | 2014 | | | | | 2015 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | # | % | Pop | Rate | Comp* | # | % | Pop | Rate | Comp* |
| DOCCS | 12 | - | 52,643 | 2.28 | - | 10 | - | 51,890 | 1.93 | - |
| SHU/LTKL/KL | 5 | 41.7% | 4,695 | 10.65 | 10.06 | 4 | 40% | 4,628 | 8.64 | 6.70 |
| ICP/TrICP | 2 | 16.7% | 736 | 27.17 | 25.66 | 0 | - | 750 | 0.00 | - |
| GP-Other | 5 | 41.7% | 47,212 | 1.06 | - | 6 | 60% | 46,512 | 1.29 | - |
| Prisons | | | | | | | | | | |
| Auburn | 3 | 25.0% | 1,613 | 18.60 | 8.16 | 1 | 10% | 1,625 | 6.15 | 3.19 |
| Clinton | 2 | 16.7% | 2,726 | 7.34 | 3.22 | 1 | 10% | 2,629 | 3.80 | 1.97 |
| Coxsackie | 0 | - | 891 | 0.00 | 0.00 | 3 | 30% | 917 | 32.72 | 16.98 |
| Elmira | 0 | - | 1,701 | 0.00 | 0.00 | 0 | - | 1,604 | 0.00 | 0.00 |
| Fishkill | 2 | 16.7% | 1,605 | 12.46 | 5.47 | 0 | - | 1,582 | 0.00 | 0.00 |
| Great Meadow | 1 | 8.3% | 2,726 | 6.74 | 2.96 | 1 | 10% | 1,524 | 6.56 | 3.41 |
| Wende | 2 | 16.7% | 861 | 23.23 | 10.19 | 0 | - | 818 | 0.00 | 0.00 |
| **Location/Facility** | **2016** | | | | | **Total 2014-16** | | | | |
| | # | % | Pop | Rate | Comp* | # | % | Pop | Rate | Comp* |
| DOCCS | 16 | - | 51,080 | 3.13 | - | 38 | - | 155,613 | 2.44 | - |
| SHU/LTKL/KL | 3 | 18.8% | 4,764 | 6.30 | 2.87 | 12 | 31.6% | 14,087 | 8.52 | 5.65 |
| ICP/TrICP | 3 | 18.8% | 736 | 40.76 | 18.58 | 5 | 13.2% | 2,222 | 22.50 | 14.93 |
| GP-Other | 10 | 62.5% | 45,580 | 2.19 | - | 21 | 55.3% | 139,304 | 1.51 | - |
| Prisons | | | | | | | | | | |
| Auburn | 0 | - | 1,541 | 0.00 | 0.00 | 4 | 10.5% | 4,779 | 8.37 | 3.43 |
| Clinton | 1 | 6.3% | 2,608 | 3.83 | 1.22 | 4 | 10.5% | 7,963 | 5.02 | 2.06 |
| Coxsackie | 1 | 6.3% | 837 | 11.95 | 3.81 | 4 | 10.5% | 2,645 | 15.12 | 6.19 |
| Elmira | 4 | 25% | 1,554 | 25.74 | 8.22 | 4 | 10.5% | 4,859 | 8.23 | 3.37 |
| Fishkill | 1 | 6.3% | 1,608 | 6.22 | 1.99 | 3 | 7.9% | 4,815 | 7.17 | 2.94 |
| Great Meadow | 1 | 6.3% | 1,493 | 6.70 | 2.14 | 3 | 7.9% | 4,501 | 6.67 | 2.73 |
| Wende | 2 | - | 814 | 24.57 | 7.84 | 4 | 10.5% | 2,493 | 16.05 | 6.571 |

The situation with regard to suicide attempts and incidents of self-harm is no less alarming. We received data from OMH that identified individuals who had attempted suicide and a second list of persons who were involved in incidents of self-harm during 2015 and 2016. There were persons who appeared in both lists for the same event, requiring that we combine the data and provide a summary eliminating any duplications. **Table 8: Summary of Suicide Attempts and Incidents of Self-Harm in DOCCS during 2015-16** contains a summary of the number of incidents of suicide attempts and self-harm for 2015 and 2016 as well as an aggregate for both years. It details the number of events, the population for the specified location, prison or prison unit, the annual rate of such incidents per 1,000 persons, and a comparison of the rate at a

specific location to the rate in the general population, or for prisons, to the entire DOCCS average rate.

**Table 8: Summary of Suicide Attempts & Incidents of Self-Harm in DOCCS during 2015-16**

| Location/ Facility | 2015 | | | | 2016 | | | | Total 2015-16 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | # | Pop | Rate | Comp | # | Pop | Rate | Comp | # | Pop | Rate | Comp | % |
| DOCCS | 666 | 51,890 | 12.8 | - | 791 | 51,080 | 15.5 | - | 1,457 | 102,970 | 14.1 | - | - |
| SHU (all) | 215 | 3,628 | 59.3 | 11.4 | 253 | 3,764 | 67.2 | 11.1 | 468 | 7,392 | 63.3 | 11.2 | 32.1% |
| LTKL/KL | 17 | 1,000 | 17.0 | 3.3 | 14 | 1,000 | 14.0 | 2.3 | 31 | 2,000 | 15.5 | 2.8 | 2.1% |
| ICP/TrICP | 59 | 750 | 78.7 | 15.1 | 77 | 736 | 104.6 | 17.3 | 136 | 1,486 | 91.5 | 16.2 | 9.3% |
| RCTP | 19 | 140 | 135.7 | 26.0 | 26 | 140 | 185.7 | 30.7 | 45 | 280 | 160.7 | 28.5 | 3.1% |
| RMHU/BHU/TBU | 114 | 179 | 636.9 | 122.0 | 147 | 200 | 735.0 | 121.4 | 261 | 379 | 688.7 | 122.3 | 17.9% |
| GP-Other | 242 | 46,372 | 5.2 | - | 274 | 45,240 | 6.1 | - | 516 | 91,612 | 5.6 | - | 35.4% |
| Prisons | | | | | | | | | | | | | |
| Albion | 44 | 1,070 | 41.1 | 3.2 | 32 | 1,089 | 29.4 | 1.9 | 76 | 2,159 | 35.2 | 2.5 | 5.2% |
| Five Points | 40 | 1,272 | 31.4 | 2.5 | 62 | 1,242 | 49.9 | 3.2 | 102 | 2,514 | 40.6 | 2.9 | 7.0% |
| FP RMHU | 24 | 50 | 480.0 | 37.4 | 32 | 59 | 542.4 | 35.0 | 56 | 109 | 513.8 | 36.3 | 3.8% |
| Bedford Hills | 47 | 751 | 62.6 | 4.9 | 39 | 748 | 52.1 | 3.4 | 86 | 1,499 | 57.4 | 4.1 | 5.9% |
| Southport | 53 | 597 | 88.8 | 6.9 | 25 | 694 | 36.0 | 2.3 | 78 | 1,291 | 60.4 | 4.3 | 5.4% |
| Downstate | 33 | 1,002 | 32.9 | 2.6 | 37 | 1,003 | 36.9 | 2.4 | 70 | 2,005 | 34.9 | 2.5 | 4.8% |
| Marcy (whole) | 84 | 1,130 | 74.3 | 5.8 | 90 | 1,116 | 80.6 | 5.2 | 174 | 2,246 | 77.5 | 5.5 | 11.9% |
| Marcy (RMHU) | 76 | 85 | 894.1 | 69.7 | 90 | 95 | 947.4 | 61.2 | 166 | 180 | 922.2 | 65.2 | 11.4% |
| Attica (whole) | 46 | 2,115 | 21.7 | 1.7 | 51 | 2,016 | 25.3 | 1.6 | 97 | 4,131 | 23.5 | 1.7 | 6.7% |
| Attica (RMHU) | 11 | 9 | 1222.2 | 95.2 | 5 | 8 | 625.0 | 40.4 | 16 | 17 | 941.2 | 66.5 | 1.1% |
| Sullivan | 23 | 484 | 47.5 | 3.7 | 35 | 480 | 72.9 | 4.7 | 58 | 964 | 60.2 | 4.3 | 4.0% |
| Wende | 18 | 818 | 220.0 | 17.1 | 33 | 814 | 405.4 | 26.2 | 51 | 1,632 | 312.5 | 22.1 | 3.5% |

For the rate of suicide attempt or self-harm incident, we used the number of incidents during the year per 1,000 residents.

**Comp:** In the comparison columns for locations, we compared the suicide attempt/self-harm rate for the residents in SHU and other mental health units to the rate in the remainder of the prison system (GP-Other), which consisted mainly of general population units. For the prisons and RMHU units, we compared the SA/SH rate to the rate for all DOCCS facilities.

