

**Testimony Before the
New York State Senate
Committee on Crime Victims, Crime and Correction
Committee on Health
Committee on Mental Health and Developmental Disabilities
Committee on Children & Families
Committee on Judiciary
Committee on Codes**

on

**Executive Budget Proposal to Delay Full Implementation of
Special Housing Unit (SHU) Exclusion Law
Until July 1, 2014**

**Public Hearing
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INTRODUCTION

Sarah Kerr is a staff attorney at the Prisoners' Rights Project ("PRP") of the Legal Aid Society. Betsy Sterling is the Director of Special Litigation and Projects at Prisoners' Legal Services of New York ("PLS"). Nina Loewenstein is a staff attorney with Disability Advocates, Inc. ("DAI"). PRP has been a leading advocate for constitutional and humane conditions of confinement for prisoners incarcerated in the New York City and New York State correctional systems since it was established by the Legal Aid Society in 1971. PLS was founded in 1976 under the sponsorship of the New York State Bar Association and has received funding from the state of New York since 1978, serving state prisoners in both individual claims for relief and systemic litigation regarding prison conditions. DAI is an authorized protection and advocacy agency under the Protection and Advocacy for Individuals with Mental Illness Act ("PAIMI"), and since 1989 has been funded under PAIMI to pursue legal, administrative, and other appropriate remedies to ensure the protection of individuals with mental illness who receive care and treatment in New York State, including prisoners housed in state correctional facilities.

In addition to litigation, each month PRP, PLS and DAI receive and respond to an enormous volume of letters and requests for assistance from prisoners incarcerated in New York state and local facilities. We advise prisoners, provide written self help legal materials, and in some cases intervene administratively with the Department of Correctional Services ("DOCS"), the Office of Mental Health ("OMH"), and other appropriate agencies such as the Commission on Quality of Care and Advocacy for Persons with Disabilities ("CQC").

It is on the basis of our ongoing contact with and advocacy on behalf of prisoners of the State of New York and our knowledge of DOCS and OMH through litigation and other advocacy, and specifically as attorneys for the plaintiff, Disability Advocates, Inc. in the *Disability Advocates, Inc. v. New York State Office of Mental Health* ("DAI v. OMH") litigation and settlement, that we offer this testimony on the Proposed Article VII Amendments to the Special Housing Unit ("SHU") Exclusion Law to the New York State Senate Standing Committee on Crime Victims, Crime and Corrections. We thank you for this opportunity.

To understand why the Article VII legislation that seeks to delay implementation of the SHU Exclusion Law for an additional three years is ill conceived, an understanding of the history of isolated confinement and a history of prior litigation in New York State is necessary.

Detrimental Effects of Isolated Confinement Are Well Known

It has long been known that isolated confinement, the deprivation of human contact and other sensory and intellectual stimulation can have disastrous consequences. The United States Supreme Court described the harmful effects of the Nineteenth Century prison solitary confinement regimes with words that still hold true today:

A considerable number of prisoners fell, after even a short commitment, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.¹

Modern courts have reiterated these consequences in addressing present-day forms of isolated confinement.² Isolation of offenders with mental illness in disciplinary Special Housing Units (SHUs) or other isolated confinement settings is a practice that courts have recognized as harmful. One decision observed that “the record shows, what anyway seems pretty obvious, that isolating a human being from other human beings year after year or even month after month can cause substantial psychological damage, even if the isolation is not total.”³ The court recognized that “there is plenty of medical and psychological literature concerning the ill effects of solitary

¹ *In re Medley*, 134 U.S. 160, 169 (1890).

² *Jones'el v. Berge*, 164 F.Supp.2d 1096, 1101 (W.D. WI 2001), p. 1101 (isolated confinement is “known to cause severe psychiatric morbidity, disability, suffering and mortality [even among those] who have no history of serious mental illness and who are not prone to psychiatric decompensation.”); *Koch v. Lewis*, 216 F.Supp.2d 994, 1001 (D.Ariz. 2001) (experts agreed that extended isolation causes “heightened psychological stressors and creates a risk for mental deterioration”); *Ruiz v. Johnson*, 37 F.Supp.2d 855, 907 (S.D.Tex. 1999), *rev'd on other grounds*, 243 F.3d 941 (5th Cir. 2001), *adhered to on remand*, 154 F.Supp.2d 975 (S.D.Tex. 2001) (the court described administrative segregation units as “incubators of psychoses-seeding illness in otherwise healthy inmates and exacerbating illness in those already suffering from mental infirmities”); *Langley v. Coughlin*, 715 F. Supp. 522, 540 (S.D.N.Y. 1988) (citing expert’s affidavit regarding effects of SHU placement on individuals with mental disorders); *Baraldini v. Meese*, 691 F. Supp. 432, 446–47 (D.D.C. 1988) (citing expert testimony on sensory disturbance, perceptual distortions, and other psychological effects of segregation), *rev'd on other grounds sub nom. Baraldini v. Thornburgh*, 884 F.2d 615 (D.C. Cir. 1989); *Bono v. Saxbe*, 450 F. Supp. 934, 946 (“Plaintiffs’ uncontroverted evidence showed the debilitating mental effect on those inmates confined to the control unit.”), *aff'd in part and remanded in part on other grounds*, 620 F.2d 609 (7th Cir. 1980); *Madrid v. Gomez*, 889 F. Supp. 1146, 1235 (N.D. Cal. 1995) (concluding, after hearing testimony from experts in corrections and mental health, that “many, if not most, inmates in the SHU experience some degree of psychological trauma in reaction to their extreme social isolation and the severely restricted environmental stimulation in the SHU”) *rev'd in part on other grounds*, 190 F.3d 990 (9th Cir. 1999).

