The Correctional Association of New York
FOUNDED 1844
2090 ADAM CLAYTON POWELL, JR. BLVD. • SUITE 200 • NEW YORK, NY 10027
TEL. (212) 254-5700 • FAX (212) 473-2807 • www.correctionalassociation.org

Testimony by Jack Beck, Director, Prison Visiting Project
The Correctional Association of New York
Before the Hearing of the Assembly's Corrections and Mental Health Committees
Mental Health Services in NY Prisons – November 13, 2014

EXECUTIVE SUMMARY

Due to a lack of community-based mental health services and the criminalization of behavioral manifestations of mental illness, New York State incarcerates large and growing numbers of people with mental health needs. Currently, 8,573 people in New York's prisons are on the Office of Mental Health (OMH) caseload (not including local jails, federal prisons, immigration detention, or youth facilities). These patients represent 15.8% of all people incarcerated in New York's prisons – the highest percentage ever in the Department of Corrections and Community Supervision (DOCCS). Prison is not an appropriate environment for people with mental health needs. The highly regimented, rigid rule-oriented, hyper-punitive, and too commonly abuse-laden environment is often very difficult for people with mental illness to manage. The trauma of this environment can exacerbate people's mental illness and create new mental health challenges for any person.

Improvement of Care. As a result of intense scrutiny and demand for enhanced services by prison mental health patients, their families, the legislature, courts, and prison and mental health advocates, DOCCS and OMH have increased and in some cases improved mental health services over the last decade. Most significantly, in large part because of a 2007 litigation settlement in *Disabilities Advocates, Inc. v. NYS Office of Mental Health* and the Special Housing Unit (SHU) Exclusion Law – passed by the NYS legislature in 2008 and gone into full effect in July 2011 – there has been a diversion of people with the most serious mental illness (SMI or S-designated) from solitary confinement, and a substantial increase in the number of both disciplinary and non-disciplinary Residential Mental Health Treatment Units (RMHTUs). In addition to the improvements and the benefits of the expanded residential units, serious challenges remain.

The ICP as a Model. Perhaps most positive, the non-disciplinary residential Intermediate Care Program (ICP) expanded its capacity by more than a third between 2007 and 2009. The ICP offers 20-hours per week of intensive therapeutic programming, mostly on the unit but at times off the unit, to patients with a serious mental illness. A Transitional ICP (TrICP) also aims to help people leaving residential mental health treatment units to be reintegrated into general population. Of all mental health units and programs within DOCCS, the ICP receives relatively positive assessments from participants. Around 70% of ICP residents reported feeling safer in the ICP than in general population. Also, most ICP residents had relatively positive ratings of group therapy, with between

80% to 90% of ICP survey respondents rating individual program groups they were in as either good or fair. ICP residents did raise some substantial concerns, including insufficient time for individual therapy (15 minutes once per month), staff harassment, and excessive use of disciplinary tickets and imposition of keeplock. However, there were less reported problems, abuse, and punishment than in most general population or disciplinary mental health units. The ICP, despite its limitations, could serve as a model for providing a relatively safer and more therapeutic environment for people with mental health needs so long as they are incarcerated. Yet, its capacity has remained stagnant in the past five years, and it has between 35 and 70 empty beds. Given that the full capacity of the ICP represents only one-third of all S-designated patients and 9% of all OMH patients, many more people with mental health needs could benefit from ICP placement.

Limited Services in General Population. With only around 1,200 total disciplinary and non-disciplinary residential mental health beds in the whole system, the vast majority of people with mental health needs, including those with serious mental illness, remain in the general prison population. At some prisons, such as Collins or Groveland, the number of people on the OMH caseload has been growing and represents about half of all people incarcerated at the prisons. Also, many OMH Level 1 facilities, such as Clinton or Fishkill, have hundreds of people in general population with the most substantial mental health needs, including Level 1 and 2 patients and those with an S-designation. This large percentage can have a major impact on the entire prison, where program and security staff, as well as other incarcerated persons, are not adequately trained on how to effectively interact with people with mental health needs. Yet, in general population there typically are very limited mental health services provided other than medications and short check-in meetings once per month lasting around 15 minutes. More positively in the last year, at least one prison, Greene, began providing limited group therapy once a month as a pilot program. Still, most people with mental health needs continue to receive very limited, if any, individual or group therapy. In addition, people with mental health needs are too frequently targeted for abuse and punishment by staff, and too frequently end up in isolated or solitary confinement.

The Torture of Solitary Confinement. The torture of solitary or isolated confinement can exacerbate pre-existing mental illness and create new mental health challenges for any person. Yet, six years after passage and three years after full implementation of the SHU Exclusion Law, each day around 3,800 people, including 650-700 people on the OMH caseload and disproportionately people of color, continue to remain in Special Housing Units (SHU). People in isolated confinement in New York prisons in SHU or keeplock spend 22 to 24 hours per day locked in a cell, with generally no meaningful human interaction, programs, jobs, therapy, group interactions, or even the ability to make phone calls. The sensory deprivation, lack of normal human interaction, and extreme idleness have long been proven to lead to intense suffering and physical and psychological damage for any person. A recent study found that people in solitary confinement were seven times more likely to harm themselves and more than six times more likely to commit potentially fatal self-harm. The United Nations Special Rapporteur on Torture has concluded that isolated confinement beyond 15 days amounts to cruel, inhuman, or degrading treatment, or torture. Yet, each year DOCCS imposes an average of more than 14,000 individual SHU sentences, nearly 8,000 of which are for three months or more and nearly 3,900 SHU sentences of six months or more. Moreover, because people often accumulate additional SHU time while in isolation, people regularly spend years in isolation, some people have been in solitary confinement in New York for more than two decades.

Positive Diversion under the SHU Exclusion Law. Thanks to the SHU Exclusion Law, on any given day around 200 people with the most serious mental illness who otherwise would be in the

SHU are diverted to a disciplinary RMHTU, where they typically can receive two to four hours a day, five days a week, of out-of-cell mental health programming and treatment. These alternative disciplinary mental health units include: Residential Mental Health Units (RMHU) at Marcy, Five Points, and Attica; a Behavioral Health Unit (BHU) at Great Meadow, and a Therapeutic Behavioral Unit (TBU) at Bedford Hills for women. For some people who were suffering the worst impacts of the SHU, these units – particularly at Marcy, but to a lesser extent at Five Points, Bedford Hills, Great Meadow, and Attica – provide a relatively more humane and effective environment. Simply the ability to come out of their cells, have some individual therapy, and participate in group programming for multiple hours a day is having a positive impact for many people, and some residents at Marcy and to a lesser extent at Five Points praised the group programs and OMH staff as being relatively supportive and helpful to deal with their mental health issues. Also positively, there is a growing number and percentage of discharges of RMHU and BHU patients to non-punitive housing, including general population, the ICP, and TrICP.

Punitive Nature of Disciplinary Mental Health Units. While many patients have benefited from being in an RMHU or BHU, many others have faced an overly punitive and abusive environment, particularly at Great Meadow, Attica, and Five Points, and to a lesser extent at Marcy. Although it is positive that people are diverted from the SHU to the RMHTUs, these units remain disciplinary confinement units, and hold people for months and even years. These units too often involve excessive use of disciplinary tickets, denial of out-of-cell programs due to purported exceptional circumstances, staff physical and verbal abuse, and relatedly patient refusals to leave cells or participate in programs. Roughly half of all persons on these units received a disciplinary ticket on the unit over a less than four year period and 115 people received 10 tickets or more (up to 60 tickets for a single person). In turn, subtracting out time cuts, over 300 people received a cumulative six months or more additional SHU time, 148 received one year or more, 35 received five years or more, and eight people received *10 years or more* of additional SHU time while on a mental health unit. In addition to this formal punishment, many RMHTU residents, at Five Points and Great Meadow in particular, reported physical abuse, verbal harassment, and threats by security staff. Respondents described horrific examples of confrontations in which security staff brutally beat them or taunted them specifically about their mental health issues or self-harm. Numerous RMHU and BHU residents also reported that staff utilize deprivation orders, including cell shields, basic service denial, and exposure suits, all of which are inhumane, to inflict even additional punishment.

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

Mental Health Patients Still in Solitary. Moreover, the vast majority of people with mental health needs in disciplinary confinement are not benefiting from the SHU Exclusion Law and remain in solitary confinement. Some people with an S-designation are still in SHU, either because DOCCS invoked exceptional safety circumstances or – potentially in contravention of the law's requirement that any person with an S-designation be removed from SHU if they could spend more than 30 days in SHU – because people's disciplinary hearings are still pending or they were removed from SHU within 30 days after the hearing disposition (regardless of the actual length of time spent or potentially to be spent in SHU). In addition, hundreds of OMH patients who do not have an S-designation but have mental health needs that many would consider serious, still remain in SHU.

Concerns about Diagnoses and Unused Diversion Beds. Related to patients in the SHU, there has been a major shift in diagnoses in the last six years from schizophrenia and psychoses (35% drop) to adjustment, anxiety, and personality disorders (72% rise). With a related 36% drop in the number of S-designations, less people are eligible for SHU diversion, raising serious concerns about whether the SHU Exclusion Law's provision of a sharp line above which people receive intensive services and below which people receive none and remain in the SHU, are leading to improper diagnoses. These concerns are even more stark given that the percentage of the total OMH caseload designated as Level 1 has risen in recent years. Moreover, after an increase from 2005 to 2010 of the number of people with S-designations placed in disciplinary confinement units in which they received mental health treatment, as people were being diverted from the SHU, the number dropped from a high of 237 to 186. Though the decrease is positive to the extent that less people with serious mental illness are being placed in disciplinary units, the decline not only raises concerns about diagnoses, but also that there are more than 100 empty beds in 288-bed capacity alternative disciplinary units when there are hundreds of OMH patients in the SHU who would benefit from diversion.

Crises and Problematic Crisis Intervention. The most visible and disturbing outcomes of many of the challenges identified – incarceration of large numbers of people with mental health needs, limited residential mental health beds and insufficient services in general population, continued and pervasive use of solitary confinement, and overly punitive nature of the RMHTUs – include people going into mental health crisis and/or committing suicide or self-harm. Incarcerated persons who are suicidal or having a mental health crisis are taken to the Residential Crisis treatment Program (RCTP) for assessment and housing in an environment intended to ensure safety and provide an opportunity for evaluation. Admissions to the RCTPs have risen 55% from 5,302 in 2007 to 8,224 in 2013. The disciplinary mental health units had RCTP admission rates 34 times the rate of the general prison population, and three times the rate of the non-disciplinary mental health units even though patients' mental health acuity are comparable. Also, the SHUs had admission rates nearly four times the rate of the general prison population, even though nearly all S-designated patients have been removed from the SHUs. Unfortunately, the RCTP often fails to address the underlying mental health issues leading to the crisis, and fails to examine the living conditions and/or experiences of patients that contributed to the deterioration of their mental health status or intention to harm themselves. Instead, the mental health response is limited to assessing only the immediate risk of serious self-harm, and generally after a few days people are returned to the very environment that led to the crisis or self-harm, including to solitary confinement. The number of RCTP discharges to the SHU are 200 people higher than the number of admissions, indicating that people who experience crisis in the SHU are returned to SHU and that persons who go into crisis elsewhere are then punitively sent to SHU after the RCTP. Indicative of the lack of an appropriately therapeutic response to crises, as RCTP admissions have dramatically increased, admissions to the Central New York Psychiatric Center (CNYPC) – where people in crisis can receive intensive in-

patient care – have decreased 57% since 2008. In addition to the failure to address people's mental health issues, many incarcerated persons view the RCTP as an ineffective, punitive, and abusive response. For a unit intended to provide people experiencing a mental health crisis a safe environment to avoid further deterioration or physical injury, patients repeatedly report that they are physically abused or otherwise mistreated by security staff during transfer to, or in, the RCTP.

High Rates of Suicide and Self-Harm. Most distressingly, too often mental health crisis leads to self-harm and suicide. NYS prisons have a suicide rate 50%-70% higher than the national average for state prisons, and roughly two times the suicide rate in the outside community. Suicides also are concentrated at a select few prisons. From 2011 through mid-2014, 54% of all suicides occurred at just five prisons: Auburn, Attica, Clinton, Elmira, and Great Meadow, at a rate nearly five times the national prison suicide rate. These facilities have a suicide rate three times the DOCCS average and five times the national rate for state prisons. Nearly a quarter of all suicides took place in the SHU – a rate more than three times the percentage people in the SHU represent of the entire prison system.

Recommendations. Dramatic reform is needed to address these myriad issues and better serve the people in our state who have mental health needs. Specifically:

- New York must **de-criminalize behavioral manifestations of mental illness**, and provide **greater community mental health care, diversion, and alternatives to incarceration** so that prisons and jails are no longer the dumping ground for people with mental illness.
- Inside prisons, DOCCS and OMH must **expand the ICPs and mental health programs and services for people in general population** so that as long as people with mental illness are incarcerated, they are able to receive the treatment and environment they need to cope with their mental illness and prepare to return home.
- The legislature and Governor must **pass the Humane Alternatives to Long Term (HALT) Solitary Confinement Act**, A. 8588A / S. 6466A, so that people with any mental illness – whether they are S-designated or not – are removed from isolation, no person is subjected to the torture of solitary confinement, and more humane and effective alternatives are utilized.
- All current and future alternative units to SHU, including the **RMHUs, BHU, and TBU, must be more therapeutic and rehabilitative**, and all staff abuse, disciplinary tickets, additional SHU time, and program denials must cease.
- DOCCS and OMH must **enhance assessments, diagnoses, and individualized treatment for all people with mental health needs**, including by relying on family input and past mental health history and treatment, and by creating a full time dedicated family liaison.
- There must be **greater suicide, self-harm, and crises prevention and therapeutic responses**, including through counseling, treatment, and transfers to an RMHTU or CNYPC.
- To ensure that the public remains aware of what is happening behind the walls, DOCCS, OMH, and the Justice Center that oversees prison mental health services, must have **greater public reporting, transparency, and in turn accountability**.

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

INTRODUCTION

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 incarcerated persons in our state prisons. As many of you may know, the Correctional Association has had statutory authority since 1846 to visit New York's prisons and to report to the legislature, other state policymakers and the public about conditions of confinement. Our access provides us with a unique opportunity to observe and document actual prison practices and to learn from incarcerated persons and staff what they believe to be the strengths and weaknesses of the prison operation. The CA testified before these committees in December, 2011,[1] at which time we noted both improvement in mental health services during the past decade and some concerns about the Department of Corrections and Community Supervision (DOCCS) and the Office of Mental Health (OMH) meeting the mental health needs of the entire prison population. We again both note positive developments in mental health care, but also raise similar substantial concerns about the adequacy of the resources and services for, and the infliction of serious harm on, the increasing number of patients in DOCCS with mental illness.

My testimony will focus on the following topics: (1) an overview of mental health services in DOCCS facilities, including the residential mental health treatment units and crisis intervention in our prisons; (2) analysis of the state's compliance with the SHU Exclusion Law and the placement of persons with mental health needs in isolated confinement and alternative mental health disciplinary units; (3) mental health services and programs in the non-disciplinary mental health units; (4) provision of limited mental health services to persons in the general prison population who require mental health care; and (5) high rates of suicide and self-harm in state prisons.

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

[1] Testimony of Jack Beck before the Hearing of the Assembly's Corrections and Mental Health Committees, December 6, 2011. Available at **http://www.correctionalassociation.org/wp-content/uploads/2012/05/12-6-2011_beck-testimony-mental-health1.pdf**.

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

In summary, we believe some 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.

TRANSPARENCY AND THE NEED FOR STATE AGENCY DISCLOSURES

For the past few years and during the course of preparing this testimony, we have experienced difficulties getting information about the mental health services provided to patients incarcerated in state prisons and documentation of the Justice Center's efforts to monitor mental health care in the prisons and to monitor DOCCS and OMH compliance with the SHU Exclusion Law. In particular, despite repeated efforts to get the 2013 summary of forensic mental health services from both OMH and the Justice Center, these agencies have delayed their response until after the hearing. Also of concern is the fact that none of the Justice Centers' monitoring efforts have been made publicly available, even though the SHU Exclusion Law requires the agency to make their findings and recommendation available to the public.[2] Finally, the failure of the agencies to testify at this hearing, as they did in 2011, reinforces the impression that they are reluctant to address significant questions about their work and the state's ability to provide comprehensive mental health service to all those in our prisons.

[2] *See, e.g.*, N.Y. Correct. Law § 401-a(2) (requiring the Justice Center to make publicly available reports of New York State's progress with implementing the SHU Exclusion Law).

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 within DOCCS facilities by OMH staff and data about DOCCS patients 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 2013, where such data was available. In addition, we reviewed system-wide data provided by DOCCS concerning its prison population. We also reviewed information provided by individual DOCCS prisons and their staff, as well as survey data, written correspondence, and in-person interviews with incarcerated persons at more than 20 state prisons since the 2011 Assembly hearing on mental health services. These prisons included six OMH Level 1 and three OMH Level 2 prisons, and involved patients in six Intermediate Care Programs (ICP), three Residential Mental Health Units (RMHU), one Behavioral Health Unit (BHU), seven Residential Crisis Treatment Programs (RCTP), three SHU200s or S-blocks, and multiple SHUs. 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.

Table 1 – Summary of Mental Health Services for DOCCS Patients

Unit	Title	Beds	Prisons	Description
Behavior Health Unit	BHU	38	Great Meadow	DOCCS/OMH residential treatment unit for persons with serious mental illness (SMI) being disciplined
Central New York Psychiatric Center	CNYPC	209	Separate OMH facility	Inpatient psychiatric hospital operated by OMH for DOCCS patients with SMI
Group Therapy Program	GTP	24	Elmira Wende	A program in group treatment room in SHU with six treatment cubicles for SHU residents with SMI
Intensive Intermediate Care Program	IICP	38	Wende	DOCCS/OMH residential treatment unit for persons with SMI who need more intensive supervision than those in ICP
Intermediate Care Program	ICP	743	13 prisons	Non-disciplinary DOCCS/OMH residential treatment program for persons with serious mental illness
Residential Crisis Treatment Program	RCTP	112 102*	14 prisons	DOCCS/OMH unit consisting of observation cells and a dorm for patients who are suicidal or in psychiatric crisis
Residential Mental Health Treatment Unit	RMHU	170	Attica, Five Points, Marcy	DOCCS/OMH residential treatment program for persons with serious mental illness who have a disciplinary sentence
Special Housing Unit	SHU	4,952	41 prisons	Disciplinary housing units in prisons
Therapeutic Behavioral Unit	TBU	16	Bedford Hills	DOCCS/OMH residential treatment unit for women with serious mental illness and a disciplinary sanction
Transitional Intermediate Care Program	TrICP	240	10 prisons	DOCCS/OMH residential program for patients with mental illness who have less service needs than ICP patients

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

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.

There is a significant population of incarcerated persons with mental health needs in our state prisons[3] and this census has risen since 2011 to 8,573 patients in January, 2014, representing 15.8% of the population, the highest percentage ever in DOCCS.[4] The number of persons on the OMH caseload increased steadily throughout the early 2000's from 7,400 to over 9,000 patients by 2008. Surprisingly, the census then dropped to 7,836 by January 2010, but has increased since then to its current level. As summarized in **Table 2 – Overview of Prison Population with Mental Illness**, the acuity levels of the patients on the OMH caseload have varied during the period 2007 to 2013. Specifically, from the period 2007-09 to the period 2010-13, the percentage of the OMH caseload designated as Level 1 has risen, while the percentage of patients assigned Level 3 has declined. In the last four years, however, the percentage of patients in each category has remained relatively stable.

The number and percentage of patients diagnosed as having a serious mental illness has declined 36% from 2008 to the present, despite increases in the number and percentage of patients assigned the highest mental health levels (Level 1 and 2) during this period. We are very concerned that patients considered to have a serious mental illness, as defined by the SHU Exclusion Law and designated as an "S" designation by OMH, have consistently declined during the period 2008 to the present, a time coincident with the passage and implementation of the SHU Law. This decline is particularly troubling when the number of patients in the highest Level has remained the same. The implications of failing to designate a patient as suffering from a serious mental illness is to make the person ineligible for the enhanced mental health services required by the SHU Exclusion Law.

The primary diagnoses of prison OMH patients has changed significantly in the past eight 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 2014, the percentage of patients diagnosed with schizophrenia or psychosis dropped from 21.4% to 14%, representing a **decline of 35%**. In just the last year, the decline in these conditions was 6%. In contrast, there has been an increase in the diagnosis of adjustment disorders, from 6.6% to 17.3% from 2007 to 2014, a 162% increase in the percentage of patients with this diagnosis. In the last three years, adjustment disorder diagnoses increased nearly 50%. Similarly, there has been a significant increase in the diagnosis of personality disorder during the period 2007 to 2014, rising 74% over these eight years. Patients diagnosed with

[3] 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.

[4] See **Appendix A – CNYPC Patient Demographics and Profile 2007-14**. This chart summarizes the data provided in the annual reports by CNYPC on patient demographics as of January 1, 2007 through January 1, 2014.

anxiety disorders also rose from 9.8% to 10.8% during this eight-year period. For the three diagnoses, adjustment, personality and anxiety disorders, the percentage of the entire OMH caseload has increased from 23.6% to 40.6%, representing **a change of 72%**. It is unreasonable to assume that the patient population has changed so dramatically during this period to justify such a significant shift is diagnoses.

Table 2 - Overview of Prison Population with Mental Illness[5]

Category	2007	2008	2009	2010	2011	2012	2013	2014
Tot Prison Pop	63,304	62,599	60,081	58,378	56,315	55,804	54,865	54,196
OMH Caseload	8,180	8,567	8,696	7,836	7,958	8,308	8,190	8,573
Percent of Pop	12.9%	13.7%	14.5%	13.4%	14.1%	14.9%	14.9%	15.8%
S-Designation		3,412	3,005		2,677	2,429	2,200	
Level 1*	1583	1,821	1,975	1,836	1,866	1,942	1,872	
L1 Percent	19.7%	21.2%	22.8%	23.3%	23.5%	23.6%	22.9%	
Level 2*	2108	2,631	2,595	2,768	2,927	2,968	2,895	
L2 Percent	26.3%	30.6%	30.0%	35.2%	36.8%	36.0%	35.3%	
Levels 1 & 2*	3,691	4,452	4,570	4,606	4,793	4,910	4,767	
Level 3*	3835	3,705	3,567	2,958	2,881	2,986	3,124	
L3 Percent	47.8%	43.1%	41.2%	37.6%	36.3%	36.3%	38.1%	
Level 4*	500	438	522	306	270	338	299	
Levels 3 & 4*	4,335	4,143	4,089	3,264	3,151	3,324	3,423	
Total Level 1-4	8,026	8,595	8,659	7,868	7,944	8,234	8,190	
Mood Dis*	24.8%	25%	21.9%	22.3%	23%	23.1%	33.5%	33.5%
Minor Mood	23%	22.8%	19.7%	20.1%	21.1%	20%		
Maj Dep/BiPol							7.6%	6.4%
Mood Total	47.8%	47.8%	41.6%	42.4%	44.1%	43.1%	41.1%	39.9%
Schiz/Psychotic	21.4%	19.3%	18.4%	19.2%	17.8%	16.2%	15.2%	14%
Anxiety Dis	9.8%	9.3%	10.3%	11.2%	10.5%	10.4%	10.1%	10.8%
Personality Dis	7.2%	8.3%	9.2%	8.9%	10.1%	10.4%	12.1%	12.5%
Adjustment Dis	6.6%	8.5%	12.1%	10.8%	11.6%	14.5%	16.4%	17.3%
Anx/Per/Adj	23.6%	26.1%	31.6%	30.9%	32.2%	35.3%	38.6%	40.6%

These changes have had a significant impact on the provision of mental health care under the SHU Exclusion Law. Patients diagnosed with schizophrenia or other psychotic disorders are automatically classified as having a serious mental illness under 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."[6] The result of the shift from schizophrenia and psychotic disorders to the adjustment/personality/anxiety disorders is likely the primary explanation for the drastic reduction in the number and percentage of patients considered to have a serious mental illness and therefore eligible for the protections under the SHU Exclusion

[5] Data presented in this section is based upon CNYPC annual patient demographic reports, which are summarized in **Appendix A - CNYPC Patient Demographics and Profile 2008-14.**

[6] Section 137 (6) (e) (v) of the Correction Law.

Law. 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 [7]

Admissions of DOCCS patients to Central New York Psychiatric Center (CNYPC) for hospitalization have significantly diminished during the past seven years. During calendar year (CY) 2013, there were only 335 admissions to CNYPC, a 57% decrease in CNYPC admissions from CY 2008 when 773 patients were admitted to the hospital. It is unclear why there has been such a dramatic change in CNYPC admissions, as the number of patients being referred to crisis intervention in the prisons has increased during this time period. The census as of December 31, 2013 at CNYPC was 154 even though the capacity of the unit is 209. The percentage of CNYPC patients with schizophrenia or other psychotic disorders was 70.7% of the patient population, an increase of 27% from the average percentage (55.6%) for these illnesses of CNYPC patients during 2009-11. Given the decrease of diagnoses of schizophrenia and other psychotic disorders in the DOCCS population, we question why the percentage is increasing in the CNYPC population. This could represent an unwillingness to hospitalize patients with axis II diagnoses, such as adjustment, anxiety and personality disorders, even as these diagnoses are on the rise in the prisons.

