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Testimony by Jack Beck, Director, Prison Visiting Project
The Correctional Association of New York
Before the Hearing of the Assembly's Corrections and Mental Health Committees
Mental Health Services in NY Prisons - December 6, 2011

I am Jack Beck, Director of the Prison Visiting Project of the Correctional Association of New York (CA), and I want to thank the Corrections and Mental Health Committees of the Assembly for this opportunity to provide testimony about our observations and concerns about the provision of mental health services to prisoners subjected to disciplinary confinement and about suicides in Department of Corrections and Community Supervision (DOCCS) facilities. As many of you may know, the Correctional Association has had statutory authority since 1846 to visit New York's prisons and to report to the legislature, other state policymakers and the public about conditions of confinement. Our access provides us with a unique opportunity to observe and document actual prison practices and to learn from inmates and staff what they believe to be the strengths and weaknesses of the prison operation.

Overall, the provision of mental health services have increased and, in many cases, improved during the last decade. This is in no small part due to intense scrutiny by the legislature, courts, prison and mental health advocates, and prison mental health patients and their families of the care provided by DOCCS and the New York State Office of Mental Health (OMH). State officials, including DOCCS and OMH employees, have responded by providing more treatment beds, assessing more prisoners for mental health needs and enhancing existing programs or creating new ones for patients with serious mental illness (SMI). These officials should be applauded for their efforts. The CA regularly visits state prisons and surveys prisoners about their treatment. Frequently, prisoners rate mental health services better than many of the 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 receiving.

However, mental health care is not uniform across the system. 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. In summary, we believe progress has been made, but we have not reached a standard of care that guarantees that each patient is receiving effective treatment. Greater transparency is needed to assess where the system is underperforming, and independent oversight is crucial if we are going to maintain the

progress the agencies have made in some areas and initiate improvements on units and programs that are not adequately meeting patients' needs.

OVERVIEW OF MENTAL HEALTH SERVICES IN DOCCS FACILITIES

In preparation for this testimony, staff at the CA reviewed documents provided by OMH's Central New York Psychiatric Center (CNYPC). These included annual summaries of the services provided both within DOCCS facilities by OMH staff and data about DOCCS prisoners transferred to the inpatient unit at CNYPC for psychiatric hospitalization. We also reviewed OMH annual reports for specific mental health programs for the periods 2007 through 2010, where such data was available. In addition, we reviewed system-wide data provided by DOCCS concerning its prisoner population. Based upon analysis of these records, we have made several observations about potential concerns in regards to the care provided to DOCCS patients suffering from mental illness.

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

Table 1 – Summary of Mental Health Services for DOCCS Patients

Unit	Title	Beds	Prisons	Description
Behavior Health Unit	BHU	102	Great Meadow Sullivan	DOCCS/OMH residential treatment unit for disciplinary prisoners with serious mental illness (SMI)
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	36	Clinton Elmira Wende	A program in the SHU in group treatment room with six treatment cubicles for SHU residents with SMI
Intensive Intermediate Care Program	IICP	38	Wende	DOCCS/OMH residential treatment unit for prisoners 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 prisoners with serious mental illness
Residential Crisis Treatment Program	RCTP	112 102*	14 prisons	DOCCS/OMH unit consisting of observation cells and a dorm for inmates who are suicidal or in psychiatric crisis
Residential Mental Health Treatment Unit	RMHU	170	Attica, Five Points, Marcy	DOCCS/OMH residential treatment program for disciplinary inmates with serious mental illness

Special Housing Unit	SHU	5,000	42 prisons	Disciplinary housing units in DOCCS prisons
Special Treatment Program	STP	108**	Attica Five Points Green Haven	A program in the SHU for group treatment in a room with six cubicles
Therapeutic Behavioral Unit	TBU	16	Bedford Hills	DOCCS/OMH residential treatment unit for women prisoners with serious mental illness and a disciplinary sanction
Transitional Intermediate Care Program	TrICP	215	10 prisons	DOCCS/OMH residential program for prisoners with mental illness who have less service needs than ICP patients

* RCTPs have a total of 112 observation cells and 102 dorm beds.
** The STPs were all closed as of July 1, 2011 in response to the SHU Exclusion Law

Overview of Prison Population with Mental Illness[1]

There is a significant population of prisoners with mental health needs in our state prisons[2] **and this census rose throughout the past decade until reaching a maximum of 9,067 patients (15.3% of all prisoners) on the OMH prison caseload as of August 2008, after which time the OMH caseload precipitously dropped to 7,836 patients as of January 1, 2010.**[3] The number of prisoners on the OMH caseload increased steadily throughout the early 2000's from 7,400 to over 9,000 patients by 2008. Surprisingly, the census dropped by January 2010, and remained close to the lower census in January 1, 2011, when the OMH prison census was reported as 7,958. Although the overall prison population dropped by 6.3% from August 2008 to January 1, 2011, the OMH caseload has decreased by 12.2%, almost double the population decline. To date, we have not received an adequate explanation for this decline in the prison patients on the OMH caseload.

The primary diagnoses of prison OMH patients has changed significantly in the past four 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 an anxiety, personality or adjustment disorders. Between 2007 and 2011, the percentage of patients diagnosed with schizophrenia or psychosis dropped from 21.4% to 17.8%, representing a decline of 16.8%. In just the last year, the decline in these conditions was 7.3%. In contrast, there has been an increase in the diagnosis of personality disorders, from 7.2% to 10.1% from 2007 to 2011, a 40% increase in the percentage of patients with this diagnosis. In the last year, personality disorder diagnoses increased from 8.9% to 10.1%, representing a 13.5% increase. Similarly, there has been a significant increase in the diagnosis of adjustment disorder, rising from 6.6% in 2007 to 11.6% in 2011, representing a 76% increase. Patients diagnosed with anxiety disorders also rose from 9.8% to 10.5% during this four-year period.

[1] Data presented in this section is based upon CNYPC annual patient demographic reports, which are summarized in **Appendix A - CNYPC Patient Demographics and Profile 2007-11.**
[2] We use the term prison OMH patients to refer to individuals with mental illness in the prisons and do not include DOCCS patients confined to the inpatient unit at CNYPC, who are separately reported by OMH.
[3] See **Appendix A – CNYPC Patient Demographics and Profile 2007-11**. This chart summarizes the data provided in the annual reports by CNYPC on patient demographics as of January 1, 2007 through January 1, 2011.

These changes can have a significant impact on the provision of mental health care under the DAI litigation or the SHU Exclusion Law. Patients diagnosed with schizophrenia or other psychotic disorders are automatically classified as having a serious mental illness under the litigation and the SHU Exclusion Law. In contrast, anxiety and adjustment disorders are not specifically mentioned in the criteria, and personality disorders only qualify for the enhanced rights under these provision if a disorder is severe and accompanied by "frequent episodes of psychosis or depression, and results in a significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health."[4] We are concerned that many patients diagnosed with anxiety, personality or adjustment disorders will not receive the enhanced mental health services mandated by the Law.

DOCCS Patients with Mental Illness Admitted to a Psychiatric Hospital [5]

Admissions of DOCCS patients to Central New York Psychiatric Center for hospitalization have significantly diminished during the past two years. As of January 2011, there was a 20.8% decrease in the OMH inpatient population in CNYPC from the previous year, which had a stable census for at least the previous four years. During calendar year (CY) 2010, there was a 27.1% decrease in CNYPC admissions from CY 2009 and a 41.4% reduction from CY 2008. 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. There also have been significant variations in the number of admissions from different OMH Level 1 prisons and a large diminution in admissions over time from several facilities. For example, Attica and Albion had low CNYPC admissions (10 and 4, respectively, in 2010) compared with high admissions from Auburn, Clinton, Elmira, Great Meadow and Wende (26, 28, 61, 28 and 25, respectively). Over the past four years, several prisons significantly decreased their CNYPC admissions, such as Albion (42 [2007] to 4); Attica (48 [2008] to 10); Clinton (86 [2007] to 28); Five Points (30 [2007] to 14); Midstate (54 [2007] to 16). Other have increased, such as Elmira (18 [2007] to 61); Great Meadow (9 [2008] to 28) and Wende (13 [2007] to 25).

DOCCS Patient Experiencing Mental Health Crises[6]

There has been a substantial increase in the number of admissions to the Residential Crisis Treatment Program (RCTP) throughout the past four years. RCTPs are located in the 15 OMH Level 1 facilities and the Marcy RMHU in a unit where prisoners who are suicidal or having a mental health crisis are taken for assessment and housing in an environment designed to ensure safety. These units usually contain several observation cells where patients are placed in paper gowns and provided no property or other items with which they could harm themselves. Patients generally remain in these observation cells for one to three days while the mental health staff evaluate what treatment should be provided and where the patients should be housed. This could include 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. Admission to a RCTP has risen from 5,302 in 2007 to 7,515 in 2010, representing a 41.7% increase. In just the last year

[4] Section 137 (6) (e) (v) of the Correction Law.
[5] Data for this section is derived from **Appendix A - CNYPC Patient Demographics and Profile 2007-11**
[6] Data for this section is derived from CNYPC annual reports on conditions in the Residential Crisis Treatment Program units throughout the prison system. Data from these reports are summarized in **Appendix B - Summary of RCTP Annual Reports for Years 2007-10**.

(2010), there was a 17.1% increase. It is important to note that there has been an increase in the number of patients coming from the combined disciplinary housing units and residential treatment areas for patients with disciplinary sentences. In 2007, inmates in a SHU and BHU represented 18.9% (there were no categories for STP and GTP in 2007); in 2010, SHU, BHU, STP, GTP and RMHU represented 23.8% of RCTP admissions, representing a 25% increase.

DOCCS Disciplinary Inmates Assigned to the SHU and Other Programs

DOCCS disciplines a large number of prisoners each year, resulting in SHU dispositions requiring placement in a disciplinary housing unit for periods typically from 30 days to many years. In **Table 2 – Summary of Disciplinary Confinement for DOCCS Patients with Mental Illness,** we have summarized the SHU population for the period 2003 through 2010, as well as identified portion of the disciplinary population who are on the OMH caseload and those who have been designated as having serious mental illness.

Table 2 – Summary of Disciplinary Confinement for DOCCS Patients with Mental Illness

Disciplinary Units	2003	2004	2005	2006	2007	2008	2009	2010	6/2011
Total SHU Pop	4,500	4,300	4,680	n/a	4,500	4,450	5,000	4,343	4,254
S-Block Pop *			1,300	1,280	1,300	1,300	1,250	1,270	1,216
SHU Patients on OMH caseload	849	798	753	711	660	644	606	561	579
"S" Designated SHU Patients**	n/a	n/a	n/a	n/a	174	166	125	104	47
BHU Patients †	n/a	n/a	76	83	96	90	62	60	78
RMHU Patients††	-	-	-	-	-	-	-	67	88
Total SHU, BHU, RMHU on OMH			829	794	756	734	668	688	792

* Residents in S-Block units, each with capacity for 200 disciplinary prisoners, are included in the SHU census total.
** The number of "S" designated patients in the SHU includes patients in the STP and GTP but not in the BHU or RMHU.
† BHU census data was obtained from DOCS population data from 7/2005, 9/2006, 6/2007, 9/2008, 6/2009 and 9/2010.
†† RMHU census figures were obtained from DOCCS 9/2010 population data.

Table 2 illustrates several important facts about DOCCS disciplinary confinement. First, a significant number of prisoners are placed in the SHU each year, and the SHU census has remained relatively stable at approximately 4,500 residents. Second, the number of SHU residents on the OMH caseload has declined somewhat during the last eight years, but at a rate that is comparable to the decline in the overall prisoner population. Despite this decline, there are still nearly 800 OMH patients in the SHU or other disciplinary mental health housing, representing 18% of the SHU and disciplinary mental health housing population. Third, the number of disciplinary inmates who have serious mental illness has declined from 260 patients in 2007 to 240 in 2011.[7] This decline is not

[7] Prisoners with serious mental illness (SMI), or an "S" designation according to OMH, meet the criteria specified in the SHU Exclusion Law. We have computed this census by adding the patients in the BHU and RMHU to the SHU residents who are listed as "S" designated. In 2011, it appears that the STP patients were not included in the listing of "S" designated patients in the SHU, so we added that population of 28 prisoners to the group of SHU, BHU and RMHU patients.

significant, but now nearly all of these patients are in a disciplinary mental health treatment program, whereas in 2007, only 53% were receiving intense mental health services.

We also analyzed the data provided by CNYPC concerning the population of patients on the OMH caseload at specific prisons. **Appendix E - Summary of SHU Patients on the OMH Caseload 2nd Quarter 2011** summarizes the most recent data available about SHU patients on the OMH caseload. A few observations are important to note. First, several prisons designated as an OMH Level 1 facility have a significant portion of their SHU populations on the OMH caseload, even if these patients are not "S" designated. For example, prisons such as Albion, Auburn, Clinton, Eastern, Elmira, Great Meadow, Groveland, and Wende have 30% to 50% of their SHU currently on the OMH caseload. Second, Southport and Upstate, two primarily disciplinary prisons with more than 1,579 disciplinary prisoners, has 196 OMH patients, representing 12.4% of their population, even though Upstate is only an OMH Level 3 facility and Southport is Level 2. We interviewed many patients now in residential disciplinary mental health units who had been at one of these institutions, and we remain concerned as to whether adequate screening is occurring to avoid placement of prisoners with SMI at these institutions with limited mental health staff. Finally, we were please to observe that there was a significant drop in "S" designated patients in the SHU at the end of this reporting period from 102 to 47 in the three-month period, demonstrating that DOCCS and OMH were preparing to fully implement the SHU Exclusion Law.