³ *Davenport v. DeRobertis*, 844 F.2d 1310, 1313 (7th Cir. 1988), *cert. denied*, 488 U.S. 908 (1989). See also *McClary v. Kelly*, 4 F.Supp.2d 195, 208 (W.D.N.Y. 1998) (the fact that “prolonged isolation from social and environmental stimulation increases the risk of developing mental illness does not strike this Court as rocket science”).

confinement (of which segregation is a variant) . . .”⁴ The district court in the Pelican Bay SHU litigation in California concluded after hearing testimony from experts in corrections and mental health, that “many, if not most, inmates in the SHU experience some degree of psychological trauma in reaction to their extreme social isolation and the severely restricted environmental stimulation in SHU.”⁵ In their amicus brief in *Wilkinson v. Austin*, (U.S. Supreme Court No. 04-495) leading mental health experts summarized the clinical and research literature about the effects of prolonged isolated confinement and concluded: “No study of the effects of solitary or supermax-like confinement that lasted longer than 60 days⁶ failed to find evidence of negative psychological effects” (Statement of Interest of Amici, p. 4).⁷

A growing number of states have taken steps, either independently or because of litigation, to exclude prisoners with serious mental illness from some isolated confinement housing areas and to increase mental health services for prisoners with serious mental illness who are held in these restrictive settings. Courts have approved remedies, many in the form of settlement agreements, for prisoners with mental illness in isolation. In New Jersey, prisoners *must* be released from administrative segregation if they have a mental illness history and it appears that ongoing confinement there would harm them.⁸ The Mississippi Department of Correction was ordered to provide yearly assessments and better mental health care for death row prisoners, who were subject to conditions of isolation.⁹ In California, the case *Madrid v. Gomez* resulted in prisoners with serious mental illness being excluded from the Pelican Bay prison’s SHU;¹⁰ in Connecticut, the settlement of *Connecticut Office of Protection & Advocacy for Persons with Disabilities v. Choinski* called for exclusion of prisoners with serious mental illness from the Northern Correctional Institution;¹¹ *Austin v. Wilkinson* resulted in prisoners with

⁴ *Davenport*, at 1316, citing Grassian, *Psychological Effects of Solitary Confinement*, 140 Am.J.Psychiatry 1450 (1983). Other courts have made similar observations. See note 3 supra.

⁵ *Madrid v. Gomez*, 889 F.Supp. 1146, 1235 (N.D.Cal. 1995).

⁶ In New York, there is no upper limit on the number of days that a prisoner may serve in SHU confinement. The SHU Exclusion Law serves to rectify this situation by requiring, for those prisoners who are designated as individuals who are seriously mentally ill, a 30 day limit to SHU confinement. As will be discussed more fully below, this is the major difference between the Private Settlement Agreement (“PSA”) in *DAI v. OMH* and the SHU Exclusion Law passed by the New York State Legislature. [*NOTE – exceptional circumstances in the law?]

⁷ Brief of *Amici Curiae* Professors and Practitioners of Psychology and Psychiatry, *Wilkinson v. Austin*, 545 U.S. 209 (2005) (No. 04-4995). See also Peter Scharff Smith, *The effects of Solitary Confinement on Prison Inmates: A Brief History of the Literature*, Crime and Justice, vol. 34 (2006).

⁸ *D.M. v. Terhune*, 67 F. Supp. 2d 401, 403 (D.N.J. 1999).

⁹ *Gates v. Cook*, 376 F.3d 323, 342 (5th Cir. 2004) (ordering mental health examinations and care for death row prisoners).

¹⁰ *Madrid v. Gomez*, 889 F. Supp. 1146, 1265 (N.D. Cal. 1995).

¹¹ *Connecticut Office of Protection & Advocacy for Persons with Disabilities v. Choinski*, Civ. No. 3:03 CV 1352 (RNC) (U.S.D.C. Conn.).

serious mental illness being excluded from the Ohio State Penitentiary;¹² in Wisconsin, the settlement in *Jones'El v. Berge* excluded prisoners with serious mental illness from super-maximum security housing.¹³ Litigation has also resulted in state regulations that require that mental illness be taken into consideration during prison disciplinary hearings.¹⁴

Litigation in New York - *Langley v. Coughlin*, *Anderson v. Goord*, *Eng v. Goord*

More than two decades ago, in 1987, New York DOCS and OMH were subject to a court-ordered stipulation in the case of *Langley v. Coughlin* concerning treatment of prisoners with mental illness in the Bedford Hills SHU. The *Langley* Stipulation required, among other things: (a) an assessment of prisoners on the OMH caseload at Bedford Hills for possible diversion from SHU "if it is clinically indicated that the inmate is unable to continue confinement in SHU"; (b) ten hours of OMH presence per week in the Bedford Hills SHU; and (c) a private interview room so that private therapy sessions may be conducted.

Two other early cases were litigated by the Prisoners' Rights Project and Prisoners' Legal Services of New York: *Eng v. Goord*, Civ 80-385S (W.D.N.Y.) and *Anderson v. Goord*, 87 CV 141 (N.D.N.Y.) . Both *Eng* and *Anderson* were filed in the 1980's as was *Langley*. The *Eng* litigation included claims that there was inadequate mental health treatment in the SHU at Attica. The *Eng* litigation led to the creation of the Special Treatment Program ("STP") for prisoners with mental illness housed in the SHU at Attica Correctional Facility. The STP was the first treatment program in New York for prisoners with mental illness serving time in SHU which provided out-of-cell mental health programming.¹⁵ *Anderson* claimed a failure to provide adequate mental health care to prisoners housed in SHUs and the failure to appropriately consider mental illness during disciplinary hearings at Green Haven and Auburn Correctional Facilities.

¹² *Austin v. Wilkinson*, Civ. No. 01 CV 071, U.S.D.C. N. Ohio.

¹³ *Jones'El v. Berge*, 164 F. Supp. 2d 1096, 1125-26 (W.D. Wis. 2001) (granting preliminary injunction requiring removal of those with serious mental illness from "supermax" prison, which isolates prisoners).

¹⁴ *Anderson v. Goord*, 87-CV-141 (N.D.N.Y. 2003) (private settlement agreement required amendments to state-wide regulations that identified specific circumstances when mental health must be considered during a disciplinary hearing to assist in determining the appropriate penalty, if any, and established case management committees to review the status of SHU prisoners with mental illness and make recommendations for restoration of privileges, time cuts and housing reassignments); 7 N.Y.C.R.R. §§ 251.2, 254.6, 254.7 and 310; *D.M. v. Terhune*, 67 F. Supp. 2d 401, 403 (D.N.J. 1999) (requiring that hearing officers are informed whether inmates are receiving treatment, and requiring removal from disciplinary detention if mental health status deteriorates).