Table 3-Admissions to CNYPC from OMH Level 1 Prisons 2010-12

	2010	2011		2012		2010-12		
OMH Level 1 Prisons	CNYPC Admits	Jan OMH Caseload	CNYPC Admits	Jan OMH Caseload	CNYPC Admits	Ave. Caseload	Ave. Admits	Admit Rate
Albion	4	331	7	375	4	353	5.0	70.6
Attica	10	403	16	476	12	439.5	12.7	34.7
Auburn	26	361	11	323	13	342	16.7	20.5
Bedford Hills	21	365	24	390	21	377.5	22.0	17.2
Clinton	28	443	17	451	9	447	18.0	24.8
Downstate	2	253	5	247	10	250	5.7	44.1
Elmira	61	451	21	393	28	422	36.7	11.5
Fishkill	4	445	8	488	10	466.5	7.3	63.6
Five Points	14	242	15	237	21	239.5	16.7	14.4
Great Meadow	28	425	23	438	16	431.5	22.3	19.3
Green Haven	23	346	18	348	25	347	22.0	15.8
Marcy RMHU	17	67	20	81	11	74	16.0	4.6
Misstate	16	489	18	501	8	495	14.0	35.4
Sing Sing	19	382	20	392	2	387	13.7	28.3
Sullivan	16	197	16	174	19	185.5	17.0	10.9
Wende IICP	25	237	29	245	14	241	22.7	10.6
TOTALS	**314**	**5437**	**268**	**5559**	**223**	**5498**	**268.3**	**20.5**

[7] Data for this section is derived from **Appendix A - CNYPC Patient Demographics and Profile 2008-14**

There also have been significant variations in the number and rate of admissions from different OMH Level 1 prisons and a large diminution in admissions over time from several facilities. **Table 3-Admissions to CNYPC from OMH Level 1 Prisons 2010-12** summarizes the data for 2010 through 2012 and computes an admission rate from each OMH Level 1 prison based upon the average OMH caseload for that prison. Although patients not on the OMH caseload can be sent to CNYPC, we anticipate this will be a very low number. Examining the admission rates shows great variability with some prisons having a rate more than three times the average rate, and other facilities a rate that is one-quarter of the average rate. We also found marked reductions in the transfer of patients to CNYPC from particular prisons, such as Sing Sing declining from 19-20 admissions in 2010-11 to only two patients in 2012, and Elmira reducing their admissions from 61 in 2010 to less than one-half that figure in 2012. We urge OMH and DOCCS to evaluate these trends to determine if prison mental health staff are failing to hospitalize patients in need of more intense mental health services.

DOCCS Patients Experiencing Mental Health Crises[8]

There has been a substantial increase in the number of admissions to the Residential Crisis Treatment Program (RCTP) throughout the past seven years, even as CNYPC admissions have declined**.** RCTPs are located in the 15 OMH Level 1 facilities and the Marcy RMHU. Incarcerated persons who are suicidal or having a mental health crisis are taken to the RCTP for assessment and housing in an environment designed to ensure safety. These units usually contain several observation cells where patients are placed in paper gowns or clothing resistant to manipulation for the purpose of self-harm. RCTP patients in observation cells are provided no property or other items with which they could harm themselves. Patients generally remain in these observation cells for one to four days while the mental health staff evaluate what treatment should be provided and where the patients should be housed. This could include eventual psychiatric hospitalization, placement in a residential mental health unit in the prisons or a return to a general population bed or special housing unit in a prison. The RCTPs may also have a small dormitory unit for patients discharged from the cells or returning from another mental health unit. Admissions to the RCTPs have risen from 5,302 in 2007 to 8,224 in 2013, representing a **55% increase**. In the last four years (2009 to 2013), there was a 28% increase. The rise in crisis interventions while the admissions to CNYPC has declined is particularly troubling and suggestive that OMH is not aggressively responding to the needs of patients in crisis.

The Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC) was originally responsible under the SHU Exclusion law to assess compliance with the Law and to monitor the quality of mental health care provided to patients in our state prisons. Although CQC's responsibilities under the SHU Exclusion Law have been transferred to the NYS Justice Center for the Protection of People with Special Needs (Justice Center) in the summer of 2013, CQC performed two reviews of conditions in the RCTPs in 2010 and 2012-13 that raise concerns about the operation of these units. We share many of these concerns based upon our observation of the RCTPs, reports we have received from residents of these units and our review of DOCCS and OMH documentation concerning the RCTPs.

[8] Data for this section is derived from CNYPC annual reports on conditions in the Residential Crisis Treatment Program units throughout the prison system.

CQC's 2010 RCTP report[9] concluded that: (1) most patients transferred to the RCTPs had a serious mental illness and a high level of mental health needs; (2) a majority of these patients experienced a mental health crisis or exhibited behavior or made statements indicating they were at risk for self-harm; (3) transfer to the RCTP was helpful to many patients, but patients' assessments varied with 22% of CQC-surveyed patients rating it as excellent or good, 27% assessing it as average, 22% finding it poor and 29% rating it as very poor; (4) many patients interviewed by CQC viewed the RCTP as punishment; (5) a few patients would have benefitted more by transfer to CNYPC; and (5) documentation was not always completed, all units had incomplete nursing notes and monitoring charts and the adequacy of documentation varied among RCTP units. In response to this report, advocates and family members of patients placed in the RCTPs raised continuing concerns about the treatment of patients in these units. Consequently, CQC performed a follow-up review of the units in 2011-12 and issued a follow-up report[10] in June 2013 that documented continuing problems on these units. In particular, CQC found: (1) inadequate documentation of patients' current mental health status, mental health history, risk factors and suicide attempts; (2) underlying issues raised by the patient's admission to the RCTP were not thoroughly explored causing extended stays; (3) no continuity of care between patients' housing unit clinical treatment team and the RCTP treatment team; (4) mandatory clinical director consultations lacked detailed information to provide clinical opinion and/suggestions for further treatment; and (5) clinical decisions about appropriate levels of care for RCTP patients were not based on a patient's length of stay, leading to deficient continuity of care and multiple RCTP admissions.

These conclusions are consistent with CA observations that the responses to mental health crises experienced by RCTP patients is often inadequate both from a clinical standpoint in terms of addressing the underlying mental health issues leading to the RCTP admission and from a non-medical approach in which there is a failure to examine the living conditions and/or experiences of these patients which often contribute to the deterioration of their mental health status or their intention to harm themselves. Instead of using the RCTP experience as a trigger for mental health staff to explore more fully with these patients their mental health needs once they are discharged, it appears that the mental health response is limited to assessing only the immediate risk of serious self-harm. Similarly, neither OMH nor DOCCS investigates with the patients what about their current living conditions may have contributed to their mental health deterioration or their intention to harm themselves. Although DOCCS staff often assert that incarcerated persons' expressions of an intention to hurt themselves is manipulative, there is no effort by either agency to evaluate why these patients would elect to be placed in the onerous conditions of the RCTP, particularly given the very likely result that their situation will not be altered by an RCTP admission. As a result of these inadequate responses, very frequently persons sent to the RCTP are returned to the same housing units, including solitary confinement, from which they were admitted to the RCTP. As one survey respondent described his experience in the Sullivan RCTP, "basically you sleep all day and eat and talk. It is not helpful because you have the same issues and problems when you go back. They don't fix the problems – they just medicate you." Because underlying issues, such as problems with staff, fears of harm from others, or oppressive living conditions are not discussed or addressed, frequently these patients will experience relapses in their mental health status or exhibit behavior or express a

[9] CQC, *Review of Residential Crisis Treatment Programs (RCTPs)*, July 2010. Available at: http://www.justicecenter.ny.gov/sites/default/files/archivereports/Publications/RCTP%20Review%20Rpt%20Appendices%207-10.pdf

[10] CQC, *Residential Crisis Treatment Program(s) Follow-up Review*, June 14, 2013. Available at: http://www.justicecenter.ny.gov/sites/default/files/archivereports/Publications/MH%20DOCCS%20Report.pdf

desire to self-harm. The cycling of some persons between their housing units and the RCTP is commonplace.

A few additional issues must be raised about the RCTP process. These units are intended to be a place where persons experiencing a mental health crisis and/or who are at serious risk of self-harm are encouraged to utilize to avoid further deterioration or physical injury. Unfortunately, too many incarcerated persons believe they do not offer this relief and instead inflict greater harm. The CA has interviewed and surveyed many persons who report that they or other incarcerated persons have been physically abused or otherwise mistreated by security staff for requesting transfer to these units. As one survey respondent reported, "Security staff] assault you for coming up there [to the RCTP]. I fear for my life. [And with] the unfairness we go through some times, I want to kill myself." Another person with serious mental illness described his experience of being assaulted:

> *Mental health care is heavily dictated by DOCCS security. Also 24/7 bright light, noise, and other sensory issues [in the RCTP] negate the care and exacerbate my illness. There is not one thing to like [about the RCTP]. It is an environment that causes naught but mental and emotional harm. I was assaulted by four officers . . . [One] sergeant cheered them on and rubbed his boot on my face. Conditions of confinement are such that I would rather be in my housing cell and harm myself. The abuse of power over [incarcerated person's] lives are performed more in that environment than anywhere else. No recourse is available.*

At the same time, patients with significant mental health needs who believe they are deteriorating and need psychiatric hospitalization may request placement in the RCTP to prompt an evaluation for CNYPC admission. As the data previously presented illustrated, admissions to CNYPC have significantly declined and several patients have reported to us that it is nearly impossible to get transferred from the RCTP to CNYPC. With only 335 CNYPC admissions and more than 8,200 RCTP admissions in 2013, their fear of a non-response to their desire for psychiatric hospitalization is well founded. Between the fears of physical harm and non-response, many incarcerated persons will do whatever they can to avoid going to the RCTP. One survey respondent in the Great Meadow BHU, for example, described how he did not feel safe telling a staff member he was contemplating harming himself "because then they will send me to OBS [observation cells], and officers like to assault [incarcerated persons] at OBS, because there are no cameras to catch them." Another survey respondent similarly reported that he doesn't feel safe going to the RCTP "because security staff has a history of assaulting [incarcerated persons] down there." Worse still, some patients described how their fear of going to the RCTP will greatly inhibit their ability to have any meaningful discussions with OMH staff about their mental health symptoms or challenges. According to one survey respondent in the Five Points RMHU, "They use RCTP as punishment and it makes someone like me, who struggles everyday with suicidal thoughts, [afraid] to discuss how I feel."

We have also analyzed the locations where persons were confined prior to their admission to the observation cells in the RCTPs and the locations to which they were transferred when released from the RCTP. **Table 4-Locations Prior to and After RCTP Admissions and Discharges 2009-12** summarizes this data for the last four years for persons sent to or discharged from the observation cells only. We have not analyzed the admissions and discharges from the dormitory units because patients in serious crisis are not placed in these units, and many of the dormitory residents have come from observation cells and are awaiting transfer to another prison or a specialized program.

Table 4-Locations Prior to and After RCTP Admissions and Discharges 2009-12

Prior Location of Admissions to RCTP	2009	2010	2011	2012	Ave. Admissions	Average Census	% of Total Admissions	Admission Rate[5]
Disciplinary MH Units[1]	254	548	559	538	475	218	8.11	217.890
SHU	1134	1224	1000	1203	1141	4310	19.48	26.473
CNYPC	136	156	113	96	126		2.15	N/A
Non-Disciplinary MH Units[2]	554	623	692	643	628	940	10.72	66.809
Gen. Pop./Other[3]	2733	3302	3568	3713	3329		56.83	6.403
Internal RTCP[4]	161	167	163	148	160		2.73	N/A
Parole/Street	4	0	N/A	N/A	N/A			N/A
Total RTCP Admissions	4976	6020	6095	6341	5858			
DOCCS Population	60081	58378	56315	55073		57462		

Locations Where RCTP Discharges are Sent	2009	2010	2011	2012	Average Discharges	Average Census	% of Total Discharges	Discharge Rate[5]
Disciplinary MH Units[1]	242	566	544	534	472	218	8.05	216.51
SHU	1197	1302	1094	1412	1252	4310	21.35	29.04
CNYPC	368	298	262	217	287		4.90	N/A
Non-Disciplinary MH Units[2]	480	556	579	524	535	940	9.13	56.91
Gen. Pop./Other[3]	2196	2802	2939	3031	2742		46.77	5.27
Internal RTCP[4]	487	538	646	618	573		9.77	N/A
Parole/Street	6	7	2	5	5		0.09	N/A
Total RTCP Discharges	4976	6069	6066	6341	5863			
DOCCS Population	60081	58378	56315	55073		57462		

All numbers are based on admissions and discharges from RCTP observation cells.

[1] - BHU/TBU, GTP, STP, RMHU [2] - TriCP, IICP, ICP

[3] - Infirmary, Other, WDTC, General Population, Other Facility, Reception, SNU

[4] - Observation Cell, Dorm Bed [5] - Admission and Discharge rates per 100 persons in unit/location

Table 4 details very high admission and discharge rates from and to both the disciplinary mental health units (RMHUs, BHUs, TBU and STP/GTP units) and the non-disciplinary residential mental health units (ICP, IICP, TrICP); these units have admission rates that are **34 times** and **10 times greater**, respectively, than the rate for the general prison population. Although higher rates would be expected from mental health units, it is of concern how frequently patients on these units experience a mental health crisis or express a concern about self-harm; there is an average of more than two admissions per year for every patient on the disciplinary mental health units. Of even greater concern is the fact that the disciplinary mental health units have an admission rate **three times** the rate for the non-disciplinary units, even though the patients' mental health acuity are comparable. As discussed later in the section on these disciplinary mental health units, we are concerned that the level of tension between the patients and staff and the highly punitive nature of these disciplinary units contribute to the much higher rates of mental health crises. Finally, **Table 4**

also confirms our experience during prison visits that persons in the SHUs are experiencing much higher rates of mental health crises than persons in the general prison population. The SHU RCTP admission rate is more than **four times** the rate for the rest of the prison population. This is particularly shocking in that nearly all "S" designated patients have been removed from the SHUs, which is not the case for the general prison population. Moreover, the percentage of patients on the OMH caseload in the SHUs, 17%, is not that much higher than the rate (15.8%) for the entire prison population to be anywhere near a four times higher admission rate.

Some additional observations can be made from **Table 4** data. In 2010, there was a marked increase in admissions to the RCTP observation cells; admissions from disciplinary mental health units more than doubled that year, in part, we assume, due to the opening of Marcy's RMHU. Admissions from general population steadily increased throughout the four-year period, as have admissions from the non-punitive mental health units. SHU admissions varied, but are consistently high.

Similar patterns can be seen with discharges. Of greatest concern is that the number of patients being sent to the SHU from the RCTP has risen by 29% in 2012 from 2011 levels. The number of persons sent to the SHU is more than 200 persons higher than the number being admitted from the SHU, signifying both that the vast majority of SHU admissions are just being returned to the SHU after their mental health evaluation and that persons not in SHU who experience a crisis are also being sent there. Again, we are seeing evidence of the very punitive response of DOCCS and OMH to persons with mental health issues who have behavior problems in the prisons, rather than a therapeutic response. We are also concerned with the large decline of 41% in the number of patients sent from the RCTP to CNYPC. On a more positive note, the number of patients being sent to the non-disciplinary mental health units from the RCTP has risen since 2009; unfortunately, it is still less than the number of patients coming from those units, signifying that more than 100 patients from these non-punitive units are not returning there. We are concerned that many of these individuals are being sent to some form of disciplinary housing.

SOLITARY CONFINEMENT, THE SHU EXCLUSION LAW, AND PEOPLE WITH MENTAL HEALTH NEEDS

Solitary confinement, even more so than prison itself, can have severe negative mental health impacts on all people subjected to it. Yet, New York State continues to use solitary and isolated confinement[11] at exorbitant rates, knowingly inflicting mental health harm directly in contradiction to attempts to promote mental health care. The state has taken some substantial, but limited, steps to limit the use of solitary for people with the most serious mental health needs. In addition to the fact that the restrictions have left the overwhelming majority of people still in solitary confinement, there have been substantial problems with implementation of the restrictions, including concerns about underdiagnoses and the punitive nature of the units created to be therapeutic alternatives to the SHU. Moreover, large numbers of people with severe mental health needs remain in isolation.

The Negative Mental Health Consequences of Solitary Confinement

Whether for disciplinary confinement, administrative segregation, or protective custody reasons, people in either SHU or keeplock in NYS prisons spend 22 to 24 hours per day locked in a cell.

[11] Because individuals confined in double cells in the SHU200s or S-blocks and Upstate C.F. are held in isolation with a second person, in this testimony we will at times use "isolated confinement" in place of solitary confinement.

People in the SHU and other forms of isolated confinement are generally not able to participate in any meaningful human interaction, programs, jobs, therapy, or group interactions. They are usually denied such basic "privileges" as making phone calls or purchases from commissary, often are only allowed non-contact visits if they receive visits at all, and are allowed a maximum of five books, letter writing supplies, and religious materials. The experience in Green Haven's SHU of one survey respondent exemplified the harm caused by the denial of these basic privileges, "I lost five family members since I've been in [SHU], and wasn't able to receive not one phone call." People in solitary receive food in their cells, and often receive increasingly harsh deprivation orders for rule violations, including restrictions on such basic amenities as food, showers, recreation, and haircuts.[12] The sensory deprivation, lack of normal human interaction, and extreme idleness that result from this isolated confinement have long been proven to lead to intense suffering and physical and psychological damage.[13] Isolation has been shown to create or exacerbate pre-existing mental health conditions.[14] More than two-thirds of CA survey respondents at Cayuga in 2013, for example, reported that the SHU caused them to suffer anxiety, and more than 70% depression, more than a quarter paranoia, 20% panic attacks, and 9% hallucinations. As one survey respondent in Cayuga's S-block described: "Being in SHU has caused me to withdraw and stress a lot. I don't have a regular sleep schedule. I'm going bald. From time to time, I hear voices whispering in my ear. I've become extremely paranoid."

Mental Health Impact of SHU on Everyone

The impact has made me hate the world. Hate authority and administration. Lost my ability to have emotion or to show feeling. Very anti-social. Lost love for everything and everyone. No ability to show remorse. Made me violent and without care of those I hurt. I've withdrawn from family and friends and lost a lot of my passion for life. SHU has become the cruelest punishment and has stripped my ability to feel like a human. All I have is thoughts of hurting people out of anger for this whole prison system. In no way am I innocent, but I am not an animal either. We should not be treated like scum because of our mistakes. SHU in no way works as a deterrent to anything. It de-sensitizes emotions and feelings and only makes a person worse. It cuts you off from family and friends and acts as a trigger to suppressed anxiety, aggression and depression. Solitary confinement should not be used as a weapon. It gives authority a false sense of control and allows mistreatment to go unchallenged. This confinement is demoralizing in every aspect. If it does anything, it's only to make a person hate and become filled with aggression and the lack of care for anyone or anything. In which case it only makes those returning home a more dangerous person, except now they're more aggressive and brutal. It's a terrible idea and way of life and should be banned from prison. Anonymous at Green Haven, after more than eight years in SHU.

[12] As a particularly harsh deprivation order, individuals are placed on a restricted diet where all meals consist of what is known as "the loaf," a dense, binding, tasteless, one pound loaf of mixed ingredients with a side of raw cabbage.

[13] *See, e.g.*, Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, Journal of Law & Policy, Vol. 22:325 (2006), *available at*: http://openscholarship.wustl.edu/cgi/viewcontent.cgi?article=1362&context=law_journal_law_policy ("*Psychiatric Effects of Solitary*"); Craig Haney, *Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement*, 49 Crime & Delinq. 124 (Jan. 2003), *available at*: http://www.supermaxed.com/NewSupermaxMaterials/Haney-MentalHealthIssues.pdf; Stuart Grassian and Terry Kupers, *The Colorado Study vs. the Reality of Supermax Confinement*, Correctional Mental Health Report, Vol. 13, No. 1 (May/June 2011); Sruthi Ravindran, *Twighlight in the Box: The suicide statistics, squalor & recidivism haven't ended solitary confinement. Maybe the brain studies will*, Aeon Magazine, Feb. 27, 2014, *available at*: http://aeon.co/magazine/living-together/what-solitary-confinement-does-to-the-brain/; Joseph Stromberg, *The Science of Solitary Confinement*, Smithsonian Magazine, Feb. 19, 2014, *available at*: http://www.smithsonianmag.com/science-nature/science-solitary-confinement-180949793/#.Uwoq5RsSWaQ.email.

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

Isolated confinement has also been demonstrated to increase the risk of suicide and self-harm. A recent study conducted in New York City jails, written by authors affiliated with the New York City Department of Health and Mental Hygiene, and published in the American Journal of Public Health, found that people who were held in solitary confinement were nearly seven times more likely to harm themselves and more than six times more likely to commit potentially fatal self-harm than their counterparts in general confinement, after controlling for length of jail stay, serious mental illness status, age, and race/ethnicity.[15] Numerous studies have shown that even short periods of time in solitary confinement – measured in days – result in negative psychological effects.[16]

Incarcerated women face additional issues related to solitary confinement and its impact on emotional and mental, as well as physical health.[17] Isolation can compromise women's ability to fulfill their particular needs related to reproductive health care, for instance by impeding pregnant women's access to critical obstetrical services and preventing them from getting the regular exercise and movement vital for a healthy pregnancy. Similarly, women in isolation may be dissuaded from requesting care related to sensitive gynecological issues because they are required to inform correction officers about details of their medical problem, may have serious difficulty accessing appropriate medical staff when they do reach out, may be shackled during gynecological appointments that do occur, and will often interact with medical providers in full view of correction officers and/or receive superficial evaluations through closed cell doors. Most relevant to mental health care, isolation can have particularly damaging effects on survivors of domestic violence and abuse, which represents the overwhelming majority of incarcerated women. Extended isolation may trigger symptoms of Post-Traumatic Stress Disorder (PTSD) such as flashbacks, self-destructive acts, emotional dissociation, difficulty sleeping, and irritable and aggressive behavior. In addition, isolation can have a devastating effect on women's sense of self-worth and ability to access needed supports, as women often place particular importance on sustaining relationships and community.[18]

New York's Widespread Use of Mental Health Harming Practice of Solitary Confinement

Despite these well-documented negative psychological and other impacts, New York State continues to impose solitary or isolated confinement at exorbitant rates. On any given day, in state prisons alone, more than 3,800 people are held in Special Housing Units (SHU), and a

[15] Homer Venters, et. al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, American Journal of Public Health, Mar. 2014, Vol. 104, No. 3, *available at*: http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2013.301742. A separate recent panel of scientists at the annual meeting of the American Association for the Advancement of Science also further reported on the harmful psychological and neurological effects of solitary. *See* Joseph Stromberg, *The Science of Solitary Confinement*, Smithsonian Magazine, Feb. 19, 2014, *available at*: http://www.smithsonianmag.com/science-nature/science-solitary-confinement-180949793/#.Uwoq5RsSWaQ.email.

[16] *See, e.g.*, Grassian, at 330-331 (finding that "even a few days of solitary confinement will predictably shift the electroencephalogram (EEG) pattern toward an abnormal pattern characteristic of stupor or delirium"); Haney, at 132 (citing scores of studies to report that "there is not a single published study of solitary or supermax-like confinement in which nonvoluntary confinement lasting for longer than 10 days, where participants were unable to terminate their isolation at will, that failed to result in negative psychological effects."

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

[18] Barbara Bloom, Barbara Owen, and Stephanie Covington, *Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders*, the National Institute of Corrections

thousand or more are subjected to keeplock in the state prisons.[19] Thousands more people are subjected to solitary confinement in local city and county jails around the state, including New York City Jails.[20] For the state prisons, as seen in **Table 5 – Summary of DOCCS Population and SHU Confinement**, the percentage of the total prison population held in SHU steadily increased over the last decade, with a slight decrease in 2013 that leveled off in 2014, with an overall percentage that is roughly a third higher than it was ten years ago. Moreover, a snapshot of the number of people in solitary confinement at any given time does not represent the full impact of how many people are subjected to this inhumane practice. In the less than four years from January 2010 to November 2013, DOCCS held a total of 269,188 disciplinary hearings and issued 53,760 SHU sentences and 102,407 keeplock sentences. In other words, DOCCS is issuing more than 14,000 SHU sentences and almost 26,700 keeplock sentences per year, sending people to conditions that are known to cause mental health damage.

