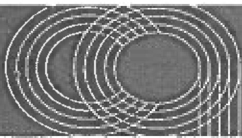

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2090 Adam Clayton Powell, Jr. Boulevard, Suite 200 New York, NY 10027
tel (212) 254-5700 fax (212) 473-2807 www.correctionalassociation.org

Testimony by Jack Beck, Director, Prison Visiting Project
The Correctional Association of New York
Before Joint Legislative Public Hearing on 2015-2016 Executive Budget Proposal
Mental Hygiene – February 27, 2015

I am Jack Beck, Director of the Prison Visiting Project of the Correctional Association of New York (CA), and I want to thank the Joint Legislative Committees for this opportunity to provide written testimony detailing our observations and concerns about two agencies included in the Governor's Fiscal Year (FY) 2015-16 Proposed Budget: (1) resources for mental health care as provided by the Division of Forensic Services of the Office of Mental Health (OMH), with a particular focus on the impact it will have on the incarcerated population with mental health needs in Department of Corrections and Community Supervision (DOCCS) prisons and (2) resources for the NYS Justice Center for the Protection of People with Special Needs concerning its legal obligation to monitor mental health care in the prisons. I will focus on four issues: (1) increased funding for OMH Forensic Services staffing; (2) expansion of OMH resources for discharge planning for persons with mental illness being released from prison and the resources in the community to provide services and housing for these individuals; (3) other needs of the incarcerated population with mental health needs which are not being adequately addressed by current resources; and (4) need for more resources for the oversight of mental health services in NYS prisons by the Justice Center for the Protection of People with Special Needs (Justice Center) pursuant to the SHU Exclusion Law.

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 mental health care provided in our state prisons.

The FY 2015-16 budget for Forensic Services (FS) for the Office of Mental Health (OMH) indicates there will be a substantial increase in FS staffing and new initiatives focused on more effective discharge planning for individuals returning home from prison and the expansion of programs and housing for persons recently released from prison with serious mental health needs. So long as the state continues to incarcerate large and growing numbers of people with mental health needs, these expanded resources are welcomed and reflect the expanding need for services for those with mental illness in NYS prisons. More resources, however, are required to address the needs of incarcerated persons with mental illness in the general prison population and such patients residing in disciplinary segregation in the prisons' Special Housing Units (SHUs) and Residential Mental Health Treatment Units (RMHTUs). The prisons are overcrowded with mentally ill patients because of the over-criminalization of behavioral manifestations of mental illness, and a lack of

community-based mental health services and alternatives to incarceration. The prison population could be decreased if policing could facilitate treatment, diversion, and recovery rather than imprisonment.

With the growing population of people with mental health needs in the state prisons, we have observed during the last decade that prison mental health services have expanded and improved in several respects. These improvements have resulted in part due to intense scrutiny and demand for enhanced services by prison mental health patients, their families, the legislature, courts, and prison and mental health advocates. For example, the number of patients in residential mental health treatment units in the prisons has increased, and more and varied programs are offered to these patients. Most significantly, 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). Pursuant to the SHU Exclusion Law, the NYS Justice Center for the Protection of People with Special Needs (Justice Center) has been monitoring mental health care in the prisons and OMH and DOCCS compliance with the SHU Law. As a result of this process, deficiencies in care have been identified by the Justice Center, and OMH and DOCCS have made efforts to rectify some identified problems and improve care. We commend all these state agencies for these efforts, but find that additional measures and resources are needed to provide appropriate care to the many persons in our prisons with mental health needs.

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 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.

Overview of Mental Health Services in DOCCS Prisons

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 are 12 OMH Level 2 prisons providing care to patients with major mental illness but without significant active symptoms; these facilities have full-time OMH staff but do not have a residential treatment unit or a crisis center. There are nine prisons designated as Levels 3 or 4 in which persons with less serious mental health needs are housed and serviced by part-time OMH staff.