¹⁵ A stipulation entered in the *Eng* litigation, ordered in 1998 and then amended and ordered in 2000, required among other things: (a) the diversion from the Attica SHU of prisoners "known to be at substantial risk of serious mental or emotional deterioration"; (b) a mental health assessment within one working day of any prisoner's placement in the Attica SHU; (c) alternative placement if the assessment finds that the patient is at substantial risk of serious mental or emotional deterioration if sent to SHU; (d) 10 hours of OMH presence per week in the Attica SHU (subject to redirections if the SHU is below 75% of capacity); (e) treatment plan review within 10 days of the transfer to SHU and (f) an available escort to a private interview room for the purpose of assessment or treatment. The STP has operated in the Attica SHU since January 2001. DOCS and OMH implemented an additional STP at Five Points Correctional Facility which has been in operation since at least November 2001.

In 2003, *Anderson* resulted in state-wide regulations that require that clinical testimony from OMH is provided when the mental health of the prisoner is at issue during the hearing process. The regulations authorize the hearing officer to use evidence of mental illness to mitigate the penalty or dismiss the charges, and determine an appropriate penalty. In addition, regulations were changed pursuant to the *Anderson* litigation which expanded the use of Joint Case Management Committees to OMH level 1 prisons statewide.¹⁶

In the more than 15 years since the *Langley* Stipulation was implemented at Bedford Hills, prisoners with serious mental illness continue to be housed in SHU and keeplock at that facility and throughout the state prison system. Even after *Eng* and *Anderson*, OMH and DOCS failed to remove prisoners from disciplinary confinement even when they repeatedly psychiatrically deteriorated under the conditions in isolation. The STP could accommodate only forty prisoners; hundreds of prisoners with serious mental illness continued to languish in the ten other maximum security prisons, as well as at Attica and Five Points; and the STP was not effective for the most seriously ill prisoners, who continued to carry SHU terms of many years.

Systemic Litigation to Improve Mental Health Treatment Throughout New York State Prisons - *Disability Advocates, Inc. v. New York State Office of Mental Health, et al.*

Based on our experience of the limitations of the earlier individual prison based litigation, we determined that the problem of inadequate mental health care in DOCS could not be solved without a more comprehensive approach. Looking solely at SHUs in a few prisons, as was done in prior litigation, did not assist those prisoners held in other prisons or in other forms of psychiatrically harmful isolated confinement or the many prisoners in need of a residential mental health setting for whom no placement was available. DOCS and OMH did not provide state-wide reform to the system to further the progress made in the prisons covered by the litigation. Therefore, our three agencies, Disability Advocates, Inc., Prisoners' Legal Services of New York, the Prisoners' Rights Project of the Legal Aid Society along with the law firm Davis Polk & Wardwell filed the state-wide lawsuit, *Disability Advocates, Inc. v. New York State Office of Mental Health, et. al*, which resulted in the Private Settlement Agreement (PSA) we are discussing here today.

Disability Advocates, Inc. v. New York State Office of Mental Health (“*DAI v. OMH*”) was brought with the goal of improving mental health treatment in New York State prisons.¹⁷ The *DAI v. OMH* complaint did not distinguish between conditions of different isolated confinement settings in different state facilities. The complaint alleged that one of the results of inadequate mental health treatment was that prisoners with mental illness became trapped in the disciplinary process and ended up in isolated confinement settings, which caused them to

¹⁶ The JCMC process has been in place state-wide since 2003.

¹⁷ A similar case is currently pending in Massachusetts. *Disability Law Center, Inc. v. Mass. Dept. of Correction, et al.*, Civ. No. 07-10463 (U.S.D.C. Mass.). In both *DAI v. OMH* and the Massachusetts case the protection and advocacy agency is plaintiff pursuing the interests of their constituents who are prisoners with mental illness.

deteriorate psychiatrically.

The case resulted in a private settlement agreement (“PSA”) which includes among its provisions a minimum of two hours per day of out-of-cell treatment or programming for prisoners with serious mental illness confined in SHU, universal and improved mental health screening of all prisoners upon admission to the state prison system, creation and expansion of residential mental health programs, required and improved suicide prevention assessments upon admission to SHU, improved treatment and conditions for prisoners in psychiatric crisis in observation cells, and modifications to the disciplinary process. A stated goal of the agreement is to treat rather than isolate and punish prisoners with serious mental health needs. Plaintiff is able to tour, review documents and with expert assistance comment on the state’s compliance with the PSA until the Residential Mental Health Unit (“RMHU”) has operated for a period of two years or one year after all PSA required treatment beds are operational, whichever is later. The differences between the PSA and the Article VII legislation currently proposed by the Governor are described in detail below.

The SHU Exclusion Law Passed After Extensive Legislative Process

Simultaneous with the *DAI v. OMH* litigation efforts, a broad coalition of prisoner and mental health advocates, ex-offenders, and family members created a coalition to end the use of isolated confinement for offenders with mental illness in New York State prisons. The Coalition, Mental Health Alternatives to Solitary Confinement (“MHASC”), participated actively in community organizing and lobbying efforts to educate the public and the legislature about the problems experienced by offenders with mental illness incarcerated in isolated confinement settings.¹⁸ Members of MHASC advised legislators in drafting state legislation to end isolated confinement for offenders with mental illness in New York State prisons altogether.¹⁹ This bill passed the NY State Assembly on more than one occasion. It then passed both in the state Assembly and the State Senate but was vetoed by then Governor Pataki, in the fall of 2007. After the veto, work was done to redraft the bill to address concerns from DOCS and OMH.

In early 2008, the New York Legislature passed and then Governor Spitzer signed S.333/A.4870.²⁰ This *redrafted* statute expands on some of the provisions of the PSA entered in the *DAI v. OMH* litigation and adopts other provisions without modification. It defines “serious mental illness,” provides for prisoners with serious mental illness to be diverted or removed from

¹⁸ On several occasions Legislators held public hearings about mental health care in the state prisons. *DAI v. OMH* counsel, psychiatric experts and MHASC family members testified about their knowledge of problems with the overuse of isolated confinement by NY DOCS and its deleterious effect on offenders with mental illness.

¹⁹ Assembly Mental Health Corrections Committee Chair Jeffrion Aubry drafted and introduced the legislation in the State Assembly. It was later co-sponsored in the State Senate by then Senate Corrections Committee Chair Michael Nozzolio.

²⁰ Most of the provisions of the statute appear as amendments to N.Y. Correction Law § 137. McKinney’s Correction Law § 137.

segregated confinement to residential mental health units and provides them with improved mental health care. The passage of this state law makes the improvements to the system permanent although most of the provisions of the legislation do not go into effect for several years.²¹ The effective date of the SHU Exclusion Law provisions take effect when plaintiff's monitoring rights under the PSA expire.