Table 5 – Summary of DOCCS Population and SHU Confinement

Population	'03	'04	'05	'06	'07	'08
Prison	66,745	65,197	63,698	62,732	63,304	62,599
Total SHU	3,450	3,500	3,500	n/a	4,500	4,504
SHU % of TP	5.17%	5.37%	5.49%		7.11%	7.20%
S-Block*	n/a	n/a	1,300	1,280	1,300	1,300
SHU Patients on OMH	849	798	753	711	660	644
S-designated in SHU**	n/a	n/a	n/a	n/a	174	166
BHU/TBU†	n/a	n/a	76	83	96	90
RMHU††	-	-	-	-	-	-
Total OMH SHU, BHU, RMHU			829	794	756	734

Population	'09	'10	'11	'12	'13	9/14
Prison	60,081	58,378	56,315	55,073	54,609	53,864
Total SHU	4,329	4,273	4,331	4,308	3,841	3,853
SHU % of TP	7.21%	7.32%	7.69%	7.82%	7.03%	7.15%
S-Block*	1,250	1,270	1,216	1,446	1,070	
SHU Patients on OMH	606	561	579	673	710	651
S-designated in SHU**	125	104	47	36	36	
BHU/TBU†	62	60	78	64	42	
RMHU††	-	67	88	149	155	
Total OMH SHU, BHU, RMHU	668	688	792	886	907	

* Residents in S-Block units, each with capacity for 200 incarcerated persons, are included in the SHU census total.
** The number of "S" designated patients in SHU includes patients in the STP, GTP but not 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, and CNYPC program census 6/2012, 7/2013.
†† RMHU census figures were obtained from DOCCS 9/2010 data, and CNYPC program census 6/2012, 7/2013.

[19] Keeplock refers to individuals confined for 23 or 24 hours a day either in their same cell in the general prison population or in a separate cellblock.
[20] *See* James Gilligan and Bandy Lee, *Report to the New York City Board of Correction*, p. 3, Sept. 5, 2013 ("Gilligan and Lee Report"), *available at*: http://solitarywatch.com/wp-content/uploads/2013/11/Gilligan-Report.-Final.pdf; Preet Bharara, *CRIPA Investigation of the New York City Department of Correction Jails on Rikers Island*, US Department of Justice, US Attorney, Southern District of NY, p. 53, Remedial Measure C(1)(c), Aug. 4, 2014, *available at*: http://www.justice.gov/usao/nys/pressreleases/August14/RikersReportPR/SDNY%20Rikers%20Report.pdf.

Deeply problematic, the people subjected to isolated confinement in NYS prisons are disproportionately African American, representing 60% of the people in SHU compared to the already vastly disproportionate 50% of people in NYS prisons and 18% of the total NYS population.[21] Moreover, youth of color are even more disproportionately subjected to isolated confinement. Looking at a snapshot of the major isolated confinement units in New York State that hold people in isolation for the longest periods of time – namely Southport and Upstate Correctional Facilities, which are entire prisons dedicated to isolated confinement (essentially supermax prisons), and the SHU 200s or S-blocks, which are 200-bed freestanding isolated confinement units – black youth represented an even more disproportionate 66% of the young people aged 21 or younger, compared to 61% of all youth 21 and under in the DOCCS system.[22]

In large part because of the devastating mental harm caused by solitary confinement, the United Nations Special Rapporteur on Torture has concluded that isolated confinement beyond 15 days amounts to cruel, inhuman, or degrading treatment, or torture. Yet, people in NYS prisons regularly remain in isolated confinement for months and years, and sometimes even decades. Each year, DOCCS imposes an average of nearly 8,000 individual SHU sentences of three months or more and nearly 3,900 SHU sentences of six months or more. Moreover, people often accumulate disciplinary infractions while in the SHU, thereby greatly extending their time beyond these initial sentences. As one example, looking at the cumulative sentences to solitary confinement[23] at Attica, a prison incarcerating around 2,000 people, from January 2010 to November 2013, 2,225 people had a cumulative sentence to isolated confinement of 30 days or more. Over 1,100 people had a cumulative sentence of six months or more, 450 people had a cumulative sentence of one year or more, over 100 people had a cumulative sentence of two years or more, 40 people had a cumulative sentence of three years or more, and eight people had cumulative sentences of *five years or more*, with the highest being just under *seven years* of solitary confinement.[24] Similarly, in the Main facility at Clinton, which incarcerates just under 2,000 people, over 2,780 people received a cumulative sentence to isolated confinement of 30 days or more, over 1,000 people had a cumulative sentence of six months or more, 400 had a cumulative sentence of one year or more, and six individuals were sentenced to five years or more, with the highest amounts of time being *eight years* and *10 years* of solitary confinement. Unfortunately, the lengths of time in solitary confinement at Attica and Clinton are not unique to those prisons. The CA has met with many people who have spent over a decade in solitary confinement in NYS, including up to as many as 26 years in isolated confinement.[25]

Restrictions on Use of Solitary for People with the Most Serious Mental Health Needs

New York State has made substantial, but limited, progress toward reducing the use of solitary confinement for people with serious mental illness, along with children, pregnant women, and people with developmental disabilities.[26] Most relevant to this hearing, as a result of the intense

[21] *See, e.g., Boxed In* at 24.
[22] Analysis of information obtained from DOCCS.
[23] Cumulative sentences were calculated by adding all SHU and keeplock time minus any time cuts received.
[24] *Ibid*.
[25] *See Voices from Solitary*, Solitary Watch, *available at*: http://solitarywatch.com/2013/03/11/voices-from-solitary-a-sentence-worse-than-death/; http://solitarywatch.com/2013/06/03/voices-from-solitary-the-loneliest-place-in-the-world/; http://solitarywatch.com/2013/05/01/voices-from-solitary-you-are-solitary-confinement/.
[26] For more information on restrictions on the use of solitary for children, pregnant women, and people with developmental disabilities, *see Leroy Peoples, et. al.v. Brian Fischer, et. al.*, Docket Number 11-CV-2964 (SAS), Stipulation for a Stay with Conditions, *available at*: http://www.nyclu.org/files/releases/Solitary_Stipulation.pdf;

focus on isolation of the seriously mentally ill by numerous advocates for a decade, and through a combination of litigation and legislation, New York implemented historic restrictions on solitary confinement for the seriously mentally ill. The SHU Exclusion Law[27] was passed by the New York State Legislature in January 2008 – expanding upon a 2007 litigation settlement in *Disabilities Advocates, Inc. v. NYS Office of Mental Health* – and took full effect in July 2011.

The SHU Exclusion Law requires that any individual who suffers from a serious mental illness (with a so-called "S-designation") and is sentenced to a period of disciplinary confinement that could exceed 30 days must be diverted from a SHU or separate keeplock unit to a Residential Mental Health Treatment Unit (RMHTU), except in "exceptional circumstances."[28] RMHTUs must be therapeutic in nature, jointly operated by DOCCS and OMH, and include all NYS Residential Mental Health Units (RMHU), Behavioral Health Units (BHU), Therapeutic Behavioral Units (TBU), Intermediate Care Programs (ICP), and the Intensive Intermediate Care Program (IICP).[29] As seen in **Table 12 – Summary of People on OMH Caseload in SHU**, there has been a more than 78% drop in the number of people with an S-designation in the SHU since the year before the SHU Exclusion Law came into full effect.

The law requires that individuals in RMHTUs be offered at least four hours a day, five days a week, of structured out-of-cell therapeutic programming and/or mental health treatment.[30] The law also requires RMHTU residents to "receive property, services, and privileges" similar to general population,[31] and places restrictions on discipline in RMHTUs, including prohibiting: restricted diets, misbehavior reports for refusing medication or treatment, and removal to disciplinary confinement absent a significant and unreasonable safety or security risk; as well as creating a presumption against disciplinary charges for acts or threats of self-harm.[32]

In addition to the provisions related to diversion, the law requires all new DOCCS staff who will regularly work in programs providing mental health treatment to receive eight hours of training on such topics as types and symptoms of mental illness, treatment goals, suicide prevention, and effective and safe management of individuals with mental illness.[33] The law empowers the Justice Center (formerly the NYS Commission on Quality Care & Advocacy for Persons with Disabilities ("CQC")) to monitor the quality of mental health care provided to incarcerated individuals, ensure compliance with the law, make recommendations related to the diversion and removal of individuals with serious mental illness from disciplinary confinement, and have an advisory committee composed of mental health experts, advocates, and family members of incarcerated individuals with serious mental illness.[34]

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http://plsny.org/assets/PLS-Landmark-Settlement-for-Juveniles.pdf;
http://nylawyer.nylj.com/adgifs/decisions14/103014settlement.pdf.

[27] SHU Exclusion Law of 2008, 2008 N.Y. Laws 1 (codified as amended at N.Y. CORRECT. LAW §§ 137 & 401-a (McKinney 2012) and N.Y. MENTAL HYG. LAW § 45 (McKinney 2012)

[28] *See* N.Y. CORRECT. LAW § 137.6(d)(i).

[29] N.Y. CORRECT. LAW § 2.21. If a diverted individual is placed in an RMHU or BHU, the time spent in those units will be credited toward any disciplinary sanction that has been imposed.

[30] N.Y. CORRECT. LAW § 2.21. The law carves out an exception to the four hour requirement for the 38 BHU unit beds currently at Great Meadow Correctional Facility, where only two hours of out of cell time are required.

[31] N.Y. CORRECT. LAW § 401.2(b).

[32] N.Y. CORRECT. LAW § 401.2(b), 3, 5(a)

[33] N.Y. CORRECT. LAW § 401.6.

[34] N.Y. CORRECT. LAW § 401-a(1), (2), (3).

Patients in DOCCS Residential Mental Health Units and Behavioral Health Unit

The Residential Mental Health Units (RMHUs) in DOCCS are located at three prisons: Marcy (104 beds), Five Points (63 beds) and Attica (10 beds). The census as of October 27, 2014, was 133 patients. This figure is a significant drop (11%) from 150 patients in the RMHU as of August 20, 2014 and a reduction of 14% from the RMHU census as of July 2013 of 155 patients. In addition to the RMHUs, DOCCS established Behavior Health Units (BHUs) for men and the Therapeutic Behavioral Unit (TBU) at Bedford Hills for women, which were used to provided mental health care to disciplinary inmates; the TBU at Bedford Hills and one BHU at Great Meadow are still operational and these units are also permitted to house patients with serious mental illness pursuant to the SHU Exclusion Law as Residential Mental Health Treatment Units (RMHTUs). Another BHU at Sullivan was closed in mid-2013, leading to a decrease in the number of patients in a BHU.

Prior to 2011, some patients with serious mental illness in the SHU would receive mental health services in the SHU's Special Treatment Program (STP) or Group Therapy Program (GTP)[35] for two hours per day, five days a week. Because the SHU Exclusion Law prohibited patients with serious mental illnesses from remaining in the SHU, in 2011, the STP and GTP programs were terminated for patients with serious mental illness and replaced with the RMHUs. **Table 6-DOCCS Residential Mental Health and Behavior Health Units 2009-13** details the capacity, census, annual admissions for the STPs, GTPs, RMHUs, and BHUs units for the period 2009 through 2013. Unfortunately, OMH and the Justice Center have been delayed in their response to requests for information about mental health services so that our summary is not complete for 2013.

Table 6–DOCCS STP, GTP, Residential Mental Health and Behavioral Health Units 2009-13

Facility Unit	CY 2009			CY 2010			CY 2011			CY2012			CY2013		
*	Cap	Cen	Adm	Cap	Cen	Adm	Cap	Cen	Adm	Cap	Cen	Adm	Cap	Cen	Adm
Attica STP	34	33	77	34	24	71	34	23	n/a	0	0	0	0	0	0
Five Pts STP	50	46	46	50	38	98	50	34	n/a	0	0	0	0	0	0
Green Haven STP	24	24	83	24	18	60	24	0	n/a	0	0	0	0	0	0
GTP programs	48	30	85	36	15	68	24	5	n/a	0	0	0	0	0	0
STP/GTP Total	108	133	291	108	95	297	108	62	n/a	0	0	0	0	0	0
Bedford H. TBU	16	7		16	15		16	14	40	16	14	40	16	11	26
Grt Meadow BHU	38	39	53	38	32	98	38	30	78	38	38	104	38	30	101
Sullivan BHU	64	23		64	28		64	44	8	64	23	44	64	17	-
Attica RMHU	0	0	0	0	0	0	0	0	17	10	7	13	10	9	277
Five Pts RMHU	0	0	0	0	0	0	0	0	74	60	52	76	60	52	
Marcy RMHU	0	0	0	100	67	n/a	100	65	138	100	82	133	100	67	
Totals	**226**	**202**		**326**	**237**		**326**	**215**	**355**	**288**	**216**	**410**	**288**	**186**	**404**

* Each year contains the capacity (Cap), census (Cen) and annual admissions (Adm) for each unit.

Overall, the transition during the last decade from mental health patients in SHUs to specialized mental health treatment units for patients with serious mental illnesses who have been given a disciplinary sanction has significantly enhanced the mental health services for these patients and reduced somewhat the negative consequences of extreme isolation associated with SHU

[35] The Group Treatment Programs were conducted at Clinton, Elmira, Southport and Wende in six caged cubicles adjacent to the SHUs in these prisons in which up to six patients could be seen in the morning and afternoon, five days per week. In 2010 the Southport program was closed, and during 2011, all the programs were closed for seriously mentally ill patients pursuant to the SHU Exclusion Law.

confinement. The programs provide daily, five days per week, two to four hours of educational, group counseling and/or therapeutic services to most patients on these units. As a result of this enhanced care, some patients are improving their behavior, not receiving additional misbehavior reports and consequently, being released from disciplinary confinement to general population or non-disciplinary mental health units such as the ICP and TrICP.

But major problems still exist on these units. Although most residents in these units receive some out-out-of cell time and programming, even these residents still remain locked down, in a disciplinary unit, 19-22 hour per day during the week and 23-24 hours per day on the weekend. According to one representative patient, "besides the four hours of group, the RMHU is run like a SHU." Although better than SHU confinement of 23-24 hours per day, the disciplinary confinement of the RMHTUs can also have devastating physical, emotional, and psychological effects, particularly in light of the other abusive conditions described below. As one survey respondent reported, "this RMHU causes me more angst, emotional anguish, anger, stress, hopelessness, fear, anxiety, and frustration than any SHU I've been in combined." Moreover, many residents report, and DOCCS data supports the conclusion, that these units are still excessively punitive, with many residents getting significant additional SHU sanctions imposed while in the program; some patients are being denied mental health services by OMH and DOCCS staff for alleged misbehavior; conflicts and tension between security staff and patients frequently arise; for some patients the group sessions being offered do not address their mental health needs; and many residents have concerns about the lack of confidentiality.

The number of patients with serious mental health illnesses being placed in disciplinary units in which they received mental health treatment increased from 2005 to 2010, but decreased in 2013. In 2005 there were only 79 patients in the STP program receiving daily mental health therapy. The number of patients in any disciplinary mental health unit increased to 159 in 2007, 199 in 2008, 202 in 2009, and peaked at 237 patients in 2010 in the RMHUs, BHUs, STP, GTP, and TBU. During the next two years, 2011 and 2012, the patient population was stable at 215 and 216, respectively, in disciplinary mental health units. However, this past year, 2013, the census dropped by 14% to 186. On the one hand, we are pleased that fewer patients with serious mental illness are in a disciplinary unit, even one that provides significant mental health care, because these units are still restrictive and excessively punitive, as described below. But we also have some concerns about this decreasing population, given the situation that there are still 650 to 700 persons with mental health conditions in the regular SHU, many of whom have Level 1 acuity signifying they are in need of substantial mental health treatment. We have earlier expressed concerns about the under-diagnosis of patients with serious mental health conditions who may not be receiving an "S" designation and therefore would be placed in the SHU when the SHU Exclusion Law would mandate a transfer to the RMHU. But even if the patients in the SHU are not misdiagnosed, during 2013 there was an average of 84 OMH Level 1 patients and 200 Level 2 patients in the SHU throughout the year. Clearly, many of these patients would have benefited from the mental health services provided in the RMHUs and it is wasteful for approximately 60 to 100 treatment beds to remain empty while patients in need of care are being denied services.

There has been an increase in the number and percentage of RMHU and BHU patients being discharged to non-punitive housing, but many are going to housing units in which there is no on-unit mental health treatment. A positive trend we observed is that the number of RMHU and BHU patients being discharged to non-disciplinary mental health units has risen during the last five years. As detailed in **Table 7-Locations Where STP, BHU, RMHU Patients were Discharged, in**

2009-12, in 2012, 276 persons released from the RMHUs, TBU and BHUs to other locations in the prison system went to general population, ICP, TrICP or some alternative non-punitive housing area, representing three-quarters of the 362 individuals discharged from these units who remained in prison. This number of releases to non-disciplinary units represents an improvement from 2009, when only 161 patients in the STP and BHU were discharged to non-punitive housing, representing two-thirds of the 239 patients in these units who were discharged during that year to in-prison housing. We believe the increased numbers of mentally ill patients getting released to non-punitive housing demonstrates the benefits that some disciplinary patients experience from the intense mental health care provided in the RMHUs and BHU.

We also note, however, that 47% and 37% of RMHU, TBU and BHU patients were discharged to prison housing locations, such as general population, that did not provide substantial mental health services in 2012 and 2011, 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 RMHUs, TBU and BHU. We question whether these discharges are a function of inadequate space in the ICPs and TrICPs to accommodate patients with significant, but somewhat less severe, mental health conditions.

Table 7-Locations Where STP, BHU, RMHU Patients Were Discharged

	2009		2010			2011			2012		
	STP*	BHU	STP	BHU	RMHU	BHU	TBU	RMHU	BHU	TBU	RMHU
ICP**	53	13	74	18	n/a	44	6	44	38	10	70
TrICP	27	5	20	6	n/a	6	4	6	10	6	10
IICP	6	0	1	0	n/a	0	0	0	1	0	0
CORP	3	0	4	2	n/a	0	0	0	0	0	0
GP	43	9	30	7	n/a	19	18	17	31	11	25
OTHER‡	3	0	4	2	n/a	2	3	5	5	0	59
SNU	0	0	2	0	n/a	0	0	0	0	0	0
SubTOTAL	135	27	135	35		71	31	72	85	27	164
SHU/KL	10	9	0	1	n/a	0	0	1	4	0	3
BHU/TBU	10	0	26	0	n/a	0	0	9	47	0	14
STP	7	5	8	0	n/a	1	0	0	0	0	0
GTP	8	11	4	8	n/a	0	0	4	0	0	0
RMHU	14	3	34	15	n/a	24	0	15	8	0	10
SubTOTAL	49	28	72	24		25	0	29	59	0	27
CNYPC	32	5	20	2	n/a	6	4	30	5	12	33
RELEASED	7	7	8	6	n/a	8	5	14	4	6	24
TOTAL	223	67	235	67		110	40	145	153	45	248

No discharge locations were available for GTP in 2009-12 or for the TBU in 2009-10.
* No data is available for 2011 STP discharges when units closed.

** The IIC discharge numbers includes the IICP for 2011data.
‡ For 2012, the RMHU OTHER category appears to include many GP discharges, based on data we received from Marcy.

We are also very concerned, discussed further below, about the lack of services provided to patients to help them with the transition from months and sometimes years of disciplinary confinement to a general population setting. This failure to provide intense mental health services to discharged patients from the disciplinary mental health housing is contributing to the cycling of these patients from the RMHUs to general housing and then back to an RMHU. Repeatedly patients we interviewed in the RMHU told us about the difficulties they experienced when discharged to a housing location that did not provide residential mental health care, often leading them to decompensate and engage in difficult behaviors that were met with punishment, rather than treatment, and being sent back to a disciplinary confinement unit.

From General Population Right Back to an RMHU

Domingo has spent most of the last six years in disciplinary confinement. Because of the DAI litigation and the SHU Exclusion Law, much of that time has been in a mental health unit – STP, BHU, and RMHU – rather than the SHU, but a punitive disciplinary confinement unit nonetheless. Early in 2014, it looked as though Domingo was finally going to be able to put disciplinary confinement behind him. He had worked his way out through his own perseverance and the support he received in Marcy's RMHU. As he stated, "Marcy is the best place for groups of all of the residential units . . . half of the . . . groups are spectacular – they give you information that you can utilize throughout your life." He had successfully participated in RMHU programs, earned his GED while there, and was ultimately able to leave. Yet, his success story quickly went wrong when he was not sent from the RMHU to an ICP as he had hoped, and was not provided the mental health services needed to help him cope with years of isolation and the transition to a general population (GP) environment at another prison. Without the necessary support during that transition, Domingo quickly deteriorated, engaged in behavior resulting in a new disciplinary charge, and was sent back to Marcy's RMHU.

Unfortunately, the response to Domingo's difficulty dealing with the transition was to punish him and send him back to a disciplinary unit rather than to provide the missing support. Worse still, Domingo has faced additional discipline and punishment since he has been back in the RMHU. In the first few months back in the RMHU, he received additional disciplinary tickets, resulting in more SHU time. Worse still, he had been placed on exceptional circumstances for several weeks, meaning that he was held in his cell without participating in programming – in complete solitary confinement. Although he still believes that Marcy's group programming is very positive, he believes "they use exceptional circumstances as punishment," and that CO provocation and abuse undermines the work of OMH staff. As Domingo said, "OMH may want to help but can't always; it is supposed to be a safe environment but isn't." Domingo still has decades left to serve in prison. Hopefully, DOCCS and OMH can learn the lessons of the past, and provide Domingo with the programs and services demonstrated to help him thrive rather than denying treatment and inflicting punishment that will only harm him and cause him to deteriorate further.

Approximately half or more of all RMHU, BHU, TBU and STP patients have received disciplinary tickets 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. Moreover, these patients receive many more tickets than other incarcerated persons and receive significant additional SHU time while on these units. Unfortunately, the practice of issuing disciplinary actions against these patients has continued at rates higher than in the rest of the prison population. During the period January 1, 2010 through October 2013, data provided by DOCCS revealed that 4,330 hearings were conducted for persons in the RMHUs, BHUs, TBU, and STPs. These hearing were held for 729 different persons, which represents about half of the estimated 1,400 persons who were on these units during this time period. Since the analysis is by unit, if a person was admitted to multiple mental health units during the period, each of their admissions would be separately counted. As indicated in **Table 8-Disciplinary Hearings for**

Disciplinary Mental Health Patients-2010-13, the rate of disciplinary hearings for these mental health patients in residential disciplinary units was two to more than **six times** the hearing rates for all maximum security prisons, and one and one-half to three times the hearing rate for Upstate CF, which is an all disciplinary prison of solely isolated confinement, with the highest hearing rate in the Department. Although the RMHTUs are supposed to be therapeutic environments that attempt to respond in non-disciplinary, therapeutic ways to any inappropriate behavior of mental health patients, the disciplinary data we received from DOCCS indicates otherwise.

In addition, as with disciplinary hearings across the system, almost all people issued a disciplinary ticket are found guilty. As one RMHU survey respondent summarized,

> *I received yet another 100% fabricated ticket with no merit in the charges. . . . Because I write and vocalize my dissatisfaction of unfair treatment, I am allowed to be found guilty 99% of all tickets. It is always the same response from hearing officers – they say 'appeal it' and Albany affirms it even with proof you were innocent. . . . When video is requested that will show in favor of the [incarcerated person], it is 'unavailable.' COs here practice cruelty, corruption, and control; not care, custody, and control. The conviction rate is totally unfair and the time/sanctions are excessive. Supervisors allow them to do what they want. . . . Please continue to investigate COs' petty, malicious, spiteful, nasty, conduct. We are human and deserve respectful, professional care and treatment.*

Table 8-Disciplinary Hearings for Disciplinary Mental Health Patients-2010-13

UNIT	Ave. Pop	Total Hearings	Years Open	Hearing Rate	Rate Compared to Upstate CF	Rate Compared to All Maximums
Marcy RMHU	71	1697	3.833	23901	3.269	5.117
Sullivan BHU	28	547	3.5	21394	2.926	4.580
Great Meadow BHU	33	621	3.833	18818	2.574	4.029
Attica RMHU	8	131	2.1666	28970	3.962	6.202
Five Pts RMHU	52	813	2.3333	25684	3.513	5.499
Five Pts STP	34	152	1.4166	12096	1.654	2.590
Attica STP	23	99	1.4166	11647	1.593	2.493

Not only are these mental health patients often disciplined, but many of them receive numerous tickets, often in short periods of time. **Table 9-Number of Disciplinary Hearings per Disciplinary Mental Health Patient-2010-13** details the number of tickets issued to each of the 729 patients disciplined on these units from January 2010 through October 2013. More than one-third of the patients disciplined received five or more hearings, a rate much higher than in the general prison population. But what is most disturbing are the 115 persons who received more than 10 tickets, a situation very few other incarcerated persons experience. And the numbers go as high as 30, 40, 50, and even 60 tickets for an individual person. What is clear from this data is that DOCCS continues to rely on issuing disciplinary tickets as a solely punitive response to problematic behavior even when it is obvious that this intervention is not effective. Although OMH and DOCCS

assert that they are using non-disciplinary information reports to deal with inappropriate behavior, the use of disciplinary sanctions continues unabated at extraordinarily excessive levels.