Patients in DOCCS Behavioral Health Units[8]

There has been a significant increase in the number of disciplinary patients admitted to the Behavioral Health Units in 2010 compared to 2009, but many of these individuals are coming from other mental health treatment programs for prisoners with disciplinary sentences. In 2009, 53 individuals were admitted to the BHU, and that number rose to 98 patients in 2010. We consider this a positive development, reflecting greater attention to disciplinary inmates' mental health needs. The percentage of BHU admissions coming from the SHU, however, has dropped from 64% to 48% from 2009 to 2010. We have observed that many disciplinary patients with serious mental illness have been repeatedly transferred between several of the disciplinary treatment units, often as a result of getting additional disciplinary sanctions on these units. In addition, in 2010, 7% of BHU admissions were from the non-disciplinary ICP program, raising concerns about the punitive response to mental health patients in those units.

There has been an increase in the number and percentage of BHU patients being discharged to an ICP or TrICP. A positive trend we observed is that the percentage of BHU patients being discharged to non-disciplinary mental health units has risen from 27% in 2009 to 36% in 2010. We believe this demonstrates the benefits that some disciplinary patients experience from the intense mental health care provided in the BHU. We also noted, however, that 13% and 10% of BHU patients were discharged to general population in the prisons in 2009 and 2010 respectively. We are concerned whether these patients, who have apparently improved in their ability to function in a prison setting, will regress when they are not receiving the intense mental health services provided in the BHU. We question whether these discharges are a function of inadequate space in the ICPs

[8] Data for this section is derived from CNYPC annual reports on conditions in the Behavioral Health Units throughout the prison system. Data from these reports are summarized in **Appendix C - Summary of BHU Annual Reports for Years 2007-10**.

and TrICPs to accommodate patients with significant, but somewhat less severe, mental health conditions.

A majority of BHU patients are receiving disciplinary sanctions while on the unit - a practice we hoped would occur much less frequently with the use of non-disciplinary information reports as the response to inappropriate behavior. Unfortunately, the practice of issuing disciplinary actions against these patients has not only continued, but also increased during the past two years. Sixty-one percent of BHU patients with serious mental illness released in 2009 received a serious disciplinary ticket (Tier 3 misbehavior reports), and that figure increased to 71% in 2010. We believe the frequent use of discipline to respond to patients' inappropriate behavior seriously undermines the therapeutic nature of the unit and the ability of these patients to progress to less restrictive mental health housing.

Many of the patients being released from the BHU are being transferred to another program with significant SHU time remaining or keeplock sentences they will be required to serve. We are concerned about where these patients are going and under what conditions they will be housed. It should be noted that keeplock is generally not recognized as a condition that requires DOCCS and OMH to provide the mental health services specified in the SHU Exclusion Law, unless the individual is placed in a SHU or separate keeplock unit. There are only a few separate keeplock units, and most inmates in keeplock would not be subject to the Law's provisions.

Patients in DOCS STP Programs within the SHU [9]

The Special Treatment Program for disciplinary prisoners with serious mental illnesses was opened at Attica C.F. in 2000 as a treatment program for prisoners who were confined to the disciplinary SHU unit. STP units were subsequently created in the SHUs at Five Points C.F. in 2001 and expanded to Green Haven C.F. in 2008. By 2010 there were a total of 108 STP beds in the three facilities: Attica (34 beds); Five Points (50 beds) and Green Haven (24 beds). The SHU Exclusion Law does not recognize these units as residential mental health treatment units pursuant to its provision, and, therefore, as of July 1, 2011, inmates with serious mental illness can no longer be housed in the STP beds. In anticipation of that limitation, DOCCS and OMH began phasing out the STP program and transferring STP patients to alternative settings, including some disciplinary and other non-punitive housing areas. The Green Haven STP was closed December 3, 2010, and the residential mental health treatment units have been established at both Attica and Five Points. Although these units are no longer operational, data analyzing the census and treatment of STP patients is relevant to demonstrate the need for residential programs for disciplinary prisoners with serious mental illness, and to what may occur when these individuals are transferred to other disciplinary mental health treatment programs.

There was a substantial increase in STP admissions throughout the past three years. Enrollment in the STP program increased by 69% from CY 2008 to CY 2010, rising from 137 to 229 annual admissions. Most admissions came from the SHU (64% to 75%), CNYPC (10% to 18%), or another residential MH program for disciplinary prisoners (4% to 14%). This data demonstrates the increasing need for residential mental health treatment for disciplinary patients.

[9] Data for this section is derived from CNYPC annual reports on conditions in the Special Treatment Program units in prison SHUs within Attica, Five Points and Green Haven. Data from these reports are summarized in **Appendix D - Summary of STP Annual Reports for Calendar Years 2008-10**.

Discharges from the STP to non-punitive mental health programs have remained stable at approximately 40% during the past three years. The feasibility of transitioning disciplinary patients with serious mental illness to non-punitive treatment programs has been amply demonstrated by experiences during the past three years. STP patients are routinely discharged to an ICP, TrICP or IICP, and such discharges constitute the largest single disposition of patients leaving these units. This is a marked change from a decade ago when few disciplinary prisoners left the SHU and were admitted to the ICP.

Discharges from the STP to CNYPC for psychiatric hospitalization occur regularly, but the numbers have varied throughout the past three years. There were 20, 32 and 20 discharges from the STP to CNYPC for psychiatric hospitalization during CY 2008, 2009 and 2010, respectively. These figures represent a significant portion of all CNYPC admissions. In CY 2010, STP patients accounted for nearly 5% of all CNYPC admissions even though the STP population is only 1.25% of the patients on the OMH caseload. The rate of admissions of STP patients to CNYPC is approximately three times higher than the rate for ICP patients, given the census of these two programs.

The vast majority of STP patients are still receiving disciplinary tickets, and many patients are discharged from the program with significant SHU or keeplock time. Less than half have received a time cut while on the unit. Alarmingly, CNYPC reported in 2010 that 98% of the patients discharged from the STP program had received a Tier 3 ticket during their stay in the STP, the most serious violation of the prison rules. Only 45.5% of the STP patients had received a time cut while on the unit, with the average reduction of 72 days of SHU time and only three days of keeplock time. Equally disturbing is that 45% of STP discharges (105 patients) had a SHU sentence pending at the time of discharge, with the average amount of SHU time remaining amounting to 303 days; 86 patients (37%) had keeplock time remaining in the average amount of 133 days. Overall, these data illustrate the continued use of discipline on the unit, the failure of the time cut process to significantly reduce SHU sentences, and a pattern of STP patients leaving the program while they still have to serve substantial time in restricted housing. It is not surprising that many STP patients are going from the program to another disciplinary treatment program. We question whether these transfers are necessary for progress in treatment or rather represent the dumping of patients who are not responding to therapy on other programs without identifying how best to treat those individuals.

PRISON VISITS TO ATTICA, AUBURN AND GREAT MEADOW

In 1846, New York passed a law granting the CA authority to inspect prisons operated by New DOCCS and report findings to the Legislature. The CA uses this unique mandate to promote improved prison conditions and issue comprehensive reports to policymakers and the public. The CA's Prison Visiting Project (PVP) carries out the organization's legislative mandate to monitor the 57 prisons in New York that house men. PVP conducts on-site assessments of prisons, issues prison-specific reports to the State Legislature, prison officials, and the general public following each visit, and publishes detailed reports on key corrections issues, such as medical and mental health care and substance abuse services, and advocates for system-wide improvements.

As part of that monitoring process, the CA visited Attica, Auburn and Great Meadow Correctional Facilities to assess general prison conditions and to evaluate the mental health services provided to

the many patients in those prisons who require mental health care. The following are some brief descriptions of our observations, concerns and recommendations.

Attica Correctional Facility

Attica is a maximum-security prison located in Wyoming County, New York, and is an OMH Level 1 designated facility, thereby providing the most intensive mental health services to patients currently on the OMH caseload. The CA conducted a visit to Attica in April 2011. Attica has the capacity for 2,253 prisoners and held 2,152 individuals at the time of our visit in 2011, 443 patients, representing 20% of the prison population, were patients on the OMH caseload. Attica operates four mental health units for individuals on the OMH caseload: the Residential Crisis Treatment Program (RCTP), the Intermediate Care Program (ICP), the Transitional Intermediate Care Program (TrICP), and the Special Treatment Program (STP) in the SHU. **Table 3** below outlines the capacity, current census and percent of "S" designated patients for each mental health program at Attica for 2011.

Table 3 - Capacity and Census of Attica Mental Health Programs

PROGRAM	CAPACITY	CENSUS	% of "S" designated
STP	34	20	Data Not Available
ICP	78	73	97.4%
TrICP	36	36	Data Not Available
RCTP	15	Data Not Available	Data Not Available

Special Treatment Program (STP)

The STP is a program within the Special Housing Unit (SHU), which provides mental health services to prisoners with serious mental illness who are currently serving a disciplinary sentence. Prisoners in the STP are allotted additional out-of-cell time compared to those in regular disciplinary housing, and attend two-hour group therapy sessions conducted five days per week by OMH staff. Patients in the STP attend group and individual therapy in "therapeutic cages" and are transferred from their cells to therapy in restraints. The CA visited Attica's STP prior to the full implementation of the SHU Exclusion Law, which went into effect on July 1, 2011. Pursuant to this Law, STPs are no longer considered adequate treatment units for inmates with a serious mental illness confined to disciplinary housing. Following our visit, we were informed that Attica's STP would be converted into a 10-bed Residential Mental Health Unit (RMHU) as of July 2011.

The CA is concerned that Attica's STP has been converted into a Residential Mental Health Unit (RMHU). As we visited Attica prior to the full implementation of the SHU Exclusion Law, we cannot determine whether that transformation has been successful. During a recent conversation with Attica administrative staff, we learned that all patients in the STP are now receiving four hours of out-of-cell time for group therapy in the morning and afternoon, as required by the conversion to an RMHU. The CA interviewed 16 STP patients during our visit and received seven written surveys after our visit from individuals still housed in the STP. During our visit, a number of issues regarding mental health treatment and prison-staff relations were raised.

Attica STP patients were housed in two SHU disciplinary units in cells that were often dirty, dark, and extremely isolating. The CA was concerned by conditions in the STP, which was situated far away from the mental health unit and was dark, isolating and extremely depressing. Many of the patient in the STP were further isolated within their cells with the additional disciplinary measure of a cell-shield, which is a Plexiglas covering that makes it more difficult to hear or speak with anyone outside the cell.

The majority of STP patients rated their group therapy sessions as poor. The majority of inmates we spoke to were not satisfied with their group therapy sessions, reporting that these sessions did not adequately address issues they felt would be most beneficial to them and that videos were too often shown during these group therapy sessions. Those who rated the groups more positively enjoyed interacting with other inmates and having the opportunity to discuss issues they had in common with other patients.

A nearly universal complaint from STP patients was that their conversations with mental health staff were not kept confidential. Like many other mental health units, patients in the STP felt that their conversations with mental health staff were not confidential and that they were often confronted by security staff with information they believed was confidential. Although the multidisciplinary treatment paradigm is beneficial within prisons in order to coordinate treatment for individuals with mental illness and to create a meaningful therapeutic environment, many STP residents are convinced they cannot trust the mental health staff, therefore undermining the therapeutic relationship.

Patient-security staff relations in Attica's STP were reported as extremely problematic. Patients reported incidents of verbal harassment, threats, retaliation for complaints and sexual abuse. Patients in the STP reported that prisoner-staff relations were extremely strained and that patients were often subjected to verbal harassment, threats of false tickets or assaults, and retaliation for filing grievances against staff. We were particularly disturbed by reports of sexual abuse, which residents reported included both abusive pat-frisks and other forms of sexual abuse.

Intermediate Care Program (ICP)

The CA received a combined total of 21 written and oral surveys from patients in the ICP. The CA was generally impressed with the ICP at Attica, which seemed to be adequately addressing the patients' needs. This was demonstrated by the fact that most ICP patients seemed to have achieved some degree of progress while in the ICP. ICP patients generally expressed that they felt safer in the ICP than in general population, and although the levels of satisfaction with individual therapy varied from patient to patient, ICP residents commonly felt that mental health staff were available and able to provide them with adequate individual attention. Patients were also generally satisfied with the programming available to them while in the ICP. However, despite being impressed with the level of mental health care and programming available to patients in the ICP, there were also some specific concerns raised by the patient population.

Confidentiality is a significant concern to patients in Attica's ICP. Confidentiality is a significant concern to all patients in Attica's mental health units. Patients reported overhearing staff discussing confidential information and that security staff would make suggestive comments about information inmates discussed with OMH staff in confidence. Although we understand the

particular challenges of providing mental health treatment in prisons, the majority of patients believe they cannot trust their mental health providers, thereby undermining the therapeutic relationship.

There are some significant concerns in regards to patient-security staff relations in the ICP. While some patients reported positive interactions with security staff, the majority complained of verbal harassment and several complained of abusive pat-frisks. Furthermore, a majority of survey respondents reported that OMH staff were not receptive to complaints regarding security staff and that there appears to be no means for ICP patients to combat potentially abusive behavior on the part of security staff.