1) Expansion of OMH Forensic Services Staffing

The Governor's budget indicates that in FY2015-16 the staffing for FS will increase from an estimated 2,228 FTE positions as of March 2015 to 2,498 positions by the end of the upcoming Fiscal Year. This increase of 270 positions is in addition to the 140 increase in FS staff during FY 2014-15. Since March 2011, the FS staff has been augmented by 549 positions, representing a 22% increase in staff. These additions have occurred during a period in which the other divisions of OMH have been losing staff, including an 11% and 21% decline, respectively, in staffing for adult services and children and youth services during this same period. The declines in these other areas, while outside the scope of this testimony and the CA's expertise, raise concerns to the extent that they represent declining mental health resources in the community. It also must be noted, that it is unclear how these increases in Forensic Services staffing are being funded; the budget for personal services for FS staff has remained fixed at $191.3M during the past three fiscal years (FY 2013-14 through FY 2015-16). We urge the legislature to have OMH identify the funding for these additional FS positions to ensure that the items can be filled in a timely manner.

To the extent that the increase in OMH FS staff means additional OMH staff working in the state prisons with mental health patients, this increase is justified for several reasons. First, since January 2011 to September 30, 2014, the OMH prison caseload has increased from 7,944, to 9,311 patients,

representing a 17% increase. Second, in July 2011, the SHU Exclusion Law was fully implemented requiring significant expansion of services to be provided by FS staff. Specifically, the Law requires that DOCCS and OMH utilize Residential Mental Health Treatment Units (RMHTUs) for any incarcerated person with serious mental illness who is given a disciplinary sanction of 30 days or more in place of sending that patient to solitary confinement. Most patients in these RMHTUs must receive at least four hours per day of programming five days per week. Much of this programming is supplied by OMH staff. Moreover, the SHU Exclusion Law requires initial and periodic assessments of all persons being sent to disciplinary confinement to determine if they qualify for RMHTU placement and/or whether their mental health status has deteriorated while in the SHU. An estimated 13,000 persons are sent to SHU each year by DOCCS and the vast majority of these persons will have an initial assessment and many will be eligible for multiple OMH assessments while in the SHU. Third, the number of persons in DOCCS who have experienced a mental health crisis requiring admission to the Residential Crisis Treatment Program (RCTP) units in the prisons has risen to 8,224 admissions in 2013, compared to 7,515 admissions in 2010, a 9% increase. Each person in the RCTP has to be seen at least daily by OMH staff while on the unit. Fourth, DOCCS and OMH have intensified the program opportunities for persons with serious mental illness housed in the non-punitive mental health residential units throughout DOCCS. These programs involve 20 hours per week of educational and treatment services for each patient. The average census on these residential units is 700 patients and annually approximately 600 patients are admitted to these treatment programs. These units require intense OMH staff providing both group sessions and individual counseling. Overall, the need for mental health services in our state prisons has significantly expanded during the past few years and the proposed increases for FY 2015-16 are essential if the prison patient population is going to receive constitutionally required mental health care.

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

Another initiative in the OMH FY 2015-16 budget involves enhancing discharging planning for persons with mental health needs leaving state prisons to return home and expanding the resources in the community to assist their reentry, including programming and housing. This $19.56M initiative has three components: $5.45M to support additional assessment of incarcerated persons with mental illness, enhanced discharge reviews, and staff training; $6.71M to support discharge planning and placement in OMH facilities outside DOCCS; and $7.8M to support 200 assertive community treatment slots and 400 housing units for persons leaving prison. It is our understanding that these funds will be used to support the hiring of 52 new OMH positions for treatment, assessment and discharging planning in the prisons. But it has been difficult to obtain more details as to how these funds will be used, and we urge the legislature to have OMH provide more specific information on the plans for the use of these funds. To the extent that these resources are used in a meaningful way for discharge planning and placement purposes other than involuntary civil commitments, this initiative is crucial because it will enhance the ability of OMH staff to assess

what the mental health needs are for persons about to be released from prison, to help these persons prepare for the often difficult transition to the community, and to increase the likelihood that they will succeed when they return home by expanding the resources that will be available for housing and support and better preparing them for their reintegration into their communities