**Table 8** reveals the shockingly high rate of suicide attempt and self-harm in the restricted housing units in DOCCS. For the two-year period 2015-16 more than one-third of these incidents occurred in the SHU or keeplock, even though they represent only about 8% of the prison population. In comparison, only 35% of all such incidents occurred in the general population or the non-mental health units in the prisons. When we compare the suicide attempt/self-harm (SA/SH) rate in general population to the SHU rate, the latter was **11 times higher.** Note these incidents all involve actual acts of self-harm and do not include threats to

hurt oneself. The rate of SA/SH incidents in the SHU represents one person out of every 16 SHU residents annually committing an act of self-harm. [4]

There were also other locations that had excessively high rates of self-injury. The ICP and TrICP had a rate of SA/SH that was **sixteen times** the rate in general population, the RCTP rate was **29 times higher,** and most alarming of all, the RMHU SA/SH rate was **122 times** the rate in the rest of the prison. To put this in perspective, there were approximately seven incidents of SA/SH in the RMHU for every 10 patients.

Incidents of suicide attempts and self-harm are also concentrated in a limited number of prisons. As illustrated in **Table 8,** 42% of all incidents occurred at six prisons (Albion, Attica, Bedford Hills, Five Points, Marcy and Southport), with a combined population representing only 13.4% of DOCCS entire census. The SA/SH rate for these facilities of 44.3 incidents per 1,000 residents is more than **three times** the rate for the entire Department. Extremely high rates of SA/SH, in excess of **four times** the DOCCS rate, occurred at Bedford Hills, Marcy, Southport and Sullivan. There is a significant overlap between these facilities and large populations of persons in the SHU or RMHU, but these special populations do not fully explain the high incidence of SA/SH. We urge OMH, DOCCS, and the Justice Center to investigate this situation and take urgent immediate steps to remedy the high incidence of self-harm.

As mentioned previously, we also analyzed DOCCS Unusual Incident Reports for 2016 and the first half of 2017. DOCCS UIR data for 2016 for suicide attempts listed 187 incidents of which 88, representing 47% of all such attempts, occurred in the SHU. Particularly disturbing is the number of such attempts in the solitary confinement S-Blocks (Greene, Lakeview, and Mid-State) and the very high numbers at Southport and Upstate CF, DOCCS' two supermax prisons that confine primarily persons in solitary confinement. For the first half of 2017, the suicide attempts in SHU remain high, representing 36% of the 80 attempts occurring during January through most of June 2017. Upstate had eight incidents in the first half of the year, representing 10% of all incidents in DOCCS and a rate much greater than any other facilities.

We urge that OMH significantly increase its efforts to address systemically and hopefully prevent the many incidents of suicide and self-harm in DOCCS. This should include: (1) improving the response to persons who express or attempt self-harm by enhancing the interventions in the RCTP with a more holistic approach to the issues that drove the patient to RCTP admission and discharging them to an environment that will better address their mental health and other needs; (2) ensure that the RCTP environment is therapeutic and that no punitive aspects impede patient's access to or treatment in these units; (3) increase the number of patients with mental health crises who are admitted to CNYPC for more intense mental health treatment; (4) in consultation with DOCCS, systemically analyze the prisons and locations within prisons at which suicide and self-harm more frequently occur to determine what measures could be taken to prevent future occurrences at these locations; and (5) implement measures to engage the incarcerated population and DOCCS staff who were in proximity to incidents of suicide and self-harm to address concerns they may have about the incident and to offer individual and/or group

[4] For 2014, comprehensive data is not available until beginning in May of that year. However, the available data reveal the same trends as found in 2015 and 2016: attempted suicide and self-harm occur at disproportionate rates in the SHU and in units meant to serve those with serious mental health issues.

discussions and educational material about how to prevent future acts of self-harm. These efforts should be coordinated with DOCCS and the recommendations made by the outside expert Lindsay Hayes, who has been consulting with DOCCS about suicide prevention.

## E. Excessive Disciplinary Tickets Imposed on Patients in DOCCS Residential Mental Health Treatment Units

The CA has been monitoring the treatment of patients in the many DOCCS residential mental health treatment units in the Department and has been concerned about the frequency in which patients on these units are given DOCCS misbehavior reports, signifying that they have allegedly violated prisons rules. Following a disciplinary hearing concerning these reports, many of these patients are given disciplinary sanctions that include solitary confinement. Often the events that trigger these disciplinary actions involve conduct that is related to the patient's underlying mental health issues, yet DOCCS and OMH often fail adequately to acknowledge or consider this factor in deciding the response and/or punishment to impose. Moreover, the excessive punitive response to the patient's maladaptive behavior is contrary to the therapeutic nature of these units, which is intended to provide treatment and not punishment for patients with serious mental health issues. Consequently, these punitive responses not only undermine the treatment for the individual patient being disciplined but also create a threatening and counterproductive environment for all those on the units who are struggling with mental health issues.

The CA has analyzed computerized records of all disciplinary hearings for calendar years 2015 and 2016. Although the data for each year has somewhat different information, we have attempted to assess both the number of disciplinary hearings held, the nature of the prison rule being charged and the disposition of the hearing in terms of whether the persons was given SHU time, meaning they would be transferred to a separate solitary confinement unit, or keeplock sentence, which could mean the persons would remain in his/her cell, but would still be isolated for 23-24 hours per day. For 2015, we also had some demographic data concerning the person subject to the disciplinary hearing.

In 2015, there were a total of 59,122 hearings involving 135,331 separate rule violations, and these hearings affected 26,995 persons, each of whom had one or more hearings. These violations occurred at 129 of the 132 prisons and separately listed prison units, the latter including all the residential mental health and medical (other than infirmary) units, SHU200 facilities (segregation units), special needs units, programs for people convicted of sex offenses, residential juvenile units, reception units and other specialized programs. Special Housing Units in each prison are not identified separately, but all SHU200s, Southport and Upstate disciplinary units are specifically indicated and were used to assess additional SHU confinement in disciplinary units.

In 2016, there was an increase in the number of disciplinary hearings and persons disciplined, despite a reduction in the DOCCS population and the implementation of the *Peoples* litigation, which was intended to reduce disciplinary sanctions. There was a total of 71,934 hearings impacting 29,110 persons. Of that group, 20,091 persons received some sanction to segregation time.

We analyzed this data to compute the rate of hearings for the RMHTUs, ICPs, SHU200s, Southport and Upstate SHUs, and all other maximum-security prisons. For each of these units or

group of facilities/units, we computed the rate per 100 residents of disciplinary hearings, and hearings resulting in a sanction that includes some segregation time. A summary of this analysis is included in **Table 9 Summary of 2015-16 Disciplinary Hearings and Rates.**

**Table 9 – Summary of 2015-16 Disciplinary Hearings and Charges**

| Prison Unit | 2015 Disciplinary Hearings | | | | | 2016 Disciplinary Hearings | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Census | Hear | Rate | Seg | Rate | Census | Hear | Rate | | Rate |
| Attica RMHU | 9 | 38 | 422 | 21 | 233 | 10 | 39 | 390 | 27 | 270 |
| Bedford Hills TBU | 8 | 43 | 538 | 35 | 438 | 9 | 89 | 989 | 65 | 722 |
| Five Points RMHU | 56 | 190 | 339 | 169 | 302 | 58 | 232 | 400 | 213 | 367 |
| Great Meadow BHU | 34 | 131 | 385 | 127 | 374 | 36 | 165 | 458 | 152 | 422 |
| Marcy RMHU | 89 | 200 | 225 | 160 | 180 | 95 | 237 | 249 | 160 | 168 |
| Southport SHU | 558 | 541 | 97 | 469 | 84 | 493 | 886 | 180 | 738 | 150 |
| Upstate SHU | 856 | 1,150 | 134 | 682 | 80 | 877 | 1,571 | 179 | 911 | 104 |
| All SHU200s | 1,311 | 2,369 | 181 | 1,863 | 142 | 1,235 | 4,327 | 350 | 3,289 | 266 |
| All ICPs | 702 | 653 | 93 | 374 | 53 | 742 | 696 | 94 | 373 | 50 |
| Other Max Prisons | 18,707 | 19465 | 105 | 15,671 | 84 | 18,610 | 25,692 | 138 | 18,490 | 99 |
| All Units | 52,808 | 59,122 | 112 | 35,583 | 67 | 52,095 | 71,934 | 138 | 39,157 | 75 |

*Rate is out of 100 persons, calculated rates over 100 represent multiple hearings for the average patient population on the unit.

It is clear from **Table 9** that the RMHUs, Great Meadow's BHU and Bedford Hills' TBU all have nearly the highest rate of disciplinary hearings and segregation sanctions of any unit in the DOCCS system. Except for two recently created juvenile units, the RMHUs, BHU and TBU were consistently at the top of the list, and even including these juvenile units, the RMHU/BHU/TBU (RMHTUs) units were generally in the top ten, and often in the top six, of all DOCCS units in each category listed above. More importantly, the rates of these hearings were often **two to five times** the rates for other segregation units or other maximum-security prisons.