Residential Crisis Treatment Program (RCTP)

The CA was able to tour Attica's RCTP at the time of our visit in April 2011. We were pleased to find that the security staff assigned to the RCTP had been specially trained to work with individuals in such a high level of crisis and had been working in mental health units in prisons for 10-15 years. The RCTP consisted of 10 observation cells and five dormitory beds. The unit was dark and extremely quiet, a stark contrast from the rest of the prison.

Based on our findings, the CA has the following recommendations:

- Implement additional measures to clean up and brighten the STP.
- Carefully assess whether the converted RMHU at Attica is fully compliant with the requirements for mental health treatment units under the SHU Exclusion Law.
- Examine whether it is necessary for inmates in the STP to have cell-shield orders.
- Review group therapy treatment plans in order to ensure that inmates receive the full benefit of group therapy engagement; reduce the use of videos or other electronic programming.
- Review confidentiality protocols with DOCCS and OMH. Ensure that all staff are aware of confidentiality protocols and the sensitivity of private information.
- Review policies with DOCCS staff to ensure that staff do not share mental health information.
- Review whether staff assigned to the mental health units are adequately trained to work with individuals suffering from a mental illness.
- Implement additional trainings and remove staff who are unable or unwilling to perform their duties.
- Thoroughly investigate all allegations of staff misconduct and, if substantiated, implement disciplinary action.
- Enhance training and oversight of treatment and security staff in the mental health units to foster an atmosphere in which patient feel the can safely raise any concerns regarding their treatment by staff and encourage OMH staff to play a more substantial role in addressing improper behavior by ICP residents in a non-punitive manner.

Auburn Correctional Facility

Auburn is a maximum-security prison located in Auburn, New York. It is the oldest operating correctional facility in the state. Auburn is an OMH Level 1 designated facility, thereby providing the most intensive mental health services to prisoners currently on the OMH caseload. The Correctional Association of New York (CA) Prison Visiting Project conducted a site visit to Auburn in June 2011. Auburn has the capacity to confine 1,821 prisoners and confined 1,724 individuals at

the time of our visit in 2011. Twenty percent of the prison population, or 353 patients, were on the OMH caseload at the time of our visit. Auburn operates three mental health units for prisoners on the mental health caseload: the Intermediate Care Program (ICP), the Transitional Intermediate Care Program (TrIPC), and the Residential Crisis Treatment Program (RCTP). Auburn also has an 83-bed Special Housing Unit (SHU), which housed 76 prisoners at the time of our visit. **Table 4** below outlines the capacity, current census and percent of "S" designated prisoners for three of the mental health programs at Auburn Correctional Facility for 2010.

Table 4 - Capacity and Census of Auburn's Mental Health Programs

Program	Capacity	Census	% With "S" designation
ICP	50	49	91.8%
SHU	83	76 (32-OMH caseload)	5
RCTP	10	6	Data not available

Special Housing Unit (SHU)

Under the SHU Exclusion Law, inmates with a serious mental illness, who receive 30 days or more of disciplinary housing, must be diverted to either the BHU or RMHU as of July 1, 2011. At the time of our June 2011 visit, the Law was not operational. However, we found very high numbers of SHU residents with mental illness. According to data provided at that time by the facility, 43% of the inmates in SHU were on the OMH caseload, and according to the OMH report issued in mid-year 2011, five individuals in the Auburn SHU had an "S" designation. Inmates who are on the OMH caseload and actively receiving mental health treatment may not qualify for an "S" designation due to their diagnosis or adequate symptom management. We are concerned, however, that mental health services in the SHU may not adequately meet the needs of SHU residents suffering from mental illness.

The CA was pleased to learn that an OMH staff person makes daily rounds to the Auburn's SHU and patients on the mental health caseload are seen for individual therapy once per month and also meet with an OMH nurse for medication once per month. We are concerned, however, that this amount of services may not be enough to adequately address the needs of prisoners suffering from mental illness housed in the SHU and that these individuals would be better suited in a BHU or RMHU. Some of the CA's additional concerns about the treatment of inmates on the mental health caseload in the SHU at Auburn are further outlined below.

SHU residents on the mental health caseload report not having enough time with mental health staff. Sixty-six percent of surveyed SHU residents reported that they did not have enough time to discuss what they needed to with the mental health staff. Although we understand that there is only one social worker assigned to make rounds to the SHU, which means a limited time with each patient, inmates in SHU seem to have significant concerns that are not being addressed in the limited time provided to them. Forty-two percent of survey participants also reported having problems receiving their mental health medication.

There are a high number of individuals in Auburn's SHU who are engaging in acts of self harm. Twenty-six percent of SHU survey participants reported that prisoners in the SHU attempted to or committed acts of self harm "very frequently," while 38% reported that prisoners in the SHU attempted acts of self harm "frequently." Fifty-eight percent of SHU survey respondents reported

that they had been in the RCPT at some point during their incarceration, indicating that at some point over half the inmates in Auburn's SHU had experienced a psychiatric crisis. There were also reports of inmates being housed in the SHU after an incident of self harm due to limited space in the RCTP. Though the SHU provides 24-hour surveillance, this is not a suitable environment for an inmate experiencing a crisis.

Intermediate Care Program (ICP)

The CA was generally impressed with the mental health services provided by OMH at Auburn. We received 18 written surveys from patients currently housed in the ICP and conducted 28 oral surveys during our visit. Fifty percent of surveyed residents rated Auburn's ICP services as "good," and 36% rated services as "fair." Inmates in the ICP reported that they felt supported by ICP staff and that staff always provided time to address personal needs or concerns. The majority of inmates in the ICP had met with the treatment team to discuss their treatment plan, and the majority of inmates felt safer in the ICP than in general population. We commend the ICP staff at Auburn for creating an environment in which patients are a part of their treatment planning, feel supported and safe. Unfortunately, there were also some significant concerns raised during our visit and in patient's surveys received after our visit.

Verbal harassment by security staff is a common occurrence in Auburn's ICP. Eighty percent of survey participants reported that verbal harassment was "very common." ICP residents reported that security staff made fun of the ICP patients due to their mental illness and had on occasion referred to residents as "retarded."

Patients in the ICP do not feel as though their meetings with OMH staff are confidential. Sixty-one percent of surveyed patients reported that their meetings with OMH staff are not confidential and they are often confronted by security staff discussing or commenting on information they discussed with OMH staff in confidence. Although the multidisciplinary treatment paradigm is beneficial within prisons in order to coordinating treatment for individuals with mental illness, it is important that confidential information remains private so that inmates may develop trusting relationships with their providers.

A high number of individuals in Auburn's ICP report receiving disciplinary tickets. Seventy-eight percent of surveyed inmates reported having received a ticket while in the ICP. During our visit, a number of individuals reported receiving tickets for smoking, and OMH informed us that the Department of Health (DOH) had recently revised the protocol that smoking was now a ticketed offense. Eighty-three percent of surveyed patients also reported having been keeplocked at some point while in Auburn's ICP. This is a significantly high number for a mental health unit, and while keeplocked, inmates are denied important opportunities to engage in therapeutic measures.

Base on these findings, the CA has the following recommendations:

- Conduct trainings with DOCCS security staff on the unit on how best to interact with individuals who are suffering from mental illness.
- Review protocols on confidentiality with security and OMH staff.
- Ensure that confidential or private information is shared with staff only if it is relevant to the staff person's interaction with the individual. Decrease the presence of security staff at

clinical treatment team meetings and conduct separate meetings with security and OMH staff to address only the confidential information that is necessary for discipline or security measures.

- Review whether non-punitive measures can be implemented for ICP patients who commit disciplinary infractions, and increase the use of informational reports rather than disciplinary actions for most inappropriate conduct. Have OMH and DOCCS staff assess alternatives to keeplock for ICP patients.
- Transfer inmates who are on the mental health caseload with significant mental health needs from Auburn's SHU to a BHU or RMHU where they can receive additional mental health services.
- Investigate whether inmates are experiencing significant delays in receiving their mental health medication and hire additional mental health staff, if necessary.

Great Meadow Correction Facility

Great Meadow C.F. is a maximum security prison located in Comstock, New York, and is an OMH Level 1 designated facility, thereby providing the most intensive mental health services to patients currently on the OMH caseload. The CA conducted two visits to Great Meadow, in July 2009 and November 2010, and conducted a limited number of interviews with patients on the OMH caseload in November 2011. The prison has a capacity to confine 1,689 prisoners and, at the time of our visit in 2010, had a prison population of 1,630 and had 395 patients on the mental health caseload, representing 24% of its population, a rate significantly higher than the system-wide average of 14%. Great Meadow operates four mental health units for individuals on the OMH caseload: the Intermediate Care Program (ICP), the Behavioral Health Unit (BHU), the Transitional ICP (TrICP), and the Residential Treatment Program (RCTP). **Table 5** below outlines the capacity, current census and percent of "S" designated patients for three of the mental health programs at Great Meadow for 2009 and 2010.

Table 5- 2009 and 2010 Capacity and Census of Great Meadow Mental Health Programs

Program	Capacity	Census	% With "S" designation
ICP 2009	68	68	95%
ICP 2010	102	100	93%
BHU 2009	38	35	100%
BHU 2010	38	37	100%
RCTP 2009	14	6	Data not available
RCTP 2010	14	6	Data not available

Behavioral Health Unit (BHU)

Great Meadow is one of two facilities, the other being Sullivan C.F., operating a Behavioral Health Unit. Behavioral Health Units are considered residential mental health treatment units under the SHU Exclusion Law, and, therefore, these units can house prisoners with serious mental illness who have received 30 days or more of disciplinary housing. The BHU at Great Meadow runs the Phase I portion of the BHU program, and residents can graduate from Phase I to Phase II at Sullivan, where they receive increased out-of-cell time. Great Meadow's BHU seems to have inconsistencies in the services provided. All the prisoners we spoke to appreciated the opportunity for increased services

while serving a disciplinary sentence. Below are some of our more significant concerns regarding the BHU program at Great Meadow.

There are inconsistencies in the group therapy provided to inmates in the BHU. Certain groups are engaged in fewer group discussions during group therapy sessions. Residents in the BHU Phase I program at Great Meadow can participate in two hours of group therapy each day. Group therapy sessions are conducted on such topics as Thinking for Change, Managing Stress, Wellness, Anger Management, and Life Skills. Security measures in Phase I are similar to those in the SHU, where inmates are escorted to therapy sessions in restraints and may be restrained during sessions. Inmates are enclosed within "individual therapeutic cubicles" (small, caged booths) for both individual and group therapy. According to the patients, certain groups seemed to be more engaged than others during group therapy sessions. Some residents reported that certain groups spent much of their time watching television or videos and participated in fewer interactions with the treatment staff. Additional concerns expressed by BHU residents included that OMH staff did not adequately address patients' behaviors and expressed needs.

Residents of the BHU report a high level of security staff assaults on residents, some of which are alleged to have occurred in the right-hand corner of the elevator on the way to and from group therapy or other activities off the unit. BHU residents reported a disturbing frequency of physical assaults by staff in the BHU. Some patients said staff assaults occurred most frequently on the way to and from activities off the unit, such as group therapy, when the residents are in the elevator with security staff. Prisoners also commented that security staff were overly involved in their mental health treatment, and mental health staff would often engage security staff for minor misbehavior problems that the patients felt would be better handled by OMH staff in a therapeutic setting. Incidents have been reported to us that BHU residents were allegedly in a confrontation with staff following interactions with treatment staff in which sensitive information was revealed. Many residents said they could not trust OMH staff to keep information confidential, and this impeded their treatment.

Residents in Great Meadow's BHU report high levels of self harm. BHU patients reported that individuals in the BHU often engaged in acts of self harm and that security staff were sometimes unwilling to take these statements of feeling suicidal seriously. One inmate reported that he expressed feeling suicidal and requested to see a mental health staff person; the security staff responded, "Why don't you just hang up?" and the inmate shortly did attempt to hang himself.

Intermediate Care Program (ICP)

Great Meadow's Intermediate Care Program is one of the largest in the state and has garnered mixed reviews from the prisoners with whom we spoke or who provided us with written surveys during our three visits. Almost all the inmates we spoke to had both positive comments about the ICP and some negative impressions. Specifically, there were mixed reviews of the group programs, individual therapy and prisoner-staff relations. Some patients said some counselors and security staff did a good job, asserting that some treatment staff supported, listened to and empathized with inmates. But some ICP residents stated that treatment and security staff were less helpful. Below are some of our more significant concerns regarding the ICP program at Great Meadow.

Prisoners in the Intermediate Care Program reported decreasing levels of satisfaction with mental health services and felt less safe compared to the previous year. Based upon surveys we

have received from ICP residents at eight facilities, the vast majority of ICP residents reported being somewhat satisfied with services in their ICP and felt safer living on the unit than in general population. According to the 28 surveys from Great Meadow ICP residents in 2009, 63% felt safer in the ICP, a rate somewhat less than the system-wide rate of 70% for all ICP residents. In addition, 86% of 2009 residents rated the mental health services as either good (36%) or fair (50%), rates comparable to other ICPs.[10] But the picture changed when we visited in 2010. Of the 29 surveys we received from 2010 Great Meadow ICP residents, 52% rated ICP mental health services as good (26%) or fair (26%), and the remaining 48% stated they were poor, a rate significantly higher than the 18% at all CA-visited ICPs. Prisoners we spoke to reported that some groups were beneficial, but they felt that many did not address their needs. Similarly, there was a diminution in the level of safety the 2010 ICP residents reported. Surprisingly, 50% of the 2010 ICP Great Meadow survey participants said they did not feel safer on the unit than in general population, a rate much higher than the 30% for all ICP survey respondents. Great Meadow ICP residents we interviewed reported that some security staff toyed with residents for no reason or tried to provoke them to act out; other patients reported that security staff made fun of them due to their mental illness. A prisoner told us, "I personally would like a peaceful relationship with officers, but their actions lead me to believe that they only wait for a reason and/or opportunity to use me as a 'combat practice dummy.'"