Table 9-Number of Hearings per Disciplinary Mental Health Patient-2010-13

UNIT	# Persons	1 hear	2 hrgs	3 hrgs	4 hrgs	5 hrgs	6 hrgs	7 hrgs	8 hrgs	9 hrgs	10 hrgs	More than 10 hearings
Attica RMHU	29	5	5	2	6	2	2	1	2	2	1	13
Attica STP	41	22	6	4	3	3	1	1	0	0	0	13
Bedford TBU	55	21	11	6	5	2	1	1	1	1	1	11, 16, 22(2),23 **[5]**
Five Points RMHU	110	30	13	10	7	12	1	4	2	3	4	11,12(2),13,14(3), 16,17,18(2),19(3), 20,22(2),23,25(2), 29,30,50,60 **[24]**
Five Points STP	40	10	7	7	1	6	3	2	2	1	0	16
Green Haven STP	15	5	4	2	0	2	1	0	0	0	1	
Great Meadow BHU	133	43	21	12	11	7	5	6	6	5	4	11(2),12(2),13(2), 15, 16, 18(2), 22, 25, 30 **[13]**
Marcy RMHU	213	62	30	19	15	8	9	4	5	4	4	11(5),12(4),13(4), 14(3),15(2),16(3), 17(2),19,21,22(3), 23(3),25,26(5),27, 29(4),31,32,35, 36(2),37,39,45, 46(2),55 **[53]**
Sullivan BHU	93	21	18	5	11	2	5	2	6	3	3	11(3), 12, 13(4), 14(2), 16, 17(2), 18(2), 19(2) **[17]**
TOTAL	**729**	**219**	**115**	**67**	**59**	**44**	**28**	**21**	**24**	**19**	**18**	**115**

The most problematic aspect of the Department's continued use of disciplinary tickets on these mental health units is that these patients are sentenced to more SHU time, which prolongs their time in disciplinary housing and also likely results in denials of parole, thereby extending their time in prison. **Table 10-Additional SHU Time for RMHU, BHU, TBU and STP Patients-2010-13** details how much additional isolation time, in months, the 729 persons received as a result of their disciplinary hearings during the period they were in these units and includes any time cuts they may have received subsequent to the hearing.

More than 200 persons on these units received one year or more of additional isolation time while in the mental health unit, 96 persons received two years or more and 26 patients received a shocking four years or more of SHU time. In addition to these extraordinarily long sentences, an additional 101 persons were sentenced to six months to one year of additional SHU time. Given a rough estimate of 1,400 total census on these units during the three year, ten month period, this data indicates that more than 20% of all patients were given six months or more of time. It must be emphasized that these calculations include any time cuts given these patients, so the notion that

DOCCS and OMH are responding to positive behavior with significant time cuts is belied by the data presented here.

Table 10-Additional SHU Time for RMHU, BHU, TBU and STP Patients 2010-13

UNIT	# Persons	No Time	>0 & <3	3 & <6	6 & <12	12 & <18	18 & <24	24 & <36	36 & <48	48 & <60	Longer Sent
Attica RMHU	29	2	2	6	4	7	2	2	3	1	69
Attica STP	41	3	12	9	7	6	2	1	1	0	
Bedford TBU	55	11	15	13	7	3	3	1	1	1	61
Five Pts RMHU	110	14	19	16	18	9	6	9	8	4	62,63, 79, 86
Five Pts STP	40	10	8	5	8	2	3	2	1	1	
Green Haven STP	15	5	3	3	2	2	0	0	0	0	
Grt Meadow BHU	133	38	32	18	21	8	7	8	0	2	
Marcy RMHU	213	56	53	26	22	16	12	14	6	8	
Sullivan BHU	93	7	28	12	12	13	5	10	3	2	110
TOTAL	**729**	**146**	**172**	**108**	**101**	**66**	**40**	**47**	**23**	**19**	**7**

All times in months

It must also be noted that the data only indicates additional SHU time these patients received while they were on a specific unit. Many of these stays were much shorter than the nearly four year period being analyzed. Many of the patients were on more than one disciplinary mental health unit. Analyzing all mental health disciplinary hearings by patient, we identified 493 separate individuals. Of this group, there were two persons who were admitted to six different units, four persons to five different units, 10 persons with four admissions, 44 persons with three admissions and 91 persons with two admissions, representing 30% of all the patients receiving disciplinary hearings on these units. This analysis does not address the issue of patients who were admitted to the same unit on multiple occasions, so it is likely that many more patients had multiple admissions during this four year period. When the total SHU time added is assessed for persons with multiple unit admissions, the length of their total accumulated SHU time is even more egregious. **Table 11-Cumulative SHU Time for Disciplinary MH Patients in MH Units** summarizes the extraordinarily long SHU sentences. Thirty percent of all disciplinary mental health patients who had a hearing had a cumulative time added of one year or more. There were 35 persons with five years or more of additional time and five persons with **11 or more years added**. It is unfathomable what is being served by adding so much time to the SHU sentences for these patients; the imposition of more time does not seem to deter any objectionable behavior taking place but undermines any notion that the units are trying to treat the patients rather than just punishing them.

Table 11-Cumulative SHU Time for Disciplinary MH Patients in MH Units 2010-13

Years Added	1 to 2 Years	2 to 3 Years	3 to 4 Years	4 to 5 Years	5 to 6 Years	6 to 7 Years	7 to 8 Years	8 to 9 Years	9 to 10 Years	10 to 11 Years	11+ Years	Total
Number	**50**	**35**	**17**	**11**	**11**	**7**	**2**	**4**	**3**	**3**	**5**	**148**

Five Years of SHU Time Accumulated in the RMHU

"I have accumulated over five additional years of SHU and keeplock as a result of my untreated mental illness." Adrian has an OMH Level 1S designation and has long been known by the DOCCS system to suffer from serious mental illness. Over the course of his incarceration, Adrian has been in the ICP at Elmira, Sing Sing, and Wende, and at the time we met him, he had resided at Five Points RMHU for nearly half of his four years in DOCCS custody. He has also committed repeated acts of self-harm and cycled back and forth to the RCTP. Despite his serious mental health needs, Adrian reported that he has not been given the mental health treatment that he needs, and instead has faced physical abuse and punishment. Adrian reported a long and detailed list of allegations of serious physical abuse by staff, in part causing him to refuse to go to groups. In the 20 months that Adrian had been in the RMHU, he had only been to groups once, because he refuses to go. In addition, Adrian believes that he is "not being properly treated for [his] mental illness," including being denied access to mental health and medical medications he believes he should be receiving. Adrian believes that he is not being given his proper medications because security staff "dictates the level of OMH/medical care provided in the RMHU." Adrian recognizes that not getting the medications he needs, and not participating in group therapy can cause him to "act out" and engage in disruptive actions that are violations of the prison rules. The response to these behavioral manifestations of his mental illness have been punishment, mostly in the form of repeated disciplinary tickets and years of additional SHU and keeplock time accumulated in the RMHU. Adrian is well aware of the link between his mental health treatment, his behavior, and disciplinary action taken against him by DOCCS, and he is crying out for proper treatment, rather than punishment and abuse.

As a representative example of this disturbing reality, between June 2010 and October 2011, one individual in Attica's STP and then RMHU had 13 disciplinary hearings while he was in one of those units, and received an additional 35 months of cumulative SHU time.[36] During roughly one month from the end of September 2011 to the end of October 2011, this individual had eight separate disciplinary hearings and received an additional eight months SHU time and two months of keeplock time. Meanwhile, he had received an additional three months of SHU time just the month before. This individual appears to have been having some behavioral issues during this time that were almost certainly connected to his serious mental illness and may have required some type of intervention. However, although he was supposedly in a therapeutic environment, the response over and over again – which repeatedly proved itself to fail since the alleged misconduct did not abate – was discipline and punishment rather than treatment or counseling, and the individual ended up with *three more years* of SHU time.

Worse still, another individual in Attica's RMHU had nine disciplinary hearings in a 10 day period at the end of October 2013 / beginning of November 2013, and received an additional *four more years* of SHU time. The largest number of charges at these hearings was "unhygienic act", again almost certainly directly connected to the individual's mental illness and requiring a therapeutic rather than punitive intervention. A third individual in the RMHU had eight disciplinary hearings in a three month period from November 2011 to February 2012 that resulted in an additional nearly *six more years* of cumulative SHU time. Not one of the charges this individual faced involved any alleged violent conduct, but rather included refusing a direct order (most frequent charge), having property in an unauthorized area, harassment, lewd conduct, interference with an employee, one charge of threats, and smuggling. As a fourth horrific example, one individual who went in and out of the RMHU and the general population, had 17 disciplinary hearings between June 2010 and February 2013, and received an additional *four and a half more years* of cumulative SHU time.

[36] He received 36 months of SHU time and two months of keeplock time, and received a three-month time cut.

Seven of those hearings, resulting in 15 months of SHU time, all took place in a one month time period from January to February 2013, and another six of the hearings took place in a three week period in October 2012, resulting in an additional three more years of cumulative SHU time. Overall, of the 34 individual persons at Attica who received the most number of disciplinary tickets from January 2010 to November 2013, nearly one third, or 11 distinct people had been in Attica's STP or RMHU. All of these examples are deeply disturbing, epitomize the nonsensical punitive approach taken, and demonstrate the complete failure of such a punitive approach to actually reduce misbehavior or address people's needs or underlying causes of their behavior.

Patients in the RMHU and BHU have a mixed assessment of the quality of care they are receiving with some very positive about the group sessions and individual counseling and others critical of these services. The CA visited Five Point's RMHU in 2013 and Marcy's RMHU in 2014, during which time we interviewed many patients on both units and received written surveys from these patients and other residents. In addition, we had visits to Great Meadow in 2010 and 2011, and interviewed and got written surveys from several BHU patients in 2012. Based upon these tours and survey data we believe there are programs that are assisting many patients, but also conclude that some residents are not getting the care they need or are experiencing problems with program and/or security staff that are undermining their ability to participate in programs. Moreover, we find significant variation in the assessment of patients based upon the unit in which they are confined.

The SHU Exclusion Law's Benefits and Failures

Steven has been in disciplinary confinement for more than 15 years. Steven's experience shows both some of the positive effects of the SHU Exclusion Law and some of its limitations. On the positive side, Steven was able to get out of the SHU and be diverted to an RMHU. In the RMHU, at the time we met him Steven was participating in programming, and had positive assessments of both his individual and group therapy. Relatedly, his mental health had achieved greater stabilization at least in the sense that he had not been to the RCTP or CNYPC in quite some time. In part due to his more stabilized mental health situation and his positive participation in programs, Steven was able to obtain time cuts to reduce his SHU sentence of what would have been 10 years still at the time of our visit to six years. On the other hand, while the RHMU is clearly an improvement upon SHU, and certainly has been a marked improvement for Steven, he is still confined to his cell 19-20 hours a day during the week and 23-24 hours a day on weekends in a generally punitive, disciplinary confinement unit. Moreover, Steven has at times become overwhelmed and refused to leave his cell because it was too stressful, as he did for a 180 day period of time in the months before our visit. Steven has achieved positive benefits from the SHU Exclusion Law, but it is sad that one of the more successful stories involves a person who still faces years of disciplinary confinement.

In all of these units, most patients are involved in two types of programs: (1) group sessions which are run twice a day in the morning and afternoon, five days a week, that can last one to two hours and (2) individual therapy with a mental health provider, usually an OMH social worker or psychologist, that occurs at least once per month, but sometimes can be more frequent based upon the needs of the patient. Overall, based upon surveys from the Great Meadow BHU and Five Points and Marcy RMHU residents, a majority of patients reported that the group sessions were good (41%) or fair (37%), with only 22% assessing them as poor. These numbers are better than many programs we evaluate within the prison, but also suggest there are areas that need improvement. The assessment also varied greatly by prison; survey respondents at Five Point's RMHU were more critical of the group sessions with 33% reporting them good and 27% assessing them as poor, in comparison to Marcy's resident surveys in which 52% said the sessions were good and only 13%

assessed them as poor. In interviews and survey comments, more residents praised Marcy's group programs and staff running those programs as being relatively supportive and helpful for people to deal with their mental health issues. On the other hand, most interviewees and survey respondents at Five Points and Great Meadow had at best mixed reviews of the quality of the programming, with some major complaints.

The major benefit of the group programming reported by RMHU survey respondents at Marcy and Five Points was simply the ability to come out of their cells and participate in some programming for four hours a day. Some people felt that, for example "in these groups we get the opportunity to speak on a variety of topics," or that, at Marcy in particular, they receive useful "self-help and mental health information provided in group sessions." On the other hand, many patients, particularly at the Great Meadow BHU and to a lesser extent at the Five Points' RMHU, felt that the programs did not offer meaningful treatment opportunities to address their mental health issues, and that too often staff appeared disinterested if not antagonistic, or even repeatedly played outdated videos. As one survey respondent at Five Points reported, in most "of all these so-called therapy groups all they do is put in a disc, which leaves no room or time for real discussion." Similarly, one Great Meadow BHU patient reported that "OMH staff don't teach in the groups. We don't do nothing but sit in cages and watch T.V. for the whole two hours of programming. . . . I'm not receiving any therapeutic treatment for my mental illness in the groups." Even at Marcy, although many patients were doing well in group programming, some did not find them useful, and still others found some group sessions and some particular staff to be helpful, while other group sessions and staff were rated poorly.

Another major concern, particularly at Five Points and Great Meadow and also to a lesser extent Marcy, was that the punitive nature of the security staff on the unit permeates even into the group programming. Indicative of the predominance of security and punishment over treatment, in the initial phase at all three RMHTUs, by policy residents often participate in group therapy in separated, individual caged cubicles (that look like caged phone booths), after being shackled in handcuffs and leg irons to get to the therapy session. It is very difficult to establish a trusting, therapeutic relationship among group participants or between participants and a therapist when they are divided by such restrictive physical barriers. As one Five Points RMHU resident reported, "treatment and therapy are limited to what DOCCS will allow and since DOCCS' main mission is contrary to OMH's main mission, needed evidence-based best practices are skewed for more controllable shackled group therapy, caged individual sessions, and pharmaceutics of sedatives and physically inhibiting types." Another survey respondent similarly reported that "this place is like hell. DOCCS officer staff run this place. They tell OMH staff what to do. Since I [have] been here, I seen seven OMH staff leave this job. They can't take it. I seen so many mentally ill [persons] get beat up and their arm broken. You just don't know. I got to get outta here. I don't feel safe here."

Patients' assessments of their individual therapists also varied but were overall mixed to somewhat positive with 38% rating the services as good, 28% as fair and 34% as poor. Again, these numbers varied by facility; at Marcy 41% said the individual therapy was good and 21% reported it as poor, whereas 29% of Five Point survey respondents assessed therapy as good and 52% rated it as poor. Moreover, 29% of Five Point survey respondents said they did not have enough time with their therapist, in contrast to only 17% of Marcy respondents who found the time insufficient. In turn, some survey respondents at Five Points reported that counseling sessions were relatively superficial, staff were not offering much substantive therapy during the sessions, and staff even did not have much continuity between sessions. One RMHU survey respondent, for example, reported that "I

mentioned the details of my illness to my therapist, and the therapist never inquired about it at any one-on-one session that we had since."

Another concern raised by the patients at both Marcy's and Five Points' RMHUs and the Great Meadow BHU is a lack of confidentiality of conversations with mental health staff. Many patients reported that information they reveal in group sessions or individual therapy is being shared with security staff who either divulge the sensitive information to other residents or confront the patient with these personal facts. Contributing to the lack of confidentiality, some patients reported that they sometimes receive their mental health therapy in "cellside interviews on the unit in front of security staff." In addition, patients who have discussed with their therapist or group session leader their frustration with security staff have sometimes been issued disciplinary tickets for threats, even though these statements were done in a therapeutic environment. We believe responding in a punitive manner to patients' efforts to deal with their negative feelings about staff which have not been acted upon, is thoroughly counterproductive and destructive of the patient-provider relationship. Indicative of the negative impact, several RMHU patients expressed their concern that OMH staff cover up for the abuses of security staff.

An RMHU, BHU, or TBU patient can be restricted from attending programs under the SHU Exclusion Law due to "exceptional circumstances" signifying that the patient "presents an unacceptable risk to the safety of inmates or staff."[37] This exception is being applied too frequently and is creating a hostile environment which often leads formerly excluded patients to refuse care even when the exceptional circumstances are terminated. Many of the patients responding to our survey at Five Points and Marcy reported that they had been denied programs in the RMHU; 75% of Five Point respondents and 42% of Marcy respondents reported being denied programs at some point. At Five Points, the RMHU staff said that denials ranged from four to nine patients at any one time, representing 8% to 17% of the patient population. To this figure must be added patients who are refusing treatment. At Five Points, staff estimated that about an additional 10% of the patients refuse treatment. The CA survey respondents, however, report much higher numbers. Forty percent of Five Point survey respondents said that they refuse programs many times and that at the time of their survey 19% said they were currently not going to the group sessions. Although Marcy staff reported fewer denials of services and Marcy survey respondents also had fewer reported cases of refusals and denials, program denials in particular still were a concern. Only one Marcy survey participant said he was currently refusing programming and three (11%) said that they refuse group sessions many times.

We are very concerned about the number of RMHU residents not participating in these programs. We believe DOCCS and OMH are applying an overly broad interpretation of what constitutes a threat to staff or other residents in specifying patients meet the SHU Law definition of exceptional circumstances. Moreover, many of the patients we interviewed who have been denied said that following the denial they had elected to refuse programs. Often the circumstances leading to a denial involved some verbal confrontation with security or program staff, past receipt of disciplinary tickets, or a physical confrontation with security staff. This often leads to greater tension between the patients and staff and results in the patients being reluctant to leave their cell out of a concern that they will have a confrontation with staff or be accused of other misconduct that could lead to a disciplinary ticket. The level of denials and refusals appear to be a direct result

[37] N.Y. CORRECT. LAW § 401.2(a)(i).

of the overly punitive nature of the unit, the tension between security staff and the patient population, and the excessive use of disciplinary sanctions in dealing with these patients.

Brutal Punishment in the RMHU

Like others in the RMHU, Simon suffers from serious mental health issues, including Tourette's syndrome, which make it difficult for him to survive let alone thrive in the rigid and rule-laden prison environment. Indicative of the challenges Simon faces, in completing his survey, Simon on a number of occasions mentions the fragility of his state of mind and how even completing certain survey questions could upend his balance and send him into fits of frustration and instability. Unfortunately, the response by the prison system to Simon's mental health issues has been one of repeated and brutal punishment.

In the five and a half years he had been in DOCCS custody at the time the CA met Simon, he had already spent a year and a half in the RMHU at Five Points, after having been at the BHU at Great Meadow and the SHU at several other facilities. Even when he was diverted from the SHU to the BHU and the RMHU, he continued to face a very punitive environment, receiving dozens of disciplinary tickets in those units and accumulating additional SHU time to the point that he had a seven year SHU sentence at the time we met him. As if the additional SHU time wasn't punishment enough, Simon has also been subjected to nearly all forms of deprivation orders at some point in time in the SHU or RMHU.

Worse still, Simon is regularly placed on exceptional circumstances, continually confined to his cell, and unable to attend programs, the main purpose and function of being in the RMHU. When not administratively confined to his cell and prevented from attending groups, Simon often refuses to leave his cell for programs or even recreation for safety reasons. Simon asserts that he has on several occasions been seriously assaulted by staff, including an incident he maintains left him with broken bones. While being physically abused by staff is his main concern, Simon also is afraid of confrontations with other incarcerated persons. Between being denied programs and refusing to attend, Simon had only been to groups once or twice in the last several months prior to our visit, meaning that he is being held in solitary confinement equivalent to the SHU without therapeutic or rehabilitative support.

The disciplinary tickets, deprivation orders, denial of programs, and staff physical abuse are the very opposite of the intended therapeutic environment of the RMHU. In Simon's mind, these conditions are designed to antagonize residents until you "have such a buildup that [you] do lash out" in response, resulting in additional tickets if directed at others or resulting in attempts at self-harm and trips to the RCTP. Either way, the prison system is failing Simon, causing him further harm rather than helping him address his mental health needs.

In a related manner, many RMHTU residents reported physical and verbal abuse by staff. Half of all survey respondents at the Five Points and Marcy RMHUs and the Great Meadow BHU reported that they had personally experienced a physical confrontation with staff at least once on the unit, a much higher percentage than the 26% of survey respondents in the general population of all CA-visited prisons. One RMHU resident, for example, reported how "while returning to my cell with my hands cuffed behind my back, I was pushed into my cell face down on the bunk and five COs beat the crap out of me, punching my face." Another alleged that "officers broke my ribs and were suffocating me with a bag over my head, threatening to kill me." Some of this physical abuse is reportedly connected to discrimination based on people's mental health limitations and because of racism. As one Great Meadow BHU resident reported, "correction officers are real racist towards me, plus they don't want to see me graduate from this program and move on. . . . These correction officers assault [incarcerated persons] behind racism and press charges against us." Indicative of the high levels of staff abuse, as well as the frequency of disciplinary tickets in the RMHUs, at Attica, for example, in disciplinary hearings involving an assault on staff charge from January 2010 to November 2013, nearly 9% of all of the people found guilty of such charges were in the STP or the RMHU, even

though the STP represented less than 1% of Attica's population while it existed and the RMHU represents less than half of one percent. While assault on staff disciplinary tickets are alleged incidents of incarcerated persons assaulting staff, they provide an indicator of the level of physical conflict between staff and incarcerated persons. Moreover, staff may reportedly write up an incident as an assault on staff after the staff had in fact assaulted the incarcerated person in order to justify staff actions.

Success at Marcy; Abuse, Punishment, and Decompensation at Great Meadow

William – a man in his fifties serving a lengthy prison sentence – had a history of depression, mental health treatment, and long-term psychiatric hospitalization prior to his incarceration. After being allegedly assaulted by staff in general population, William was sent to a SHU and ultimately Marcy's RMHU. William had a very positive experience at Marcy, appreciating the programs and the many mental health staff he viewed as well-intentioned and sincere. He described the Marcy RMHU as "beautiful." He actively and successfully participated in programs, and was stable and managing his mental health issues.

After requesting a transfer to Great Meadow's BHU in an attempt to eventually reach Sullivan's BHU to be closer to his home and family, his situation rapidly and horribly turned tragic. After only a few months at Great Meadow, the insufficient mental health programming (William described group sessions in caged cubicles watching T.V. or playing games of throwing paper in a trash can) and security staff's verbal and physical abuse took its toll. William began to decompensate mentally and emotionally, and eventually was pushed beyond his breaking point, causing him to engage in some difficult behavior. The response was only more staff violence and abuse, as well as infliction of disciplinary tickets as punishment, leading William to decompensate further and perpetuating the downward spiral.

William reported, and showed the CA copies of, more than 20 disciplinary tickets he received in only a few month period at Great Meadow's BHU. The tickets, most of which William claimed were false, but some he admitted were true, involved allegations of creating a disturbance, flooding, lewd conduct, unhygienic acts, and verbal harassment. These types of tickets indicated mental health decompensation and its behavioral manifestations. William went into mental health crisis and was cycled back and forth between the RCTP and BHU numerous times. There were periods where William was receiving tickets almost daily in the BHU or even multiple times in one day, punishment that clearly was a combination of intended abuse and failed interventions. Ultimately, William accumulated an additional four years of box time in only a several month period at Great Meadow.

Perhaps worse still, William reported being physically brutalized. On one occasion, for example, William described officers punching him in the head, neck, and back on his way to the RCTP. He described CO behavior as "brutal, sadistic, heartless, and vicious" and the overall environment at Great Meadow as "not fit for an animal." Officers also engaged in repeated abusive verbal harassment and threats, calling William "useless, worthless, garbage"; responding to his legitimate complaints with "F*** you and your directives; I don't care what the directive says;" telling him "they should've killed you a long time ago"; and taunting him that they were going to abuse him so much as to make him commit suicide. Moreover, William was issued repeated deprivation orders, including multiple months of a cell shield, which made him feel like he was hyperventilating. Officers were even tampering with his food – for example, emptying cartons of milk, taking a bite out of his apple, or mixing trash with his food before delivering his tray. Besides the obvious effect of denying him food, this bullying and provocation, in combination with all of the other abuses, caused a further sense of helplessness, outrage, and despair. Even during an interview with the CA, William broke down emotionally on several occasions describing the abuses he had endured.

William's situation is particularly tragic when one compares how successful he was at Marcy with the abusive environment at Great Meadow's BHU (as well as Attica's RMHU – which he also described as similarly laden with physical abuse and punishment). Someone who was eager to positively engage in treatment at Marcy and was motivated to come to Great Meadow and succeed to be closer to his family, instead encountered a uniformly abusive and punitive environment at Great Meadow that could not do anything for him except reverse the gains he had made and contribute to his deterioration and suffering.

In addition to physical abuse, 75% of disciplinary mental health survey respondents from Marcy, Five Points, and Great Meadow reported that verbal harassment frequently occurs in their unit, and over 40% had personally experienced verbal harassment frequently, rates similar to system-wide averages in general population for all CA-visited prisons. Worse than the other two units, 85% of Great Meadow BHU survey respondents reported that verbal harassment occurs frequently, compared to 70% at Five Points and 72% at Marcy. As if additional SHU sanctions and physical and verbal abuse are not punishment enough, numerous RMHU and BHU residents reported that staff utilize deprivation orders, including cell shields, denial of basic services, and so-called exposure suits, all of which are inhumane, to inflict even additional punishment. As one survey respondent reported, "I have SHU time past my max date now which is 7/2017, which is senseless and is only a form of harassment. They are now using the full restraints and cell shield as a form of harassment now. The[re] is no longer a valid reason for them and [they are] a big reason why I don't go to program."