These added resources for discharge planning and reentry for persons with mental illness in prison is sorely needed. OMH is responsible for discharge planning for patients with mental health needs leaving the state prisons. In 2013, 3,661 patients on the OMH caseload were discharged from our state prisons, of whom 103 were placed in a psychiatric hospital. OMH staff attempt to assist its patients leaving prison who are seriously or moderately mentally ill, but not those deemed to be situationally mentally ill who only are engaged in counseling, do not take psychotropic medications and have minimal treatment and discharge needs. As of October 2014, there were 9,376 persons in state prison on the OMH caseload, of which 6,590, representing 70% of the caseload, were receiving psychotropic medications. Of the total October 2014 OMH caseload, 2,272, and 3,128 patients, respectively, were diagnosed as mental health levels 1 and 2, representing 58% of the entire caseload and signifying that they have a major mental illness. These patients would clearly require discharging planning. In addition, many of the 3,473 patients diagnosed as OMH level 3 are on medications and would also be in need of discharge planning. Similarly, most of the 70% of the caseload on psychotropic medications will require discharge services. Based upon these figures, we estimate that annually more than 2,500 patients leaving DOCCS require assessment and discharge planning.

The discharge services provided by OMH are currently divided into two categories: comprehensive discharge planning services for patients deemed seriously mentally ill and more limited discharge planning for patients diagnosed as moderately mentally ill and who are capable of self-support through work and can advocate for themselves. Currently, many persons leaving prison with mental health needs are not carefully assessed to determine the type of care they will need in their community and how this care can be integrated into the other essential services they will require to be successful and to avoid re-incarceration. Information we have obtained from our interaction with DOCCS patients released from prison and other organizations providing services to OMH patients discharged from prison indicate that the discharge services provided by OMH are limited for many patients coming home, even those who have a history of serious mental illness. Moreover, the support and services in the community are insufficient for these patients, with approximately 30% of formerly incarcerated persons leaving prison still going to shelters. Without adequate planning and significant support and appropriate housing in the community, these persons are at great risk for being lost to care and subsequently being re-incarcerated. The additional resources proposed in the FY 2015-16 budget are sorely needed to address the pressing need to get recently released persons with mental illness enrolled in appropriate care and housed in a location that will foster safe reintegration into their community

3) Other Needs Not Adequately Addressed with Current Resources[1]

While it is positive that the FY 2015-2016 budget includes the above additional funds for increased FS mental health staff and increased discharge planning services, the following serious needs regarding mental health care remain unaddressed under current projected resources.

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

There are only limited mental health services for patients on the OMH caseload who reside in the prisons' general population housing units. With only approximately 1,200 disciplinary and non-disciplinary residential mental health beds in the whole DOCCS system, the vast majority of people with mental health needs, including many with serious mental illness, remain in the general prison population. As of October 2014, there were more than 7,500 patients with mental illness who were in the general population housing. At many prisons designated as OMH Level 1 or 2 facilities, 20% to 50% of the total prison population are currently on the OMH caseload. For example, at Collins and Groveland C.F., both OMH Level 2 prisons with no residential mental health program, the number of people on the OMH caseload has been growing and represents about half of all people incarcerated at these facilities. Also, many OMH Level 1 facilities, such as Clinton or Fishkill C.F., have hundreds of people in general population with the most substantial mental health needs, including Level 1 and 2 patients and those diagnosed with serious mental illness. Even the current OMH caseload does not reflect the scope of the need for mental health services for this population. During our prison visits we have identified many persons who are not currently receiving mental health care even though prior to their incarceration or at some point earlier in their prison sentence they had received mental health care. For example, at Collins C.F., in addition to the 55% of all person surveyed by the CA who reported currently on the OMH caseload, an additional 23.5% of surveyed persons reported that they previously had been on the caseload. The large percentage of incarcerated persons with mental health needs can have a major impact on the entire prison, where program and security staff, as well as other incarcerated persons, are not adequately trained on how to effectively interact with people with mental health needs.