From prisoner reports and the CA's visits in 2010 and interviews in 2011, there seems to be a significant number of ICP residents who are hygienically challenged. ICP residents with whom we spoke during our visit in 2010 and patients we recently interviewed in 2011 reported that there are a number of ICP residents who are unable to adequately take care of themselves hygienically. Therefore, the ICP has been nicknamed the "stinky ICP." Residents reported that although the facility had once provided free hygiene items and patient support to assist those in need of help keeping themselves and their cells clean, both those initiatives have been removed. The CA is concerned that these individuals' needs are not being adequately addressed by DOCCS and OMH staff, which is adversely affecting other patients and staff on the ICP unit.

ICP residents report that there is a lack of confidentiality between patients and ICP staff, resulting in security staff confronting inmates with sensitive information. Patients in all the mental health units the CA has visited, including Great Meadow, report a lack of confidentiality. Over half of all surveyed ICP residents state that their meetings with OMH staff are not confidential and that they are often confronted by security staff discussing or commenting on information a patient revealed to OMH staff during confidential therapy sessions. Patients in Great Meadow's ICP reported that some security staff made fun of residents due to their diagnoses, or openly discussed private information in front of additional staff or other ICP patients. Although the multidisciplinary treatment paradigm is beneficial within prisons in order to coordinate treatment for individuals with mental illness and to create a meaningful therapeutic environment, many ICP residents are convinced they cannot trust the mental health staff, therefore undermining the therapeutic relationship.

Patients in Great Meadow's ICP report high levels of self harm. Great Meadow ICP residents reported frequent occurrences of self harm in the ICP. Forty-three percent of surveyed ICP residents in 2010 reported that incidents of self harm occurred frequently in the ICP. Patients we interviewed in 2011 confirmed this trend, and reported that it was a significant issue in the ICP. Residents also

[10] For all ICP survey participants in the CA surveys, 44% rated mental health care on the unit as good, 38% said the services were fair and only 18% stated they were poor.

reported that security staff did not always take inmates' concerns seriously, and that there were incidents of security staff assaulting prisons who attempted to commit acts of self harm. When a suicide was successfully completed, little additional support was given to the other residents on the ICP, a practice experts recommend would be helpful in order to ensure that no one else was also feeling suicidal.

Residential Crisis Treatment Program (RCTP)

Prisoners experiencing a crisis are afraid to go to the RCTP due to security staff assaulting them on their way to or from the RCTP. Prisoners who are undergoing a crisis have only one option, which is to notify staff and be transferred to the RCTP. At Great Meadow, many prisoners reported that it is common for security staff to assault them while being transferred to or from the RCTP or prior to going to the unit. As a consequence of this widely held perception of the risk of assault when requesting crisis intervention, individuals who are experiencing a crisis at Great Meadow may be reluctant to report it because their concerns may not be taken seriously by staff and/or they fear for their safety when being transferred.

The environment in the RCTP is extremely isolating, further separating the individual from much needed engagement. Prisoners placed in the RCTP are not allowed any personal belongings, their clothing is removed, and they are only permitted to wear a protective smock for their own safety. This environment is extremely isolating and may further exacerbate suicidal thoughts. During our 2010 visit to Great Meadow, we were able to tour the RCTP, and our mental health experts found that there were certain aspects of the environment in the RCTP that could make it difficult to meet the needs of patients in crisis. The RCTP cells, though created for easy observation and protection from self harm, made it extremely difficult to communicate with the patient because the sides were encased in heavy Plexiglas. RCTP patients can see OMH staff at least once a day while in the unit, but our experts deem this inadequate for some individuals experiencing this level of crisis. Although patients in the RCTP are under constant surveillance by a security staff member, these staff members are not generally interacting with the patients.

Base on these findings, the CA has the following recommendations:

- Institute additional and increased trainings for security staff on working with individuals with mental illness.
- Insert cameras into the right-hand corner of the elevator and all areas of the route to the RCTP.
- Increase training protocols so that security staff can better recognize the seriousness of prisoners in crisis.
- Ensure that both OMH and security staff treat all threats of suicide or incidents of self harm as serious, instead of seeing such behavior as manipulative.
- Review ICP and BHU programming to ensure that a wide range of topics are addressed in order to ensure that every patient is involved in meaningful programming.
- Review protocols on confidentiality with security and OMH staff for patients in both the ICP and BHU.
- Ensure that confidential or private information is shared with staff only when it is relevant to the staff person's interaction with the individual.

- Decrease the presence of security staff at clinical treatment team meetings and conduct separate meetings with security and OMH staff to discuss the confidential information that is necessary for discipline or security measures.
- Reinforce with security staff the importance of keeping medical information confidential.
- Treat all suicidal threats as serious, and provide a safe and effective way for patients who may be experiencing a crisis to report such feelings to security or OMH staff.
- Provide opportunities for residents in mental health units to discuss their own concerns after an incident of suicide or self harm during community meetings.
- Have OMH conduct morning rounds of the ICP and use motivational interviewing to encourage hygienic acts.
- Provide hygiene items to those who have difficulty maintaining hygienic measures.
- Re-instate or establish a peer support system, in which other prisoners are trained to help these individuals maintain hygienic levels of self care.
- Review confidentiality protocols with OMH and DOCCS staff, and review and adjust policies with OMH and DOCCS so that inmates are not disciplined by DOCCS for minor rules infractions.
- OMH staff person should conduct more frequent rounds through the RCPT and enhance the level of engagement.

SUICIDE AND SELF HARM IN DOCCS FACILITIES

Unfortunately, in 2010, DOCCS experienced a significant increase in suicides in the state system, rising from 10 suicides per year in 2008 and 2009 to 20 last year. Data recently obtained from the New York State Commission of Corrections indicate that the number of suicides has dropped back to the pre-2010 figure; as of the end of November 2011, there have been only nine suicides in the state prisons. **Table 6 – Summary of DOCCS Suicides 2000 - 2011** lists annual suicides from 2000 through 2011, and provides the annual suicide rate per 100,000 inmates. We also analyzed the trend in suicides in the state prisons for the period 2000 to date and present that data in **Appendix F – DOCCS Suicides During 2000 to 2011 by 2007-2011 Rate**.

Table 6 – Summary of DOCCS Suicides 2000 – 2011

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Population	71,172	69,157	67,117	66,050	64,659	63,357	63,318	62599	61,724	59,471	57,182	55,600
Suicides	16	7	12	14	8	18	8	18	10	10	20	9
Rate*	22.5	10.1	17.9	21.2	12.4	28.4	12.6	28.3	16.2	16.8	35.0	16.2

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

The information contained in **Table 6** and **Appendix F** reveals a disturbing trend of increasing suicides in the system at a time when mental health services have been increasing. The suicide rate in 2010 was the highest rate not only for this decade, but also for the past 28 years, according to research by Mary Beth Pfeiffer, an independent reporter who has been investigating suicides in DOCCS for several years.[11] Moreover, in the past six years, DOCCS has experienced its three highest suicide rates over the same 28-year period. For the 12 years summarized in **Table 6** the

[11] 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).

average annual suicide rate is 19.7 incidents per 100,000 prisoners. The most recent national data for 2001-2004 demonstrates that New York is 30% higher than the national average of 15 suicides per 100,000 prisoners.[12] In 2010, New York was more than double the national average. The only justifiable conclusion is that the state prison system has a problem that requires greater attention.

Equally disturbing is the location where many of these suicides have occurred. As has been reported by the CA in its reports about disciplinary confinement and mental health care in 2000-2004 and the recent analysis of Ms. Pfeiffer, far too many of the individuals committing suicide are confined in the SHU or keeplock, and many of them also suffer from mental illness. Between 1998 and April 2004, 34% of prison suicides occurred in disciplinary confinement, although prisoners in these units comprised less than 7% of the total prison population.[13] That rate only declined a little, to 29%, for the period 1998 to 2009, according to the research from Ms. Pfeiffer. In 2010, the percentage of suicides in disciplinary confinement dropped to 10%, but there is still a concern that some of the individuals who killed themselves had recently been recently transferred from disciplinary housing.

The data also reveals a concentration of suicides at certain prisons at rates that far exceed the department-wide figures and extend throughout the decade. The most problematic prisons for suicides are Elmira, Downstate, Great Meadow, Wende, Bedford Hills, Southport, Clinton and Attica. Besides being maximum security facilities with significant populations of prisoners with mental illness, these facilities also have larger SHU populations, and some also house reception areas where newly admitted prisoners are processed. The suicide rates at these institutions are three to seven times higher than the system-wide average. However, other facilities, that have maximum-security individual, many patients with mental illness and large numbers of individuals in disciplinary confinement, have much lower rates of suicide. Examples of such facilities include Green Haven, Sing Sing and even the disciplinary prison Upstate. We believe it is crucial that a systemic analysis be performed of the history of suicides in the Department during at least the last decade to ascertain a reason why there is such variability in rates among the prisons.

Suicides should not be viewed in isolation. We believe the incidents of self harm and suicide attempts can reveal patterns of destructive behavior that could help DOCCS and OMH official identify mechanisms to reduce self abuse and suicide. **Appendix G – Self Harm and Suicide Attempt UIRs for 2007-2010** details the Unusual Incident Reports for each prison for the 2007-2010 time period concerning incidents of self harm and suicide attempts, ranked by the highest rates for suicide attempts. This data reveals a pattern of personal abuse at many of the same facilities at which suicides frequently occur. In particular, Bedford Hills, Elmira, Downstate, Great Meadow and Southport have high rates for acts of self abuse and also exhibit high suicide rates. As with the suicide data, the rates of self harm and suicide attempts at the most problematic facilities are five to 10 times higher than the department-wide average. We believe it is essential that practices at these prisons be reviewed to determine what action can be taken to reduce self harm incidents.

DOCCS and OMH Policies Concerning Suicide Prevention

In preparation for this hearing, we reviewed OMH and DOCCS policies on suicide prevention and concluded that, for the most part, they seem to be consistent with national standards. It is our

[12] BJS,US DOJ, *Medical Causes of Death in State Prisons*, at Appendix Table 1, p. 5 (2007).
[13] Correction Association, *Mental Health in the House of Corrections* at 57 (2004).

understanding that as part of the DAI litigation, OMH and DOCCS consulted with Lindsay Hayes, a nationally recognized expert on suicides in correctional settings. As a result of those consultations, policies were modified to comply with the standards developed by Mr. Hayes. These standards include Staff Training, Identification and Evaluation, Communication, Housing, Levels of Observation, Reporting, and Follow-up/Mortality and Morbidity Review. We could not identify any significant inconsistencies between state policies and Mr. Hayes's recommended standards, although we have no information about what specific suggestions he may have made to DOCCS and OMH, and whether they were implemented.

The issue, we believe, is not a failure to promulgate policies, but rather whether there is adequate training on those policies and, more importantly, whether they are effectively implemented. We are also concerned as to whether an adequate system exists to measure compliance with those policies.

An essential element of suicide prevention is appropriate communication. This involves communication between security, medical and mental health staff, communication between staff at different facilities when an individual is transferred, and, most importantly, communication between staff and the person who may be contemplating self harm. Research consistently shows that approximately two-thirds of all suicide victims communicate their intent at some point prior to their death. Research also indicates that any individual with a history of one or more suicide attempts is at a much greater risk for suicide. Thus, for this prevention to be effective, someone must be in a position to hear the person's concerns, and then they must appropriately act upon that information. Some of the mortality reviews we have seen suggest that a lack of communication and other failures by staff to follow policies arose in some of the suicides that have recently occurred.

The CA recently received a limited number of mortality reviews of incidents of suicide in 2009 and 2010 prepared by CQC and SCOC. Although we will be receiving substantially more documentation in the near future, a few observations can be made from the preliminary sample of mortality reviews. While the agencies did not find identifiable problems in every review, there were many examples of deficiencies in the monitoring and care of these patients prior to their deaths. Issues we identified from these reviews included:

- Inadequate follow-up by DOCCS with OMH when a prisoner at assessment indicates a history of mental illness.
- Inadequate assessment of suicide risk by DOCCS or OMH when a prisoner is placed in the SHU or keeplock.
- Inadequate communication between DOCCS and OMH staff regarding the treatment needs of patients with mental illness.
- Inadequate mental health care provided to individuals who subsequently committed suicide.
- Inattention to prisoners who are withdrawn or noncommunicative with staff or who are not medically compliant.
- Inadequate communication among the agencies concerning prisoners who are fearful of transfer or who exhibit inappropriate behavior prior to transfer.
- Inadequate documentation of patients' symptoms and their interactions with treatment staff.

Once a suicide occurs, it is essential that the staff respond appropriately in order to understand what can be done to avoid a similar tragedy in the future and to deal with the impact of a suicide on all those who were associated in any way with the victim, including staff and prisoners. Suicide is extremely stressful for both staff and other prisoners, and the facility must intervene to deal with

those emotions. Staff may feel ostracized by other employees or the prison administration and may have potentially misguided guilt about the event. Prisoners can be traumatized by the event, and "such trauma may lead to suicide contagion," according to Lindsay Hayes.[14] Certainly the four suicides within six weeks at Great Meadow in the summer of 2010 would appear to fall into that category.