THE REASONING SET FORTH IN SUPPORT OF PROPOSED ARTICLE VII LEGISLATION TO DELAY IMPLEMENTATION AND AMEND THE SHU EXCLUSION LAW IS SIGNIFICANTLY FLAWED²²

Limiting the Scope of the Law to OMH Level 1 and 2 Facilities Ignores the Fact That OMH Level 3 and 4 Facilities Regularly House Prisoners with Serious Mental Illness and There is No Mandate Requiring Transfer of Prisoners with Serious Mental Illness to OMH Level 1 and 2 Facilities

Many of the proposed amendments to the SHU Exclusion Law remove protections for prisoners housed in OMH level 3 and level 4 facilities. These are prisons that provide a lower level of mental health services than do OMH level 1 and 2 facilities. The Article VII Memorandum fails to inform that an individual with an OMH level of 3 may have a serious mental illness that is in remission (or currently controlled through medication) and that OMH level 3 and 4 prisoners may have histories of serious mental illness.

OMH level 3 and 4 facilities regularly house prisoners with serious mental illness and with histories of serious mental illness. OMH level is only a measure of current need—that is, the current acuity of mental illness. A prisoner who is designated as an OMH level 3 patient may carry a diagnosis of a serious mental illness. OMH level 3 is defined as follows: “Needs/may need short-term chemotherapy for disorders such as anxiety, moderate depression, or adjustment disorders OR suffers from a mental disorder which is currently in remission and can function in a dormitory facility which has part-time Mental Health staff.” OMH Form 167 MED CNYPC (4/08). It is very common for prisoners to experience changes in their OMH level from level 1 or 2 to a lower level of need. Prisoners who were classified previously as OMH level 1 or level 2, may be in a state of sometimes fragile remission. The danger of relapse, resulting in periods of

²¹ Much of the statute will not go into effect until “two years after the date that the commissioner of correctional services certifies to the legislative bill drafting commission that the first residential mental health unit constructed by the department of correctional services is completed and ready to receive inmates, provided, however that such sections shall take effect no later than July 1, 2011.” The statute provides for oversight responsibilities by the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (“CQC”). The oversight provisions went into effect July 1, 2008.

²² There are two documents that were produced in support of the delay and amendment to the SHU Exclusion Law. The first document is the *2009-10 New York State Executive Budget Public Protection and General Government Article VII Legislation Memorandum in Support* (“Article VII Memorandum”). The second is titled *Prison Based Mental Health Services in New York State, Rationale for Limited Delay of SHU Exclusion Law Requirements* (“Article VII Rationale”). The documents are attached to this testimony for your convenience.

greater treatment needs, is always present. That danger is especially serious when prisoners with a history of serious mental illness are placed under severe stress—which is precisely what happens if they are placed in segregated confinement in SHU or Keeplock.

This risk of relapse to OMH level 3 and level 4 prisoners is a primary reason why the PSA does not distinguish among prisoners based on their OMH level, or the OMH level assigned to their facility, but instead guarantees a heightened level of care for all prisoners with serious mental illness who are subject to a SHU sentence longer than 30 days.²³ The danger of relapse is ever-present. Approximately 50% of SHU beds are located in OMH level 3 and 4 facilities which make eliminating protections for prisoners at these prisons unduly risky.

There is no DOCS or OMH regulatory mandate requiring transfer of prisoners with serious mental illness to OMH Level 1 and 2 facilities. The Article VII Memorandum states that OMH level 3 and 4 facilities “*should not* be housing prisoners with serious mental health needs.” That may well be, but as stated above, in reality they *do* house such prisoners, and there is no reason to believe this long-standing practice will suddenly change, or that DOCS is even capable of implementing change in the space available. The proposed amendment to paragraph (d) subdivision 6 of Correction Law § 137 which would make diversion of persons with a history of mental illness from SHU necessary only in OMH level 1 and 2 facilities, would drastically decrease the likelihood of identification and removal of prisoners with serious mental illness from segregated confinement housing at OMH level 3 and level 4 facilities, even though OMH and DOCS agree they should not be housed at those facilities. Moreover, the Article VII Memorandum incorrectly asserts that “there is little danger that prisoners in these facilities [Level 3 and 4] would be at risk of decompensating if they are placed in disciplinary housing, because prisoners who have long terms of disciplinary housing are transferred to S-blocks in level 1 and 2 facilities with appropriate levels of mental health staff.” There is no DOCS or OMH policy which requires that a prisoner be transferred to a level 1 or 2 facility based on the length of his/her SHU sentence.

A major part of the long-standing problem that led to the *DAI v. OMH* litigation is that many prisoners who are placed in SHU initially for short terms quickly decompensate and begin to receive additional disciplinary charges and additional SHU time as their condition deteriorates in the harsh environment of segregated confinement. Prisoners with serious mental illness entered an uninterrupted cycle of discipline, psychiatric deterioration, crisis care and further punishment. The State’s failure to interrupt this harmful cycle caused disabled prisoners to repeatedly experience the depths of severe psychiatric illness—at the cost to them of untold misery, and to the State of increased disruption and violence, injury to prisoners and staff, and psychiatric hospitalization in many cases.

²³ The SHU Exclusion Law provides additional protection for prisoners with serious mental illness who are subject to a SHU sentence longer than 30 days. The SHU Exclusion Law requires that those prisoners be moved to a Residential Mental Health Unit (“RMHU”) where they will receive 4 hours of out-of-cell treatment per day.

The Projected Savings set forth in the Article VII Memorandum and Article VII Rationale are Misleading

The Article VII Memorandum and Article VII Rationale claim significant financial savings will be attained by eliminating the heightened level of care requirement and the controls on the imposition of the restricted diet penalty for prisoners with serious mental illness in segregated confinement at OMH level 3 and 4 facilities, eliminating the mental health and suicide risk assessments of all prisoners in segregated confinement at OMH level 3 and 4 facilities and delaying the construction of RMHU bed space. These claims, however, are misleading because the various provisions of the PSA setting forth requirements regarding the heightened level of care for prisoners with serious mental illness and SHU sanctions, maintenance of the current level of mental health treatment available, and the restricted diet penalty, must be followed even if the Article VII amendments to the SHU Exclusion Law are implemented. In addition, the current SHU Exclusion Law has no requirement that additional RMHU bedspace be built unless it is needed to properly treat prisoners with serious mental illness.