Overall, of the three disciplinary mental health units from which the CA received survey responses, Great Meadow BHU survey respondents had the worst reported relations with security staff and reported feelings of being unsafe. Specifically, nearly two-thirds of Great Meadow BHU survey respondents reported that relations with security staff were very bad and that they feel frequently unsafe, with 85% reporting that when they feel unsafe they feel very unsafe. At Five Points and Marcy, 43% and 63% of survey respondents, respectively, reported that relations with security staff were either somewhat or very bad; 39% and 37%, respectively, reported feeling frequently unsafe, and 58% and 40%, respectively, reported that they feel very unsafe at times they feel unsafe. Taken together, some residents in all of the three units faced abuse by security staff, with Great Meadow's BHU having the worst reported levels of abuse.

Patients in the disciplinary mental health units frequently have mental health crises and/or express concerns that they are at risk for self-harm, and we are concerned that their needs are not being adequately addressed both while they are in the RCTP or when they return to their disciplinary mental health unit. As discussed above, patients in the disciplinary mental health units have admission rates to the RCTP that are **34 times** the rates of the general prison population and more than **three times** the rate of the non-disciplinary mental health units, indicating major concerns about the role that the conditions of these disciplinary confinement units play in leading people into mental health crisis. Also, as noted above, the number of discharges from an RCTP to a disciplinary mental health unit is nearly identical to the number of admissions to the RCTP from a disciplinary mental health unit, indicating that people who go into crisis on one of these units are returning back to the same conditions that caused them to go into crisis. At the same time, the number of admissions to CNYPC has dramatically declined, even as RCTP admission increased, again further indicating that OMH and DOCCS are not generally utilizing an intense therapeutic approach to people going into crisis on these units. This data parallels repeated experiences from interviewees and survey respondents about cycling back and forth between the RMHUs or BHU and the RCTP.

Worsening Mental Health from Punishment in Prison

Richmond is someone who entered DOCCS when he was 20 years old and has been incarcerated for over a decade. When we met Richmond in the Marcy RMHU and in his survey response, he described his belief that security staff were using electromagnetic microwave devices to torture him. He has serious mental health needs that predated his incarceration and led to his hospitalization on at least one occasion before he entered prison. His long period of imprisonment has been an extremely troubled one so far. He has had a physical confrontation with another incarcerated person and with a corrections officer. He has cycled through the SHU and various alternative disciplinary mental health units at multiple different prisons. He also has engaged in repeated acts of self-harm, and has gone in and out of the RCTP and CNYPC many, many times. He spent several weeks on one occasion in the RCTP, and months at a time in CNYPC. Through all of these many transitions the one constant seems to be a lack of stability or continuity in his mental health care.

It is troubling that as someone with such severe mental health needs, Richmond has now spent several years in the SHU and the BHU/RMHU. Moreover, over the years he has been dealt various "deprivation orders" including the loaf, loss of showers, loss of recreation, and full restraints. Each of these obviously punitive responses aimed at a man suffering from a serious mental health condition is counterproductive and can only further destabilize him and derail any improvement in his mental state. He also reports that he has experienced a steady stream of verbal harassment and provocation from security staff. For someone experiencing delusions and constant fears about the privacy of his innermost thoughts, abuse and provocation by staff completely undermines any efforts at treatment.

With several years left on his SHU sentence, he will likely remain in a disciplinary mental health unit for the entire rest of his time in prison. What is painfully clear is that while Richmond has gone from young adulthood to adulthood in prison, his dozens of transitions between facilities, the SHU, alternative disciplinary mental health units, and CNYPC have left his severe mental health needs even more persistent than when he entered prison.

The Continued Solitary Confinement of People with Mental Health Needs

In addition to implementation problems with respect to the punitive nature of the RMHTUs, the SHU Exclusion Law also allows for large numbers of people with substantial mental health needs to remain in solitary confinement with limited mental health services. First, people with an S-designation can still be placed in SHU if they have SHU sentences less than 30 days, indefinitely if the department finds "exceptional circumstances," or for purposes of administrative segregation or protective custody. In addition, people with an S-designation can still be held in keeplock, where isolation can be just as devastating, and are not afforded the law's protections unless placed in a SHU or separate keeplock unit. Moreover, as seen in **Table 12 – Summary of People on OMH Caseload in SHU,** there still remain a number of people with S-designations in the SHU every month, fluctuating between 25 and 36 since the time of the full implementation of the SHU Exclusion Law.

Table 12 – Summary of People on OMH Caseload in SHU

	2nd Q 2010	3rd Q 2010	4th Q 2010	1st Q 2011	2nd Q 2011	3rd Q 2011	4th Q 2011	1st Q 2012
Total SHU	4273	4505	4343	4331	4254	4314	4314	
OMH in SHU	**571**	**592**	**561**	**571**	**551**	**523**	**569**	**607**
S-designated in SHU	**130**	**116**	**104**	**102**	**47**	**31**	**29**	**36**
OMH L1 in SHU	**94**	**93**	**93**	**98**	**56**	**38**	**59**	**70**
OMH L2 in SHU	**160**	**170**	**140**	**137**	**134**	**118**	**114**	**142**
OMH L3 in SHU	**281**	**287**	**294**	**299**	**314**	**324**	**339**	**344**
OMH L4 in SHU	**36**	**42**	**34**	**37**	**47**	**43**	**57**	**51**
STP/GTP	92	79	77	69	5	6	6	
Non-programmed	18	37	27	33	42	25	23	

	2nd Q 2012	3rd Q 2012	4th Q 2012	1st Q 2013	2nd Q 2013	3rd Q 2013	4th Q 2013	1st Q 2014
Total SHU*							3,841	
OMH in SHU	**671**	**673**	**647**	**657**	**660**	**716**	**636**	**651**
S-designated in SHU	**35**	**36**	**25**	**28**	**35**	**36**	**28**	**28**
OMH L1 in SHU	**64**	**79**	**81**	**81**	**81**	**88**	**85**	**79**
OMH L2 in SHU	**179**	**187**	**167**	**187**	**197**	**223**	**194**	**197**
OMH L3 in SHU	**387**	**368**	**343**	**331**	**325**	**349**	**300**	**315**
OMH L4 in SHU	**41**	**39**	**56**	**58**	**57**	**56**	**57**	**60**
STP/GTP								
Non-programmed								
Exceptional Circumstances						3	3	5

*OMH stopped providing the total number of people in SHU in its quarterly reports.

OMH claims that these individuals with serious mental illness are in the SHU because either exceptional circumstances have been applied (the smallest number), their disciplinary proceedings are still pending, or they were removed or diverted from SHU "within 30 days of their sanction/serious mental illness determination."[38] While any person with an S-designation in the SHU is of deep concern, the latter two explanations are wholly inadequate and on their face contravene the letter and the spirit of the SHU Exclusion Law. The law explicitly states that DOCCS "shall divert or remove inmates with serious mental illness . . . from segregated confinement, where *such confinement could potentially be* for a period in excess of thirty days" (emphasis added).[39] Claiming that people were removed from SHU within 30 days of their *sanction* or that their disciplinary proceedings are still pending does not mention how long these individuals were in the SHU prior to their sanction being imposed and thus ignores the law's prohibition on the possibility of 30 days in the SHU total, including both time in the SHU before a sanction is imposed or after. In addition, the fact that the law uses the language "could potentially be," envisions that

[38] Active Mental Health Inmate-Patients Housed in Segregated Confinement, First Quarter 2014, CNYPC, OMH, April 22, 2014.
[39] N.Y. CORRECT. LAW § 137(6)(d)(i).

anyone who could potentially face SHU time beyond 30 days, i.e. anyone who has a SHU sentence beyond 30 days or is facing a disciplinary charge that could result in a SHU sentence beyond 30 days, should be removed, not that people can remain in the SHU until they have already spent 30 days in the SHU. It appears to be regular policy to hold people known to have serious mental illness in the SHU pending the conclusion of their disciplinary proceedings and/or after they have been sentenced to more than 30 days of SHU until they have actually reached the limit of 30 days.

The CA's recent visit to Green Haven in 2014 confirmed that this policy is also the practice within DOCCS prisons.[40] During that visit, there were four individuals in the SHU who reported that they had an S-designation and had already been in the SHU for weeks and months. When confronted with these allegations, the prison administration and staff admitted that there were two individuals with S-designations who had already been in the SHU for longer than 30 days, that these individuals were still in the SHU because their disciplinary proceedings were still pending, that at least one of the individuals had multiple hearings to complete, and that these individuals could remain in the SHU until all of the proceedings on the multiple disciplinary charges were completed. Such a policy and practice is in direct contradiction to the law, and more importantly, continues to subject people with serious mental illness to long periods of solitary confinement known to be harmful to them.

Beyond people who have an S-designation, many other people in SHU have some form of mental illness, including diagnoses many would consider serious. The SHU Exclusion Law creates a hard line set by its definition of "serious mental illness," with those who fall above the line being diverted from the SHU and receiving the intensive mental health treatment described above and those who fall below receiving little to none. Under the law, an individual has a serious mental illness if: a) diagnosed with listed Axis I disorders;[41] b) actively suicidal or engaged in a serious suicide attempt; c) diagnosed with a mental condition, organic brain syndrome, or severe personality disorder with particular characteristics that leads to a significant functional impairment involving acts of self-harm or their equivalent; or d) determined to have substantially deteriorated in isolation to the point of experiencing impairments indicating serious mental illness and involving acts of self-harm or their equivalent. Those not assessed to be in these categories do not receive diversion, treatment, programs, or other protections of the law.

Questioning Diagnoses of People in SHU

They give too much SHU time for tickets, and I don't care who you are, long term SHU effects you mentally. Then when you try to get some mental help, they say you're faking. I been in prison 25 years and it affected me mentally but mental health thinks everyone is faking. Also since they now have to put you in a mental health program if you are diagnosed with certain things, they just don't diagnose you with it. They just say its depression. I cut my wrist in Upstate, and I feel depressed a lot. Most of the time I wish that I would go to sleep and never wake up. I lay there at night and think of different ways to kill myself. I'm very unhappy with my life and I don't think it will ever get better. –Anonymous at Clinton

[40] The CA has also been to other prisons where people with S-designations were in the SHU at the time of our visit, including five people at Fishkill C.F.

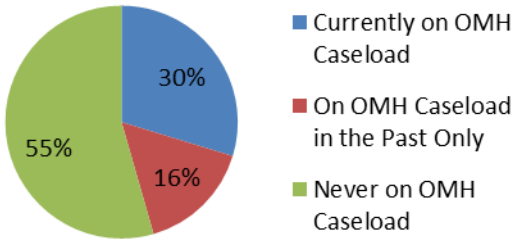
[41] The Axis I diagnoses include: schizophrenia, delusional disorder, schizophreniform disorder, schizoaffective disorder, brief psychotic disorder, substance induced psychotic disorder other than intoxication or withdrawal, psychotic disorder NOS, major depressive disorders, and bipolar disorder I and II.

Moreover, the creation of a hard line inherently creates an incentive for OMH and DOCCS to classify people below the line. Diagnoses data over the last few years raises concerns about potential under-diagnosis. As noted above, from January 2011 to July 2013, while the total OMH caseload *increased* 6.7%, (and increased a total of 7.9% between January 2011 and January 2014), people with S-designations who are covered by the SHU Exclusion Law *dropped* by 20.7%. Similarly, as discussed above, the percentage of the OMH caseload diagnosed as schizophrenic or psychotic dropped by over 20%, while adjustment disorders went up over 90% and personality disorders went up more than 45%. Especially since examples like those documented in this testimony indicate that OMH is often not providing people with non-traditional-Axis I diagnoses with an S-designation even where people have engaged in repeated serious acts of self-harm, this dramatic shift in diagnoses raises serious concerns about people not receiving the protections intended by the SHU Exclusion Law.

As a result, and even apart from the question of under-diagnoses, there have been large and overall increasing numbers of people in solitary confinement. While, as noted above, the number of people in the SHU with S-designations substantially dropped from the year prior to the SHU Exclusion Law's full implementation, as seen in **Table 12** the total number of people in the SHU has fluctuated and overall increased. As of April 2014, there were 651 people on the OMH caseload in the SHU, 18% higher than the number of OMH patients in the SHU just prior to the implementation of the SHU Exclusion Law in 2011 and 14% higher than the year before the implementation. Similarly, when looking specifically at people with more serious mental health needs, the number of people designated as OMH L1 and L2 increased 45% from just before the implementation of the SHU Exclusion Law and 9% from the year prior to the implementation.

Given that, as discussed below, there is very limited mental health services for people in general population, and given that prison is a very rigid environment in which people whose mental health issues may make it difficult to strictly follow such rules, it is not surprising that these large numbers of people with mental health needs end up in solitary confinement. Indeed, people on the OMH caseload represent nearly 17% of all people in SHU, which is slightly higher than their proportion of people in the total prison system. In addition, in some SHU units, such as Collins' S-block and Fishkill's SHU, people on the OMH caseload represented 40% of the people in isolated confinement at the time of the CA's visit. In Green Haven's SHU in June 2014, 46% of the people in the SHU were on the OMH caseload, including, as noted above, four people with S-designations, and an additional six OMH L1 patients and six OMH L2 patients. Moreover, as with the overall population, the number of people on the OMH caseload underrepresents the total number of people in the SHU with mental health needs. As seen in **Figure 1 - Survey Respondents on OMH Caseload in SHU**, 46% of survey respondents from visits to 39 SHU units in the past eight years reported that at the time of our visit they either were currently on the OMH caseload or had been on the OMH caseload in the past. Moreover, 50% of survey respondents reported that they had at some time received, been recommended for, or attempted to use mental health services in DOCCS prisons.

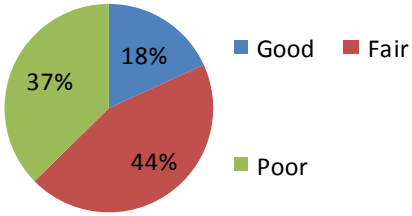
Figure 1 - Survey Respondents on OMH Caseload in SHU



For all of individuals with mental health needs who remain in the SHU, and everyone else in the SHU, there is very limited mental health services provided. The SHU Exclusion Law did positively provide for additional periodic encounters with mental health staff. Following an initial assessment upon being placed in the SHU, individuals at OMH L1 or L2 prisons are required to be offered the opportunity to receive an additional mental health interview within 14 days of that assessment and every 30 days thereafter, and individuals at OMH L3 or L4 prisons must receive a mental health interview within 30 days of their initial assessment and offered one every 90 days thereafter.[42]

However, people with mental health needs in SHU do not participate in any group therapy and there is minimal individual therapy. Survey respondents who were on the OMH caseload in SHU units the CA visited since 2011 estimated a median length of 10 minutes for individual sessions with OMH staff, with only a quarter of these OMH patients indicating they had enough time in these sessions, a third reporting they didn't have enough time, and the remainder indicating they sometimes had enough time. In addition to concerns about the limited amount of individual therapy people receive, survey respondents in CA-visited SHU units since 2011 who were currently or previously on the OMH caseload had relatively negative assessments of the quality of the individual therapy, with only 16% rating it as good, 39% as poor, and the remainder as fair. Moreover, 60% of survey respondents reported that their interactions with mental health staff were not confidential and 54% of those who are taking mental health medication reported that they at least sometimes have difficulties getting their mental health medications in the SHU. Meanwhile, these individuals who already have pre-existing mental health conditions, and are receiving no group therapy and insufficient individual therapy are being subjected to complete isolation known to exacerbate their mental health conditions. Overall, as seen in **Figure 2 – Survey Respondents' Ratings of MH Care in SHU**, only 18% of people in 39 different SHU units who responded to a CA survey in the past eight years rated mental health care in the SHU as good, while more than double that number, 37%, rated it as poor.

Figure 2 - Survey Respondents' Rating of MH Care in SHU



People with Mental Health Needs in SHU

[*G]uys who have pre-existing mental health needs are often treated the worst . . . OMH is frequently dropping guys from the caseload . . . Both DOCCS and OMH at Attica always think that everyone is faking it. . . . Then, correction officers will deny people on the OMH caseload showers and food because they don't believe anyone actually has a mental health need. And people with mental health needs don't get the proper treatment and deteriorate further in the SHU. The guy in the cell next to me has deteriorated substantially and they are not doing anything for him. He hasn't showered in a year and he is really suffering. Some guys will hang up or set their cell on fire, which happened four or five months ago here. If there is a suicide attempt in the Attica box, like at many other boxes, they will take you to the observation cells and then bring you right back to the box without any medications or treatment or anything.*– Anonymous at Attica.

[42] N.Y. CORRECT. LAW § 137(6)(d)(v).

In addition to the lack of mental health services, people with mental health needs face a hyper-punitive environment in the SHU that has even more detrimental effects on people with mental health needs. Of survey respondents in CA-visited SHU units across the state who either were currently on the OMH caseload or had been in the past, 38% reported having received at least one Tier III disciplinary ticket while in the SHU and 27% reported having received at least one Tier II ticket. Moreover, of those who had received a ticket, a majority reported receiving multiple tickets while in the SHU, and the median length of additional SHU time reportedly received while in the SHU was six months. The percentages of people receiving disciplinary tickets were higher than the percentage of all people in the SHU (29% of all people in the SHU reported having received at least one Tier III disciplinary ticket), meaning that people on the OMH caseload are receiving even more tickets in the SHU and accumulating more additional SHU time than others.

Moreover, as discussed above, solitary confinement can create new mental health challenges for people and can have even more detrimental impacts on people with pre-existing mental health issues. As one of the most serious indicators of the negative mental health effects of the SHU on people with mental health needs, as discussed further below, many people in the SHU attempt self-harm. Over 31% of all SHU survey respondents since 2009, when the CA began asking the question, reported that they had attempted to harm themselves at least once during their current incarceration, and 22% reported that they had attempted self-harm at least once while in the SHU. This high amount of reported self-harm not only raises concerns about the number of people in the SHU with mental health needs, but also the negative impact of the SHU on people's mental health. Moreover, at facilities with a larger number of patients with more severe mental health issues, the amount of reported self-harm was at extremely high levels. At Clinton, for example, nearly 87% of SHU survey respondents reported that they had attempted to harm themselves at least once during incarceration, and over 30% reported that they had attempted to harm themselves at least once while in the SHU or keeplock at Clinton.

As a related indicator, a large number of people are transferred from the SHU to the RCTP, indicating that these individuals had gone into mental health crisis. Worse still, many people are transferred directly back from the RCTP to the SHU, to the very conditions that led them to go into mental health crisis. As one survey respondent lamented at Clinton, "I've been extremely sick before and was not ready to come back to my SHU cell, yet still the doctor, knowing I was suicidal still sent me back to my cell to cope by myself. The officers wrote me up for harming myself and I got more time in the box. All because I did not have the proper medication at the time." Unfortunately, the CA has observed numerous people across many DOCCS prisons cycling back and forth between the SHU and the RCTP. In 2012, according to OMH's annual report, 1,220 people were transferred

SHU Self-Harm Cycle

Juan has been incarcerated for nearly forty years on a 15 to life sentence. For the past 14 years, except for a short period of three months, he has been held in the SHU. While in solitary confinement, Juan has committed self-harm on multiple occasions, cycling back and forth between the RCTP and the SHU, most recently in 2014. Yet, he has remained in the SHU, does not have an S-designation, is currently classified as being an OMH L3 patient, and reports seeing mental health staff one time per month for approximately 10 minutes. To make matters worse, Juan reported that security staff act in a racist and abusive manner toward him, and that he has been assaulted by security staff in the SHU, as recently as the middle of 2014. Overall, Juan reports that as a result of his experience in isolation, he suffers from, among other things, anxiety, depression, and paranoia; feels disoriented; and has panic attacks, difficulty interacting with other people, and sensitivity to sights and sounds.

from a SHU to the RCTP, just under the 1,409 peopled transferred from general population, despite the fact that there are more than fourteen times the number of people, and thirteen times the number of mental health patients, in general population than there are in the SHU. Of related concern, in 2012, there were 1,423 transfers from the RCTP to the SHU, again on par with the 1,537 people transferred to general population. Related to this negative cycle, and as discussed further below, many DOCCS staff and administrators have expressed the belief during the CA's visits that people who attempt to harm themselves in the SHU are "malingerers" who are faking their mental health needs in order to get out of disciplinary confinement. Unfortunately, many OMH staff also follow this approach. As one survey respondent wrote, "mental health does nothing" and "they believe everyone is faking until you really kill yourself."

Young Man in Solitary Confinement – CNYPC Back to SHU

Antonio is a young man the CA met in the SHU on a prison visit in 2014. Antonio was incarcerated at age 17, and was 20 at the time of our visit. Antonio reported that he originally had a conditional release date earlier this year, meaning that he had the possibility of release under his court-imposed sentence. However, just prior to his release, he reported that a correction officer had falsely planted a weapon in his cell just so that he did not make his release and was instead sent to the SHU, subjecting him to isolated confinement and extending his time in prison. This isolation caused his mental health to deteriorate rapidly. During our visit, when we entered the tier of the SHU in which Antonio was being held, Antonio was yelling out. He appeared to be potentially suffering from hallucinations or delusions, screaming to no one in particular, claiming that he was Jesus and lamenting that he did not want to go with the devil or to hell. Literally during the night after the first day of our visit, Antonio attempted to hang himself by tying a sheet around his neck. An officer making rounds luckily found Antonio in time, and he was taken to the RCTP, where we saw him on the second day of our visit. Through subsequent correspondence with Antonio, we learned that Antonio' OMH level was changed from an OMH Level 3 or a Level 2 to a Level 1. However, he was diagnosed as having a personality disorder and was not given an S-designation, despite his self-harm. Antonio reported that he was eventually sent to CNYPC and spent several weeks at the psychiatric hospital. After being returned from CNYPC, Antonio still did not have an S-designation and he was sent back to the SHU, the very location that had caused his mental health to deteriorate and him to self-harm. Not surprisingly, Antonio ended up back again in the RCTP as a result of being in mental health crisis. As of our last correspondence with Antonio this fall of 2014, he was in the SHU. Despite his age, he was not participating in any programs, out-of-cell activities, or even cell study. Antonio reported that he did not even go out to recreation, and thus stayed in his cell 24 hours a day, day after day, because as he said "I feel I'm not getting nothing from being locked in a cage for an hour." Antonio reported that he was having difficulty sleeping and interacting with people, and that he was suffering anxiety, depression, panic attacks, and feelings of paranoia. Antonio is soon to reach his 21st birthday, and unless something changes he will spend that birthday in complete isolation, continuing to serve his 14 month SHU sentence in the torture of solitary confinement.

Looking at admissions to CNYPC in comparison to admissions to the RCTP for people in the SHU, as was discussed in more detail above, provides further evidence of DOCCS and OMH staff not sufficiently addressing self-harm in the SHU as an indicator of mental health crisis in need of a therapeutic intervention. At the same time that the total number of CNYPC admissions has been steadily decreasing in recent years even though RCTP admissions have been increasing, the percentage of people who are admitted to CNYPC from the SHU has also been steadily declining. Specifically, the percentage of people sent to CNYPC from the SHU dropped by two-thirds from 26.6% in 2007 to 9% in 2012, while the percentage of people sent to the RCTP from the SHU remained relatively stable, varying between 13% and 17%, over the same time period. The drop in

percentage of CNYPC admissions from the SHU, despite a steady percentage of RCTP admissions from the SHU, would suggest that while similar numbers of people in the SHU are going into mental health crisis and/or committing acts of self-harm, DOCCS and OMH are not providing appropriate treatment for these patients. While some of this decline in CNYPC admissions can be attributed to people with the most serious mental health needs being diverted from the SHU, even from 2010 to 2012, the percentage of people admitted to CNYPC from the SHU dropped by a third. Moreover, staff and administrators during the CA's visits, as confirmed by incarcerated persons' experiences, have reported that it is policy and practice for people to return directly from CNYPC back to the SHU (after a short stay in the RCTP) if that was their housing location prior to being sent to CNYPC. Indeed, the percentage of people discharged from the RCTP to the SHU over the last several years is similar to, and a little higher than, the percentage admitted to an RCTP from the SHU, further evidence that people are discharged from the RCTP and CNYPC (all people coming from CNYPC go first to the RCTP before being transferred to another housing area) to the SHU.

Overall, there continue to remain far too many people – including those with pre-existing mental health conditions and otherwise – in isolated confinement, for far too long, in conditions that are known to have devastating mental health consequences. Although the Department does not think these individuals can be let out of isolated confinement to be in general population even within a prison setting, many of them (around 2,000 people each year) will be released directly from isolated confinement to the street, without any meaningful transitional services or programs.