Mr. Hayes recommends that when staff and prisoners are affected by such a traumatic event, they should be offered immediate assistance in the form of a Critical Incident Stress Debriefing (CISD). This CISD team should include professionals trained in crisis intervention and traumatic stress awareness. The team should provide staff and prisoners "an opportunity to process their feelings about the incident, develop an understanding of the critical stress symptoms, and seek ways of dealing with those symptoms. For maximum effectiveness, the CISD process or other appropriate support services should occur within 24 to 72 hours of the incident."[15]

Our observations at Great Meadow suggest that this type of intervention did not occur at that prison, even after four suicides. Although the prison asserted that a CISD team was available, we were told that no staff sought their assistance. Concerning the prison population, we were told that the senior administration toured the units where the suicides occurred and a message about suicide prevention was broadcasted on the prison television system. But no group or coordinated individual counseling occurred, even for the prisoners on the units where the suicides took place. The prison administration told us that they suggested to correction counselors and teachers that they address the issue in their classes. However, during our visit, we found that this instruction apparently was not effectively communicated to the staff, and in fact the discussions did not occur. Certainly there was no meaningful effort made by the prison to have the prisoner population process their feelings and develop an understanding of the events. In fact, when we visited the prison four months after the series of suicides there was an abundance of rumors regarding the recent deaths. Many of the prisoners questioned whether some of the incidents were even a suicide; some suspected that one or more of the victims had been killed by security staff.

As mentioned earlier in my testimony, the CA also has grave concerns about the mechanism available to individuals experiencing a crisis. When a prisoner expresses thoughts of self harm or believes he/she is experiencing a mental health crisis, he/she is told to raise this issue with staff. Staff is instructed to immediately communicate this information to higher officials, and if the person is in an OMH Level 1 prison, he/she will be taken to the Residential Crisis Treatment Program (RCTP). Unfortunately, in many prisons, transfer to an RCTP is not a pleasant experience. At facilities such as Great Meadow, there are serious concerns as to whether prisoners are physically abused when they seek this assistance. We heard multiple reports of assaults by staff when a prisoner requested crisis intervention. Second, the conditions in the RCTP can be harsh and isolating. Residents in the RCTP have almost nothing to do while in this setting and experience great difficulty communicating with anyone. Although OMH staff are required to speak with the residents at least once a day, for the remainder of the time they are in barren cells and held essentially incommunicado. Such isolation can be devastating for someone experiencing a mental health crisis. Finally, there have been many reports by prisoners of staff harshly treating prisoners while they are in RCTP cells. The Commission on Quality of Care and Advocacy for Persons with

[14] Hayes, L., *Guide to Developing and Revising Suicide Prevention Protocols with Jails and Prisons*, National Center on Institutions and Alternatives (2011).
[15] Ibid.

Disabilities (CQC) reviewed conditions in many of the RCTP units across the Department.[16] Although CQC found that RCTP patients were treated well by OMH and DOCCS staff, it noted that "many inmates view the RCTP as punishment."[17] It identified some disturbing practices apparently employed at some RCTP units of uncomfortably cold temperatures or turning fans on residents as a form of punishment. When they asked prisoners to rate the quality of the mental health care they received on the unit, "the majority of inmates rated the overall quality of mental health care as poor or very poor."[18] For many prisoners, the RCTP is an undesirable choice from which to seek help when they are in the greatest need for care.

The final recommendation for an appropriate response to a suicide is a mortality-morbidity review. Ideally, this should include a psychological autopsy and should be coordinated by an outside agency to ensure impartiality. In New York, multiple agencies have some role in reviewing a prison suicide. In all cases, DOCCS and the State Commission of Correction (SCOC) review each death. It is our understanding that OMH performs a review of anyone who committed suicide who was on the OMH caseload and may review additional cases upon request. CQC has a more limited role and only assesses the mental health care that was provided to an individual who was on the OMH caseload and committed suicide; CQC may review additional cases if requested by other state agencies.

As you may already be aware, the generation of mortality reviews is a cumbersome and length process that it does not produce timely results or consistent and clear guidance to the DOCCS and OMH. DOCCS reviews the cause of death and is required to prepare an Unusual Incident Report about any death. Usually these are done soon after the event. OMH reviews suicides of prisoners who are on the OMH caseload through its risk management office in CNYPC. Great Meadow OMH officials informed us that the risk management office conducts an independent review of these deaths and issues a comprehensive report, which is reviewed by the Incident Review Committee. As part of this report, there may be a psychosocial autopsy and/or a root cause analysis, but these additional activities are not performed in each case. The results of the risk management review are shared with OMH and DOCCS staff, as well as SCOC. Since the SHU Exclusion Law requires CQC to review mental health care, OMH's mortality reviews are also provided to CQC staff. OMH mortality reviews are not made available to the public, and, therefore, we cannot comment on how comprehensive the reports are or what impact they have on facility operations. In some of the CQC reviews, however, there are notations about the OMH reviews indicating that they sometimes identify deficiencies and mandate corrective action. We were told that OMH reviews are usually completed in 30 to 90 days after the death.

CQC has its mortality review board and is charged with investigating all deaths in state prisons and jails. SCOC has limited staff and resources, and its review is a comprehensive analysis of the deaths, including review of medical and mental health care and the activities of DOCCS staff and the prisoner population. The SCOC death reviews are frequently not publicly available for a year or more after the event, and although eventually available to the public, most of the content is redacted, including nearly all factual elements of the investigation that entail an analysis of the patient's medical or mental health care. Generally, recommendations are left un-redacted, as well as any responses by the agencies. We have received only a few SCOC suicide reviews, but these

[16] CQC, *Review of Residential Crisis Treatment Programs (RCTPs)* (2010).
[17] Id. at 11.
[18] Id.

indicate that the agency is making a substantial effort to evaluate all the contributing factors to the suicide and provide recommendations to reduce incidents of prisoner self harm.

CQC is a new player in this process, and it reviews deaths of prisoners who have been identified by OMH as on the mental health caseload, and may also review additional individuals identified by state officials or the public. CQC's review is more limited, focusing on the mental health care provided to the individual in the months prior to his/her suicide. We have recently received reviews for 13 deaths, and our initial assessment is that CQC is performing a thorough evaluation of the mental health care provided. This includes reviews of the relevant portions of the mental health records, visits to the prison to speak with staff and any individuals who may have interacted with the individual prior to his/her death. CQC's recommendations are directed at correcting policies and practices that could improve DOCCS and OMH response to individuals requiring mental health care and services. OMH and DOCCS' response to CQC's recommendations sometimes reveal some tension between the agencies concerning what remediation is required to address the concerns raised by CQC. However, it is clear that CQC is identifying legitimate concerns about patient care and is focusing on methods to avoid future deficiencies.

We believe the current process requires better coordination and improvement. Both CQC and SCOC need additional resources to perform these reviews in a timely manner. There also needs to be better communication between the agencies being reviewed, DOCCS and OMH, and the reviewing authorities, CQC and SCOC. We believe mortality reviews could be conducted more efficiently if there was a series of joint meeting of all four agencies to discuss pending cases and share of pertinent information about each case. The findings and recommendations of both CQC and SCOC should remain independent and separate, but coordination of the investigation and the production of findings would result in the development of a corrective plan that addresses all the items needing remediation. Given the involvement of multiple agencies, we believe direct involvement of the Governor's office will be needed to ensure appropriate coordination and cooperation between all parties.

CONCLUSION

Provision of mental health services in prison is a complex issue with many barriers and obstacles to providing effective care. Both DOCCS and OMH have made progress in expanding and improving such care, but more needs to be done. The issues raised in my testimony support the notion that the SHU Exclusion Law is important legislation that is improving the care for patients, and making prisons more safe and easy to manage. Nevertheless we have not achieved a level of care that meets all patients' needs. In order to do that, the following initiatives are needed. First, greater oversight of mental health care and it's interaction with security staff is required by CQC and SCOC, and these agencies must be provided with sufficient resources to perform this oversight. Moreover, additional resources may be required by OMH and DOCCS to meet the needs of their patients. Second, a systemic evaluation of the trends in patient census, hospitalization, and assignment to mental health programs must be performed in order to determine whether prisoners in need of treatment are adequately being assessed and provided care. Third, a thorough investigation should be initiated to assess the system-wide occurrence of prisoner self harm and suicide, to determine how these acts can be prevented and the prison population better protected.

APPENDICES TO TESTIMONY BY

JACK BECK

CORRECTIONAL ASSOCIATION OF NEW YORK

DECEMBER 6, 2011

APPENDIX A - CNYPC PATIENT DEMOGRAPHICS and PROFILE 2007-11

YEAR 1/1	DOCS Pop.	OMH Outpatient - DOCCS Facilities						OMH Inpatient - CNYPC Inpatient						
		Census	% of Pop	Gender	Ethnicity	Primary Diagnosis Group	Selected 1st or 2nd Diagnosis	Census	Gender	Ethnicity	Primary Diagnosis	Selected 1st or 2nd Diagnosis	Admit **	Disch. **
2007	63,304	8,180	12.92%	85.4%-M 14.6%-F	43.2%-AA 33.3%-W 21.0%-H	24.8%-Mood Dis 23%-Minor Mood 21.4%-Schiz/Psych 9.8%-Anxiety Dis 7.2%-Person. Dis 6.6%-Adjust. Dis	31.0%-Subst. Abuse 29.6%-Person. Disorder	179	91.6%-M 8.4%-F	50.8%-AA 26.3%-W 20.1%-H	60.3%-Schiz/Psych 20.1%-Mood Dis 7.8%-Person. Dis 4.5%-Adjust. Dis 1.7%-Minor Mood	52.6%-Person. Disorder 12.3%-Subst. Abuse	751	728
2008	62,599	8,567	13.69%	86.3%-M 13.7%-F	43.1%-AA 31.6%-W 21.7%-H	25.0%-Mood Dis 22.8%-Minor Mood 19.3%-Schiz/Psych 9.3%-Anxiety Dis 8.3%-Person. Dis 8.5%-Adjust. Dis	31.0%-Subst Abuse 29.6%-Person. Disorder	171	90.6%-M 9.4%-F	53.8%-AA 25.1%-W 18.1%-H	61.4%-Schiz/Psych 18.7%-Mood Dis 7.6%-Person. Dis 2.3%-Adjust. Dis 3.5%-Minor Mood	52.6%-Person. Disorder 12.3%-Subst. Abuse	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%-Mood Dis 19.7%-Minor Mood 18.4%-Schiz/Psych 10.3%-Anxiety Dis 9.2%-Person. Dis 12.1%-Adjust. Dis		164	90.4%-M 9.6%-F	52.7%-AA 29.3%-W 17.4%-H	55.7%-Schiz/Psych 21.0%-Mood Dis 10.2%-Person. Dis 1.8%-Adjust. Dis 3.0%-Minor Mood		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%-Mood Dis 20.1%-Minor Mood 19.2%-Schiz/Psych 11.2%-Anxiety Dis 8.9%-Person. Dis 10.8%-Adjust. Dis		173	93.1%-M 6.9%-F	45.7%-AA 33.5%-W 19.1%-H	54.3%-Schiz/Psych 16.2%-Mood Dis 9.2%-Person. Dis 3.5%-Adjust. Dis 4.0%-Minor Mood		583	570
2011	56,315	7,958	14.13%	89.3%-M 10.7%-F	41.9%-AA 33.9%-W 21.1%-H	23.0%-Mood Dis 21.1%-Minor Mood 17.8%-Schiz/Psych 10.5%-Anxiety Dis 10.1%-Person. Dis 11.6%-Adjust. Dis		137	93.4%-M 6.6%-F	46.0%-AA 33.4%-W 18.2%-H	56.9%-Schiz/Psych 17.5%-Mood Dis 12.4%-Person. Dis 4.4%-Adjust. Dis 2.9%-Minor Mood 2.9% Substan Dis		425	471

** Admissions and Discharge data for CNYPC reflect the annual total for the calendar year prior to the January 1st census data.

OMH outpatient census reached a maximum in August 2008 of 9,067 inmates (15.26% of population). The caseload dropped to 13.42% as of January 1, 2010, representing a 12% drop in the percentage of the population on the OMH caseload in 16 months, while the DOCS population dropped only 5.5%. January 1, 2011 represented a 1.6% increase in facility-based caseload, but a 20.8% decrease in inpatient census, including 27.1% reduction in CNYPC admissions. CNYPC admissions dropped 19.6% from calendar year (CY) 2008 to CY 2009, and a 41.4% reduction from 2008 to 2010. During this period the DOCCS population decreased by only 6.3%.