The PSA Mandates a Heightened Level of Care for *All* Prisoners with Serious Mental Illness in Segregated Confinement Including at OMH Level 3 and 4 Facilities

Most significantly, and alarmingly, proposed amendments to the SHU Exclusion Law include a provision that eliminates the heightened level of care requirement for prisoners with serious mental illness in segregated confinement at OMH level 3 and 4 facilities. As stated above, the rationale for the proposed amendment is without foundation. Moreover, contrary to assertions in the Memorandum in Support of the Article VII Legislation (“Article VII Memorandum”), this proposed amendment is in direct violation of the terms of the PSA ¶ 1 which require that:

[A] heightened level of care (i.e. at least 2 hours of structured out-of-cell therapeutic programming and/or mental health treatment per day, five days a week, in addition to exercise) will be offered to all inmates subject to a confinement sanction in a Special Housing Unit (“SHU”) who meet the diagnostic criteria [for serious mental illness].

This essential element of the PSA was the result of lengthy litigation after DOCS and OMH failed to remedy the long-standing problem in the New York state prisons that resulted in the segregated confinement housing areas being disproportionately and inappropriately filled with prisoners who suffered from serious mental illness. Yet, the proposed amendments would deny prisoners with serious mental illness this right to a heightened level of care unless they are housed at certain facilities. Denying these prisoners adequate treatment is inhumane and increases the risk of serious psychiatric deterioration, acts of self-harm and suicide. We want to make it very clear that the PSA’s heightened level of care requirement applies to all facilities

regardless of OMH level. Because of the PSA, DOCS and OMH cannot eliminate the heightened level of care for prisoners with serious mental illness in segregated confinement at OMH level 3 and 4. Therefore, any cost savings set forth as support for this amendment are elusive.

Moreover, providing inadequate mental health treatment does not produce overall fiscal savings. Experience amply demonstrates that the failure to provide adequate treatment result in an increase in other expenses including emergency psychiatric and medical services and increased utilization of costly segregated confinement housing. Indeed, it was the harsh over utilization of harmful segregated confinement housing of prisoners with serious mental illness that led to the filing of *DAI v. OMH* in the first place. It is striking that the Article VII Memorandum fails to inform that an individual with an OMH level of 3 may have a serious mental illness that is in remission and that OMH level 3 and 4 prisoners may have histories of serious mental illness. Before the legislature agrees to take action based on this Memorandum they should establish whether the alleged savings are real and how many prisoners may be adversely affected by adopting the proposed revisions.

The PSA Mandates Continued Mental Health and Suicide Assessments at OMH Level 3 and 4 Facilities

The proposal to eliminate mental health and suicide risk assessments of prisoners in segregated confinement at OMH level 3 and 4 facilities will also result in DOCS and OMH violating the legal requirements embodied in the PSA. DOCS and OMH are required by the PSA not to reduce the level of mental health services that were available at the time of the PSA's execution. PSA ¶ 9. At OMH level 3 and 4 facilities, current DOCS Directive 4101, Section II. B. 2 requires that a suicide risk assessment be performed within one day of admission to SHU. OMH policy, CNYPC Policy Section 6, OMH Services to DOCS, requires a mental health assessment within 30 days of admission to segregated confinement. Both policies were in effect when the PSA was signed. The proposed amendments cannot result in savings because OMH and DOCS cannot repeal these essential policies without violating PSA ¶ 9. If the OMH policy remains, as is required by the PSA, the only reduction in assessments (and savings) will be for prisoners who remain in SHU for less than 30 days.

PSA ¶ 3 requires that OMH adopt the National Commission on Correctional Health Care (NCCHC) standard for reception screening. PSA ¶ 3 was designed to improve the detection and diagnosis of prisoners in need of mental health services at the outset of their incarceration, before they psychiatrically deteriorate and run afoul of prison rules. In testimony recently submitted by PRP and PLS, we noted that the state had not lived up to this promise to employ universal comprehensive mental health assessments at reception. Instead, only a brief screen was being used at reception far below the NCHHC standard. Soon after we provided this testimony, in February 2009, OMH and DOCS revised their reception screening instrument to incorporate provisions of the NCCHC standard. The screening instrument is only one part of the NCCHC standard. We are pleased with this development, however, the inadequacy to date of reception screening continues to affect prisoners with mental illness who have already passed through the

reception process. We are also concerned with OMH's implementation of other parts of the NCCHC standard including further evaluation of an inmate's mental health and service needs following a positive finding on the initial mental health screen.

We continue to believe that screening for mental illness and suicide risk at OMH level 3 and 4 facilities is critical if tragedy is to be avoided. Particularly alarming is the proposal to eliminate the SHU Exclusion Law's requirement of suicide prevention screening upon placement into a SHU at an OMH level 3 and 4 facilities. Segregated confinement housing is a well known suicide risk factor in DOCS and elsewhere.²⁴

The PSA Places Significant Restrictions on Restricted Diet Sanctions at OMH Level 3 and 4 Facilities

Amendments to the SHU Exclusion Law include eliminating the provision that protects prisoners with serious mental illness at OMH level 3 and 4 facilities from imposition of the restricted diet penalty. Neither the Article VII Memorandum nor the Article VII Rationale provide a rationale for eliminating this protection in level 3 and 4 prisons. This proposed amendment has no fiscal savings other than the seemingly negligible difference in the cost of feeding a prisoner with serious mental illness a loaf of nutribread and cooked cabbage versus a standard prison meal. (This odious punishment is contrary to American Correctional Association standards.) Regardless of any reason that may be offered for this proposed amendment to the SHU Exclusion Law, the proposed amendment is meaningless because the PSA does not exclude OMH level 3 and 4 facilities from these protections. Pursuant to the PSA, the use of the restricted diet is significantly restricted for all prisoners for whom mental health is "at issue" as defined under DOCS' disciplinary regulations. This category of prisoners is far broader than prisoners with serious mental illness and clearly include prisoners housed at OMH level 3 and 4 prisons. The proposed amendment encompasses a much more narrow definition than the PSA and also more narrow than the SHU Exclusion Law, without any fiscal justification whatsoever.