In the general prison population there typically are very limited mental health services provided other than medications and short check-in meetings once per month lasting around 15 to 30 minutes with a mental health provider who is usually a mental health social worker. In addition, these patients may see a psychiatrist through a telemedicine video conference once every three months for medication renewals. Except as noted below, there are no group counseling sessions for these patients or daily opportunities to check up on their mental health status, including patients with serious mental illness in general population. Even when these patients experience a mental health crisis, they are often sent back to their cells without substantially augmenting their mental health

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

care. The one exception we have found to this paucity of care for general population patients was a recently established program at Greene during which limited group therapy is provided once a month as a pilot program. We urge OMH to develop group counseling programs for general population patients at more facilities with large OMH caseloads, but this will require increases in staffing which does not appear to be part of the staff augmentation included in the FY 2015-16 budget.

b) Expansion of the ICP as a Model

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

c) Mental Health Services for People Currently in Solitary Confinement

People held in solitary confinement currently do not participate in any group therapy and receive very limited other mental health services while in solitary. This lack of mental health support is particularly problematic given that solitary or isolated confinement can exacerbate pre-existing mental illness and create new mental health challenges for any person. 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. However, still each day over 3,600 people, including 650-700 people on the OMH caseload,[2] continue to remain in Special Housing Units (SHU), while many others are in keeplock. 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, and some people have been in solitary confinement in New York for more than two decades.

We believe that no person should be subjected to the torture of solitary confinement, and we urge the legislature and Governor to pass the Humane Alternatives to Long Term (HALT) Solitary Confinement Act, A. 4401 / S. 2659 so that people with any mental illness – whether they are S-designated or not – are removed from isolation, no person is subjected to the torture of solitary confinement, and more humane and effective alternatives are utilized.[3] In the meantime, so long as people, including people with mental illness, continue to remain in solitary confinement, we urge that FY 2015-16 budget include allocations for the operation of out-of-cell congregate mental health group programming for people held in SHU.

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

The RMHTUs need to be expanded, to allow for increased out-of-cell programming for current residents and allow diversion of a larger number of people from the SHU. For some people who were suffering the worst impacts of the SHU, the RMHTUs – particularly at Marcy, but to a lesser extent at Five Points, Bedford Hills, Great Meadow, and Attica – provide a relatively more humane and effective environment than SHU. Simply the ability to come out of their cells, have some

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[2] Hundreds of OMH patients who are not considered to have the statutorily defined "serious mental illness" or S-designation but have mental health needs that many would consider serious, still remain in SHU. In addition, 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).

[3] We also support passage of other legislation that would substantially restrict the use of solitary, including A. 1346A, which among other limitations would prohibit solitary for all people with mental illness and any person under the age of 21, and A. 1347, which would prohibit solitary confinement for women who are pregnant, have recently given birth, or who have infants in the prison nursery program.

individual therapy, and participate in group programming for multiple hours a day is having a positive impact for many people, and some residents at Marcy and to a lesser extent at Five Points praised the group programs and OMH staff as being relatively supportive and helpful to deal with their mental health issues. Also positively, there is a growing number and percentage of discharges of RMHU and BHU patients to non-punitive housing, including general population, the ICP, and TrICP. While many patients have benefited from being in an RMHU or BHU, many others have faced an overly punitive and abusive environment, particularly at Great Meadow, Attica, and Five Points, and to a lesser extent at Marcy. Although it is positive that people are diverted from the SHU to the RMHTUs, these units remain disciplinary confinement units and hold people for months and even years. Roughly half of all persons on these units received a disciplinary ticket on the unit over a less than four year period and 115 people received 10 tickets or more (up to 60 tickets for a single person). In turn, subtracting out time cuts, over 300 people received a cumulative six months or more additional SHU time, 148 received one year or more, 35 received five years or more, and 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 RMHTUs gave a mixed assessment of the quality of group and individual care, and some were highly critical. Many patients, particularly at the Great Meadow BHU and to a lesser extent at the Five Points' RMHU, felt that the programs did not offer meaningful treatment opportunities to address their mental health issues, and that some staff appeared disinterested if not antagonistic, or repeatedly played outdated videos. Many others felt that the punitive nature of the security staff on the unit dominates even the group and individual treatment, exemplified by the use of individually caged cubicles for group therapy, and information told confidentially by patients to therapists leading to disciplinary tickets or security staff harassment. Worse still, DOCCS is too often denying some patients the opportunity to come out of their cell or participate in programming due to "exceptional circumstances" signifying a patient presents an unacceptable safety risk. Three-quarters of Five Points survey respondents and 42% respondents at Marcy reported to us that they had been denied programs at some point. Past denials, security staff abuses, and excessive use of disciplinary tickets, also lead many people to refuse to come out of their cell for programs.