Help Me Go Home Prepared

Eric is an OMH L2 patient and has been in the SHU for seven years, with still a couple more years of SHU time left on his disciplinary sentence. Eric is going to the Parole Board next year and will max out in 2016. His remaining SHU sentence is beyond his max date, so he will likely go from solitary confinement directly to the street. DOCCS apparently does not believe it is safe for him to be with other incarcerated persons while in prison, but will likely release him directly from complete isolation to the outside community without any transitional services or programs. Although Eric suffers from anti-social, personality disorder and has been receiving psychiatric treatment since he was a child, he reports that OMH claims that they don't have the records of his mental illness from the community that would justify him receiving an S-designation. So he remains in the SHU. Moreover, as a result of his mental health needs and his long time in the SHU, Eric is prone to anger problems and impulsive actions. The SHU just exacerbates those issues. Not surprisingly, then, Eric has accumulated additional SHU time while in solitary confinement because of the behavioral manifestations of his mental illness exacerbated by the SHU. Eric wants transitional help to prepare for his release, but he can't get it. No one wants to go home like this.

THE INTERMEDIATE AND TRANSITIONAL INTERMEDIATE CARE PROGRAMS

The Intermediate Care Program (ICP) is a non-disciplinary residential treatment program for OMH patients, generally for those with a serious mental illness (SMI). Around 90% of the people in ICPs have an S-designation. According to the ICP orientation manual used at Five Points, "the ICP is a therapeutic community that provides mental health services and promotes development of self-regulation, symptom management, social, recreational, and habilitative skills." The ICP's model is to provide patients with 20-hours per week of intensive therapeutic programming. Patients in the ICP generally participate in numerous programs on the unit, and sometimes have an opportunity to participate in programs outside of the unit.

As seen in **Table 13 – Intermediate Care Program Participation**, the ICP currently has a capacity of 743 beds. Due to the DAI litigation and other advocacy, the ICP capacity increased by more than a third between 2007 and 2009, from 551 beds to 743 beds, and the capacity has not changed since that time. Although, as discussed above, the ICP's capacity represents only roughly one-third of all S-designated patients in the prison system and many more individuals could benefit from the program, the ICP is often not full. In 2013, the ICP was between 90% and 95% at capacity during the course of the year.

TABLE 13 – Intermediate Care Program Participation

	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
# Beds	551	577	743	743	743	743	743
# Patients in ICP Program	527	581	650	715	705-730	715	674-708
% Patients w/ S-designation	91.1%	93.6%	93.2%	95.8%	93.0%	89.8%	
# Patients admitted	373	451	658	723	712	646	599
# Patients discharged					707	661	
% Receiving 20 hrs./wk therapy	95.5%	87.1%	87.5%	88.5%			

Since the ICP is not a disciplinary unit, as seen in **Table 14 – Transitions to and from ICP**, the largest number of people who come to the ICP come from general population (around one-third of admissions each year), followed by another ICP (over 20% each year). While some people in the ICP will receive sufficient mental health treatment and support that they may eventually return to general population, some patients may suffer persistent and debilitating symptoms that lead them to spend the duration of their sentence in the ICP. For those discharged from all ICPs in the last year of available data, the median length of stay had been just over six months, and the median lengths of stay range from under four months to 11 months. Each year, over 20% of all people discharged from the ICP are people released from incarceration.

Table 14 – Transitions to and from ICP

Housing Location after ICP Discharge

SHU	45	6.81%
BHU/TBU	9	1.36%
TrICP	71	10.74%
ICP	132	19.97%
IICP	5	0.76%
RMHU	22	3.33%
CORP/STEP	33	4.99%
CNYPC	81	12.25%
GP	90	13.62%
Released	150	22.69%
Other	23	3.48%
Total	661	

Housing Location before ICP Admission

SHU	6	0.93%
BHU/TBU	52	8.05%
TrICP	34	5.26%
ICP	134	20.74%
IICP	4	0.62%
RMHU	63	9.75%
CORP/STEP	2	0.31%
CNYPC	72	11.15%
GP	228	35.29%
Other	51	7.89%
Total	646	

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

Regarding mental health treatment, survey respondents from CA-visited ICPs generally had relatively positive ratings of group therapeutic programming and an expressed desire to have additional individual therapy. Between 80% to 90% of ICP survey respondents rated individual program groups they were in as either good or fair, with around 45% rating their programs as good. As one survey respondent at Sullivan declared, "the ICP is the best thing that ever happened to me. All the groups are very good because we get to express ourselves and get feedback." Another commented that "the best part of the ICP is that you are away from [general] population and get programs. The program isn't that good, but something is better than nothing." DOCCS co-facilitates some programs in the ICP, including Thinking for a Change, Activities of Daily Living (ADL), and Integrated Dual Disorder Treatment (IDDT) (substance abuse program for individuals suffering from mental illness). DOCCS has reported that the curriculum for Thinking for a Change has been altered from the general population program to meet the needs of ICP patients. DOCCS also runs academic programs, structured recreation, and other classes such as socialization and current events. At the same time, OMH runs various classes specifically related to mental health, such as wellness, medication education, psych rehabilitation, trauma and recovery, humor, coping skills, working, communication skills, activities of daily living, and art therapy. The schedule of classes and programs in the ICP change every quarter and OMH develops an individualized program plan for each ICP patient. In addition to the programs on the unit, some ICP residents participate in programs off of the unit. At Sullivan, there were even two people in the ICP who were enrolled in the college program at the prison at the time of the CA's visit.

While people in the ICPs who have been interviewed or submitted surveys generally have positive views of the programming, some concerns have also been raised and ratings of the programs varied by prison and even within prisons by different patients. One concern was the degree to which the punitive aspects imposed by security staff, discussed below, permeate into the programs, leading, at times, to staff harassment or a disciplinary approach to patients. For example, one survey respondent reported that "the counselor supervisor here at the ICP treats us in a disrespectful manner. She has cursed at several individuals and tries to intimidate people. . . . She told a [patient] to 'kill himself if he really means it' when a [patient] was going through a crisis and had suicidal thoughts." Another concern is whether the programs are relevant or effective for all who participate. While others praised the group programs, some people complained that the programs did not provide useful information, that the same programs or lessons are repeated even when course names change, or that movies were too often shown. According to one survey respondent at Sullivan, "this prison's ICP lacks material as well as staff that can bring difference to the program. Every cycle is basically the same material which becomes a problem. People stop wanting to go or pay attention. Some of the staff want to do other things to make the learning experience worthwhile, but I feel sometimes they are afraid because of new senior counselor that works with ICP or because security staff bully them to do other things." There were also particular concerns about how appropriate the groups were for people who are relatively low functioning. Many people interviewed by the CA at various facilities were not able to even name the programs they were in, raising some concerns about whether they are able to engage effectively in the programs. Similarly, some, mostly elderly

or more low functioning people in the ICPs have raised concerns about their inability to participate in the volume and/or type of structured programs and chores required. As an indication of the varying levels of functioning on the ICP, the ADLs mentioned earlier are designed to help residents with their personal hygiene, take showers, wash their clothing, and clean their cells. In addition, as is a concern with all programs across DOCCS prisons, the pay people receive in the ICP is extremely low, ranging from ten cents an hour to 17 and a half cents an hour.

In addition to these concerns about programs raised by ICP patients, the Justice Center has reported some limitations in ICP programming. The Justice Center did find that participants were knowledgeable about ICP programs and were engaged in their treatment. On the other hand, the Justice Center found that program schedules were inaccurate and there were discrepancies between the log books and actual participation, such that program hours were actually less than what was recorded and any reported program hours by OMH were overstated. Also, the Justice Center reported that although IDDT (integrated substance abuse treatment for people with mental health needs) should be a program co-facilitated by DOCCS and OMH, OMH was often not involved in the program and not co-facilitating. In addition, the Justice Center found that community meetings often did not occur as they should, and did not occur at all at some ICPs. Furthermore, the Justice Center found individual treatment plans to be severely lacking. Some treatment plans did not have any individualized goals, while other plans stayed the same even after patients had achieved the goals laid out in the plan. Also with respect to treatment plans, the Justice Center found that patients often do not participate in the planning for the treatment plans or meetings about the plans, and sometimes the treatment plans were not even signed by individual patients.

With respect to individual therapy, survey respondents at CA-visited ICPs had mixed ratings. On the positive side, some survey respondents appreciated the support provided by staff. According to an ICP survey respondent at Clinton, "the counselors help motivate you to do your best in whatever you try to do." Another survey respondent asserted, "the ICP staff are all overworked and not paid enough . . . .[T]hey sometimes go up and beyond what is required of them and their jobs." On the other hand, the biggest complaint was that people felt that they did not see mental health staff for individual therapy as frequently or for as long as they would like. The median number of times that ICP survey respondents across CA-visited prisons reported meeting with OMH staff for individual therapy in the ICP was one time per month, and the median length of those individual therapy sessions was 15 minutes. Staff at Clinton reported that they conduct structured utilization reviews every 90 days, where individuals are assessed, staff make a decision as to whether to retain the person in the ICP, and for the majority of patients who will remain in the ICP provide comments and treatment recommendations specifying the patient's ICP programs. Some survey respondents expressed concerns that the individual therapy was not as extensive or individualized as it could be to help patients address their mental health needs. Also, across various ICPs, patients expressed concerns that their conversations with mental health staff were not always confidential, and that security staff would sometimes harass them with information they provided to mental health staff.

Turning from treatment to the overall environment and feelings of safety, around 70% of ICP residents across CA-visited prisons reported that they felt safer in the ICP than in general population. Still, over 44% reported that they frequently feel unsafe in the ICP, and a total of 78% reported that they feel unsafe at least once in a while. Interrelated, ICP survey respondents overall reported less, though still disturbing, staff physical and verbal abuse than other prison units. Specifically, over three-quarters of ICP survey respondents reported that they hear about physical confrontations with staff at least once in a while, compared to 85% of all CA general population

survey respondents. Similarly, 20% of ICP survey respondents reported that they personally had been in a physical confrontation with staff in the ICP, compared to 26% of all CA general population survey respondents. As one survey respondent from Green Haven's ICP wrote, "the officers need to be trained to work with us. Most of them provoke [incarcerated persons] so they can put their hands on [us]. The officers like to offend the [incarcerated persons], so when the [person] says something back, they can hit him."

For verbal harassment, more than 73% of survey respondents reported that they hear about verbal harassment once in a while, and over half of survey respondents had experienced verbal harassment from staff at least once. Again, these responses are better than general population, where 95% of survey respondents across CA-visited prisons report verbal harassment takes place, and 83% had personally experienced verbal harassment at least once. It is positive that ICP residents report less staff abuse than most general population survey respondents, particularly because they are most often located in maximum security prisons where staff abuse is most frequent. For instance, at Clinton, where levels of staff abuse in general population are among the worst of all DOCCS prisons, 88% of ICP survey respondents at Clinton reported feeling safer in the ICP than in general population. On the other hand, individuals in the ICP are people with the most serious mental health needs, and it is disturbing that physical abuse and verbal harassment permeates these units as well. At Five Points, for example, the most common complaint from people interviewed and surveyed in the ICP was problems with security staff, including harassment and disciplinary tickets. Even at Fishkill, where ICP residents generally reported a positive atmosphere, some people on the unit raised concerns about verbal harassment by security staff, and others noted that staff could benefit from enhanced training on how to interact with people with mental health needs. According to one survey respondent at Sullivan, "the worst part of the ICP is the way a few of the COs treat us. They don't show any kind of respect for us and they treat [incarcerated persons] like animals, calling us names."

In a similar manner, the ICPs have less of a punitive environment than other RMHTUs and the general population, but staff still use disciplinary tickets too frequently. Specifically, half of ICP survey respondents reported that they had received a disciplinary ticket while in the ICP, slightly lower than the percentage in CA-visited general populations. Looking at DOCCS reported disciplinary data, over the period from January 2010 to November 2013, the ICPs held disciplinary hearings at rates between one and a half hearings per person in the ICP to more than seven hearings per person, similar to or slightly less than the rates across all DOCCS prison units of between less than one hearing per person to over 10 hearings per person, and much less than the rates in the BHUs, STPs, and RMHUs, which ranged from over four hearings per person to nearly 24 hearings per person. Much more

Keeplock in ICP

Antoine suffers from schizophrenia and manic depression. He has tried to "hang up" a number of times, and has gone back and forth to the RCTP. Antoine has spent the last several years in ICPs at two different facilities. Antoine finds the ICP to be a positive environment for him. He feels safer in the ICP than general population, and he likes participating in programing, including general academic courses and art therapy. Even within this overall more positive environment, Antoine has been subjected to the solitary confinement of keeplock on numerous occasions. At the time we met Antoine, he reported that he had been in keeplock for two weeks about a month earlier for masturbation and was in keeplock about a month before that for smoking. Antoine estimated that he had been sentenced to keeplock dozens of times for smoking or similar behavior.

positively, the frequency with which SHU sanctions were imposed on people in the ICP were much less than most other prison units. The percentage of disciplinary hearings in the various ICPs that resulted in SHU sanctions ranged from less than one percent to just over 10%, compared to an average of 20% for all DOCCS prisons and between 30% and 68% for other RMHTUs. In addition to SHU, staff at various ICPs reported using keeplock fairly regularly. At Green Haven, staff reported that an average of about five people are typically in keeplock in the ICP on any given day, representing 4% of all people in the ICP. At Sullivan, numerous people the CA interviewed reported that they had spent time in keeplock, sometimes for weeks and months at a time. Even many individuals who reported very positive things about the ICP programming at the same time described abusive security staff, and excessive use of punishment, disciplinary tickets, and keeplock.

ICP – a Model, but Still Laden with Punishment an Isolation

Mohamed has been incarcerated for over thirty years. He told the CA he never had any mental health problems before he came to prison nor until he was sent to solitary confinement. Mohamed spent several years in "the box" in the 2000s. When back in general population, his mental health had deteriorated so much that he ended up in CNYPC. Mohamed reported that subsequently he went back and forth to CNYPC on numerous occasions, spending over six months there during his last hospitalization. Positively, Mohamed has spent the last few years – when he has not been at CNYPC – in an ICP. When the CA met him in Sullivan's ICP, he reported having a mixed experience in the unit. On the positive side, Mohamed was participating in group programming – including socialization, healthy living, and life skills. He found these programs to be a positive opportunity for those who want to improve themselves and he found life skills in particular to help prepare people to be a part of society upon release. On the other hand, Mohamed reported facing a lot of verbal and physical abuse by security staff, to the point that he even felt he would be safer in general population. As Mohamed related, "security staff create problems . . ., try to set people up with tickets [and] try to interfere if you try to help someone else. They want to sabotage. They jump on you and beat you." Mohamed has received a number of disciplinary tickets in the ICP, including one right before he was supposed to go to his most recent Parole Board, the third time in which he was denied. As a result of the punitive response to such behavior as not having a curtain up or an allegedly positive urinalysis, Mohamed has spent long periods of time in keeplock, upwards of a month and two months on two recent occasions. During these keeplock periods, he has spent 24 hours a day in his cell, did not participate in any programs, and did not even go to recreation out of fear of being set up with another ticket. Even in the context of the ICP, where Mohamed is benefiting from and wanting to participate in programs, he continues to face a punitive and sometimes violent environment.

Related to the more limited abuse and safety concerns, as well as the intensive and relatively positive view of mental health programs and services, people in the ICP showed more positive outcomes than in other units. As seen in **Table 14** above, apart from those released from prison at the time of ICP discharge, almost a quarter of people leaving the ICP are transitioning either to a TrICP or directly to general population, and another 20% are transferring to another ICP. Of concern, a number of people are still going from the ICP to the SHU. It is positive that the percentage of SHU transfers just under 7% is relatively small compared to other housing locations. On the other hand, it is of concern that any patients with such severe mental health needs are being sent to the SHU. Moreover, at some facilities the number of people going from the ICP to the SHU was much higher. At Green Haven, for example, 17% of all discharges from the ICP were to the SHU. Also of concern system-wide, over 12% of people leaving any ICP are going to CNYPC. It is positive that people in mental health crisis in the ICP are able to go to the psychiatric hospital. On the other hand, it is concerning that such a large number of people are going into psychiatric crisis

while in the ICP. Relatedly, more than a third of ICP survey respondents reported that they had attempted self-harm while in the ICP. Both of these indicators, CNYPC admission and self-harm, are representative of the seriousness of the mental health needs of people in the ICP and at the same time, raise some concerns about whether the ICP is able to provide the appropriate therapeutic and supportive environment for these patients.

The Transitional Intermediate Care Program (TrICP) is intended in part as a transitional step-down unit from the ICP. The purpose of the TrICP is to help these individuals be reintegrated into general population. At the TrICPs the CA has visited in the last few years, a substantial portion of the residents in the TrICP – around one half to two-thirds– are members of the general population, while a smaller number of residents are people transitioning from the ICP. Residents in the TrICP typically engage in regular prison life, as in general population, including general population programming, while in addition having periodic individual or group counseling sessions. At Green Haven, for example, the TrICP is just one small part of a longer tier of cells where the first 18 cells incarcerate people in the TrICP, who attend periodic group counseling sessions off the unit, and the rest of the gallery are people in general population.

From TrICP to SHU

Mariano suffers from serious mental illness. After being subjected to disciplinary confinement in SHU and then the BHUs at Great Meadow and Sullivan, he was able to transition into ICPs at Elmira and Green Haven. He even was able to succeed in the ICP to the point that he was able to get to a TrICP. Not long after being in the TrICP, he was given another disciplinary ticket and sent to the SHU. At the time the CA met him, he had already been held in solitary confinement in the SHU for three weeks waiting for the disposition of his hearing, despite the fact that he has an S-designation. – Anonymous at Green Haven

Overall, looking at mental health services all together in the ICP, just under half of all ICP survey respondents across CA-visited prisons rated the quality of the overall mental health care available in the ICP as good and more than another third rated it as fair. The ICP provides a relatively positive model for how people with mental health needs, so long as they are incarcerated, can be in a relatively safer and more therapeutic and rehabilitative environment than the rest of the prison system. This model should be expanded so that the large number of people with mental health needs in the DOCCS system can receive better and more appropriate care. At the same time, the experiences of patients in the ICP indicate the ongoing difficulties of providing a sufficiently supportive environment for people with mental health needs within a prison context, and calls into question whether and why many of these patients are incarcerated.

LACK OF MENTAL HEALTH SERVICES FOR PEOPLE IN GENERAL POPULATION

As noted above, there are only 1,200 residential beds in DOCCS prisons for persons with serious mental illness, leaving the vast majority of people with mental illness, including those with serious mental illness, residing in general population or the SHU. OMH patients in general population have limited, short check-in meetings with OMH staff, and may receive medications. For example, half of the prison population at Collins and just under half of the population at Groveland are on the OMH caseload; yet there is no residential mental health program, there are no group therapy programs, and individual therapy is limited to a fifteen minute appointment once a month with a social worker and a 15 to 30 minute session with a psychologist once every three months. As one survey respondent at Collins proclaimed, "it's like a time bomb waiting to happen."

The Trauma and Negative Mental Health Effects of the Prison Experience

I am so sick and tired of the inhumane and cruel ways we are treated and abused in the New York State prison system. . . . Legislators . . . pass laws that send people to cages for years and years . . . instead of helping men and women address their issues. There are people in prison for very bad crimes and yes they must pay for their actions. But isn't time enough for justice? Instead, we are abused and treated so poorly that our souls are touched, that is how deep we are abused. A lot of us won't say anything about the abuse or what they have seen out of fear from retaliation of being beaten and set-up and sent to the SHU for years at a time, and meanwhile the correction officers involved say we assaulted them and we receive a new sentence on top of the one we have just so they can cover themselves and justify the serious beating they gave us. . . .

During this sentence, my mother passed away and DOCCS did not allow me to attend her wake or funeral even though I was 45 minutes away. . . There is nothing in this world more cruel than that. I was so deeply hurt I never had the chance to say good bye to her because DOCCS had so much power to rip my soul away and just leave me in a cell to deal with it. . . . They send us to SHU for years at a time for having a trace of marijuana in our system instead of a mandatory program or work details. Sometimes our behaviors reflect our only escape of the insanity in here 24/7. Sometimes we engage in drugs to protect our sanity, when being on the verge of losing it. It is such a depressing place behind these walls. So many times over the years did I want to end my life.

I . . . now realize that being good of heart and merciful is the ways we all should live. I started out in here when it was a gladiator school as a kid, hung around with convicted mob bosses, fought in makeshift UFC rings run by COs to bet on, and seen the ugly of the world inside. But now as a grown man, I just want to help people. maybe it's my calling, so I hope I didn't waste 20 years of my life in here for nothing. . . . Some of us are bad people, but a lot are also good, even certain staff and COs are decent good people of heart. I need you to know that I do not tell this story out of anger or resentment for my years in here spent. I tell this story of truth because truth of the heart is pure and so very real. – Anonymous at Five Points

Moreover, the prison environment itself has negative mental health impacts on all incarcerated persons – those with pre-existing mental health conditions and otherwise. Yet there are no services available for people to address the trauma they have experienced prior to incarceration or while they are incarcerated. Moreover, there is currently a lack of comprehensive discharge planning services. OMH does limited discharge planning for many OMH patients leaving DOCCS custody. OMH also has more comprehensive discharge planning services at a small 31-bed Community Orientation & Re-entry Program (CORP), although the capacity is limited and needs to be expanded.

Limited Services for Many People with Mental Health Needs in General Population

More specifically, many individual prisons have large and growing numbers of people incarcerated who have mental health needs. Collins, for example, recently experienced a dramatic increase in the number of incarcerated persons who are in need of mental health services after the facility became an Office of Mental Health (OMH) level 2 facility in the two years prior to our visit in 2013. Half of the prison population, 524 people, were on the OMH caseload at the time of our visit,[43] including over 260 people who were OMH L2 patients and 34 people who were S-designated. Moreover, in addition to the 55% of survey respondents who reported being on the OMH caseload, an additional 23.5% reported they had previously been on the OMH caseload, and consequently, there may be additional people at Collins in need of mental health treatment. While some survey respondents reported that mental health staff were supportive and tried to provide them with assistance, despite

[43] By contrast, at another OMH Level 2, albeit maximum security, prison, Eastern, there were only 56 people on the OMH caseload in July 2014.

the limited resources and time they had, the lack of group therapy and insufficient short individual therapy once a month raises serious concerns.

Similarly at Groveland, there had again been a recent influx of people with mental health needs and there were 460 people on the OMH caseload at the time of our visit, representing nearly 44% of Groveland's population. Some incarcerated persons at Groveland complained of the difficulties receiving mental health care, including difficulties obtaining medications, problems with staff not believing patients, short sessions with OMH staff, staff failures to make individualized assessments about what people need, staff lowering diagnosis levels in a way that results in patients being eligible for less mental health services, and challenges when people face mental health difficulties outside of regular business hours. Some people reported that mental health interventions tend to only happen if a major incident occurs; otherwise, people with mental health needs face difficulties and sometimes receive disciplinary tickets for conduct that resulted from their mental health needs.

Even at OMH L1 facilities that have residential treatment programs, there are large numbers of people with mental health needs in general population. As of July 31, 2013, Clinton, for example, had 447 people on the OMH caseload. Over 50% of the people on the OMH caseload at Clinton were either OMH L1 or L2 patients, indicating more significant mental health needs, and just under 30% were S-designated. Yet, over 83% of the OMH patients at Clinton were *not* in a residential program and were thus in general population or SHU. At Clinton, there were 230 patients on the OMH caseload for every psychiatrist, 459 patients per psychologist, and 115 patients for every social worker. These relatively high caseloads raise concerns about the ability of OMH staff to provide meaningful one-on-one interactions with patients in general population and otherwise; again, as at other DOCCS prisons, there was no group therapy. While some patients expressed positive comments about OMH staff and how OMH staff cared about patients and tried to help them, others complained about difficulties accessing mental health services, problems with confidentiality, and the limited scope of services that was confined primarily to providing medications. Similarly at Fishkill, 464 people, or 28% of the total population, were on the OMH caseload. With only 42 residential mental health beds, over 90% of people with mental health needs were in general population or SHU. A larger 48% of CA survey respondents had been recommended for, or had received, mental health services at some point during their incarceration. While survey respondents rated the mental health care received relatively well, again these individuals were receiving little mental health support other than medications. In the same pattern, Attica had 456 people on the OMH caseload in 2013, 335 of whom, including 34 with an S-designation, were in general population or SHU

Difficult to Get Mental Health Services

One survey respondent at Groveland noted past suicide attempts and significant mental health issues resulting from serious abuse as a child. This patient reported that he had repeatedly asked for counseling and other mental health assistance since arriving at Groveland. Despite his repeated attempts, however, he reported that OMH staff claimed he was a liar, disregarded his attempts to discuss the child abuse he faced, and essentially was dismissive because he "didn't hear voices." – Anonymous at Groveland

Very positively, the CA recently learned that OMH began providing limited group therapy in general population in at least one facility, Greene, in September 2013. As of October 2014, there were four to six group sessions held weekly in Greene's general population, lasting approximately one hour, with roughly 10 participants in each session. According to Greene administrators, every person on the OMH caseload (151 people in October 2014) participates in at least one group session per month. It is very positive that OMH has begun implementing group therapy opportunities, and

such opportunities should be expanded at Greene to allow for more frequent sessions, and replicated and expanded across DOCCS prisons.