The SHU Exclusion Law Only Requires Additional RMHU Beds if Necessary

The SHU Exclusion Law does not go into effect until 2011 and the law has no requirements that additional RMHU space be built based on anything other than the need to do so in order to properly treat prisoners with serious mental illness. If a need for additional RMHU space is established, providing for appropriate and adequate treatment is necessary and will save rather than waste resources.

²⁴ Way B, Sawyer D, Barboza S, Nash R: Inmate Suicide and Time Spent in Special Disciplinary Housing in New York State Prison, Psychiatric Services, 2007; Way B, Miraglia R, Sawyer D, Beer R, Eddy J: Factors Related to Suicide in New York State Prisons, International Journal of Law and Psychiatry, 2005; Miraglia R, Beer R: Quality Assurance Review of Suicides in New York State Correctional Facilities. Albany, NY, New York State Office of Mental Health, 2002.

The Projected Available Bed Space is Inaccurate and Misleading

The Article VII Rationale provides a list of bed space that will be available by March 31, 2010 for prisoners with mental illness. The listing inflates the amount of bed space that is actually available for treatment of prisoners with mental illness. Many beds on this list existed long before *DAI v. OMH* was filed, and have nothing to do with remedying the long-standing problem of prisoners with serious mental illness ending up in SHU and Keeplock confinement (examples of this include: 166 Special Needs Unit (“SNU”) beds, 32 Sensorially Disabled Unit (“SDU”) beds, 258 Assessment and Program Preparation (APPU) beds, and 216 Merle Cooper Program (“MCP”) beds). In addition, many beds on this list are not intended for long term housing of people with serious mental illness:

- 166 SNU beds are intended for people with developmental disabilities, including limited intellectual functioning. In fact, prisoners with coexisting mental illness and mental retardation are frequently *denied* access to these beds because programming is not geared towards coexisting disorders, and prisoners with SHU sanctions also have no access to SNU;
- 32 SDU beds are for people with hearing and vision impairments. The unit is not geared towards treating people with serious mental illness;
- 214 Residential Crisis Treatment (“RCTP”) beds are a combination of observation cell beds plus dormitory space located in the Satellite Mental Health Units. These beds are solely utilized as short term housing for people with mental illness who are in current crisis, and regardless of the name of the program, this is not a long-term residential setting. The observation cell beds are intended for crisis management, and the PSA has a goal of no more than 4 days in any such bed. The dorm beds are intended for limited duration and with little exception DOCS frequently forbids the use of these beds for inmates transferred to the RCTP from SHU and Keeplock even when OMH makes a determination that it is clinically appropriate for an inmate to be housed in the less restrictive dorm setting.
- 259 APPU beds are intended as a protective custody environment for inmates who may be vulnerable in general population due to their crime, their personal characteristics or the presence of enemies.
- 216 Merle Cooper Program (“MCP”) beds are not intended for inmates with serious mental illness. In fact, DOCS Director of Public Information, Erik Kriss, is quoted as stating: “From a technical standpoint, all MCP participants must meet certain security and mental health thresholds. MCP will not take the highest security inmates nor the most seriously mentally ill.”²⁵

²⁵ http://www.apnmag.com/winter_2009/smith_Dannemora.php

Statistics Claiming a Significant Reduction in SHU Confinement for Prisoners with Serious Mental Illness are Incomplete

The Article VII Rationale indicates that as of December 31, 2008 there were 237 inmates with SMI serving SHU confinement and indicates that the more recent report reduces that number to 221.²⁶ The Article VII Rationale does not provide any information about the length of SHU terms that are currently to be served by these inmates. It does report that only 7 of these inmates are serving a term of less than 30 days. The claimed success of these numbers is impossible to ascertain without knowing the information about the SHU terms that are left to be served by the SMI population in SHU. Are these prisoners with SMI sentenced to excessively long periods of SHU confinement? Are they continuing to accumulate additional SHU confinement sanctions through new misbehavior reports and disciplinary hearings? Will they serve the remainder of their criminal sentence in SHU before release from custody?

DOCS and OMH's failure to fully report information concerning SHU confinement sanctions so that progress toward reducing lengths of confinement can be fully measured, is not new. During the trial of *DAI v. OMH*, plaintiff's psychiatric expert Dr. Terry Kupers indicated that he could not credit the efforts to provide SHU time cuts to prisoners with SMI when he had not been provided additional information to ascertain how much SHU time they were left to serve after the time cut was granted. Southern District of New York Judge Gerard Lynch agreed stating:

It might be a perfectly appropriate question to ask Dr. Kupers, I think it is an appropriate question, to point out that a certain number of days of time cuts occurred, but, of course, that lacks a denominator, and one thing that Dr. Kupers referred to was how much are these time cuts relative to the amount of time the people are facing.

So that even a very impressive number of aggregate time cuts then averaged across x number of prisoners, and then contrasted with people who had ten years of SHU time may turn out to be less impressive. It may not turn out to be less impressive when it's disaggregated that way, but I'd be interested in knowing these facts.²⁷

²⁶ The Article VII Rationale indicates successful reduction of SHU confinement through a variety of steps, most of which are required pursuant to the PSA: training, mental health screening of inmates, expansion of Joint Case Management Committees to Level 2 facilities, and review of hearings by Superintendents. These additional efforts are in place and DOCS and OMH are progressing in implementation and utilization of these mechanisms.

²⁷ When Judge Lynch approved the PSA he stated the following: "greater attention should probably be paid to the problem of extremely lengthy SHU confinement even to those who are not mentally ill. As we learned during the trial, New York does not have a formal Supermax prison, but when numerous lengthy disciplinary sanctions of SHU confinement are made to run consecutively, prisoners in effect are kept in conditions at least as rigorous and perhaps

DAI v. OMH, Tr. Transcript pp.127-28, 4/3/06.

The agencies' failure to provide sufficient information to evaluate progress persists and therefore the assertions concerning reduced SHU confinement for prisoners with serious mental illness are not reliable. Before the Legislature can make an informed decision as to whether the SHU Exclusion Law should be delayed, it should demand that both DOCS and OMH provide the statistical information necessary to evaluate whether the reasoning set forth in support of delay of the law is complete and accurate.²⁸

Delay in the Effective Date of the SHU Exclusion Law will Harm Prisoners with Serious Mental Illness in Isolated Confinement

The proposed Article VII amendments to the SHU Exclusion Law provide for delaying the effective date of the law for a period of three years from 2011 to 2014. The Article VII Memorandum asserts that this delay will permit an assessment of the effectiveness of the Residential Mental Health Unit (RMHU) and the Article VII Rationale asserts that “[a]bsent legislative approval to delay, the State must begin building new RMHUs *immediately* in order to have sufficient beds and treatment slots operational when the SHU Exclusion Law is scheduled to take effect.”

even more so than in any official Supermax facility perhaps without as carefully thought about consequences as would exist in more official decision to relegate a prisoner to a formal Supermax institution.” Tr. p. 9, 4/27/07.