We urge that the FY 2015-16 budget include allocations to expand and improve the RMHTUs, including to increase the number of people who are diverted from SHU to the RMHTUs, provide more and improved programs to people already in the RMHTUs, enhance the qualifications and number of mental health staff, increase mental health training for all mental health, program, and

security staff in the RMHTUs, and utilize responses and interventions focused on de-escalation, communication, mutual respect, treatment, and growth rather than discipline and punishment.

e) Concerns about Diagnoses and Unused Diversion Beds

Related to patients in the SHU, there has been a major shift in diagnoses of all DOCCS mental health patients in the last six years from schizophrenia and psychoses (35% drop) to adjustment, anxiety, and personality disorders (72% rise). Commissioner Sullivan testified at the budget hearing that the diagnostic changes had occurred some years ago, but they have been stable in recent years. The data we have obtained from OMH do not support this contention. In the annual summaries for the last three years available from OMH, calendar years 2010 through 2013, the percentage of patients diagnosed with schizophrenia and psychoses dropped 21%, while the percentage for adjustment disorders rose 49%. In just the last two years for which data is available (2011 to 2013), the schizophrenia and psychoses diagnoses dropped 13.5% and adjustment disorder diagnoses rose 19%.

We have also observed similar declines in the percentage of patients diagnosed with serious mental illness pursuant to the SHU Exclusion Law. Specifically, during the six-year period 2008 through 2013, there has been a 36% drop in the number of S-designations, resulting in fewer people eligible for SHU diversion. This drop raises serious concerns about whether the SHU Exclusion Law's provision of a sharp line above which people receive intensive services and below which people receive none and remain in the SHU, are leading to improper diagnoses. These concerns are even more stark given that the percentage of the total OMH caseload designated as Level 1 has risen in recent years. 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. It is a waste of this valuable resource to leave treatment beds unfilled when many persons with significant mental health needs remain in a SHU and could clearly benefit from the mental health services available in the RMHTUs.

f) Crises and Problematic Crisis Intervention

The most visible and disturbing outcomes of many of the challenges identified – incarceration of large numbers of people with mental health needs, limited residential mental health beds and insufficient services in general population, continued and pervasive use of solitary confinement, and overly punitive nature of the RMHTUs – include people going into mental health crisis and/or committing suicide or self-harm. Incarcerated persons who are suicidal or having a mental health

crisis are taken to the Residential Crisis treatment Program (RCTP) for assessment and housing in an environment intended to ensure safety and provide an opportunity for evaluation. Admissions to the RCTPs have risen 55% from 5,302 in 2007 to 8,224 in 2013. The disciplinary mental health units had RCTP admission rates 31 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 is 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. OMH must intensify its resources to more comprehensively respond to the needs of patients being sent to the RCTP. In addition, it should re-examine its process for determining whether DOCCS patients would benefit from admission to CNYPC. If resource limitations at CNYPC are deterring placement at the hospital, these should be adjusted. But whether resource driven or a result of policies and practices, OMH must expanded its response to incarcerated persons who are experiencing mental health crises in the prisons, including placement in a psychiatric hospital when needed.

g) High Rates of Suicide and Self-Harm

Most distressingly, too often mental health 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 of people in the SHU represent of the entire prison system. OMH is one of several state agencies that review all suicides. Unfortunately, OMH plays a much less significant role in

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

h) Large and Growing Numbers of People with Mental Illness

As discussed above, the number of people with mental health needs in NYS prisons is large and growing. 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. 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 many are no longer involved in the criminal justice system and are removed from prisons and jails. The FY 2015-16 Budget should include greater funding for various components of those necessary changes, including expanded and enhanced provision of outside community mental health care, utilization of alternatives to incarceration and crisis intervention teams for people with mental health needs, and reform of the bail and jail systems.