Difficulties for Mental Health Patients in General Population Programs/Environment

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

On the security staff side, many survey respondents across CA-visited facilities told us that people with mental health needs are often targeted by correction officers for abuse. At Collins, for example, survey respondents reported that security staff engage in verbal harassment, make fun of people with mental health needs, and often send mental health patients to the box. One survey respondent reported a personal experience in which an "officer grabbed me by my shirt and shoved me and two other [incarcerated persons] into a corner because we were late for our mental health medication . . . He said he would 'pull the pin' and swear I assaulted him." Statements made by DOCCS staff also indicated a lack of understanding of mental health needs and a disturbing attitude that incarcerated persons claim mental health issues in order to avoid discipline or responsibility. As an even worse example, at Clinton, some people in general population observed a targeted "abuse toward the mental health population." One survey respondent at Clinton recalled, "I have seen people who are on mental health medications . . . slapped by COs; the surroundings are hostile and not geared toward rehabilitation." Similarly, at other facilities, like Attica and Great Meadow, incarcerated persons also alleged that people with mental health needs were particularly targeted for abuse by security staff. As one survey respondent reported, "in Attica they lied when they said I attempted to hang myself with a paper gown. In Comstock [Great Meadow] COs choked me unconscious." Some staff themselves noted the lack of training to work with people who have mental health needs, and in particular, that general population correction officers who have the most interactions with people with mental health needs have the least amount of training. One survey respondent at Groveland implored, "COs and employees need to please try to take the time to understand [people with mental illness]. It should be part of [their] training. . . . I believe if COs can take time to yell at us, they should take the time to let us explain . . . As of today, I would rather die than ask most COs or DOC for help; they don't seem to care at all."

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

Abuse in General Population after Long-Term Solitary

From the age of 14 to 29, I have spent much of my time in isolated confinement alone in a cell 23 or 24 hours a day without any meaningful programs or contact with other people. I came to Attica in solitary confinement . . . in late 2012 . . . from Southport, where I had spent five and a half years in isolated confinement. I had previously spent 10 months in isolated confinement at Southport on a different occasion, 10 months in isolated confinement at Upstate, and had even been subjected to room confinement when I was in youth facilities. Although I did not used to have mental health needs, all of that isolated confinement seems to have taken its toll. I now suffer from bipolar disorder, depression, and anxiety, and am on the Office of Mental Health (OMH) caseload as a Level 1 patient, meaning that I require the most mental health services. . . . I have been on the OMH caseload since early 2012 when I was at Southport. I at first was an OMH Level 3. But later in 2012, I wigged out in the box. I was talking about the king of the minion, biting my wrist and spitting out blood, and banging my head against the wall. . . . Since Southport doesn't have a mental health crisis area, I was brought to Attica and taken to the "boom boom room" (otherwise known as observation cells or the RCTP). I became an OMH Level 1 patient at that time, and then I was sent from the RCTP to the SHU at Attica, directly back to the conditions that had caused me to try to harm myself. . . . I was released from SHU to the general population after 10 months in late 2013. However, the transition was very difficult, I was not given any supports, and instead I was targeted by staff because of my time in the box and my mental health issues. I ended up back in the box after only five days in general population. . . . Because I had come from so much time in isolated confinement and because of my mental health needs, I was having difficulty adjusting in the general population. There are always guards there ordering you to do things and yelling at you, and doing so-called "credit card checks," where they swipe your buttocks. Sometimes I would forget to bring my ID or to respond to officers, and they would yell at me and target me. I just wasn't used to it after years in the box, and there was no time for a transition from isolation to general population. . . . One day [an] officer punched me in the face, twice on the left side. Then four other COs surrounded me with their sticks out. [Soon thereafter], some officers came and called me out for a cell search. . . . [five] COs started punching me and dropped me to the ground. . . . They rammed my head against the gate, causing me to need five stiches in my head. . . . I was in the infirmary for an extended period of time, and then I was sent back to the SHU. I was given 12 months of box time. – Anonymous at Attica

SUICIDE AND SELF HARM IN DOCCS FACILITIES

Unfortunately, during the past 15 years, DOCCS has experienced many years in which there have been a high number of suicides in the state prison system, and the annual suicide rate has been rising in the last five years. Data recently obtained from the New York State Commission of Correction indicate that the number of suicides in 2014 will also be high, with 9 suicides in the state prisons as of June 14, 2014. **Table 15 – Summary of DOCCS Suicides 2000 - 2013** lists annual suicides from 2000 through 2013, and provides the annual suicide rate per 100,000 incarcerated persons. We also analyzed the trend in suicides in the state prisons for the period 2000 to date and present that data in **Appendix B – DOCCS Suicides During 2000 to 2013 by 2007-2013 Rate**.

Table 15 – Summary of DOCCS Suicides 2000 – 2013

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

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

The information contained in **Table 15** and **Appendix B** reveals a disturbing trend of increasing suicides in the system at a time when mental health services have also been increasing. The suicide rate in 2010 was the highest rate not only for this decade, but also for the past 30 years, according to research by Mary Beth Pfeiffer, an independent reporter who has been investigating suicides in DOCCS for several years.[44] Moreover, in the past nine years, DOCCS has experienced its five highest suicide rates over the same 30-year period. For the last nine years summarized in **Table 15,** from 2005-13, the average annual suicide rate is 22.5 incidents per 100,000 incarcerated persons. The most recent national data for 2000-2011 demonstrates that New York's suicide rate for 2005-13 is 41% higher than the national average of 16 suicides per 100,000 incarcerated persons.[45] For the period 2010-13, New York's prison suicide rate is 59% higher than 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 2010 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 incarcerated persons in these units comprised less than 7% of the total prison population.[46] That rate only declined a little, to 29%, for the period 1998 to 2009, according to the research from Ms. Pfeiffer. The CA has obtained data from the State Commission of Corrections which contains the location of 38 of the 43 suicides in 2011 through March 2014. Twenty-four percent of these suicides were in the SHU, a rate **more than three times** the percentage the SHU population represents of the entire prison system. It is also disturbing to note that there were at least three more suicides of persons in reception during this three year period, three suicides also occurred in the ICP and one in the Marcy RMHU.

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 during the period 2011 through June 2014 were Attica, Auburn, Clinton, Elmira, and Great Meadow. These five prisons accounted for 54% of all suicides in the state prisons, even though they have only 18% of the prison population. The annual suicide rate for these five prisons was 71.6 suicides per 100,000 persons. This is a rate **4.5 times** the national prison suicide rate. Besides being maximum security facilities with significant populations of incarcerated persons with mental illness, these facilities also have larger SHU populations, have relatively high allegations of staff abuse, and some also house reception areas where newly admitted incarcerated persons are processed. The suicide rate for these institutions was three times higher than the system-wide average. However, other facilities, that have maximum-security individuals, 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 Southport. 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.

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[44] 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).
[45] BJS,US DOJ, *Mortality in Local Jails and State Prisons, 2000-2011 – Statistical Tables*, at Table 26, p. 27 (2013).
[46] Correction Association, *Mental Health in the House of Corrections* at 57 (2004).

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 officials identify mechanisms to reduce self-abuse and suicide. We have analyzed suicide attempts from data provided by OMH for the period 2007 through 2012 and again found that these incidents of self-harm are concentrated at a few prisons. **Appendix C - DOCCS Suicide Attempts During 2007 to 2012 by Rate 2007-12**, summarizes the suicide attempt rate for all DOCCS prisons. In the four-year period, 2009-12, the prison system has averaged 141 suicide attempts per year, representing a rate of 247 attempts per 100,000 residents. Nearly half of the suicide attempts during this period were at seven prisons: Auburn, Bedford Hills, Elmira, Five Points, Great Meadow, Southport and Sullivan, even though these institutions represent only 15% of the prison population. The other high suicide rate prisons (Attica and Clinton) also had higher than average self-harm rates during this same period. We strongly believe action must be taken by DOCCS to reduce the level of self-harm system-wide, and to analyze why certain facilities are the locus of much of the self-harm occurring in the system.

DOCCS and OMH Policies Concerning Suicide Prevention

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 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. The ineffective and punitive crisis intervention described above indicates serious problems with communication, a lack of recognition of self-harm attempts as indicators of crisis, and a failure to respond appropriately. 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 received through FOIL requests a limited number of mortality reviews of incidents of suicide conducted by CQC and its successor agency, the Justice Center, in 2011 through 2014. A

few observations can be made from this sample of mortality reviews. Although not all reviews found problems in mental health care, 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:

- Failure of OMH to obtain mental health treatment records or review patient's pre-sentence report leading to an inadequate assessment of a patient's needs.
- Failure to perform an adequate assessment of suicide risk by DOCCS or OMH throughout a person's incarceration, including when a person is placed in the isolated confinement.
- 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.
- Premature discharge of a person from the OMH caseload.
- Inattention to incarcerated persons who are withdrawn or non-communicative with staff or who are not medically compliant.
- Inadequate training of security staff assigned to the SHU on recognizing mental illness signs and symptoms.
- 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 incarcerated persons. Suicide is extremely stressful for both staff and other incarcerated persons, 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. Incarcerated persons can be traumatized by the event, and "such trauma may lead to suicide contagion," according to Lindsay Hayes.[47] This is important at facilities with frequent suicides, such as three at Southport in 2012, three at Attica in 2013, and two each at Auburn and Clinton within a one-month period during 2014.

Mr. Hayes recommends that when staff and incarcerated persons 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 incarcerated persons "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."[48]

As discussed in some detail earlier in my testimony, the CA also has grave concerns about the mechanisms available to individuals experiencing a crisis. When an incarcerated person expresses thoughts of self-harm or believes he/she is experiencing a mental health crisis, by official policy he/she is told to raise this issue with staff. Staff is instructed by policy 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). As discussed above, at facilities such as Great Meadow, there are serious concerns as to whether incarcerated persons are physically abused

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

when they seek this assistance. Interviews we conducted in 2012 reinforced the earlier experience we observed at that prison that persons going to the RCTP are harassed and sometimes physically abused by security staff. Second, as noted above, 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, as detailed above, there have been many reports by incarcerated persons of staff harshly treating incarcerated persons while they are in RCTP cells. The CQC reports noted above found that while RCTP patients were treated well by OMH and DOCCS staff, it noted that "many [incarcerated persons] view the RCTP as punishment."[49] For many incarcerated persons, 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. The Justice Center has a more limited role and is only assessing a small number of suicides and these only entail persons who were on the OMH caseload and committed suicide.

The generation of mortality reviews is a cumbersome and lengthy process that does not produce timely results or consistent and clear guidance to 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 incarcerated persons who are on the OMH caseload through its risk management office in CNYPC. 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 the Justice Center to review mental health care, it is our understanding that OMH's mortality reviews are also provided to Justice Center 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 older 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.

SCOC has a 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 incarcerated person 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

[49] Ibid. at 11.

well as any responses by the agencies. We have received only a few SCOC suicide reviews, but these 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 incarcerated person self-harm.

The Justice Center's precise role in mortality reviews of suicides is unclear. We have recently received reviews for 3 deaths, and our initial assessment is that the Justice Center is performing a thorough evaluation of the mental health care provided. The Justice Center'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 the Justice Center's recommendations sometimes reveal some tension between the agencies concerning what remediation is required to address the concerns raised by the Justice Center. However, it is clear that the Justice Center 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 the Justice Center 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, the Justice Center 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 pertinent information about each case. The findings and recommendations of both the Justice Center 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.

CONCLUSIONS AND RECOMMENDATIONS

Prison is not an appropriate environment for people with mental health needs. The highly regimented, rigid rule-oriented, hyper-punitive, and too commonly abuse-laden environment is often very difficult for someone with mental health needs to manage. Indeed, the trauma of the prison environment can exacerbate people's mental health issues and create new mental health challenges for any person in prison. Unfortunately, there are large and growing numbers of people with mental illness inside of New York's prisons.

It is very positive that, due to targeted advocacy and agency and this Legislature's action, the number of residential treatment unit beds – both the non-disciplinary ICPs and the disciplinary RMHUs and BHU – increased from the early 2000s to the period from 2009-2011. These units have helped to provide greater mental health programs and services to people with the most serious mental illness. Particularly the ICPs can serve as a model for how, so long as people with mental health needs continue to be incarcerated, the prison system can provide a relatively more supportive, therapeutic, and safer environment for these individuals.

However, the capacity of non-disciplinary residential beds has stagnated and remained constant in the last five years since 2009, and the capacity of disciplinary residential units has declined with the closing of the Sullivan BHU. Also, the sharp decline in S-designations and the dramatic change in diagnoses from schizophrenia or other psychotic disorders to anxiety, personality, or adjustment disorders, raise serious concerns about underdiagnoses. Moreover, the available beds in both types

of units are not filled, despite the fact that there are – for the former – large numbers of people with serious mental illness in general population and– for the latter – large numbers of people with severe mental health issues in SHU. More importantly, even if all beds were filled, the vast majority of people on the OMH caseload, including many S-designated persons, remain in the general prison population, with very limited provision of mental health care and an environment often harmful to these individuals.

Worse still, the lack of mental health services coupled with the difficulty that people with mental illness often have managing the harsh and rigid prison rules is met with the punitive approach to addressing rule infractions, including those that directly result from behavioral manifestations of mental illness. As a result, large and disproportionate numbers of people with mental illness continue to be sent to isolated confinement. In turn, the torture of isolated confinement, even more so than general prison conditions, exacerbates mental health needs of people with pre-existing mental illness, and can create new mental health challenges for any person. Isolated confinement is directly contradictory to efforts to provide mental health treatment.

Again it is positive that due to the DAI litigation and this Legislature's action in passing the SHU Exclusion Law, many people with the most serious mental illness are being diverted from the SHU into the RMHTUs and receiving upwards of four hours a day of mental health programming and treatment. For some people who were suffering the worst impacts of the SHU, often causing them to repeatedly harm themselves, howl in the night, or throw urine and feces, the RMHTUs – particularly at Marcy, and to a lesser extent at Five Points, Great Meadow, and Attica – provide a relatively more humane and effective environment. Group and individual therapy and programming, and the support from some OMH and DOCCS staff dedicated to assisting individuals with the most serious mental health needs and disciplinary challenges, have allowed some patients in the RMHTUs to better cope with their illness and issues.

Still, these alternative units continue to operate in much more of a hyper-punitive and sometimes abusive manner than the therapeutic and rehabilitative environment they were intended to provide. Particularly at Attica, Great Meadow, and Five Points, but also at Marcy, the RMHTUs are dominated by their disciplinary nature. They are permeated by excessive use of disciplinary tickets, too frequent denials of programs and out-of-cell time under purported exceptional circumstances, instances of staff physical and verbal abuse, and conditions and treatment by staff that lead to people's refusals to leave their cell or participate in programs. The dominant culture continues to remain one that emphasizes repeated, excessive, and counter-productive punishment in response to difficult behaviors and manifestations of mental illness, rather than communication, de-escalation, and treatment.

Taken all together, the large and growing incarceration of people with mental health needs, the insufficient mental health services or discharge preparation and planning for most people on the OMH caseload, the overly punitive response to behavioral manifestations of mental illness, and the continued pervasive use of isolated confinement and other abusive disciplinary confinement units lead to suffering, exacerbation and creation of mental illness, and negative outcomes. The most visible and disturbing outcomes include people going into mental health crisis, and/or committing suicide and self-harm, along with insufficient responses to crises by DOCCS and OMH. Although the numbers of RCTP admissions continue to rise – indicating people going into mental health crisis – the numbers of psychiatric hospitalizations at CNYPC have declined. Too often there is a lack of meaningful crisis intervention, people face abusive conditions on the way to and in the RCTP, and after short stays in the observation cells and dorms people return to the very conditions – including

isolated confinement – that caused them to go into crisis. With suicide rates in DOCCS prisons at levels that are nearly 60% higher than the national average for all US prisons, and roughly two times the rate in the outside community, dramatic changes need to take place.

The challenges of New York State to create appropriate support, services, and environments for people with mental health needs in prisons and in the state are vast and complex. First and foremost, numerous changes are necessary to facilitate treatment, diversion, and recovery of New Yorkers with mental illness currently involved in the criminal justice system so that they are no longer involved in the criminal justice system and are removed from prisons and jails. Specific detailed recommendations related to major components of those necessary changes, including the expanded and enhanced provision of outside community mental health care, utilization of alternatives to incarceration and traditional policing for people with mental health needs, and reform of the bail and jail systems, are outside the scope this testimony, and the testimony of others with more expertise in these areas should guide policy-makers. Our recommendations will focus more on the intersection of mental health and the state prison system discussed throughout this testimony, including the need for improved and expanded: mental health services, restrictions on the use of solitary confinement, therapeutic and rehabilitative alternatives to solitary, crisis intervention and suicide prevention measures, discharge planning and efforts throughout incarceration to reduce the number of people returning to the prison system after release, and public reporting and outside oversight of mental health services and the use of isolated confinement. At its core, in the prison system as well as in jails and the outside community, there must be a fundamental shift in the culture, philosophy, and approach to people with mental health needs from one of punishment, control, and abuse to one of treatment, recovery, and empowerment.

Specifically, **we recommend that DOCCS, OMH, the Legislature, the Governor, and other State Policy-Makers:**

Better Prepare People in Prison to be Successful upon Return Home, Stop Incarcerating People with Mental Health Needs, De-Criminalize Behavioral Manifestations of Mental Illness, Provide Greater Community-Based Care

We recommend that DOCCS:

- End practices that inflict trauma, create or exacerbate mental health conditions, and make it more difficult for people to be successful upon returning home, such as solitary confinement and staff violence and abuse.
- Provide earlier and greater transitional services to people with mental health needs to ensure that they are best prepared to return to the outside community in terms of housing, employment, education, family, and medical and mental health care.
- Foster greater connections between incarcerated persons and their families and outside communities throughout their period of incarceration.
- Modify the COMPAS instrument to properly account for people's mental health issues, and increase the likelihood that people with mental health needs are released on parole.

We recommend that OMH:

- Expand and replicate CORP to provide more and earlier opportunities for dedicated units to implement comprehensive mental health discharge planning and preparation.

- Within existing prisons and programs, provide greater comprehensive discharge planning services throughout the prisons, connect people being released to community-based mental health services while they are inside, and ensure continuity of mental health treatment.
- Ensure appropriate documentation of patients' mental health needs, past courses of treatment, and level of services needed upon release.
- Help patients locate and enroll in community mental health treatment, apply for public benefits, and obtain housing.
- Throughout incarceration and prior to release, better help people prepare mentally and emotionally for return to their outside communities.

We recommend that the Legislature, Governor and other State Policy-Makers:

- Enhance and expand in-patient and out-patient community-based mental health services, through greater funding, resources and support.
- Create and expand alternatives to incarceration for people with mental health needs.
- De-criminalize behavioral manifestations of mental illness and divert people with mental health needs convicted of crimes from incarceration to treatment.
- Utilize mental health crisis intervention teams across New York State for responding to incidents involving people with mental health needs.

Expand the SHU Exclusion Law to End the Torture of Isolated Confinement

We recommend that DOCCS:

- Utilize empty bed space in the RMHTUs for people without an S-designation on the OMH caseload who are in SHU, prioritizing based on OMH level.
- Stop holding S-designated people in keeplock, or in SHU for periods less than 30 days, during the pendency of disciplinary proceedings, or under exceptional circumstances.
- Stop issuing disciplinary tickets in response to behavioral manifestations of mental illness and utilize de-escalation, communication, and therapeutic and rehabilitative interventions.
- Stop placing people with mental health needs in SHU, keeplock, or any form of isolated confinement, and instead utilize existing or new therapeutic and rehabilitative alternatives.
- Stop placing any person in any form of isolated confinement beyond 15 days to limit the mental health damage to people subjected to such confinement.
- Reduce the frequent imposition and lengthy amounts of time of SHU and keeplock sentences for people with mental illness and all people who are being sanctioned for prison rule violations.
- Expand programming opportunities, out-of-cell time, and meaningful human interaction for people with mental health needs and all people in the SHU and keeplock, and consider adding additional recreation equipment and allowing congregate recreation.
- Investigate and address the racial disparities in the imposition of SHU sentences.

We recommend that OMH:

- Undertake more thorough review processes of all people in SHU on the OMH caseload to ensure that all who should qualify for an S-designation are diverted from the SHU.

- Increase reliance on individuals' mental health history, past treatment, and family input to determine accurate diagnoses. Create a dedicated full-time OMH family liaison position to better engage with family members.
- Utilize a rebuttable presumption that a person be given an S-designation if that person has been diagnosed in the past – in prison, jail, or the community – with a condition that would qualify for an S-designation under the SHU Exclusion Law.
- Take more seriously acts of self-harm in the SHU as likely indicative that a person has deteriorated mentally or emotionally in the SHU and should be given an S-designation and diverted from the SHU.
- Provide greater mental health support and services to people in the SHU.
- More thoroughly assess, document, report on, and take proactive measures to address and limit the mental health impacts of the SHU.

We recommend that the Legislature, Governor and other State Policy-Makers:

- Expand the SHU Exclusion Law to apply to all people with mental illness, in addition to only those who have an S-designation, and all forms of isolated confinement, including administrative segregation, pre-hearing confinement, and keeplock.
- Pass the Humane Alternatives to Long Term (HALT) Solitary Confinement Act, A. 8588A / S. 6466A,[50] or otherwise adopt the following key components of HALT to end the torture of solitary confinement for all people:[51]
  - Mandate the creation of more humane and effective alternatives. Under HALT, these would take the form of alternative residential rehabilitation units (RRUs) in which persons in need of separation from the prison population can be placed and receive at least six hours of out-of-cell programming in addition to one hour of recreation each day;
  - Limit the length of time anyone can be placed in isolated confinement to at most 15 consecutive days and 20 days total in any 60 day period;
  - Restrict the criteria in determining whether a person can be sent to isolated confinement or an alternative therapeutic confinement setting to the most serious acts;
  - Exempt particularly vulnerable people – including young people 21-years-old and younger and people with mental health needs – from being placed in isolated confinement for any length of time; and
  - Enhance staff training, procedural protections, transparency through periodic public reporting, and accountability through independent, outside oversight.

[50] Humane Alternatives to Long Term (HALT) Solitary Confinement Act, A. 8588A / S. 6466A, *available at*: http://assembly.state.ny.us/leg/?default_fld=&bn=A08588&term=2013&Summary=Y&Memo=Y&Text=Y.

[51] For a more thorough explanation of the provisions of the HALT Solitary Confinement Act and the reasons why those provisions are necessary, please *see, e.g.*, Report on Legislation by the Corrections and Community Reentry Committee and International Human Rights Committee, *New York City Bar*, A.8588-A/S.6466-A, *available at*: http://www2.nycbar.org/pdf/report/uploads/20072748-HALTSolitaryConfinementReport.pdf; Testimony by the Correctional Association of New York, Before the Senate Judiciary Committee's Subcommittee on the Constitution, Civil Rights, and Human Rights Reassessing Solitary Confinement, February 25, 2014, *available at*: http://solitarywatch.com/wp-content/uploads/2014/02/Correctional-Association-testimoney-for-Congressional-Hearing-2-25-14-with-attachment.pdf; Testimony by the Campaign for Alternatives to Isolated Confinement (CAIC), Before the Senate Judiciary Committee's Subcommittee on the Constitution, Civil Rights, and Human Rights Reassessing Solitary Confinement, February 25, 2014, *available at*: http://solitarywatch.com/wp-content/uploads/2014/02/Testimony-of-the-NY-Campaign-for-Alternatives-to-Isolated-Confinement-2014.pdf.

Improve the Therapeutic and Rehabilitative Nature of the RMHTUs

We recommend that DOCCS:

- End all staff verbal and physical abuse of RMHTU residents, and better train, encourage, and equip line staff to engage people in more positive interactions.
- Enhance training for all security and program staff, as well as other incarcerated persons, on how to effectively work with people with mental health needs.
- Stop issuing disciplinary tickets and SHU time in the RMHTUs, and provide more therapeutic responses and interventions in response to people's needs and behaviors.
- Fundamentally transform the culture from force, punishment, and abuse to de-escalation, communication, and empowerment.
- Stop using exceptional circumstances to deny people the opportunity to participate in programming and treatment.
- End the practice of placing residents in exposure suits and develop a more effective and proactive intervention to address the inappropriate behavior receiving this response.

We recommend that OMH:

- Ensure all OMH staff adopt a non-punitive, therapeutic approach to RMHTU patients.
- Document allegations of DOCCS staff abuse by RMHTU patients, and take appropriate action to seek redress for those allegations in a manner most protective of patients.
- Explore best practices of mental health care, particularly those being employed at Marcy, and adopt those practices across the RMHTUs.
- Provide more intensive and supportive one-on-one mental health therapy to people not participating in group programming because of exceptional circumstances or refusals.

We recommend that the Legislature, Governor and other State Policy-Makers:

- Remove the exceptional circumstances for group programming, so that all people with S-designations receive at least the minimum out-of-cell time and programming required.
- Increase the mandatory out-of-cell time offered to people in the RMHTUs.
- Provide funding to expand the number of therapeutic and rehabilitative alternative units to the SHU so that more people with mental health needs can be diverted from SHU.