²⁸ The PSA requires that DOCS and OMH take numerous steps to meet the goal of moving inmates from more restrictive to less restrictive environments and to significantly reduce the time that inmates with serious mental illness spend in restrictive environments, PSA ¶ 5. To accomplish this goal, DOCS and OMH must take various steps: an automatic review of all disciplinary hearing dispositions when mental health was at issue in the hearing under specific circumstances and a review of all SHU time accruals to assess the feasibility of diverting inmates from SHU and granting time cuts. PSA ¶¶ 6 e. & h. In reference to the “Review of Existing SHU Sentences” in PSA ¶ 6 h., plaintiff has requested clarifying information concerning a report that was provided by DOCS and OMH pertaining to implementation of this provision. The additional information, that would permit plaintiff to understand the SHU terms that remained after the review, was requested from the defendants without adequate response. Our questions remain unanswered.

The PSA further requires the production of various quality assurance data to allow for monitoring of the requirements that focus on restricting SHU time for inmates with serious mental illness. The data that has been provided is insufficient to permit a substantive analysis. For example, to measure the effect of Superintendent review of disciplinary sanctions, DOCS and OMH should provide for each hearing: the total SHU and Keeplock sanction issued; total SHU and Keeplock time accruals for each individual; and the SHU and Keeplock release dates after the Superintendent's review is complete. This would indicate if an individual is having his SHU time reduced, if he is actually being moved out of SHU and would reflect the overall impact on total SHU confinement time. Similarly, to measure the effect of reviewing all SHU time accruals for purposes of diversion, the data provided should include: the total time cuts provided, the total SHU accrual after the review is complete, and whether the individual is actually diverted from SHU. Without this type of data, there is no way to measure the stated success in reducing SHU confinement for inmates with serious mental illness, or predicting need for additional treatment beds.

Moreover, questions must be raised concerning the estimation of the numbers of prisoners with serious mental illness in DOCS custody. Plaintiff has raised repeated questions with DOCS and OMH concerning the diagnoses of individual prisoners including concerns that prisoners who are not designated as having a serious mental illness are nonetheless medicated with psychotropic drugs.

The data reported in the Article VII Rationale supports the conclusion that there is insufficient RMHU bed space to transfer prisoners with serious mental illness out of SHU as is required by the SHU Exclusion Law.²⁹ According to the numbers provided, there are currently 221 inmates with serious mental illness in SHU and only 7 are serving less than 30 days. The RMHU, due to open in September 2009, will have 100 beds available. If all of these inmates require placement in an RMHU, there will be approximately 121 inmates without a bed in the RMHU. The conclusion is clear. Delay in implementation of the SHU Exclusion Law would mean plainly that further treatment beds would not be provided for another five years. This will delay for another five years a law that was passed to ameliorate a problem that has been well known and well documented for decades.³⁰

The Article VII Rationale professing the need to delay and reconfigure the RMHU is overstated. An assessment requirement is already in place pursuant to the PSA. PSA ¶ 4 f. requires that DOCS and OMH conduct an assessment within one year of the opening of the RMHU in order to determine whether an additional 50 beds are needed. The best way to ensure that future needs assessments will be accurate, so that the necessary heightened level of care is provided to prisoners with serious mental illness, is to continue to tie the effective date of the law to the end date of the PSA requirements, which is the present state of the SHU Exclusion Law. In addition, by 2011, DOCS and OMH will have operated the Behavioral Health Units (BHUs) for six years; the Special Treatment Programs (STPs) for more than ten years, the Group Treatment Programs (GTPs) for three years. Nothing in the PSA, the SHU Exclusion Law or elsewhere prevents DOCS and OMH from improving and enhancing these and other mental health treatment programs while the PSA remains in effect. There is no need to delay the SHU Exclusion law as a means to improve the RMHU model.

Moreover, between the sunset of the PSA in 2011 and the proposed Article VII amendment delay until 2014, a three year gap in monitoring the provision of mental health services in the New York State prisons will occur. Based on DOCS and OMH's history of failing to provide adequate mental health treatment unless mandated to do so, and current misstatements in the Article VII Memorandum and Article VII Rationale noted herein, the three year gap will predictably lead to retrenchment.

Delay in construction of needed treatment programs for solely fiscal reasons has already occurred and the proposed delay in the effective date of the SHU Exclusion Law, via an Article VII bill, is an attempt to add more time to that delay. Although needed, opening of the 99 bed ICP at Green Haven and the 110 bed RMHU were deliberately deferred until after April 2009 as a cost savings measure.³¹ Operation of the RMHU is now slated for September 2009. After deliberately delaying the opening of a needed treatment program, the current rationale provided

²⁹ This transfer is not required by the PSA, which requires a heightened level of care in the SHU.

³⁰ See testimony above at pp. 2-7.

³¹ *DOCS Today*, Vol. 1, No 5, Autumn 2008.

to delay implementation of the SHU Exclusion Law states “[p]roviding sufficient time to evaluate the effectiveness of the new RMHU model would ensure that taxpayer dollars are spent on programs that provide the greatest success.”³² This assertion, that delay in providing treatment creates a savings, should not be countenanced. Moreover, if as stated there is a continued commitment to reduce the number of inmates with serious mental illness serving SHU terms, the increase in ICP beds is a welcome alternative to SHU and time cuts should be implemented to reduce the number of inmates with serious mental illness who require placement in an RMHU as an alternative to SHU. Moving these prisoners to ICP would significantly reduce the need for additional RMHU space.