The rate of disciplinary infractions does not fully reflect the extent to which patients in these units are receiving significant additional segregation time instead of receiving therapeutic care. For each of the special residential mental health and segregation units, the CA analyzed the data for each specific person on that unit to calculate the number of hearings and additional SHU time the person received while the patient was in a specific RMHTU, ICP, Upstate or Southport during calendar years 2015 and 2016. If a patient was in multiple RMHUs or the BHU, those sentences were not aggregated, but are reported separately for each unit. Concerning the number of hearings, the majority of persons disciplined in the RMHTUs had more than one hearing, with more than 20% having five or more hearings during 2015 or 2016. In 2015, 11 patients had 10 or more hearings while on the units and that number increased to 15 patients in 2016. It is obvious that excessive discipline is the operative mode of control in the RMHTUs.

**Table 10 - Total Segregation Time for Patients in RMHTUs in 2015-16** lists the number of patients and the total and average segregation time period they received of additional SHU/keeplock time during their stay in a single RMHTU during each calendar year. We also analyzed the total number of patients that received a disciplinary ticket on the residential mental

health treatment and compared it to the annual general census on the unit to compute the number of tickets given per the average census on the unit.

| Table 10: Total Segregation Time for Patients in RMHTUs in 2015 and 2016 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Attica RMHU | | Bedford TBU | | Five Pts RMHU | | Grt Mead BHU | | Marcy RMHU | | Totals |
| | #/Pts | Tck | #/Pts | Tck | #/Pts | Tck | #/Pts | Tck | #/Pts | Tck | |
| **2015 Total Segregation Time** | | | | | | | | | | | |
| Tot Time days | 1,928 | | 1,363 | | 10,335 | | 31,858 | | 16,240 | | 61,724 |
| Patients Discip. | 12 | 1.3 | 11 | 1.4 | 68 | 1.2 | 36 | 1.1 | 74 | 0.8 | 201 |
| **Ave Tot Seg '15** | **161** | | **124** | | **152** | | **885** | | **219** | | |
| **2016 Total Segregation Time** | | | | | | | | | | | |
| Tot Time days | 4,035 | | 7,144 | | 22,163 | | 34,650 | | 17,778 | | 85,770 |
| Patients Discip | 9 | 1.0 | 17 | 2.0 | 69 | 1.2 | 46 | 1.3 | 91 | 0.9 | 232 |
| **Ave Tot Seg '16** | **448** | | **420** | | **321** | | **753** | | **195** | | |
| **2015-16 Total Segregation Time** | | | | | | | | | | | |
| 2015-16 Seg | 5,963 | | 8,507 | | 32,498 | | 66,508 | | 34,018 | | 147,494 |
| Tot Patients | 21 | 1.2 | 28 | 1.7 | 137 | 1.2 | 82 | 1.2 | 165 | 0.9 | 433 |
| **Ave Tot 15-16** | **284** | | **304** | | **237** | | **811** | | **206** | | **341** |
| **Ave Tot Month** | **9.5** | | **10.1** | | **7.9** | | **27.0** | | **6.9** | | **11.4** |

This data further illustrates the excessive level of punishment being imposed on these patients. Most disturbing, however, is the amount of disciplinary segregation time added to the sentences of these RMHTU patients during their individual stays. As **Table 10** illustrates, these disciplined patients received on average between 124 to 885 days additional segregation days during 2015 and between 206 to 811 days in 2016, while they were on a single unit; in some cases, patients were on multiple units during the year and had even longer cumulative sentences. In 2015, 47 patients received an additional year or more of segregation time while in the RMHTUs, representing about 10% of the entire RMHTU population of about 445 patients. Great Meadow was the most egregious unit, where the average accumulated time added to patients disciplined on that unit was more than **two years**. Eleven DOCCS RMHTU patients received more than **four years** of additional SHU time during 2015. In 2016, the number and amount of segregation time increased in the RMHTUs in each of the units, except Great Meadow where it remained extremely high. Particularly disturbing were the increases at Attica, Bedford and Five Points, where the average segregation time increased by 76%, 145% and 56%, respectively. For the two-year period, 433 people received an average of nearly one year of additional segregation time with the average at each unit ranging from 7 months (Marcy) to more than 2.3 years (Great Meadow).

Various examples in 2015 demonstrate the excessive use of disciplinary actions by RMHTU staff at each of these units. At **Attica**, one patient had four hearings in six weeks and received an additional year of segregation time. Another patient had five hearings in approximately two months and received one and one-half years of SHU time; a third patient had nine hearings in 11 months resulting in an additional year of segregation time. At **Bedford Hills'** TBU, one woman had a total of 13 disciplinary hearings during the year and received ten months additional segregation time. Another TBU resident had eight disciplinary hearings in two and one-half

months and received an additional ten months of segregation time. At **Five Points RMHU** one patient had 12 hearings in less than four months and received more than two years of additional segregation time; half of his offenses were related to lewd or other sexual behavior, conduct that may be a consequence of his underlying mental health condition. Another patient was sentenced to more than two years of disciplinary segregation time during eight hearings held in less than four months on the unit. A third Five Points patient received 1.85 years of additional segregation time in just three months during eight hearings conducted on the unit. Overall, **Marcy RMHU** had fewer hearings, but the unit still issued significant disciplinary sentences to many of its patients. Specifically, 20% of the Marcy disciplinary patients (15 persons) received more than one year of additional segregation time. This included having 20 hearings for one person, primarily for lewd conduct/unhygienic acts, which added more than **five years** of SHU time. Another patient received an additional **four years** for similar behavior as a result of 16 hearings during the year. This latter patient received more than two years of SHU time in an 8-week period at six separate hearings, with most violations related to lewd conduct. Many of the other patients who received more than one year of cumulative SHU time also had disciplinary hearings related to inappropriate sexual conduct.

**Great Meadow BHU** is the most punitive RMHTU unit by far, sentencing more patients to multiple years of SHU time than other units. During 2015, 22 of the 36 patients (61%) who were disciplined on the unit received more than one year of additional segregation time. Seven patients, or 20%, received more than **five years** of additional time. There are several common themes in the BHU's response to the behavior of these patients that illustrate the inappropriate and ineffective use of disciplinary sanctions. These include: (1) several patients being given very significant additional segregation time for conduct, such as unhygienic acts or lewd conduct, which is likely related to their underlying mental health condition; (2) sanctions being imposed that went well beyond the patients' release date, illustrating their lack of reasonableness or effectiveness; and (3) multiple single sentences given for one to two years, demonstrating an excessively punitive response devoid of any therapeutic intent in the sanction and projecting a belief by the unit staff that these patients will not change and cannot respond to treatment.

The overwhelming conclusion that must be drawn from this data is that DOCCS has not altered its disciplinary response to many of these patients who suffer from serious mental illness. Rather, the Department is consistently adding massive segregation time to these patients' SHU sentences, perpetuating their isolation on these units and providing them little hope that they will be transferred to non-punitive residential programs that will permit them greater freedom. This is a fundamental failure because it contradicts the therapeutic purpose of these units, which were intended to prepare these patients for reintegration into the prison population. But equally disturbing is the failure of OMH to intervene in the process and to curtail a practice that must be undermining the intended therapeutic intent of these units. Rather, it seems that OMH has acquiesced in DOCCS punitive response and failed to insist on treatment being the primary response to these patients. This practice must change if the units are to be successful.

Related to, and beyond disciplinary tickets, the extreme punitive approach toward people held in the RMHTUs and people with mental illness more generally also manifests itself in staff verbal and physical abuse. People incarcerated in the RMHTUs too frequently report substantial staff physical brutality against people with serious mental health needs on the units. As two of the worst examples, Samuel Harrell and Karl Taylor were both OMH patients who were reportedly brutally beaten to death by correction officers at Fishkill C.F. and Sullivan C.F. respectively. The

CA is not aware of DOCCS or OMH even making any official public explanation of their deaths, let alone taking any remedial action to ensure that such abuse never occurs again against a mental health patient, or any person within the prison system.

**F. Devastating Impact of Solitary Confinement on the Mental Health of DOCCS Residents**

Solitary confinement has long been known to cause devastating mental health impacts on people. Governor Cuomo, the New York Legislature, OMH, and DOCCS must do much more than what is proposed in the Governor's budget in order to end the torture of solitary confinement in New York's prisons and jails and implement more humane and effective alternatives.