APPENDIX B - SUMMARY OF RCTP ANNUAL REPORTS for YEARS 2007-10

No.	INDICATOR	CY 2007	CY 2008	CY 2009	CY 2010
	Treated in RCTP	5,302 (4,059 observation cell; 1,243 dorm bed)	5,861 (4,440 observation cell; 1,421 dorm bed)	6,415 (4,976 observation cell; 1,439 dorm bed)	7,515 (6,069 observation cells; 1,446 dorm bed)
1	Admissions	5226	5802	6415	7,515
2	Length of Stay	3 days (obs cell and dorm bed)	3 days (obs cell and dorm bed)	3 days (obs cell and dorm bed)	3 days (obs cell and dorm bed)
3	Admitted From	SHU-16.2%; CNYPC-4.9%; BHU/TBU-2.7%; ICP 7.5%; GP 29.3%; Other facility-17.7%; Reception-6.3%; Obso cell-7.9%; Dorm bed-1.5%; SNU-0.4%; Infirmary-3.7%; Other-1.9%	SHU-15.0%; CNYPC-4.8%; BHU/TBU-2.1%; ICP 8.4%; GP-27.2%; Other facility-17.4%; Reception-6.2%; Obso cell-9.2%; Dorm bed-2.2%; Parole/Street-0.02%; SNU-0.4%; Infirmary-2.6%; Other-3.6%; Willard DTC-0.65%; Missing -0.1%	SHU-17.8%; CNYPC-3.5%; BHU/TBU-2.4%; ICP 9.2%; GP-25.4%; Other facility-15.2%; Reception-6.0%; Obso cell-7.8%; Dorm bed-1.6%; Parole/Street-0.1%; SNU-0.5%; Infirmary-3.1%; Other-2.9%; Willard DTC-0.9%; TrICP-1.5%; GTP-0.3%; STP-1.4%; IICP-0.3%; RMHU-0.02%	SHU-16.4%; CNYPC-3.1%; BHU/TBU-2.4%; ICP 9.7%; GP-21.7%; Other facility-15.4%; Reception-6.1%; Obso cell-7.0%; Dorm bed-1.5%; Parole/Street-0.0%; SNU-1.0%; Infirmary-4.2%; Other-3.0%; Willard DTC-1.1%; TrICP-1.7%; GTP-0.2%; STP-2.0%; IICP-0.7%; RMHU-2.8%
4	Discharges	5263	5790	6342	7,515
5	Discharged To	SHU-17.1%; CNYPC-8.5%; GP 29.2%; ICP-8.6%; BHU/TBU 2.8%; Released from Prison-0.2%; Other facility 15.1%; Reception-5.1%; Obso cell-1.3%; Dorm bed-7.4%; SNU-0.5%; Infirmary-1.9%; Other-2.3%	SHU-15.1%; ICP- 8.8%; CNYPC-7.4%; GP-25.8%; Other facility-16.6%; Reception-3.5%; Obso cell-2.1%; Dorm bed-8.8%; Released from prison-0.2%; SNU-0.5%; Infirmary-1.3%; BHU/TBU 2.2%; Other-4.7%; Willard DTC-0.6%; Missing-2.3%	SHU-18.8%; ICP- 10.3%; CNYPC-6.1%; GP-24.2%; Other facility-15.3%; Reception-3.0%; Obso cell-1.7%; Dorm bed-7.1%; Released from prison-0.2%; SNU-0.6%; Infirmary-1.7%; BHU/TBU-2.4%; Other-4.3%; Willard DTC-0.7%; TrICP-1.7%; GTP-0.3%; STP-1.3%; IICP-0.3%; RMHU-0.02%	SHU-17.4%; ICP- 11.0%; CNYPC-4.2%; GP-21.5%; Other facility-15.8%; Reception-3.5%; Obso cell-1.7%; Dorm bed-6.8%; Released from prison-0.1%; SNU-0.9%; Infirmary-1.9%; BHU/TBU-2.6%; Other-4.3%; Willard DTC-0.9%; TrICP-1.7%; GTP-0.2%; STP-2.3%; IICP-0.7%; RMHU-2.5%
	Trans OBS to dorm	351	482	425	451
6	OMH Level Prior to Admittance	L1-44.4%; L2-20.6%; L3-24.1%; L4-7%; L6-3.5%; L7-0.4%; SMI-37.2%	L1-46.3%; L2-19.9%;L3-20.3%; L4-8.7%; L6-3.8%; L7-0.6%; Miss MHL-0.3%	L1-45.7%; L2-20.3%; L3-19.0%; L4-9.1%; L6-5.8%; L7-0.1%	L1-44.4%; L2-20.5%; L3-17.5%; L4-8.6%; L6-9.0%
7	% SMI - "S" Desig.	SMI-37.2% est. b/c SMI def changed by PSA during 2007	SMI-50.9%; Non-SMI 49.1%	SMI-42.4%; Non-SMI 57.6%	SMI-42.8%; Non-SMI 57.2%
8	% on Meds at Intake	No data presented	No data presented	No data presented	No data presented
9	Comply Meds at Intk	No data presented	No data presented	No data presented	No data presented
10	Daily Out-of-Cell Prog. for Patients Housed in Observation Cells	87.7%- offered; 97.1%-participating; Bedford Hills (43.5%), Elmira (42.9%), and Sing Sing (50%) offered out-of-cell treatment sessions much less frequently	94%-offered; 95.7%-participating; Bedford Hills (86.2%), Elmira (70.3%), and Sing Sing (70.2%) improved but still lagged behind other facilities	97.5%-offered; 96.5%-participating; all were above 90% except Bedford Hills (89.5%)	99.2%-offered; 97.3%-participating; all were above 95% except Marcy RMHU (84.5%) and Great Meadow (91.6%)

APPENDIX B - SUMMARY OF RCTP ANNUAL REPORTS for YEARS 2007-10

No.	INDICATOR	CY 2007	CY 2008	CY 2009	CY 2010
11	Pts RCTP discharged participating in prog	No data presented	No data presented	No data presented	No data presented
12	Discharged from RCTP medication	No data presented	No data presented	No data presented	No data presented
13	% w/ Tier 2 or 3 Tkts	No data presented	No data presented	No data presented	No data presented
14	# on KL in RCTP	No data presented	No data presented	No data presented	No data presented
15	% Inm-pts w/ SHU/ KL time cut, ave. cut, time remaining	No data presented	No data presented	No data presented	No data presented
16	Discipline History (Non-PSA required	No data presented	No data presented	No data presented	No data presented
17	Mental Health Treatment prior to	No data presented	No data presented	No data presented	No data presented
18	Axis I Diag at Intake	No data presented	No data presented	No data presented	No data presented
19	Axis II Diag at Intake	No data presented	No data presented	No data presented	No data presented
20	Informational Rpts	No data presented	No data presented	No data presented	No data presented
21	# Admitted to CNYPC	443	433	393	314
22	% admitted to CNYPC from RCTP with original housing area	SHU-26.6%; ICP-10.6%; CNYPC-2.0%; GP-30.2%; Other facility-10.2%; Reception-3.6%; Obs cell-4.1%; Dorm bed-2.5%; SNU-0.5%; Infirmary-5.4%; Other-2.5%; BHU/TBU-1.8%	SHU-22.9%; SNU-0.2%; Infirmary-4.2%; Other-4.6%; BHU/TBU-1.6%; ICP-15.5%; CNYPC-0.5%; GP-29.1%; Other facility-10.9%; Reception-3.2%; Obs cell-3.2%; Dorm bed-4.2%	16.3%-SHU; 0.8%-SNU; 6.1%-Infirmary; 5.1%-Other; 2.8%-BHU/TBU;0.3%-WDTC; TrICP-2.3%; GTP-0.5%; STP-4.3%; IICP-1.0%; ICP-15.8%; CNYPC-1.0%; GP-21.6%; Other Facility-12.2%; Reception-2.3%; Obs cell-3.3%; Dorm bed-4.3%	16.%-originated in ICP; 15.3%-originated in GP; 13.4%-SHU; 1.9%-SNU; 11.1%-Infirmary; 4.8%-Other; 2.2%-BHU/TBU; 2.9%-TrICP; 0.3%-GTP; 5.1%-STP; 2.5%-IICP; 4.8%-RMHU; 0.3%-CNYPC; 6.1%-Other facility; 1.6%-Reception; 3.5%-Obs cell; 7.6%-dorm bed.

Notes: There was a 10.6% increase in RCTP admissions from 2008 to 2009.There was also a 17.1% increase in RCTP admission from 2009 to 2010. There was a significant increase in admissionn from the RMHU in 2010. Inmates were discharged to the RMHU at a higher percentage in 2010 compared to 2009. The percent of individuals admitted to RCTP that resulted in a transfer to CNYPC has decreased for those coming from SHU each year since 2007. As had the percent orinigated in GP transfered to RCPT and then CNYPC.

APPENDIX C - SUMMARY OF BHU ANNUAL REPORTS for CALENDAR YEAR 2009-10

No.	INDICATOR	CY 2009	CY 2010
1	Admissions	53	98
2	Length of Stay	346	245
3	Admitted From	SHU-64.2%; STP-20.8%; CNYPC-7.5%; SHU GTP-7.5%	SHU-48%; CNYPC-6.1%; STP-27.6%; ICP-7.1%; SHU GTP 3.1%; Gen Pop-4.1%; LTKL, RMHU & TriICP-1.0%
4	Discharges	67	67
5	Discharged To	ICP-19.4%; SHU GTP-16.4%; TrICP-7.5%; STP 7.5%; RMHU-4.5%; CNYPC-7.5%; GP-13.4%; Rleased from incarceration-10.4%; KL-3.0%; LTKL-1.5%; SHU-9%	ICP-27%; SHU GTP-11.9%; TriICP-9.0%; RMHU-22.4%; CORP-3.0%; CNYPC-3.0%; Gen Pop-10%; Release from incarceration-9.0%; SHU-1.5%
6	OMH Level Prior to Admit	L1S-64.2%; L2S-35.8%	L1S-61.2%; L2s-38.8%
7	% SMI - "S" Desig.	SMI-100%	SMI-100%
8	% Not on Meds at Intake	38%	24%
9	Compliance w/ Meds at Intake	No medication needed-22.6%; refused 15.1%; Little compliant-3.8%; Somewhat-5.7%; Moderately-30.2%; Fully-22.6%	No meds needed-12.2%; Refused meds-14.3%; Little complaint-3.1%; Somewhat-7.1%; Moderately-20.4%; Fully-41.8%; Court ordered-1.0%
10	% SMI patients offered two hours of out-of-cell program	GM BHU- 95.7%. SCF BHU-92.4%	GM BHU-100%; SCF BHU-92%.
11	% SMI patients participating in two hours of programming	GM BHU-81.2%. SCF BHU- 89.4%	GM BHU-78.6%; SCF BHU-86.1%
12	% SMI patients refusing two hours of programming	GM BHU- 12.9%; SCF BHU- 3.1%	GM BHU-20.6%; SCF BHU-5.7%
13	Of BHU "S" pt discharges, # receiving Tier 2 or 3 Tickets	Of 67 discharges, 54 were "S" inmates, of whom 33 (61%) rec'd Tier III. Tier-2 or 3 tickets: 30%-0; 12%-1; 9%-2; 13%-3; 6%-4; 6%-5; 6%-6; 9%-7-9; 6%-10-15; and 3%-over 20.	Of 67 discharges, 63 were "S" inmates, of whom 45 (71.4%) rec'd Tier III. Tier-2 or 3 tickets: 8.2%-0, 13.3%-1, 9.2%-2, 16.3%-3, 7.1%-4, 10.2%-5, 8.2%-6, 7.1%-7, 8.2%-8, 2.0%-9, 7.1%-12-16, 3.1%-20-25.
14	# with KL status in STP	0	0
15a	# Inm w/ SHU/KL time cut, average cut, time remaining	36 (66.6%)received a cut in SHU time. Average time cut 90 days. 1-inmate received 10 days of KL	Of the 63 "S" inmates, 27 (42.9%) rec'd cut in SHU. Average time cut -78 days.
15b	SHU and KL remaining time at discharge	N/A	Started in April 2010, data available for 39 of 63 "S" inmates. 13 of these 39 (33.3%) had SHU time left. Average time-427 days. 10 of these 39 (25.6%) had KL time left. Average time-463 days.
16	Informational Reports	51% received one or more positive infrmational report. 84% received a negative informational report	54% rec'd one or more positive information reports. 70.1% rec'd a negative information report.

APPENDIX C - SUMMARY OF BHU ANNUAL REPORTS for CALENDAR YEAR 2009-10

No.	INDICATOR	CY 2009	CY 2010
17	Discipline History	12 months prior to BHU 96% received a Tier 2 or 3 ticket. 89% served SHU time.	12 months prior to BHU 93.9% rec'd a Teir 2 or 3 ticket. 97% served SHU time.
18	Total # serious disciplinary infractions prior to BHU	Tier 2 or 3 Tickets ranged from 0 (3.8%)-20(5.7%), median 4 tickets (17%)	Teir 2 or 3 tickets ranged from 0 (8.2%) to over 20 (3.1%), median 2 tickets.
19	Axis I Diagnosis at intake	21%-psychotic disorder; 17%-major mood disorder; 8%-mood disorder; 6%-adjustment disorder, 22%-substance abuse related disorder; 8%-impulse control disorder; 9%-another Axis I; 9%- Axis II disorder.	28.6%-psychotic disorder; 27.6%-major mood disorder; 5.1%-mood disorder; 4.1%-adjustment disorder; 5.1%-anxiety disorder; 6.1%-substance-related disorder; 9.2%-impulse control disorder; 8.2%-another Axis I diagnosis; 6.1%-no Axis II disorder.
20	Axis II diagnosis at intake	74%-antisocial personality disorder; 8%-borderline personality disorder; 8%- personality disorder (NOS)	68.4%-antisocial personality disorder; 7.1%-borderline personality disorder; 3.1%-personality disorder (NOS); 1%-paranoid personality disorder, schizotypal personality disorder, mental retardation, respectively.