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

Pursuant to the Special Housing Unit (SHU) Exclusion Law (Correction Law §§ 137, 401 and 40-a) the Justice Center is mandated to monitor mental health care in our state prisons. Specifically, the agency is required to assess whether DOCCS and OMH are in compliance with the various provisions of the SHU Exclusion Law concerning the treatment of persons with serious mental illness who are sentenced to long-term disciplinary confinement through the DOCCS prison disciplinary system and OMH's periodic assessments of the mental health status of all persons placed in disciplinary confinement in our prisons. In addition, the Justice Center has more general jurisdiction to monitor "the quality of mental health care provided to" incarcerated persons throughout the prisons. For these forensic duties, the Justice Center is the successor agency to the Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC), which was originally assigned these tasks when the SHU Exclusion Law was enacted in 2008. Although CQC started its work monitoring mental health care in the state prisons in 2008, the full terms of the SHU Exclusion Law were not required to be implemented until 2011. Throughout the period from 2008 to the present, both CQC and now the Justice Center have *not* had sufficient staff to fully perform their duties under the SHU Law.

After the SHU Exclusion Law was signed, in the next fiscal budget (FY 2008-09) CQC was budgeted to hire 14 staff members to perform its duties under the Law. Unfortunately, these needed staff members were not hired during that fiscal year and only six staff members were assigned to the unit performing the forensic monitoring work. In FY 2010-11, CQC staffing for its forensic work was reduced to only four persons, although frequently staff from other units of CQC assisted in the prison monitoring duties. It must be emphasized, however, that during this time the vast majority of the SHU Exclusion Law requirements were not enforceable and therefore, CQC was not required to monitor specific implementation of the Law. When CQC was disbanded, the Justice Center was statutorily assigned the responsibility of monitoring mental health services in the prisons. It assumed those duties in 2013 and presently there are six positions funded for its prison monitoring work during this current fiscal year. Although the assigned staff are working hard to meet the Justice Center's statutory duties, the current allocation of staff is insufficient to accomplish all needed tasks in a timely manner.

I am a member of the Justice Center's Psychiatric Correctional Advisory Committee and prior to that appointment I was part of a coalition of advocates and concerned citizens who regularly met with both CQC and Justice Center staff to review their activities, and to discuss what issues the agency could investigate and what actions might be needed to address concerns we had about the mental health care within the prisons. I have consistently found that the Justice Center staff have been diligent and thorough in investigating treatment and conditions in the prisons concerning mental health care and thoughtful and balanced in their findings and recommendations. I have been particularly impressed with their reports on: (1) the treatment of persons sent to the mental health crisis units in the prisons; (2) the mental health screening of persons being admitted to DOCCS; and (3) the Center's evaluation of the process used by OMH to diagnose and monitor patients with mental health needs. More importantly, the reports prepared by CQC and the Justice Center have identified problems in care and resulted in both DOCCS and OMH taking action to improve how people with mental health needs are cared for in the prisons. But it is also clear that the forensic unit of the Justice Center does not have sufficient staff to do all that is required by the SHU Exclusion Law.

As noted earlier in my testimony, from 2011 to 2014 the OMH population has expanded by 17% to 9,311 patients, the highest level in DOCCS history despite a reduction in the overall DOCCS population, with those needing mental health care representing 17.4% of the DOCCS census as of October 2014. Monitoring mental health care for such a large population spread throughout 38 prisons and specialized units throughout the prison system providing mental health services by itself would be a daunting task requiring more than six staff items.