*1) Mental Health and Other Harm Caused by Solitary*

The devastation wrought by solitary confinement on thousands of New Yorkers is horrific and unacceptable. Whether for disciplinary confinement, administrative segregation, or protective custody reasons, people in either SHU or keeplock in NYS prisons and jails generally spend 22 to 24 hours per day locked in a cell, without any meaningful human interaction, programming, therapy, or generally even the ability to make regular phone calls, and often being allowed only non-contact visits if they receive visits at all. The sensory deprivation, lack of normal human interaction, and extreme idleness that result from the conditions in solitary confinement have long been proven to lead to intense suffering, and psychological and physical damage.[5] Solitary has also long been shown to increase the risk of suicide and self-harm.[6] For people who have pre-existing mental health needs, solitary has been shown to exacerbate such conditions.[7] Moreover, solitary is also recognized as causing a deterioration in people's behavior, while restrictions on the use of solitary have had neutral or positive effects on institution safety.[8]

Innumerable people have reported to the Correctional Association that as a result of being in solitary confinement they suffer from anxiety, depression, paranoia, panic attacks, hallucinations, and other mental health challenges. As discussed earlier in this testimony, from 2014-2016, 32% of the suicides in New York's prisons happened in solitary confinement, a rate that was almost six times higher than in DOCCS' general population. Worse still, rates of suicide attempts and

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[5] *See, e.g.*, http://www.newyorker.com/news/news-desk/kalief-browder-1993-2015; James Gilligan and Bandy Lee, *Report to the New York City Board of Correction*, p. 3, Sept. 5, 2013, *available at*: http://solitarywatch.com/wp-content/uploads/2013/11/Gilligan-Report.-Final.pdf; Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, Journal of Law & Policy, Vol. 22:325 (2006), *available at*: http://law.wustl.edu/journal/22/p325grassian.pdf ("*Psychiatric Effects of Solitary*"); Craig Haney, *Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement*, 49 Crime & Delinq. 124 (Jan. 2003), *available at*: http://www.supermaxed.com/NewSupermaxMaterials/Haney-MentalHealthIssues.pdf; Stuart Grassian and Terry Kupers, *The Colorado Study vs. the Reality of Supermax Confinement*, Correctional Mental Health Report, Vol. 13, No. 1 (May/June 2011); Sruthi Ravindran, *Twilight in the Box: The suicide statistics, squalor & recidivism haven't ended solitary confinement. Maybe the brain studies will*, Aeon Magazine, Feb. 27, 2014, *available at*: http://aeon.co/magazine/living-together/what-solitary-confinement-does-to-the-brain/; Joseph Stromberg, *The Science of Solitary Confinement*, Smithsonian Magazine, Feb. 19, 2014, *available at*: http://www.smithsonianmag.com/science-nature/science-solitary-confinement-180949793/#.Uwoq5RsSWaQ.email.

[6] Homer Venters, et. al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, American Journal of Public Health, Mar. 2014, Vol. 104, No. 3, *available at*: http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2013.301742.

[7] See Gilligan and Lee Report at 3-5.

[8] http://www.vera.org/sites/default/files/resources/downloads/solitary-confinement-misconceptions-safe-alternatives-report_1.pdf.

self-harm were 11 times higher in solitary than in the general prison population, and an outrageous 122 times higher in the residential mental health unit alternatives to solitary for people with the most serious mental illness.

Incarcerated women face additional special mental health and other issues related to solitary confinement[9] and its impact on emotional, psychological, and physical health,[10] including issues related to exacerbated impacts on survivors of domestic violence and abuse, triggering of Post-Traumatic Stress Disorder (PTSD), limitations on access to children and loved ones, and infringements on reproductive health care (including limitations on access to sanitary pads, toilet paper, obstetrical services, exercise and movement).

*2) The Need for Much More than the Governor's Proposal to End the Torture of Solitary*

In the Governor's proposed budget (and as further elaborated upon in his state of the state book), the Governor has not outlined any new proposals or policy changes to limit the use of solitary for people with mental health needs or for any people, and instead plans to carry out the limited changes in the state prisons required under the *Peoples* litigation settlement and the deeply flawed proposed regulations for local jails, neither of which place limitations on solitary for people with mental health needs.[11]

Much bolder leadership and fundamental changes are required to bring New York State in line with even the average state in the country, let alone what is required by international standards and what some states have already implemented. Governor Cuomo touts the 29% reduction in the number of people in Special Housing Units (SHU) and the fact that on any given day around 5% of people incarcerated in the state prisons are in SHU. However, the 5% of people in SHU in NY prisons the Governor applauds (which according to the most recent data available of Jan. 23, 2018 is closer to 5.8%: 2,899 people in SHU out of 49,635 people physically in prison) is still worse than the national average (of roughly 4.4%) and much worse than many states around the country with less than 1-2%. Moreover, while NY has supposedly reduced the use of solitary in prisons by 29%, other states have reduced solitary by 75% - 90%. Colorado reduced the number of people in solitary on a given day from around 1,500 people to 18 people. Also, the 5% is the number of people in SHU at a snapshot in time on a given day; over the course of the year many more thousands of people are sent to solitary and during the course of incarceration the vast majority of people in prison spend at least some time in solitary. Further, DOCCS will not release the number of people who are held in keeplock in their own cells – another form of 23-24 hour a day solitary confinement – and whether that number has changed in any way.[12] As such, it is hard to assess the full impact of the reduction in the number of people in SHU.

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[9] Bedford Hills and Albion are the only two women's facilities with a SHU – Bedford's unit has 24 cells and Albion's has 48 – and all facilities have a Keeplock area.

[10] *See Reproductive Injustice: The State of Reproductive Health Care for Women in New York State Prisons*, A Report of the Women in Prison Project of the Correctional Association of NY, p. 145-158, Feb. 11, 2015, *available at*: http://www.correctionalassociation.org/wp-content/uploads/2015/03/Reproductive-Injustice-FULL-REPORT-FINAL-2-11-15.pdf.

[11] For a more extensive analysis and critique of the proposed jail regulations and the issue of solitary in New York more generally, *see Correctional Association Public Comments for Proposed Solitary Confinement Regulations*, Dec. 12, 2017, *available at*: http://nycaic.org/wp-content/uploads/2017/12/Correctional-Association-Comments-re-Proposed-Solitary-Regs-2017.pdf.

[12] The Correctional Association has, through the Freedom of Information Law (FOIL), made requests for information on the number of people held in keeplock in the state prisons. DOCCS refuses to provide that information, indicating that it does not have records responsive to the request. The CA makes the estimate of around

Beyond the limitation of these claimed reductions, the larger problem is that thousands of people remain in solitary each day – in conditions that amount to torture, and people continue to spend months, years, and even decades in solitary. Specifically, on any given day there are 2,900 people in Special Housing Units (SHU) in the state prisons alone, and an additional estimated 1,000 people in keeplock. After a reduction in the number of people in SHU in the prisons in 2016 and early 2017, the number of people in SHU has remained relatively stable over the last four months. Despite the 2008 SHU Exclusion Law's requirement that people with serious mental illness be diverted from solitary, as of the end of 2016, there were 844 people with pre-existing mental health needs who are on the Office of Mental Health (OMH) caseload still in the SHU. Black people, and other people of color, are specifically targeted and sent to solitary confinement at racially discriminatory rates to the extent that the *New York Times* referred to the disparities as a "scourge of racial bias."[13]

Further, people regularly are sent to solitary confinement for petty or minor, non-violent rule violations or even as a way to cover-up officer misconduct or as a tool for officer oppression of people who are incarcerated. "Disobeying a direct order" is one of the more common reasons that people are sent to solitary. Contrary to popular belief, isolated confinement is not primarily used to address chronically violent behavior or serious safety or security concerns, but often comes in response to non-violent prison rule violations, even retaliation for questioning authority, talking back to staff, or filing grievances,[14] or even because staff have brutalized an incarcerated person.[15]

Also, there is still no total limit on how long a person can spend in solitary confinement in New York prisons or jails. People regularly spend months and years in solitary, and some people have spent decades (upwards of over 30 years)[16], despite the fact that international standards state that people with mental health needs should not spend any time in solitary and no person should be held in solitary beyond 15 days because it otherwise can amount to torture. The Mandela Rules – adopted by the entire United Nations General Assembly, supported by a US delegation

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1,000 people in keeplock based on older data the CA collected through individual prison visits to prisons around the state. Particularly at a time that the Governor is stating that there is a substantial reduction in the use of solitary confinement in New York's prisons, it is imperative that DOCCS or other state officials report on the number of people who are held in keeplock – one form of solitary – and any other form of solitary confinement. Otherwise, it is difficult to assess the full significance of the reduction in the number of people held in SHU in New York's prisons. While people in keeplock are often able to retain their property while in keeplock, conditions are otherwise almost identical to conditions in SHU – with people held 23-24 hours a day without any meaningful human contact or out-of-cell programs. Are the number of people in keeplock and people's length of stay in keeplock also declining? Or are they increasing? Or remaining the same? Since keeplock is another form of 23-24 hour a day solitary confinement that can also cause devastating harm, the answers to these questions are necessary to understand if, and how much, solitary is being reduced in the state prisons.

[13] Michael Schwirtz, Michael Winerip and Robert Gebeloff, *The Scourge of Racial Bias in New York State's Prisons*, The New York Times, Dec. 3, 2016, *available at*: https://www.nytimes.com/2016/12/03/nyregion/new-york-state-prisons-inmates-racial-bias.html?_r=0.