Expand and Improve the Intermediate Care Programs

We recommend that DOCCS:

- End all staff physical and verbal abuse of ICP residents.
- Stop issuing disciplinary tickets in the ICP, placing ICP patients in keeplock, or sending ICP patients to the SHU.
- Take appropriate remedial action against officers who utilize information learned from mental health staff in treatment team meetings or otherwise to harass ICP patients.

We recommend that OMH:

- Fill all empty ICP beds to provide as many opportunities as possible for enhanced mental health services.
- Ensure the relevance and effectiveness of ICP programs for all ICP residents of various degrees of functioning.
- Enhance the individualized nature of care in the ICP to avoid a one-size-fits-all model and individually tailor treatment plans and programming to each patient.
- Expand and improve ADL and other habilitative programs to increase people's capabilities upon reentry to the outside community.
- Better protect confidentiality of information provided by patients to mental health staff.

We recommend that the Legislature, Governor and other State Policy-Makers:

- Expand and replicate the ICP and TrICP to create more opportunities for in-patient intensive mental health programming and services for people with mental health needs.
- Ban the placement of ICP residents in keeplock.

Enhance Mental Health Services for People in General Population

We recommend that DOCCS:

- End all staff verbal and physical abuse of people with mental health needs, and encourage line staff to engage people in more positive interactions.
- Enhance training for all security and program staff, as well as other incarcerated persons, on how to effectively work with people with mental health needs.
- Stop issuing disciplinary tickets for behavioral manifestations of mental illness, and provide more therapeutic responses and interventions.
- Fundamentally transform the culture from force, punishment, and abuse to de-escalation, communication, and empowerment.

We recommend that OMH:

- Expand group therapy and broader therapeutic programming in general population throughout state prisons.
- Enhance mental health support for people in the TrICP and in general population who have transitioned from spending extended period in SHU, RMHTUs, or ICPs.
- Initiate and empower peer support programs led by incarcerated persons.
- Increase the frequency, length, and scope of individualized therapy so as to help individuals address the range of mental health issues they face.
- Provide greater trauma-informed care and treatment opportunities for all people in general population to address trauma issues prior to and during incarceration.
- Expand IDDT for people with both mental health and substance abuse issues, and enhance OMH collaboration in all prison substance abuse programs.

We recommend that the Legislature, Governor and other State Policy-Makers:

- Increase funding for residential programs for people with mental illness and expansion of mental health programs and services in general population.
- Require access to mental health care in prison in a manner akin to access to medical care.

Take Action to Reduce Suicide and Self-Harm in Prisons

We recommend that DOCCS:

- End all security staff abuse of people who have attempted self-harm, are in mental health crisis, and/or are being brought to or from an RCTP.
- Ensure that no person in mental health crisis or who expresses a desire to harm himself is physically or verbally harassed or abused.
- Implement mechanisms to investigate the living conditions and other circumstances experienced by a person who has attempted self-harm and take efforts to address these concerns prior to returning that person to these conditions.
- Carry out additional training about mental health crises, suicide, and self-harm with all executive staff and line staff working in the RCTP to ensure an appropriate understanding of the conditions facing individuals in crisis and to ensure all staff engage people on the way to and in the RCTP with the appropriate care required for those in crisis.
- Enhance efforts to respond to the impact of incidents of suicide and self-harm on the incarcerated persons and staff who are affected by these events through individual counseling, information sharing and group counseling.
- Better coordinate between OMH, SCOC and the Justice Center the process of mortality reviews of suicides to expedite the process and to implement any recommended changes in policies and practices resulting from this review process.

We recommend that OMH:

- Analyze the changes in utilization of CNYPC, and take appropriate measures to ensure that people in mental health crisis are receiving the interventions they need.
- Explore preventative measures for self-harm and suicide, and at a minimum ensure staff do not penalize such incidents and instead provide an appropriate response, including counseling, treatment, and/or transfer to another facility or CNYPC if appropriate.
- Ensure the facility appropriately engages the rest of the population after an incident of self-harm, including through individual or group discussions, and educational materials.

We recommend that the Legislature, Governor and other State Policy-Makers:

- Carry out thorough investigations into the causes of the high number of suicides at Auburn, Attica, Clinton, and Elmira, and take appropriate responsive action.

Increase Transparency and Accountability for Mental Health Services and the use of Isolation

We recommend that DOCCS:

- Promptly and thoroughly respond to all FOIL requests.

- Provide quarterly public reports, posted on the DOCCS website, of:
  - the number and characteristics of people in RMHTUs, SHU, and keeplock, and the length of time they have spent on these units.
  - the number and characteristics of people in RMHTUs who have been placed on exceptional circumstances, and those who refuse to participate in programs, and the lengths of time in which they have remained in their cells.

We recommend that OMH:

- Make public and easily available, including on the OMH website, all currently existing reports on mental health care inside the prisons, including, but not limited to:
  - Annual Central New York Center Patient Demographic and Diagnostic Profile
  - Annual Corrections-Based Operations Statistical Report
  - Quarterly Active Mental Health Inmate-Patients Housed in Special Housing Units
  - Monthly CNYPC Net Facility Caseload Census
  - Monthly CNYPC Program Census
- Provide quarterly public reports, posted on the OMH website, of suicides, suicide attempts, and incidents of self-harm.

We recommend that the Legislature, Governor and other State Policy-Makers:

- Require that the Justice Center comply with the SHU Exclusion Law's public reporting requirement and make all of its reports, studies, findings, and recommendations publically available and accessible on the Justice Center website in a timely manner.
- Require the Justice Center to immediately make public on its website:
  - Its system-wide studies of the ICPs and all reports and responses received from DOCCS and OMH with regard to these studies.
  - Any documentation of its SHU monitoring visits and other facility-specific findings, along with all reports and responses received from DOCCS and OMH.
- Provide greater funding and support for the Justice Center to carry out its monitoring work of the SHU Exclusion Law and mental health services within the state prisons.
- Empower the Justice Center with effective enforcement power and mechanisms to require DOCCS and OMH to implement its recommendations.

APPENDICES

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 – November 13, 2014

Appendix A - CNYPC Patient Demographics and Profile 2008-14

Appendix B - DOCCS Suicides During 2000 to 2014 by 2011-2014 Rate

Appendix C - DOCCS Suicide Attempts During 2007 to 2012 by Rate 2007-2012

APPENDIX A - CNYPC PATIENT DEMOGRAPHICS and PROFILE 2008-14

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 Diag	Census	Gender	Ethnicity	Primary Diagnosis	Selected 1st or 2nd Diag	Admit **	Disch. **
2008	62,599	8,567	13.69%	86.3%-M 13.7%-F	43.1%-AA 31.6%-W 21.7%-H	25.0%-MD 22.8%-MM 19.3%-Schiz/Psych 9.3%-AxD 8.3%-PD 8.5%-AdD	31.0%-SD 29.6%-PD	171	90.6%-M 9.4%-F	53.8%-AA 25.1%-W 18.1%-H	61.4%-Schiz/Psych 18.7%-MD 7.6%-PD 2.3%-AdD 3.5%-MM	52.6%-PD 12.3%-SD	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%-MD 19.7%-MM 18.4%-Schiz/Psych 10.3%-AxD 9.2%-PD 12.1%-AdD		164	90.4%-M 9.6%-F	52.7%-AA 29.3%-W 17.4%-H	55.7%-Schiz/Psych 21.0%-MD 10.2%-PD 1.8%-AdD 3.0%-MM		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%-MD 20.1%-MM 19.2%-Schiz/Psych 11.2%-AxD 8.9%-PD 10.8%-AdD		173	93.1%-M 6.9%-F	45.7%-AA 33.5%-W 19.1%-H	54.3%-Schiz/Psych 16.2%-MD 9.2%-PD 3.5%-AdD 4.0%-MM		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%-MD 21.1%-MM 17.8%-Schiz/Psych 10.5%-AxD 10.1%-PD 11.6%-AdD		137	93.4%-M 6.6%-F	46.0%-AA 33.4%-W 18.2%-H	56.9%-Schiz/Psych 17.5%-MD 12.4%-PD 4.4%-AdD 2.9%-MM 2.9% SD		425	471
2012	55,804	8,308	14.88%	88.4%-M 11.6%-F	40.8%-AA 34.8%-W 20.3%-H	23.1%-MD 20.0%-MM 16.2%-Schiz\Psych 14.5%-AdD 10.6%-AxD 10.4%-PD		137	93.9%-M 6.1%-F	48.0%-AA 23.6%-W 20.3%-H	58.1%-Schiz\Psy 20.3%-MD 8.8%-PD 6.8%-AdD 1.4%-SD 1.4%-Develop Dis		428	441
2013	54,865	8,190	14.92%	88.9%-M 11.1%-F	41.1%-AA 35.5%-W 20.1%-H	33.5%-MD 16.4%-AdD 15.2%-Schiz\Psych 12.1%-PD 10.1%-AxD 7.6% Maj Dep/BP		154	93.5%-M 6.5%-F	51.3%-AA 24.7%-W 20.8%-H	64.3%-Schiz\Psy 14.3%-PD 8.4%-Maj Dep/BP 3.9%-AdD 3.9%-DD 3.2%-MD		385	379
2014	54,196	8,573 (4.7% inc.)	15.80%	88.4%-M 11.6%-F	40.4%-AA 36.5%-W 19.3%-H	33.5%-MD 17.3%-AdD 14.0%-Schiz\Psych 12.5%-PD 10.8%-AxD 6.4%-Maj Dep/BP		154	91.7%-M 8.3%-F	52.9%-AA 28.0%-W 15.9%-H	70.7%-Schiz\Psy 8.3%-Maj Dep/BP 5.7%-PD 5.1%-AdD 3.8%-MD 1.9%-DD		335	332

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

Abbrev: AdD:Adjustment Dis.; AxD:Anxiety Dis.; DD: Developmental Dis.; MD:Mood Dis,; MM:Major Mood Dis.; PD:Personality Dis,; SD:Substance Abuse Dis.

OMH outpatient census reached a maximum in August 2008 of 9,067 inmates (15.26% of DOCCS pop). The caseload dropped to 7,836 (13.42%) as of January 1, 2010, representing a 12% drop in the percentage of DOCCS pop on the OMH caseload in 16 months, while the DOCS pop dropped only 5.5%. The January 1, 2014 outpatient census of 8,573 (15.8% of the DOCCS pop.) represented a 4.7% increase in OMH caseload from 2013 and the highest percentage of the DOCCS pop. on the caseload ever recorded. But the inpatient census at CNYPC has remained low with far fewer CNYPC admissions. **CNYPC admissions dropped 57%** since 2008, including a drop of 19.6% from 2008 to 2009, a 41.4% drop from 2008 to 2010, and a 42.5% drop from 2010 to 2014, while overall DOCCS pop decreased only 13.4% from 2008 to 2014.

Appendix B - DOCCS Suicides During 2000 to 2014 by 2011-2014 Rate

Prison	*Annual Suicides*															*Total*	*Rate*	*Pop*	*Total*	*Rate*
	2000	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*	*2013*	*2014*	*00-13*	*00-13*	*11-14*	*11-14*	*11-14*
1. Auburn	1	1	1	1	0	2	0	0	0	0	1	1	2	1	2	11	45.64	1702	6	101.18
2. Ogdensburg	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	14.79	374	1	77.29
3. Great Meadow	1	0	0	1	0	1	0	0	3	1	4	2	0	1	1	14	61.24	1631	4	70.20
4. Upstate	1	1	0	0	0	0	0	0	0	0	1	0	3	0	0	6	40.29	1271	3	67.60
5. Attica	1	2	1	0	2	2	1	1	0	2	1	0	1	3	1	17	14.85	2153	5	66.38
6. Elmira	2	0	1	2	3	5	2	2	1	2	3	2	2	0	0	27	110.42	1770	4	64.96
7. Wende	0	0	1	2	0	1	0	1	0	0	2	0	1	0	1	8	64.32	883	2	63.47
8. Clinton	1	0	3	5	0	2	2	1	1	2	2	1	2	1	2	23	57.76	2799	6	61.12
9. Sullivan	1	0	0	0	0	0	0	0	1	0	0	0	0	1	0	3	34.70	504	1	56.69
10. Coxsackie	0	0	0	1	1	0	1	1	0	0	0	0	1	1	0	6	42.23	1003	2	56.43
11. Marcy	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	2	12.46	1060	2	53.77
12. Otisville	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	12.56	524	1	53.21
13. Fishkill	2	0	0	0	0	0	1	1	0	1	0	0	0	1	1	6	25.80	1549	2	36.58
14. Woodbourne	0	0	0	0	0	2	0	0	0	0	0	0	1	0	0	3	26.87	801	1	35.42
15. Southport	1	0	2	0	0	1	0	0	1	1	0	1	0	0	0	7	57.60	868	1	32.90
16. Eastern	1	0	0	0	0	0	0	1	1	0	0	1	0	0	0	4	25.65	1000	1	28.65
17. Downstate	0	2	0	0	1	1	0	3	1	0	2	0	0	1	0	11	74.25	1154	1	24.81
18. Mid-State	0	0	0	0	0	0	0	2	0	1	0	0	0	0	1	3	14.31	1404	1	19.77
19. Sing Sing	2	0	0	0	0	0	0	0	0	0	0	1	0	0	0	3	11.60	1667	1	17.34

Appendix B - DOCCS Suicides During 2000 to 2014 by 2011-2014 Rate

Prison	*Annual Suicides*															*Total*	*Rate*	*Pop*	*Total*	*Rate*
	2000	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*	*2013*	*2014*	*00-13*	*00-13*	*11-14*	*11-14*	*11-14*
20. Green Haven	0	0	0	0	0	1	0	1	0	0	0	0	1	0	0	3	10.25	2030	1	14.16
21. Adirondack	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	405	0	0.00
22. Albion	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	7.17	858	0	0.00
23. Altona	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	436	0	0.00
24. Bare Hill	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	2	8.50	1626	0	0.00
25. Bayview	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	121	0	0.00
26. Beacon	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	138	0	0.00
27. Bedford Hills	1	0	2	0	0	0	0	1	0	0	1	0	0	0	0	5	45.96	769	0	0.00
28. Cape Vincent	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	821	0	0.00
29. Cayuga	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	881	0	0.00
30. Chateaugay	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	32.50	224	0	0.00
31. Collins	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	880	0	0.00
32. Five Points	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	2	10.49	1363	0	0.00
33. Franklin	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	1643	0	0.00
34. Gouverneur	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	825	0	0.00
35. Gowanda	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	1531	0	0.00
36. Greene	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	1644	0	0.00
37. Groveland	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	1023	0	0.00
38. Hale Creek	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	345	0	0.00

Appendix B - DOCCS Suicides During 2000 to 2014 by 2011-2014 Rate

Prison	*Annual Suicides*															*Total*	*Rate*	*Pop*	*Total*	*Rate*
	2000	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*	*2013*	*2014*	*00-13*	*00-13*	*11-14*	*11-14*	*11-14*
39. Hudson	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	378	0	0.00
40. Lakeview (male)	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	8.82	537	0	0.00
41. Lincoln	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	168	0	0.00
42. Livingston	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	803	0	0.00
43. Mohawk	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	2	11.41	1162	0	0.00
44. Monterey	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	190	0	0.00
45. Moriah	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	167	0	0.00
46. Mt. McGregor	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	435	0	0.00
47. Orleans	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	813	0	0.00
48. Queensboro	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	352	0	0.00
49. Riverview	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	8.02	826	0	0.00
50. Rochester	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	66	0	0.00
51. Shawangunk	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	13.14	534	0	0.00
52. Taconic	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	299	0	0.00
53. Ulster	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	708	0	0.00
54. Wallkill	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	562	0	0.00
55. Washington	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	755	0	0.00
56. Watertown	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	533	0	0.00
57. Wyoming	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00	1609	0	0.00

Appendix B - DOCCS Suicides During 2000 to 2014 by 2011-2014 Rate

Prison	*---------- Annual Suicides ----------*															*Total*	*Rate*	*Pop*	*Total*	*Rate*
	2000	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*	*2013*	*2014*	*00-13*	*00-13*	*11-14*	*11-14*	*11-14*
58. Arthur Kill	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	2			0	
59. Butler	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0	
60. Fulton	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0	
61. Mid-Orange	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0	
62. Oneida	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1			0	
	16	**7**	**12**	**14**	**8**	**18**	**8**	**18**	**10**	**10**	**20**	**10**	**14**	**13**	**9**	**194**	**20.62**	**52,570**	**46**	**25.00**

Appendix C-DOCCS Suicide Attempts During 2007 to 2012 by Rate 2007-2012

Prison	-- Annual Suicides Attempts --						Pop 07-12	Total Attempts	Attempts Rate	Tot Suicides 2000-13	Suicide Rate 2000-13	Tot Suicides 2007-13	Suicide Rate 2007-13
	2007	2008	2009	2010	2011	2012							
1. Bedford Hills	4	5	5	11	10	26	740	61	1178.14	5	45.96	2	38.63
2. Sullivan	2	6	9	3	3	7	589	30	727.21	3	34.70	2	48.48
3. Elmira	11	10	11	11	15	11	1709	69	576.78	27	110.42	12	100.31
4. Great Meadow	3	5	10	14	19	12	1633	63	551.13	14	61.24	11	96.23
5. Five Points	1	5	12	3	10	10	1361	41	430.46	2	10.49	0	0.00
6. Southport	2	1	7	2	7	8	899	27	429.21	7	57.60	3	47.69
7. Auburn	0	13	22	7	3	3	1688	48	406.15	11	45.64	5	42.31
8. Downstate	3	9	4	3	4	3	938	26	395.84	11	74.25	7	106.57
9. Mid-State	3	5	8	5	6	7	1503	34	323.23	3	14.31	3	28.52
10. Coxsackie	0	2	10	5	5	0	1010	22	311.28	6	42.23	3	42.45
11. Wende	0	1	3	4	5	2	860	15	249.27	8	64.32	4	66.47
12. Marcy	3	1	0	2	5	7	1111	18	231.52	2	12.46	2	25.72
13. Shawangunk	1	0	3	0	1	3	537	8	212.82	1	13.14	1	26.60
14. Green Haven	1	1	6	4	11	7	2061	30	207.98	3	10.25	2	13.87
15. Upstate	1	4	6	2	0	4	1282	17	189.44	6	40.29	4	44.57
16. Albion	2	0	2	3	3	2	911	12	188.25	1	7.17	0	0.00
17. Sing Sing	0	2	2	3	8	6	1736	21	172.78	3	11.60	1	8.23
18. Clinton	0	4	8	9	4	7	2805	32	162.99	23	57.76	10	50.94
19. Attica	1	2	4	5	5	6	2166	23	151.72	17	14.85	8	52.77
20. Fishkill	1	4	3	1	6	2	1619	17	150.04	6	25.80	3	26.48

Appendix C-DOCCS Suicide Attempts During 2007 to 2012 by Rate 2007-2012

Prison	-- Annual Suicides Attempts --						Pop	Total	Attempts	Tot Suicides	Suicide Rate	Tot Suicides	Suicide Rate
	2007	2008	2009	2010	2011	2012	07-12	Attempts	Rate	2000-13	2000-13	2007-13	2007-13
21. Livingston	0	0	1	3	2	1	808	7	123.81	0	0.00	0	0.00
22. Woodbourne	0	2	0	0	1	3	803	6	106.74	3	26.87	1	17.79
23. Eastern	1	1	2	1	1	1	1071	7	93.40	4	25.65	3	40.03
24. Groveland	5	0	0	0	1	1	1080	7	92.56	0	0.00	0	0.00
25. Bayview	1	0	0	0	0	0	170	1	84.03	0	0.00	0	0.00
26. Watertown	2	1	0	0	0	0	540	3	79.32	0	0.00	0	0.00
27. Franklin	1	0	2	0	2	4	1665	9	77.24	0	0.00	0	0.00
28. Collins	1	1	1	0	1	1	978	5	73.04	0	0.00	0	0.00
29. Greene	2	3	1	1	0	1	1638	8	69.79	0	0.00	0	0.00
30. Bare Hill	2	1	5	0	0	0	1653	8	69.14	2	8.50	1	8.64
31. Ulster	0	0	0	0	2	0	524	2	54.49	0	0.00	0	0.00
32. Willard DTC (male)	0	0	0	0	2	0	576	2	49.60				
33. Taconic	0	0	0	0	0	1	301	1	47.41	0	0.00	0	0.00
34. Lakeview (male)	0	0	0	1	1	0	683	2	41.81	1	8.82	1	20.91
35. Washington	0	0	0	2	0	0	804	2	35.54	0	0.00	0	0.00
36. Wyoming	0	0	0	1	0	3	1632	4	35.02	0	0.00	0	0.00
37. Ogdensburg	0	0	0	0	0	1	412	1	34.67	1	14.79	1	34.67
38. Queensboro	0	0	0	0	0	1	417	1	34.23	0	0.00	0	0.00
39. Cape Vincent	0	0	0	1	1	0	838	2	34.08	0	0.00	0	0.00
40. Altona	0	0	0	1	0	0	438	1	32.64	0	0.00	0	0.00

Appendix C-DOCCS Suicide Attempts During 2007 to 2012 by Rate 2007-2012

Prison	-- Annual Suicides Attempts --						Pop	Total	Attempts	Tot Suicides	Suicide Rate	Tot Suicides	Suicide Rate
	2007	2008	2009	2010	2011	2012	07-12	Attempts	Rate	2000-13	2000-13	2007-13	2007-13
41. Mt. McGregor	0	1	0	0	0	0	457	1	31.28	0	0.00	0	0.00
42. Wallkill	1	0	0	0	0	0	576	1	24.82	0	0.00	0	0.00
43. Riverview	1	0	0	0	0	0	823	1	17.35	1	8.02	0	0.00
44. Orleans	0	0	0	0	1	0	884	1	16.17	0	0.00	0	0.00
45. Cayuga	1	0	0	0	0	0	959	1	14.89	0	0.00	0	0.00
46. Adirondack	0	0	0	0	0	0	442	0	0.00	0	0.00	0	0.00
47. Beacon	0	0	0	0	0	0	160	0	0.00	0	0.00	0	0.00
48. Chateaugay	0	0	0	0	0	0	215	0	0.00	1	32.50	1	66.45
49. Gouverneur	0	0	0	0	0	0	913	0	0.00	0	0.00	0	0.00
50. Gowanda	0	0	0	0	0	0	1591	0	0.00	0	0.00	0	0.00
51. Hale Creek	0	0	0	0	0	0	401	0	0.00	0	0.00	0	0.00
52. Hudson	0	0	0	0	0	0	417	0	0.00	0	0.00	0	0.00
53. Lincoln	0	0	0	0	0	0	190	0	0.00	0	0.00	0	0.00
54. Mohawk	0	0	0	0	0	0	1220	0	0.00	2	11.41	2	23.42
55. Monterey	0	0	0	0	0	0	156	0	0.00	0	0.00	0	0.00
56. Moriah	0	0	0	0	0	0	158	0	0.00	0	0.00	0	0.00
57. Otisville	0	0	0	0	0	0	553	0	0.00	1	12.56	1	25.85
58. Rochester	0	0	0	0	0	0	72	0	0.00	0	0.00	0	0.00
59. Arthur Kill	1	2	0	2	1	0		6		2		0	
60. Bedford Hills RMU	0	0	0	0	0	0		0					

Appendix C-DOCCS Suicide Attempts During 2007 to 2012 by Rate 2007-2012

Prison	-- Annual Suicides Attempts --						Pop	Total	Attempts	Tot Suicides	Suicide Rate	Tot Suicides	Suicide Rate
	2007	2008	2009	2010	2011	2012	07-12	Attempts	Rate	2000-13	2000-13	2007-13	2007-13
61. Butler	0	0	0	0	0	0		0		0		0	
62. Cayuga S-Block	0	0	0	0	0	0		0					
63. Clinton Annex	0	0	0	0	0	0		0					
64. Collins S-Block	0	0	1	0	0	1		2					
65. Coxsackie RMU	0	1	0	0	0	0		1					
66. Fishkill RMU	0	0	0	0	0	0		0					
67. Fishkill S-Block	0	0	1	0	0	0		1					
68. Fulton	0	0	0	0	0	0		0		0		0	
69. Gouverneur S-Block	0	0	0	0	0	0		0					
70. Greene S-Block	0	0	0	0	0	0		0					
71. Lakeview S-Block	0	0	0	0	0	0		0					
72. Marcy S-Block	0	0	0	0	0	0		0					
73. Mid-Orange	0	0	0	0	0	0		0		0		0	
74. Mid-State S-Block	0	0	4	1	0	0		5					
75. Oneida	3	0	1	0	0	0		4		1		1	
76. Orleans S-Block	0	0	0	0	0	0		0					
77. Wende RMU	0	0	0	0	0	0		0					
78. Willard DTC female	0	0	0	0	0	0		0					
	61	**93**	**154**	**111**	**146**	**152**	**54,372**	**717**	**188.38**	**178**	**20.62**	**95**	**24.96**