Notes:

CY 2009: Most inmates are admitted from the SHU (64%) and discharged to the ICP/TrICP (27%) or a SHU STP/GTP (24%). In addition, 13% are released to GP. Most patients were not fully compliant with medications at intake. There is a larger % of pts refusing treatment at GM (13%) than at Sullivan (3%). Majority of BHU patients receive tickets in BHU: 61% had tier III and 70% had tier II or III. 30% of patients had 5 or more tickets.

CY 2010: BHU almost doubled in admissions mostly from SHU (48%) and discharged to ICP (27%) and RMHU (22.4%). In addition, 10% are released to GP. The percentage of patients being compliant with meds almost double from 2009 (41% from 22%). There was an increase in refusal of 2 hour programming at GM BHU (12% to 20%). There was an increase in "S" inmates recieving Teir 3 tickets (61% to 71%). New data on SHU (average 427 days) and KL (average 463 days) time remaining after discharged from BHU this year.

APPENDIX D - SUMMARY OF STP ANNUAL REPORTS for CALENDAR YEARS 2008-10

No.	INDICATOR	CY 2008	CY 2009	CY 2010
1	Admissions	135	206	229
2	Length of Stay	137	123	74
3	Admitted From	SHU-63.7%; CNYPC - 13.3%; BHU-9.6%; STP 5.2%; ICP 4.4%; GP 3.0%; Other 0.7%	SHU-75.2%; CNYPC-18.9%; BHU-0.5%; STP-0.5%; ICP 4.9%;1%-STP and BHU	SHU-72.9%; CNYPC-10%; GP-9.6%; RMHU-2.6%; STP-1.7%; TrICP-1.3%; ICP+Other-1.8%
4	Discharges	97=100%	223=100%	235=100%
5	Discharged To	CNYPC-20.6%; ICP-17.5%; GP-16.5%; TrICP-9.3%; JCMC/ICP-6.2%; STP-6.2%; BHU-5.2%; IICP 4.1%; Released from Prison-4.1%; SHU- 4.1%; SHU GTP 3.1%; CORP-1%; Protective Custody-1.0%; LTKL-1.0%	CNYPC-14.3%; ICP- 15.2%; GP-19.3%; TrICP-12.1%; JCMC/ICP-8.5%; STP-3.1%; BHU-4.5%; IICP-2.7%; Released from prison-3.1%; SHU-4.0%; SHU GTP-3.6%; CORP-1.3%; RMHU 6.3%; LTKL-0.4%; Other-1.3%	CNYPC-8.5%; ICP-31.5%; GP-12.8%; TrICP-9%; STP-3.4%; RMHU-14.5%; BHU-11.1%; IICP-0.4%; SHU GTP-1.7%; Released frm prison-3.4%; CORP-0.9%; SNU-0.9%; Other-1.7%
6	OMH Level Prior to Admittance	L1-3.7%; L1S-74.0%; L2-0.7%; L2S-19.3%; L3S-2.2%	L1S-71.8%; L2-0.5%; L2S-27.2%; L3S-0.5%	L1-4.4%; L1S-63.8%; L2-1.7%; L2S-30.1%
7	% SMI - "S" Desig.	SMI-95.6%; Non-SMI-4.4%	SMI-99.5%; Non-SMI 0.5%	SMI-93.9%; Non-SMI-6.1%
8	% on Meds at Intake	186-taking medication; 36-no medication	305-taking medication, 51- no medication	323-taking medication; 58-no medication
9	Compliance w/ Meds at Intake	No-Meds-3.1%; Rufuses-29.7%; Somewhat-2.3%; Moderately-12.5%; Fully-51.6%; Ct Ord-0.8%	No-Med-2.9%; Refused-27.2%; Little-1.0%; Somewhat-1.9%; Moderately-3.9%; Fully-61.7%; Ct-Ord-1.5%	No-Medication-10.5%; Refused-15.7%; Little-2.6%; Somewhat-1.7%; Moderately- 9.2%; Fully-55.9%; Ct-Ord-4.4%
10	Daily Out-of-Cell Prog. for S-designated patients	AT- 91.4%- offered; 58.3%-participating; 32.1%-refused. FP- 95.6%-offered; 60.5%-participating; 14.9%-refused. GH-95.1%-offered; 76.6%-particpating; 20.2%-refused.	AT-93.8%-offered; 66.2%-participating; 24.2%-refused. FP- 100%-offered; 68.2%-particpating; 31.8%-refused. GH-98.0%-offered; 80.9%-participating; 11.9%-refused.	AT-100%-offered; 71.4%-participating; 28.6%-refuse. FP-100%-offered; 68.7%-participating; 31.9% refuse.
11	Patients discharged from STP participating in progamming		10.8%-refused; No-MH needed-1.8%; Little compliant-4.5%; Somewhat-9.4%; Moderately-9.4%; Fully-64.1%	10.2%-refuse; No-MH needed-0.4%; Little- 7.2%; Somewhat-6.8%; Moderately-12.3%; Fully-63%
12	Discharged from STP medication compliance		No meds needed- 2.7%; Refused-23.5%; Little-4.1%; Somewhat-5.0%; Moderately-6.8%; Fully-57.9%	No meds needed-5,1%; Refused-17.9%; Little-0.4%; Somewhat-5.1%; Moderately-14.1%; Fully-56%; Crt-Ord-1.3%
13	% w/ Tier 2 or 3	26%	27%	98.1% received Tier II or III during STP program
14	# on KL status in STP	0	0	0
15	% Inmates-patients with a SHU or KL time cut, average amount cut, time remaining	49%-received a SHU cut, average amount of time cut was 94 days. 4%- received keeplock (KL) time cut and average amount of KL time cut was 42 days.	50.2% received SHU cut, ave. time cut was 87 days; 17-inmates had a remaining SHU sentence, ave. days remaining was 71. 35.1% received keeplock (KL) cut, ave. time cut 165 days; 63 had remaining KL time when discharged ave. KL day remaining was 183.	45.5% received SHU time cut; ave. time cut-72 days. 5.4% received keeplock (KL) time cut; ave. KL time cut- 3 days; 105 had SHU time remaining at discharge; ave. amount of SHU remaining- 303 days; 86 had KL time remaining; ave. KL time- 133 days.
16	Discipline History (Non-PSA required variables)	No data presented	94.7% received Tier 2 or 3 tickets in 12 months prior to STP. 98% receievd SHU time in 12 months prior to STP.	98.7% received Tier 2 or 3 tickets in 12 month prior to STP. 99% served time in SHU in 12 months prior to STP.

APPENDIX D - SUMMARY OF STP ANNUAL REPORTS for CALENDAR YEARS 2008-10

No.	INDICATOR	CY 2008	CY 2009	CY 2010
17	Mental Health Treatment prior to STP	No data presented	31.1% admitted to CNYPC; 53.4% admitted to RCTP; 14.6%-displayed self-injuries behavior; 6.8% had suicide attempt	20.5% admitted to CNYPC; 65.9% admitted to RCTP; 25.9% displayed self-injurious behavior; 3.1% had a suicide attempt.
18	Axis I Diagnosis at Intake	No data presented	55.8%- psychotic disorder; 24.8% -major mood disorder; 2.9%-mood disorder; 1,0%-substance related disorder; 3.4%-anxiety; 2.4%-otjer; 6.8%- no	52%-psychotic disorder; 26.2%-major mood disorder; 1.7%-mood disorder; 5.2%-adjustment disorder; 3.1%-substance related disorder; 1.7%-anxiety disorder; 2.2%-impulse control disorder; 3.5%-other; 3.9%-no
19	Axis II Diagnosis at Intake	No data presented	49.0%-Antisocial PD; 3.4%-Boderline PD; 2.9%-PD NOS;0.5%-Histrionic PD; 1.5%-Schizotypal PD; 0.5%-Narcissistic; 1.0%-Mental Retardation; 41.3%-No Axis II diagnosis	53.3%-Antosocial PD; 3.5%-Boderline PD; 3.9%-PD NOS; 1.7%-mental retardation; 33.2%-no Axis II
20	Informational Rpts	No data presented	18% received 1 or more positive inform. rpts; 30% received negative inform. rpts.	27%-received one or more positive inform. Rpts; 33.2%- received negative inform. Rpts.

NOTES: There are no admissions from GP in 2009. The % of inmates discharged to GP was 17-19%, while the amount discharged to SHU has remained at 4%. The number discharged to the ICP was 18-15%, and those sent to the BHU was ~ 5%. In 2008 and 2009 approximately 26% of inmate-patients received tickets. Similarly, in 2008 and 2009 about half of the inmates received time cuts, but the days remaining increased.

NOTES: There was an increase of inmates admitted to the STP from 2009 to 2010 and a decrease in the amount of time inmate were spending in the STP. There was a greater number discharged to the ICP, BHU or RMHU and a decrease in the number discharged to CNYPC. There was a higher percent of individuals with a L2S designation and a lower number with an L1S designation. Higher percent of individauls in the STP in 2010 were non-S designated. Alarmingly 98.1% had received a Tier 3 ticket during stay in STP. Also across all three years, inmates are discharged from the STP with significant SHU or keeplock time remaining.

Appendix E - Summary of SHU Patients on the OMH Caseload 2nd Quarter 2011

Prison	Capacity	SHU census	% SHU Cap	# "S" Desig	# Psych Meds	# Anti-Psychotic	# Atyp Anti-Psychotic	# Refusing
Albion	48	14	29.2%	1	11	1	1	1
Arthur Kill	32	11	34.4%	3	8	4	4	0
Attica	112	20	17.9%	1	10	2	1	0
Auburn	83	35	42.2%	5	16	7	6	1
Bedford Hills	24	4	16.7%	0	1	0	0	0
Cinton	48	16	33.3%	1	11	3	3	0
Collins	200	42	21.0%	1	30	7	7	0
Coxsackie	32	4	12.5%	1	3	1	1	0
Downstate	36	4	11.1%	0	0	0	0	0
Eastern	32	10	31.3%	1	7	0	0	0
Elmira	54	20	37.0%	4	8	1	1	1
Fishkill	284	45	15.8%	5	33	6	3	2
Five Points	100	10	10.0%	2	7	4	4	1
Franklin	32	2	6.3%	0	2	0	0	0
Great Meadow	68	19	27.9%	2	13	3	3	0
Green Haven	50	7	14.0%	4	5	3	2	0
Greene	200	16	8.0%	0	14	0	0	0
Groveland	24	13	54.2%	2	9	3	3	0
Marcy	32	5	15.6%	1	4	2	2	0
Midstate	232	25	10.8%	5	12	2	1	1
Oneida	44	1	2.3%	0	0	0	0	0
Shawangunk	24	6	25.0%	0	4	0	0	0
Sing Sing	30	6	20.0%	1	4	1	1	2
Southport	789	146	18.5%	0	92	5	4	3
Sullivan	24	4	16.7%	1	4	2	1	1
Upstate	1040	50	4.8%	0	27	0	0	0
Washington	32	1	3.1%	0	1	0	0	0
Wende	34	13	38.2%	6	9	4	3	1
Woodburne	14	2	14.3%	0	2	0	0	0
TOTAL	**3754**	**551**	14.7%	**47**	**347**	**61**	**51**	**14**

NOTES: On 6/30/2011, 4254 inmates were in the SHU of which 13% (551) were on OMH caseload. There was a 3.7% decrease in the number of inmates from 6/2010 to 6/2011. Of the 551 inmates in SHU, 8.5% (47) had an S-designation. Of all inmates in SHU, 63%were prescribed at least one psychotropic medication. Only 1.8% of the total inmates with an S-designation were housed in the SHU. Of the 47 S-designation in the SHU, five were partici[ating in GTP, so there were **42 non-programmed inmates.** A reveiw of the 42 inmates was conducted on 7/26/2011, 20 inmatess hade been transferred to OMH special program, nine were released to GP, seven were transferred to TICP, two were released from SHU to serve KL in GP, two inmates were transferred to CNYPC, one inmate had a change in S-designation, and one was back in SHU due to a new ticket. **There is a drop in active OMH cases by 20, but a drop of 95 S-designations. Each quarter saw fewer S-designations reported. Also, the non-programmed inmates grew each quarter while the GTP/STP participating numbers decreased. Also, it is rare when inmates are transferred to CNYPC.**

			Level 1 Patient	Level 2 Patient	Level 3 Patient	Level 4 Patient	Total
April 29, 2011	All Active		81	140	302	46	**569**
	% S-Designated		65.4%	23.6%	0.0%	0.0%	**15.1%**
May 31, 2011	All Active		89	149	330	43	**611**
	% S-Designated		66.3%	20.1%	0.0%	0.0%	**14.6%**
June 30, 2011	All Active		56	134	314	47	**551**
	% S-Designated		48.2%	14.9%	0.0%	0.0%	**8.5%**

Appendix F - DOCCS Suicides During 2000 to 2011 by Rate for 2007-2011

Prison	*Annual Suicides*						*Ave Pop*	*# Suicides*	*Yrly Suicide*	*Suicide Rate*	*Ave Pop*	*# Suicide*	*Suicide Rate*
	2000-06	*2007*	*2008*	*2009*	*2010*	*2011*	*2000-11*	*2000-11*	*#s 2000-11*	*2000-11*	*2007-11*	*2007-11*	*2007-11*
Downstate	4	3	1	0	2	0	1,143	10	0.83	97.24	1,057	6	141.91
Great Meadow	3	0	3	1	4	2	1,637	13	1.08	75.78	1,643	10	127.85
Elmira	15	2	1	2	3	2	1,766	25	2.08	145.73	1,748	10	120.17
Chateaugay	0	1	0	0	0	0	222	1	0.08	49.98	217	1	115.21
Wende	4	1	0	0	2	0	889	7	0.58	87.49	818	3	91.74
Bedford Hills	3	1	0	0	1	0	803	5	0.42	69.16	747	2	66.93
Southport	4	0	1	1	0	1	854	7	0.58	79.18	893	3	61.62
Mid-State	0	2	0	1	0	0	1,471	3	0.25	22.66	1,358	3	55.25
Clinton	13	1	1	2	2	0	2,887	19	1.58	73.12	2,817	6	53.25
Eastern	1	1	1	0	0	1	1,181	4	0.33	29.00	1,097	3	50.14
Lakeview (male)	0	0	1	0	0	0	913	1	0.08	12.17	529	1	47.26
Attica	9	1	0	2	1	0	2,173	13	1.08	66.47	2,150	4	46.51
Shawangunk	0	0	0	0	1	0	549	1	0.08	20.25	540	1	46.34
Mohawk	0	0	0	0	2	0	1,271	2	0.17	17.49	1,130	2	44.27
Sullivan	1	0	1	0	0	0	691	2	0.17	32.16	629	1	39.78
Fishkill	3	1	0	1	0	0	1,641	5	0.42	33.85	1,491	2	33.53
Coxsackie	3	1	0	0	0	0	1,009	4	0.33	44.05	978	1	25.56
Oneida	0	1	0	0	0	0	1,152	1	0.08	9.64	1,024	1	24.43

Rates are computed on an annual bases for every 100,000 prisoners.