[14] *See, e.g.*, Correctional Association of NY, *Voices from Attica*, 2014, p. 24-25, 32-40, *available at*: http://www.correctionalassociation.org/wp-content/uploads/2014/10/Voices-From-Attica-2014.pdf.

[15] *See, e.g.*, Correctional Association of NY, *Clinton Correctional Facility: 2012-2014*, p. 10, *available at*: http://www.correctionalassociation.org/wp-content/uploads/2015/03/Clinton-Correctional-Facility-Final-Draft-2.pdf (documenting how incidents involving alleged assaults on staff resulted in no injury to staff in 72% of the UIRs and only minor injury in just under 25%, while resulting in injury to incarcerated persons in 87% of the incidents).

[16] *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/.

consisting of corrections administrators, and voted for by the US government – prohibit solitary beyond 15 consecutive days for all people and ban even one day of solitary for people with mental health needs. Given that the UN Special Rapporteur on Torture has defined any use of solitary beyond 15 days to amount to torture or cruel, inhuman or degrading treatment,[17] and the entire United Nations (including the US) thus supported a ban beyond 15 days of solitary in the Mandela Rules,[18] 15 days should be the absolute limit for isolated confinement in New York prisons and jails. Colorado has already implemented a 15-day limit on solitary and has seen positive results.[19] Similarly, given that international standards prohibit people with pre-existing mental health needs from spending any length of time in solitary, New York should also ensure that no person with mental health needs spends even one day in solitary.

3) *The HALT Solitary Confinement Act: Ending the Torture of Solitary for People with Mental Health Needs and for All People*

Governor Cuomo and the New York legislature must go much further in limiting the use of solitary in the current budget and/or otherwise. The HALT Solitary Confinement Act, A.3080A/S.4784 would ensure that *no* person is subjected to the torture of solitary confinement beyond 15 days and would create more humane and effective alternatives. HALT would also prohibit people with mental health needs from spending even one day in solitary. For any person that needs to be separated from the general prison population for longer than these time limits, HALT would create separate, secure, rehabilitative and therapeutic units providing programs, therapy, and support to address underlying needs and causes of behavior, with at least seven hours out-of-cell time per day consisting of six hours of out-of-cell congregate programming and one hour of out-of-cell recreation. HALT would also restrict the criteria for placement in solitary or alternative units, ban the use of solitary for other people particularly vulnerable to its damaging effects or additional abuse in solitary, such as young people, and expand staff training, procedural protections, transparency, and oversight.

The use of solitary confinement traumatizes the individual being isolated and the corrections staff assigned to monitor them. It negatively impacts the prison and community safety and has led our state into an urgent human rights crisis. The Governor and legislature must HALT solitary confinement in New York State and end this torture.

## G. Non-Punitive Residential Mental Health Programs in DOCCS

The Intermediate Care Program (ICP) is a non-disciplinary residential treatment program for OMH patients, generally for those with a serious mental illness (SMI). Around 90% of the

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[17] United Nations General Assembly, *Interim Report of the Special Rapporteur of the Human rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, p. 21, 23, Aug. 2011, available at: http://solitaryconfinement.org/uploads/SpecRapTortureAug2011.pdf (The United Nation's Special Rapporteur on Torture has concluded that "any imposition of solitary confinement beyond 15 days constitutes torture or cruel, inhuman or degrading treatment or punishment" and called for "an absolute prohibition" on isolation beyond 15 days for all people).

[18] United Nations Standard Minimum Rules for the Treatment of [Incarcerated Persons] – otherwise known as the "Nelson Mandela Rules" or "Mandela Rules", Rules 43-45, *available at*: https://www.unodc.org/documents/justice-and-prison-reform/GA-RESOLUTION/E_ebook.pdf. These rules are the product of five years of negotiation and deliberation involving UN member countries (including the United States, whose delegation included corrections commissioners), intergovernmental organizations, civil society groups, and independent experts.

[19] Rick Raemisch, *Why We Ended Long-Term Solitary Confinement in Colorado*, Oct. 12, 2017, *available at*: https://www.nytimes.com/2017/10/12/opinion/solitary-confinement-colorado-prison.html.

people in ICPs have an S-designation. According to the ICP orientation manual, "the ICP is a therapeutic community that provides mental health services and promotes development of self-regulation, symptom management, social, recreational, and habilitative skills." The ICP's model is to provide patients with 20-hours per week of intensive therapeutic programming. Patients in the ICP generally participate in numerous programs on the unit, and sometimes have an opportunity to participate in programs outside of the unit.

As seen in **Table 13 – Intermediate Care Program Participation**, the ICP currently has a capacity of 781 beds. Due to the DAI litigation and other advocacy, the ICP capacity increased by more than a third between 2007 and 2009, from 551 beds to 743 beds, and the capacity was increased to 781 by 2013. Although, as discussed above, the ICP's capacity represents only roughly one-third of all S-designated patients in the prison system and many more individuals could benefit from the program, the ICP does not have a census reaching full capacity. However, recently we have received information that patients who have been designated to be placed in the ICP are not being transferred but have been placed on a waiting list that in some cases has extended for months. We have recently requested from OMH and DOCCS information about the delay in getting patients admitted to the ICP in a timely manner and to describe what services if any are being provided to them. Overall, we urge that the ICP capacity be significantly expanded. With 2,600 patients being diagnosed with serious mental illness and a total of only 1,300 residential mental health beds, both punitive and non-punitive units, in the system, DOCCS and OMH have not provided sufficient resources to treat all the patients that need intensive mental health care.

**Table 11 – DOCCS Intermediate Care Program Participation**

| | 2014 | 2015 | 2016 | 1/2017 |
|---|---|---|---|---|
| # Beds | 781 | 781 | 781 | 781 |
| # Patients in ICP Program | 718 | 714 | 750 | 735 |
| % Patients w/ S-designation | 87.3% | 89.5% | | |
| # Patients admitted | 688 | 625 | 844 | |
| # Patients discharged | 653 | 704 | 828 | |

Since the ICP is not a disciplinary unit, the largest number of people who come to the ICP come from general population (around 30% of admissions each year), followed by another ICP (over 20% each year). While some people in the ICP will receive sufficient mental health treatment and support so that they may eventually return to general population, some patients may suffer persistent and debilitating symptoms that lead them to spend the duration of their sentence in the ICP. For those discharged from all ICPs in 2015, the median length of stay had been just over six months. Each year, about 20% of all people discharged from the ICP are people released from incarceration.

Of all the mental health units and programs within DOCCS, the ICP receives relatively positive assessments from participants, although there are substantial concerns and ratings vary from prison to prison. Overall, relative to other units and programs within CA-visited prisons, the participants in the ICPs reported generally: a) relatively positive assessments of group therapeutic programming; b) insufficient time for individual therapy; c) greater feelings of safety, and d) less, but still disturbing, staff abuse.

Regarding mental health treatment, survey respondents from CA-visited ICPs generally had relatively positive ratings of group therapeutic programming and expressed a desire to have additional individual therapy. Between 80% to 90% of ICP survey respondents rated individual program groups they were in as either good or fair, with around 48% rating their programs as good. DOCCS co-facilitates some programs in the ICP, including Thinking for a Change, Activities of Daily Living (ADL), and Integrated Dual Disorder Treatment (IDDT) (substance abuse program for individuals suffering from mental illness). DOCCS has reported that the curriculum for Thinking for a Change has been altered from the general population program to meet the needs of ICP patients. DOCCS also runs academic programs, structured recreation, and other classes such as socialization and current events. At the same time, OMH runs various classes specifically related to mental health, such as wellness, medication education, psych rehabilitation, trauma and recovery, humor, coping skills, working, communication skills, activities of daily living, and art therapy. The schedule of classes and programs in the ICP change every quarter and OMH develops an individualized program plan for each ICP patient. In addition to the programs on the unit, some ICP residents participate in programs off the unit.

While people in the ICPs who have been interviewed or submitted surveys generally have positive views of the programming, some concerns have also been raised and ratings of the programs varied by prison and even within prisons by different patients. One concern was the degree to which the punitive aspects imposed by security staff, discussed below, permeate into the programs, leading, at times, to staff harassment or a disciplinary approach to patients. Another concern is whether the programs are relevant or effective for all who participate. While others praised the group programs, some people complained that the programs did not provide useful information, that the same programs or lessons are repeated even when course names change, or that movies were too often shown. Some patients expressed the opinion that some patients stop wanting to go or pay attention because of the repetitive nature of the program. There were also particular concerns about how appropriate the groups were for people who are relatively low functioning. Many people interviewed by the CA at various facilities were not able to even name the programs they were in, raising some concerns about whether they are able to engage effectively in the programs. Similarly, some, mostly elderly or more low functioning people in the ICPs have raised concerns about their inability to participate in the volume and/or type of structured programs and chores required. As an indication of the varying levels of functioning on the ICP, the ADLs classes mentioned earlier are designed to help residents with their personal hygiene, take showers, wash their clothing, and clean their cells. In addition, as is a concern with all programs across DOCCS prisons, the pay people receive in the ICP is extremely low, ranging from ten cents an hour to 17 and a half cents an hour.