In order to monitor the specific provisions of the SHU Exclusion Law, however, the Justice Center must assess activities and services provided to persons engaged in the prison disciplinary system. Specifically, the SHU Exclusion Law requires that each person sent to a SHU for more than 30 days in a prison that is an OMH Level 1 to 4 must be initially assessed and then offered follow-up OMH

consultations on a 30 or 90 day schedule, depending on the OMH Level. These assessments occur at 29 different prisons' SHU units and four S-Block units (200-bed segregation units in a separate building on a prison's ground). With 650-700 persons at any one time on the OMH caseload within the total SHU population of more than 3,600 individuals, and 29 facilities to visit, this aspect of the SHU Exclusion Law will require significant staff resources to monitor. OMH reported that it conducted 54,828 evaluations in segregated housing in 2013. Although many of these encounters result from the daily OMH rounds conducted at some of the SHUs, the Justice Center will need to review an appropriate number of initial and follow-up evaluations to determine whether OMH is identifying candidates who are in the SHU who may be appropriate candidates for transfer to an RMHTU. It is unrealistic that at current staffing levels, the Justice Center will be able to monitor OMH compliance with this review process.

The SHU Law also requires that the Justice Center monitor the placement, movements and treatment of persons with serious mental illness who have been sentenced to a SHU sentence but who have been diverted to one of three Residential Mental Health Units at Attica, Five Points or Marcy C.F., the Behavior Health Unit at Great Meadow C.F. or the Therapeutic Behavioral Unit for women at Bedford Hills C.F. There are many complex requirements about how these patients must be treated, or may be excluded from treatment in exceptional circumstances, that necessitate close monitoring of the approximately 460 patients who are annually admitted to one of these units. This includes interviewing patients, meeting with DOCCS and OMH staff and reviewing prison and mental health records. With the current allocation of Justice Center staff it is not reasonable to expect them to be able to assess whether DOCCS and OMH are meeting all the requirements of the SHU Law for so many patients who have serious mental health challenges and are being confined in an often stressful environment in which they are still isolated 19 or more hours per day.

Another aspect of mental health care that requires close scrutiny and monitoring are the Residential Crisis Treatment Programs. In 2013, there were 8,224 patients serviced in the observation cells (6,763 patients) and dormitory units (1,461) of the RCTP. Patients are sent to these units if they are at risk for self-harm, are having a mental health crisis or are returning from NY Central Psychiatric Center. There are 16 RCTPs throughout the prison system and many of the people sent to the RCTP come from a SHU or one of the RMHTU units. In 2013, of the 6,763 persons sent to an observation cell, 27.6% (1,868 patients) came from the SHU or RMHTUs, a rate that is nearly **four times** greater than the 7.4% of the population these units represent of the entire prison population. CQC and the Justice Center have been monitoring these units, and this effort must continue given the high number of SHU and RMHTU patients who are having mental health crises and accessing these services.

Finally, the SHU Exclusion Law requires that the Justice Center make public its findings and recommendations in part so that legislators, those affected by the Law and their family members and advocates, and the public can evaluate the impact of the SHU Law and assess whether DOCCS and OMH are in full compliance with its provisions. To date, the Justice Center has been very

delayed in publishing its recent activities. We suspect this is in part due to the challenges of getting this new agency fully operational and limitations of staffing. We urge that the Justice Center expedite the publication of its work and that sufficient staff be assigned to this aspect of its legal obligations so that the public can be fully informed about the Justice Center's activities and DOCCS and OMH compliance with the SHU Exclusion Law.

It is crucial for the new Justice Center unit dedicated to the monitoring of the SHU Exclusion Law and prison mental health services to have adequate resources to evaluate the mental health care being provided in our prisons. Only through independent monitoring can the state identify where resources are needed, evaluate the effectiveness of the SHU Exclusion Law and assess the impact these new programs are having on the care of incarcerated individuals with serious mental illnesses.

Recommendations. Dramatic reform is needed to address these myriad issues and better serve the people in 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 should pass the Humane Alternatives to Long Term (HALT) Solitary Confinement Act, A. 4401 / S. 2659, so that people with any mental illness – whether they are S-designated or not – are removed from isolation, no person is subjected to the torture of solitary confinement, and more humane and effective alternatives are utilized.

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

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

- OMH should re-evaluate its processes for diagnosing patients to ensure that persons who have a history of serious mental illness are appropriately diagnosed and that patients who experience

deterioration of their mental health status or a mental health crisis while in prison are carefully reassessed to determine whether their diagnoses and treatment plans should be changed.

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

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

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

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

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