Appendix F - DOCCS Suicides During 2000 to 2011 by Rate for 2007-2011

Prison	*Annual Suicides*						*Ave Pop*	*# Suicides*	*Yrly Suicide*	*Suicide Rate*	*Ave Pop*	*# Suicide*	*Suicide Rate*
	2000-06	*2007*	*2008*	*2009*	*2010*	*2011*	*2000-11*	*2000-11*	*#s 2000-11*	*2000-11*	*2007-11*	*2007-11*	*2007-11*
Upstate	2	0	0	0	1	0	916	3	0.25	36.40	1,277	1	19.58
Auburn	6	0	0	0	1	1	1,741	8	0.67	45.20	1,703	2	17.62
Bare Hill	1	1	0	0	0	0	1,703	2	0.17	13.05	1,629	1	15.35
Green Haven	1	1	0	0	0	0	2,107	2	0.17	10.55	2,059	1	12.14
Marcy	0	0	0	0	0	1	1,170	1	0.08	0.79	1,081	1	4.63
Sing Sing	2	0	0	0	0	1	1,935	3	0.25	11.96	1,751	1	2.86
Adirondack	0	0	0	0	0	0	534	0	0.00	0.00	455	0	0.00
Albion	1	0	0	0	0	0	1,093	1	0.08	10.16	959	0	0.00
Altona	0	0	0	0	0	0	467	0	0.00	0.00	424	0	0.00
Arthur Kill	2	0	0	0	0	0	953	2	0.17	23.33	938	0	0.00
Bayview	0	0	0	0	0	0	235	0	0.00	0.00	170	0	0.00
Beacon	0	0	0	0	0	0	207	0	0.00	0.00	183	0	0.00
Butler	0	0	0	0	0	0	225	0	0.00	0.00	188	0	0.00
Cape Vincent	0	0	0	0	0	0	950	0	0.00	0.00	835	0	0.00
Cayuga	0	0	0	0	0	0	964	0	0.00	0.00	830	0	0.00
Collins	0	0	0	0	0	0	1,099	0	0.00	0.00	853	0	0.00
Five Points	2	0	0	0	0	0	1,366	2	0.17	16.27	1,372	0	0.00
Franklin	0	0	0	0	0	0	1,704	0	0.00	0.00	1,633	0	0.00

Rates are computed on an annual bases for every 100,000 prisoners.

Appendix F - DOCCS Suicides During 2000 to 2011 by Rate for 2007-2011

Prison	*Annual Suicides*						*Ave Pop*	*# Suicides*	*Yrly Suicide*	*Suicide Rate*	*Ave Pop*	*# Suicide*	*Suicide Rate*
	2000-06	*2007*	*2008*	*2009*	*2010*	*2011*	*2000-11*	*2000-11*	*#s 2000-11*	*2000-11*	*2007-11*	*2007-11*	*2007-11*
Fulton	0	0	0	0	0	0	150	0	0.00	0.00	154	0	0.00
Gouverneur	0	0	0	0	0	0	964	0	0.00	0.00	803	0	0.00
Gowanda	0	0	0	0	0	0	1,799	0	0.00	0.00	1,630	0	0.00
Greene	0	0	0	0	0	0	1,661	0	0.00	0.00	1,552	0	0.00
Groveland	0	0	0	0	0	0	1,215	0	0.00	0.00	1,089	0	0.00
Hale Creek	0	0	0	0	0	0	441	0	0.00	0.00	431	0	0.00
Hudson	0	0	0	0	0	0	514	0	0.00	0.00	415	0	0.00
Lincoln	0	0	0	0	0	0	205	0	0.00	0.00	202	0	0.00
Livingston	0	0	0	0	0	0	856	0	0.00	0.00	805	0	0.00
Mid-Orange	0	0	0	0	0	0	716	0	0.00	0.00	675	0	0.00
Monterey	0	0	0	0	0	0	172	0	0.00	0.00	133	0	0.00
Moriah	0	0	0	0	0	0	206	0	0.00	0.00	161	0	0.00
Mt. McGregor	0	0	0	0	0	0	520	0	0.00	0.00	460	0	0.00
Ogdensburg	0	0	0	0	0	0	566	0	0.00	0.00	454	0	0.00
Orleans	0	0	0	0	0	0	1,011	0	0.00	0.00	807	0	0.00
Otisville	0	0	0	0	0	0	593	0	0.00	0.00	539	0	0.00
Queensboro	0	0	0	0	0	0	413	0	0.00	0.00	423	0	0.00
Riverview	1	0	0	0	0	0	939	1	0.08	11.83	815	0	0.00

Rates are computed on an annual bases for every 100,000 prisoners.

Appendix F - DOCCS Suicides During 2000 to 2011 by Rate for 2007-2011

Prison	*Annual Suicides*						*Ave Pop*	*# Suicides*	*Yrly Suicide*	*Suicide Rate*	*Ave Pop*	*# Suicide*	*Suicide Rate*
	2000-06	*2007*	*2008*	*2009*	*2010*	*2011*	*2000-11*	*2000-11*	*#s 2000-11*	*2000-11*	*2007-11*	*2007-11*	*2007-11*
Rochester	0	0	0	0	0	0	71	0	0.00	0.00	65	0	0.00
Taconic	0	0	0	0	0	0	338	0	0.00	0.00	309	0	0.00
Ulster	0	0	0	0	0	0	671	0	0.00	0.00	576	0	0.00
Wallkill	0	0	0	0	0	0	595	0	0.00	0.00	587	0	0.00
Washington	0	0	0	0	0	0	998	0	0.00	0.00	846	0	0.00
Watertown	0	0	0	0	0	0	653	0	0.00	0.00	545	0	0.00
Woodbourne	2	0	0	0	0	0	792	2	0.17	28.07	789	0	0.00
Wyoming	0	0	0	0	0	0	1,657	0	0.00	0.00	1,622	0	0.00
	83	18	10	10	20	9	60,337	150	13	20.72	56,078	67	23.90

Rates are computed on an annual bases for every 100,000 prisoners.

Appendix G - Self Harm and Suicide Attempts UIRs for 2007-2010

Prison	*-----Incidents of Self Harm -------*					*2007-10 Rate Self Harm*	*Incidents of Suicide Attempts*					*2007-10 Rate Suicide Attempts*
	2007	*2008*	*2009*	*2010*	*Total*		*2007*	*2008*	*2009*	*2010*	*Total*	
Sullivan	3	3	6	1	13	32.34	2	6	9	3	20	176.62
Bedford Hills	4	3	5	1	13	29.04	4	5	5	11	25	149.69
Auburn	6	5	2	4	17	16.71	0	13	22	7	42	144.46
Elmira	5	4	7	1	17	16.38	11	10	11	11	43	133.96
Downstate	1	6	1	0	8	13.05	3	9	4	3	19	109.26
Five Points	4	3	5	8	20	24.32	1	5	12	3	21	91.20
Coxsackie	1	2	1	1	5	8.51	0	2	10	5	17	90.20
Great Meadow	14	13	4	1	32	32.45	3	5	10	14	32	87.20
Mid-State	3	4	3	4	14	16.87	3	5	8	5	21	83.13
Southport	1	3	3	0	7	12.95	2	1	7	2	12	77.72
Upstate	4	1	4	1	10	13.06	1	4	6	2	13	60.07
Shawangunk	0	0	0	0	0	0.00	1	0	3	0	4	49.41
Wende	1	2	2	5	10	20.50	0	1	3	4	8	41.00
Bayview	0	0	0	0	0	0.00	1	0	0	0	1	38.39
Fishkill	1	1	1	4	7	7.85	1	4	3	1	9	37.03
Watertown	0	0	1	0	1	3.01	2	1	0	0	3	36.12
Clinton	8	4	5	4	21	12.37	0	4	8	9	21	33.58
Bare Hill	0	0	0	0	0	0.00	2	1	5	0	8	32.49
Albion	0	2	1	0	3	5.09	2	0	2	3	7	32.26

Rates are computed on an annual bases for every 10,000 prisoners.

Appendix G - Self Harm and Suicide Attempts UIRs for 2007-2010

Prison	*-----Incidents of Self Harm -------*					*2007-10 Rate Self Harm*	*Incidents of Suicide Attempts*					*2007-10 Rate Suicide Attempts*
	2007	*2008*	*2009*	*2010*	*Total*		*2007*	*2008*	*2009*	*2010*	*Total*	
Groveland	1	0	1	1	3	4.46	5	0	0	0	5	29.76
Green Haven	6	1	5	5	17	13.78	1	1	6	4	12	29.17
Marcy	2	0	0	1	3	4.59	3	1	0	2	6	27.51
Greene	0	0	0	0	0	0.00	2	3	1	1	7	27.14
Attica	9	9	7	1	26	20.18	1	2	4	5	12	25.61
Oneida	0	0	0	1	1	1.59	3	0	1	0	4	25.40
Eastern	0	0	0	0	0	0.00	1	1	2	1	5	25.14
Arthur Kill	1	0	0	1	2	3.53	1	2	0	2	5	24.69
Collins	0	1	0	0	1	1.90	1	1	1	0	3	22.85
Sing Sing	9	5	2	5	21	19.90	0	2	2	3	7	18.00
Woodbourne	0	0	0	0	0	0.00	0	2	0	0	2	16.85
Livingston	0	0	0	0	0	0.00	0	0	1	3	4	14.39
Mt. McGregor	0	0	0	0	0	0.00	0	1	0	0	1	14.14
Franklin	2	0	1	0	3	3.03	1	0	2	0	3	12.14
Wallkill	0	1	0	0	1	2.82	1	0	0	0	1	11.26
Riverview	0	0	0	0	0	0.00	1	0	0	0	1	8.12
Cayuga	0	1	0	0	1	2.00	1	0	0	0	1	7.98
Altona	0	0	0	0	0	0.00	0	0	0	1	1	3.86
Washington	0	0	1	0	1	1.91	0	0	0	2	2	3.82

Rates are computed on an annual bases for every 10,000 prisoners.

Appendix G - Self Harm and Suicide Attempts UIRs for 2007-2010

Prison	*-----Incidents of Self Harm -------*					*2007-10 Rate Self Harm*	*Incidents of Suicide Attempts*					*2007-10 Rate Suicide Attempts*
	2007	*2008*	*2009*	*2010*	*Total*		*2007*	*2008*	*2009*	*2010*	*Total*	
Lakeview (male)	2	2	0	0	4	11.11	0	0	0	1	1	2.78
Cape Vincent	0	0	0	0	0	0.00	0	0	0	1	1	1.97
Wyoming	0	1	1	0	2	2.04	0	0	0	1	1	1.02
Ulster	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Hudson	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Hale Creek	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Lyon Mountain	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Summit	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Taconic	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Lincoln	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Mid-Orange	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Rochester	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Queensboro	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Otisville	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Orleans	0	1	0	0	1	2.05	0	0	0	0	0	0.00
Ogdensburg	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Moriah	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Buffalo	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Mohawk	0	0	0	0	0	0.00	0	0	0	0	0	0.00

Rates are computed on an annual bases for every 10,000 prisoners.

Appendix G - Self Harm and Suicide Attempts UIRs for 2007-2010

Prison	*-----Incidents of Self Harm ------*					*2007-10 Rate Self Harm*	*Incidents of Suicide Attempts*					*2007-10 Rate Suicide Attempts*
	2007	*2008*	*2009*	*2010*	*Total*		*2007*	*2008*	*2009*	*2010*	*Total*	
Adirondack	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Gowanda	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Gouverneur	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Fulton	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Edgecombe	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Chateaugay	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Butler	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Beacon	0	0	0	0	0	0.00	0	0	0	0	0	0.00
Monterey	0	0	0	0	0	0.00	0	0	0	0	0	0.00
	88	78	69	50	285	12.62	61	92	148	110	411	18.20

Rates are computed on an annual bases for every 10,000 prisoners.