In addition to these concerns about programs raised by ICP patients, the Justice Center has reported some limitations in ICP programming during its review of these units a few years ago. The Justice Center did find that participants were knowledgeable about ICP programs and were engaged in their treatment. On the other hand, the Justice Center found that program schedules were inaccurate and there were discrepancies between the log books and actual participation, such that actual program hours were less than what was recorded and any reported program hours by OMH were overstated. Also, the Justice Center reported that although IDDT (integrated substance abuse treatment for people with mental health needs) should be a program co-facilitated by DOCCS and OMH, OMH was often not involved in the program and not co-facilitating. In addition, the Justice Center found that community meetings often did not occur as they should and did not occur at all at some ICPs. Furthermore, the Justice Center found individual treatment plans to be severely lacking. Some treatment plans did not have any

individualized goals, while other plans stayed the same even after patients had achieved the goals laid out in the plan. Also, with respect to treatment plans, the Justice Center found that patients often do not participate in the planning for the treatment plans or meetings about the plans, and sometimes the treatment plans were not even signed by individual patients. Recently we have learned that the Justice Center intends to perform an updated review of the ICPs, and we look forward to reviewing those results and comparing it to the CA's more recent observations.

One additional new development has been the conversion of some of the ICPs to specialized programs. Specifically, OMH has established ICP programs focused on issues related to discharge planning for patients who will be leaving DOCCS in the not-too-distant future. Similarly, they have established an anti-violence program at some ICPs, focusing on patients who have had some violent experiences while incarcerated or were convicted of a violent crime. Again recently, we have requested more details about these programs and the admission criteria. Once this documentation is provided we look forward to comparing the program design with the experiences of patients in these programs.

With respect to individual therapy, survey respondents at CA-visited ICPs had mixed ratings. On the positive side, some survey respondents appreciated the support provided by staff. According to some ICP residents, the counselors help to motivate them to do better and are readily accessible when patients need their assistance. On the other hand, we did receive many complaints that the patients did not see mental health staff for individual therapy as frequently or for as long as they would like. The median number of times that ICP survey respondents across CA-visited prisons reported meeting with OMH staff for individual therapy in the ICP was one time per month, and the median length of those individual therapy sessions was 15 minutes. Some survey respondents expressed concerns that the individual therapy was not as extensive or individualized as it could be to help patients address their mental health needs. Also, across various ICPs, patients expressed concerns that their conversations with mental health staff were not always confidential, and that security staff would sometimes harass them with information they provided to mental health staff.

A more general issue for the patients is the overall environment and feelings of safety. The vast majority of ICP residents across CA-visited prisons reported that they felt safer in the ICP than in general population. However, at some facilities, patients reported that they frequently feel unsafe in the ICP, and a majority of patients reported that they feel unsafe at least once in a while. Interrelated, ICP survey respondents overall reported less, though still disturbing, staff physical and verbal abuse than on other prison units. Similarly, a small but significant percent of ICP survey respondents reported that they personally had been in a physical confrontation with staff in the ICP, although at rates less than the rates reported by all CA general population survey respondents.

As noted earlier in this testimony, we reported on the number of disciplinary tickets issued against ICP residents. Although significantly less than the rates in other more punitive environments, there is still a large number of misbehavior reports issued to ICP residents and many residents are sanctioned with keeplock time and, more infrequently, SHU time. More disturbing, ICP participants are sometimes sanctioned with additional segregated confinement time for manifestations of their mental health illness. A review of 2015-16 DOCCS disciplinary data for all persons in the ICPs reveals a disturbing trend of frequent and significant keeplock sentences for many ICP participants. Specifically, 221 and 255 ICP participants in 2015 and

2016, respectively, were given keeplock or SHU time during the calendar year. Given an average ICP census of approximately 715 to 742 people for each year, the percentage of ICP participants receiving isolation represented 31% and 34% of the annual ICP census for 2015 and 2016, respectively. The median sentence each year was 30 days per disciplined participant, but 90 and 70 participants were isolated for 60 days or more, and 31 and 12 were isolated for 180 days or more, in 2015 and 2016, respectively. We are greatly concerned about how many people in ICP are disciplined and the length of time they are placed in isolation.

Also of concern is the number of negative informational reports and tier 1 and tier 2 tickets in the ICPs that result in sanctions that do not involve isolation, but do entail loss of privileges, fines and impede the patients' progression to less restrictive housing. Overall, we are concerned these punitive actions undermine the therapeutic nature of these units and slows the patients' therapy and evolution to more positive behavior and avoidance of maladaptive conduct that results in punishment rather than treatment and personal insight.

**H. Insufficient Mental Health Services for Patients in General Population**

With only 1,300 residential mental health beds in DOCCS and a OMH caseload greater than 10,000, most people with mental health needs, including many with serious mental health issues, reside in the prisons' general population or the SHU. OMH patients in general population have limited, short check-in meetings with OMH staff, and may receive medications. As of January 2017, 7,190 OMH patients, representing 69% of the caseload, were on psychotropic medication. For patients in general population on the caseload, OMH requires that they have at least one mental health encounter per month. This usually means that the patient sees an OMH mental health social worker for individual therapy once per month for a session that often lasts on average for fifteen minutes and a 15- to 30-minute session with a psychologist once every three months.

The CA has long advocated that OMH augment these individual sessions with group programs for general population patients. This was not adopted until recently, but with a disappointing outcome. Now, at some prisons, patients with Level 2 to Level 4 diagnoses are being assigned to group sessions of from 5 to 15 patients once per month, but as a substitute for their individual therapy. We were told at Albion CF, the largest women's facility, that these group sessions last about 30 minutes and include generally a 15-minute program with the remaining part of the session open for group discussion. Clearly these groups are no substitution for individual therapy, and based upon the patients' level, they will only have an individual session every 60 to 90 days. These group sessions are not voluntary, and if a patient refuses to participate, it appears they could be removed from the caseload. We are very concerned about this substitute of individual therapy, which already was very limited, with monthly group meetings that appear to be mostly educational and not individualized therapy.

There are many prisons with very large OMH caseloads, some of which can reach 50% or more of the entire prison population. As of January 2017, four prisons had more than 50% of its population on the caseload – Bedford Hills-59%, Mid-State-59%, Albion-57% and Collins-53%. Fishkill and Groveland had more than 40% of their population on the caseload, and Great Meadow had more than 30%. Collins and Groveland are OMH Level 2 prisons, so there are no residential or crisis intervention units in these prisons. We are very concerned about facilities

with high OMH caseload and the ability of these prisons to meet the needs, both chronic and emergent, of so many patients requiring mental health treatment.

In addition to the concerns about the adequacy of mental health services, general security and program staff are not consistently and adequately trained on how to work with people with mental illness, sometimes leading to difficult interactions, diminished effectiveness of programs for all participants, and staff abuse, including physical abuse, verbal harassment, and frivolous or false disciplinary tickets. On the program side, at Collins, for example, many staff and incarcerated persons throughout the facility reported that the conversion of Collins to an OMH Level 2 facility and the influx of people with mental health needs had a tremendous impact on the whole facility. For example, many academic and vocational program staff at Collins indicated that the change in the population made their jobs much more difficult, that they had to modify how they run their programs, and that there was insufficient training and support to effectively work with so many people with mental health needs. Similarly, at Groveland, ASAT staff indicated that significant portions of their program participants have mental health needs and are on the OMH caseload, and staff in all aspects of the prison indicated they have had to make adjustments and accommodations in order to work with people with mental health needs.

On the security staff side, many survey respondents across CA-visited facilities told us that people with mental health needs are often targeted by correction officers for abuse. Both OMH patients and other incarcerated persons have told us that patients on the caseload are subject to verbal and sometime physical abuse from staff. They are more likely to receive a disciplinary infraction for behavior that may be related to their mental illness, and these individuals are often given less credibility at disciplinary hearings or when they appeal their disciplinary sanction. During our meetings with security staff, we frequently have encountered a bias expressed by staff toward patients on the OMH caseload; the staff have stated that they feel some persons are using their mental health illness as an excuse for violating prisons rules and staff said these patients are receiving somewhat shorter disciplinary sentences as a result. We are disturbed about this trend to minimize the challenges persons with mental health needs experience in prison, and an inclination for security and program staff to respond with punishment rather than with treatment as a response to any maladaptive or inappropriate behavior.

Finally, people who return to general population from the SHU or RMHTUs often do not receive transitional support to help adjust to being in general population after their traumatizing experiences in disciplinary confinement. Without such supports, these individuals often have a difficult time adjusting to being in general population, particularly if they have remained in isolated confinement for extended periods of time. Moreover, many such individuals face additional abuse from correction officers because they are viewed as being people guilty of disciplinary infractions.

To improve the mental health services for general population patients, OMH must expand its staff and programming for these individuals, it should work with DOCCS staff to educate them about mental illness and how to more effective interact with patients on the OMH caseload and how mental health treatment can improve both the lives of the patients and the staff who interact with them on a daily basis.

**I. Enhance the Justice Center for the Protection of People with Special Needs (Justice Center) Concerning Activities Related to the SHU Exclusion Law**

In FY 2018-19 budget there apparently 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 therefore, who should be diverted to an RMHTU, 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 Exclusion 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 10,300 patients on the OMH caseload in the prisons at any one time, representing 20% 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 2,900 persons in disciplinary confinement in 47 different prison units and about 13,500 persons are sentenced to the SHU each year. With only four 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.[20] Also, the Justice Center's 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 – were very limited in scope. Finally, the Justice Center has limited resources to review suicides in DOCCS and has been unable to expand its review to self-harm incidents that often are focused in the disciplinary and residential treatment units in the prisons. It is crucial that additional resources be provided if the Justice Center is going to meet its legislative mandate to assess compliance with the SHU Exclusion Law and evaluate general mental health care in the prisons.

The CA has recently reviewed the Justice Center's 2015 and 2016 assessments of DOCCS and OMH compliance with the SHU Exclusion Law and its evaluations of the quality of care provided in both the SHUs and in the RMHTUs. We have significant concerns about these evaluations. As an overview, we want to emphasize the importance of the Justice Center's duty to vigorously evaluate the implementation of the SHU Exclusion Law and to assess the quality of mental health care that is provided to all patients in DOCCS who have mental health needs. We believe the analysis should be expanded to measure compliance beyond the limited review of objective time limits for action and should include an assessment of the quality of mental health interaction as a component of compliance with the Law. Moreover, efforts should be made by the Justice Center to identify systemic deficiencies and not only failures to provide services to specific patients.

Concerning the reviews of the prisons' SHUs, we find the Justice Center's process is too limited because: (1) the criteria for review is much too limited; (2) documentation of the reviews contain insufficient details to assess whether the reviews are comprehensive or to evaluate whether OMH and DOCCS are in compliance with the Law's mandates; and (3) the reviews contain insufficient guidance on the nature of systemic remediation needed to ensure future compliance. Most importantly, there must be an evaluation of the adequacy of intake and follow-up assessments to determine whether they are thorough, adequately document the patient's concerns and conditions, and contain appropriate follow-up to any identified mental health needs. The Justice Center review should evaluate whether (1) encounters were sufficient to determine if significant mental health symptoms/concerns were presented by the patient, and (2) the OMH assessment included documentation demonstrating that the provider considered whether the patient should have been evaluated for a transfer out of SHU to an RMHTU based upon the patient's mental health status.

Of particular concern are patients who have engaged in acts of self-harm, have expressed intentions of self-harm, and/or have previously been transferred to an RCTP but then returned to solitary confinement. Given the high rates of suicide and self-harm in disciplinary confinement, we believe it is essential that the SHU mental health staff rigorously adhere to the SHU Exclusion Law requirement that identifies patients for removal from SHU who have engaged in a "recent, serious suicide attempt" or who have engaged in "acts of self-harm" and have deteriorated mentally or are diagnosed with other significant mental health conditions. The Justice Center should examine charts of patients who have been admitted to the RCTP and then returned to SHU during the six-month period prior to their review visit, even if the patient is not currently on the unit. Similarly, we urge the Justice Center to evaluate another important

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

requirement of the Law that has not been explicitly discussed in any of the Justice Center letters, namely whether there are instances of patients who were diagnosed with serious mental illness but had not been diverted to an RMHTU.

We also have concerns about the reviews of the RMHTUs, which are the centerpiece of the SHU Exclusion Law. Based upon our assessment of two reviews, we conclude that the Justice Center must reevaluate its protocol and process for assessing these units. There are numerous provisions of the Law that should be an explicit component of the Center's compliance review process. Of particular concern is the requirement that RMHTU patients "receive therapy and programming in settings that are appropriate to their clinical needs while maintaining the safety and security of the facility." Correction Law § 401(1). This necessitates an evaluation of the adequacy of the treatment provided the residents, as well as the timeliness of such services. This should include a review of the program schedule, an assessment of the specific programs to which a patient is assigned, and the impact such programming is having on the mental health needs of the patient. The review should also ensure that the programs are being held as scheduled to meet the four-hour treatment requirement, and that patients are being encouraged to attend. Another major concern is the punitive nature of the RMHTUs, particularly focused upon the number of disciplinary actions, what rule violations result in additional SHU sanctions and the length of additional SHU time added to these patients. The Center should ascertain if these sanctions are being adequately reviewed in a timely fashion by the joint case management committee. For the disciplinary sanction assessment, the Center should include a record review of sentences for all RMHTU residents, not just those who are currently on the unit. The Center should also be evaluating the overall environment in the RMHTUs, including related to alleged staff abuse and brutality of people held in the units.

In order to evaluate these many requirements, the Justice Center will need to develop an audit instrument that contains specific items to be assessed by the Center's visiting team in interviews, reviews of patient records and agency documentation. Moreover, the Center will have to expand its review process to include records of patients who may not be on the unit in order to ensure that it is investigating a sufficient number of records for each element of the SHU Law. We would gladly assist the Center in developing this instrument and augmenting it review process.

The CA and other advocates have raised these concerns with the Justice Center and believe they are making a good faith effort to address our issues. But without adequate resources, we believe it will be very difficult to perform the reviews adequately with the current staffing levels. More resources are clearly needed.

## RECOMMENDTIONS

**1. Enhance OMH Forensic Staff** – Given the tremendous growth in the DOCCS OMH caseload, additional OMH forensic staff is needed to serve patients in the general prison population, the solitary confinement units and the residential mental health treatment units.

**2. Expand the Non-Punitive Residential Mental Health Treatment Units** –The Intermediate Care Programs (ICPs) and the transitional ICPs are inadequate to meet the needs of patients with serious mental illness in the prisons and therefore, should be expanded.

**3. Increase the Transfer of Patients with Serious Mental Health Needs to Central New York Psychiatric Center** – Many patients in DOCCS are experiencing mental health crises that would justify psychiatric hospitalization, but this is not occurring. OMH must enhance its efforts to evaluate these patients for potential transfer to CNYPC.

**4. Improve the Services being Provided to Patients Experiencing Mental Health Crises who are Transferred to DOCCS Residential Crisis Treatment Programs (RCTP)** – Many patients experience serious mental health crises and acts of self-harm in the prisons and are placed in the RCTPs. The needs of these patients are not being fully addressed on these units, and they are sometimes treated by staff in abuse manner. These units should provide timely evaluation of all the patients' needs, those needs should be addressed expeditiously, and the patients should be returned to a safe environment that will foster their mental health care.

**5. Enhance Efforts by OMH to Investigate and Appropriately Respond to Incidents of Suicide and Self-Harm in the Prisons** – OMH, in conjunction with DOCCS, should address systemically the high incidence of suicide and self-harm in our prisons. This should include improving the response to persons who self-harm and those, both incarcerated persons and staff, who have been exposed to such incidents.

**6. Reduce the Use of Disciplinary Actions in the Residential Mental Health Treatment Programs and Expand Efforts to Make these Units More Therapeutic** – OMH, in consultation with DOCCS, should significantly reduce the number of disciplinary sanctions imposed on its patients in the RMHTUs. In addition, it should undertake measures to ensure that all staff on these units, including DOCCS and OMH, are taking a therapeutic approach to patients' maladaptive behavior.

**7. End the Practice of Long-Term Solitary Confinement for all DOCCS Residents, Prohibit the Placement of any Person with Mental Health Needs in Solitary, and Enact the HALT Solitary Confinement Act** – No persons with mental illness should be placed in solitary confinement, and all persons should be removed from long-term isolation as mandated by the U.N. Mandela Rules, which prohibit isolation beyond 15 days. By enacting the HALT Solitary Confinement Act, A.3080A/S.4784, New York could end this brutal, torturous form of ineffective punishment in our prisons and jails.

**8. Increase the Capacity and Programs in the DOCCS Intermediate Care Programs and Reduce the Use of Disciplinary Sanctions Against ICP Patients** –DOCCS has inadequate capacity to treat in a residential mental health treatment setting all its patients with serious mental health needs. OMH and DOCCS must expand the ICP program and enhance its programs so that each patient is receiving the individualized care they need to address their mental health needs.

**9. Expand the Treatment Programs for Mental Health Patients in DOCCS General Population** – Most patients with mental health needs are in the general population of the prisons, and the services they are receiving are often inadequate to meet their needs. Group treatment programs should be used to expand the individual treatment being provided and not used as an alternative. Moreover, more interactions between mental health providers and their patients are needed for many patients with significant mental health issues.

**10.Increase the Resources for the Justice Center and Improve its Assessment Protocols to Ensure DOCCS' and OMH's Comprehensive Compliance with the SHU Exclusion Law and Center's Duty to Monitor Overall Mental Health Care in the Prisons** – More resources are needed for the Justice Center to meet its legislative duties under the SHU Exclusion Law. Moreover, the Center's protocols should be revised to more thoroughly evaluate compliance with the SHU Law and identify systemic deficiencies in the provision of services to patients in the SHUs, RMHTUs and other mental health treatment units.

**11. Stop All Staff Brutality and Abuse against People with Mental Illness, and All People, in DOCCS Prisons, Redress Past Brutality and Deaths, and Create a Safe Environment** – DOCCS and OMH must ensure that all people who are incarcerated within their care are in a safe, supportive environment. There must be a fundamental change in culture in order to end all staff abuse of people with mental health needs, and all people. DOCCS and OMH must issue official public reports on the deaths of Samuel Harrell and Karl Taylor and take all necessary actions to ensure such brutal incidents never happen again.

**12. Expand Resources for Mental Health Services in the Outside Community and Divert People with Mental Illness from Prisons and Jails** – 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.

## EXHIBIT A - CNYPC PATIENT DEMOGRAPHICS and PROFILE 2008-17

| | | OMH Outpatient - DOCCS Facilities | | | | | OMH Inpatient - CNYPC Inpatient | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1/1/Yr | DOCCS | OMH | % Pop | Gender | Ethnicity | Primary Diagnosis Group | OMH | Gender | Ethnicity | Primary Diagnosis | Admit | Disch |
| 2008 | 62,599 | 8,567 | 13.69% | 86.3%-M 13.7%-F | 43.1%-AA 31.6%-W 21.7%-H | 25.0%-MM, 22.8%-MD, 19.3%-Schiz/Psych, 9.3%-AxD, 8.3%-PD, 8.5%-AdD | 171 | 90.6%-M 9.4%-F | 53.8%-AA 25.1%-W 18.1%-H | 61.4%-Schiz/Psy, 18.7%-MM, 7.6%-PD, 2.3%-AdD, 3.5%-MD | 773 | 781 |
| 2009 | 60,081 | 8,696 9,067 (8/08) | 14.47% | 87.2%-M 12.8%-F | 43.1%-AA 30.4%-W 21.3%-H | 21.9%-MM, 19.7%-MD, 18.4%-Schiz/Psych, 10.3%-AxD, 9.1%-PD, 12.3%-AdD | 164 | 90.4%-M 9.6%-F | 52.7%-AA 29.3%-W 17.4%-H | 55.7%-Schiz/Psy, 21.0%-MM, 10.2%-PD, 1.8%-AdD,3.0%-MD | 725 | 732 |
| 2010 | 58,378 | 7,836 | 13.42% | 87.7%-M 12.3%-F | 42.5%-AA 33.7%-W 21.0%-H | 22.3%-MM, 20.1%-MD, 19.2%-Schiz/Psych, 11.2%-AxD, 8.9%-PD, 10.8%-AdD | 173 | 93.1%-M 6.9%-F | 45.7%-AA 33.5%-W 19.1%-H | 54.3%-Schiz/Psy, 16.2%-MM, 9.2%-PD, 3.5%-AdD, 4.0%-MD | 583 | 570 |
| 2011 | 56,315 | 7,959 | 14.13% | 89.3%-M 10.7%-F | 41.9%-AA 33.9%-W 21.1%-H | 23.0%-MM, 21.1%-MD, 17.8%-Schiz/Psych, 10.5%-AxD, 10.1%-PD, 11.6%-AdD | 137 | 93.4%-M 6.6%-F | 46.0%-AA 33.4%-W 18.2%-H | 56.9%-Schiz/Psy, 17.5%-MM, 12.4%-PD, 4.4%-AdD, 2.9%-MD | 425 | 471 |
| 2012 | 55,804 | 8,308 | 14.88% | 88.4%-M 11.6%-F | 40.8%-AA 34.8%-W 20.3%-H | 23.1%-MM, 20.0%-MD, 16.2%-Schiz\Psych, 14.5%-AdD 10.6%-AxD, 10.4%-PD | 137 | 93.9%-M 6.1%-F | 48.0%-AA 23.6%-W 20.3%-H | 58.1%-Schiz\Psy, 20.3%-MM, 8.8%-PD, 6.8%-AdD, 0.7%-MD, 1.4%-DD | 428 | 441 |
| 2013 | 54,865 | 8,190 | 14.92% | 88.9%-M 11.1%-F | 41.1%-AA 35.5%-W 20.1%-H | 33.5%-OMD, 16.4%-AdD, 15.2%-Schiz\Psych, 12.1%-PD, 10.1%-AxD, 7.6%-Maj Dep/BP | 154 | 93.5%-M 6.5%-F | 51.3%-AA 24.7%-W 20.8%-H | 64.3%-Schiz\Psy, 14.3%-PD, 8.4%-Maj Dep/BP, 3.9%-AdD 3.2%-OMD, 3.9%-DD | 385 | 379 |
| 2014 | 54,196 | 8,573 (4.7% inc.) | 15.80% | 88.4%-M 11.6%-F | 40.4%-AA 36.5%-W 19.3%-H | 33.5%-OMD, 17.3%-AdD, 14.0%-Schiz\Psych, 12.5%-PD, 10.8%-AxD, 6.4%-Maj Dep/BP | 154 | 91.7%-M 8.3%-F | 52.9%-AA 28.0%-W 15.9%-H | 70.7%-Schiz\Psy, 8.3%-Maj Dep/BP, 5.7%-PD, 5.1%-AdD, 3.8%-OMD, 1.9%-DD | 335 | 332 |
| 2015 | 52,932 | 9,412 (9.8% inc.) | 17.78% | 88.3%-M 11.7%-F | 39.1%-AA 36.4%-W 20.0%-H | 23.7%-OMD, 19.8%-AdD, 13.7%-PD, 13.3%--Sch/Psy, 8.3%-Oth Dx, 6.3%-AxD, 3.2%-BP, 2.8%-MajD | 161 | 95.0%-M 5.0%-F | 49.4%-AA 26.9%-W 17.5%-H | 70.8%-Schiz\Psy, 13.7%-PD, 6.2%-BP, 2.5%-MajD, 2.5%-OMD, 1.9%-Trauma, 1.2%-AdD | 402 | 394 |
| 2016 | 52,415 | 10,005 (6.3% inc.) | 19.09% | 87.7%-M 12.3%-F | 38.4%-AA 36.2%-W 20.3%-H | 20.2%-MajD, 19.7%-AdD, 13.7%-Sch/Psy, 13.3%-PD,11.7%-Oth Dx,6.4%-BP,6.1%-AxD,4.9%-Traum | 145 | 91.0%-M 9.0%-F | 52.4%-AA 24.1%-W 17.2%-H | 61.4%-Schiz\Psy, 12.4%-PD, 9.7%-AdD, 6.2%-BP, 5.5%-MajD, 1.6%-Trauma | 344 | 361 |
| 2017 | 51,406 | 10,484 (4.8% inc.) | 20.39% | 87.7%-M 12.3%-F | 39.3%-AA 36.1%-W 19.9%-H | 2.8%-MajD, 20.6%-OMD, 19.7%-AdD, 13.2%-Sch/Psy, 15.5%-PD, 3.7%-BP, 5.6%-AxD, 5.6%-Traum | 141 | 91.8%-M 8.2%-F | 46.6%-AA 28.1%-W 19.2%-H | 50.0%-Schiz\Psy, 20.5%-PD, 8.9%-AdD, 8.9%-BP, 3.4%-MajD,3.4%-OMD,0.7%-Trauma | 372 | 361 |

* Admissions and Discharge data for CNYPC reflect the annual total for the calendar year prior to the date indicated in the first column.

Abbrev:AdD:Adjust. Dis; AxD:Anxiety Dis; BP:Bipolar, DD:Develop Dis; MM:Major Mood Dis (MD); MajD:Major Depres; MD: Minor MD, OMD: Other MD; PD:Person Dis

OMH outpatient census reached a maximum 10,484 by the end of 2016 and the highest percentage (20.4%) of the DOCCS population ever on the OMH caseload, representing an increase of 52% in the caseload percentage in the last nine years. The percentage of the outpatient population diagnosed with schizophrenia or other psychotic disorders is 32% below the level it was in 2008, while the percentage of patients diagnosed with adjustment or personality disorders is 110% higher than it was in 2008. There has been significant changes in the diagnoses of mood disorders, including bipolar disorders. In the category of "major mood disorders" to "major depressive/bipolar disorders" to the two categories of "major depressive DO" and "bipolar and related disorders"; the totals have varied from 6.0% to 26.6%. There also have been changes from "Minor Mood Disorder" to "Other Mood Disorder." In 2016 there was no minor or other mood disorder category. Trauma and stessors diagnosis was added in 2014.