CONCLUSION

The Article VII amendments would violate provisions of the PSA, cause harm to prisoners with psychiatric disabilities, and cost the State more money. Inappropriate and factually incorrect arguments are being made that use the PSA in *DAI v. OMH* to argue that the Article VII amendments to the enacted SHU Exclusion Law are fiscally responsible and without consequence to prisoners with serious mental illness. The proposed amendments to the SHU Exclusion Law, which exclude OMH level 3 and 4 prisons from the scope of the law, will increase spending rather than reduce spending, and other proposed amendments provide minimal or no fiscal savings at all. The SHU Exclusion Law was enacted with an understanding that there was a long-standing failure to provide adequate mental health services in our prisons and that the result included far too many prisoner with serious mental health needs languishing and psychiatrically deteriorating in the punitive segregated confinement settings of SHU and Keeplock. The SHU Exclusion Law expanded on improvements reached in the *DAI v. OMH* PSA and made those expanded improvements New York State law.

Improved prison health care, mental health care and substance abuse treatment service are good public health and fiscal policy. They increase prison safety and public safety. The proposals to reduce protections as put forth in the Article VII legislation are not money saving, and are in fact costly and dangerous for prisoners with disabilities and others. They serve no budgetary or other proper purpose.

Respectfully submitted,

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³² See Article VII Rationale, Attachment B p. 5.

**Attachments to Testimony Before the
New York State Senate**

**Public Hearing
March 17, 2009**

- Attachment A: Referred to in testimony as “Article VII Memorandum”
2009-2010 New York State Executive Budget Public Protection and
General Government Article VII Legislation: Memorandum In Support
- Attachment B: Referred to in testimony as “Article VII Rationale”
Prison-Based Mental Health Services in New York State Rationale for
Limited Delay of SHU Exclusion Law Requirements

ATTACHMENT A

2009-10 NEW YORK STATE EXECUTIVE BUDGET

PUBLIC PROTECTION AND GENERAL GOVERNMENT

ARTICLE VII LEGISLATION

MEMORANDUM IN SUPPORT

Part I – Delay the expansion of mental health programs authorized by the SHU Exclusion Bill and curtail or modify other provisions of the bill relating to the Department of Correctional Services (DOCS) facilities that do not generally house inmates with serious mental illnesses and the training of DOCS personnel

Purpose:

This bill reduces the cost of implementing the Special Housing Unit (SHU) Exclusion Bill by delaying the effective date of the bill by three years from July 2011 until July 2014, limiting the scope of the bill to level 1 and level 2 mental health designated correctional facilities, and re-configuring the mental health training requirements for Department of Correctional Services (DOCS) personnel.

Statement in Support, Summary of Provisions, Existing Law, and Prior Legislative History:

Chapter 1 of the Laws of 2008, referred to as the Special Housing Unit (SHU) Exclusion Bill, required an expansion of mental health programs within the Department of Correctional Service (DOCS) correctional facilities. The bill imposed requirements for the housing of inmates with mental illness that exceed those in a Private Settlement Agreement (PSA) that DOCS and the Office of Mental Health (OMH) reached with Disability Advocates, Inc. in April 2007. The SHU Exclusion bill had an effective date of either two years after the DOCS Commissioner certifies that the first new Residential Mental Health Unit is completed and ready to receive inmates or at the latest by July 1, 2011. This proposal modifies some of the provisions of the SHU Exclusion Bill that exceed the provisions of the PSA.

The PSA required the expansion of several existing mental health programs and creation of a new 100-bed Residential Mental Health Unit (RMHU) at the Marcy Correctional Facility for inmates who are in disciplinary housing but have been assessed as having a serious and persistent mental illness. The SHU Exclusion Bill included provisions that could add additional RMHUs beyond the one at Marcy. Delaying the effective date of the bill by three years will allow DOCS and OMH to evaluate the effectiveness of the new RMHU program, refine their approach, and reevaluate the need for expanded RMHU capacity.

Additionally, this proposal would eliminate the application of the SHU Exclusion Bill requirements to level 3 and level 4 DOCS correctional facilities. There are currently five designated levels for mental health services (1, 2, 3, 4, and 6) at DOCS correctional facility. Level 1 and 2 facilities generally house inmates who have the most serious mental health conditions, and OMH and DOCS mental health related staff and programs are concentrated at

these level 1 and 2 facilities. Because level 3, 4 and 6 facilities should not be housing inmates with serious mental health needs, it is arguably excessive – and costly – to require mental health services in these facilities. Moreover, there is little danger that inmates in these facilities would be at risk of decompensating if they are placed in disciplinary housing, because inmates who have long terms of disciplinary housing are transferred to S-blocks in level 1 and 2 facilities with appropriate levels of mental health staff.

Finally, this proposal also sets appropriate levels of training for DOCS staff that are transferred into residential mental health units. Instead of participating in sixteen hours of initial specialized mental health training, the amount of such training will be reduced to eight hours plus an orientation program that will allow staff to receive hands-on experience in the units. Furthermore, the requirement for an additional eight hours of annual training for such staff is modified to two four-hour sessions during which the out-of-cell mental health programming and treatment for inmates may be suspended or decreased. This level of training is adequate based on existing DOCS training standards.

Budget Implications:

Enactment of this bill is necessary to implement the 2009-10 Executive Budget as this bill will increase savings by \$19 million in 2009-10, and \$27.4 million in 2010-11 for both DOCS and OMH.

Effective Date:

This bill takes effect immediately.

ATTACHMENT B

Prison-Based Mental Health Services in New York State

Rationale for Limited Delay of SHU Exclusion Law Requirements

The Governor remains fully committed to ensuring that all New Yorkers with mental illness, including inmates incarcerated in the State's prisons, receive appropriate and quality care. Even in these difficult economic times, the State remains committed to:

- fully implementing the Private Settlement Agreement (PSA) with Disability Advocates, Inc. (DAI);
- reducing the number of inmates with serious mental illness (SMI) serving a disciplinary sanction in a Special Housing Unit (SHU); and
- expanding prison-based mental health services.

Proposed changes to the SHU Exclusion Law will not undermine this commitment, but instead, will ensure that the State's scarce resources are well invested to provide the most appropriate care for inmates with SMI.

Continuing Commitment to the Private Settlement Agreement

The Department of Correctional Services (DOCS) and the Office of Mental Health (OMH) are moving ahead at full pace with the implementation of the PSA resulting from the DAI v. OMH lawsuit, which involves the ongoing investment of significant resources and has resulted in changes in how behavioral issues of inmates with SMI are evaluated and addressed. Advocates have described the PSA as, "historic in the scope of its comprehensive programs which include highly innovative approaches to correctional mental health in the State."

- During 2008, all DOCS Superintendents, facility Executive Team members, Disciplinary Hearing Officers, and facility Mental Health staff received 8 hours of training in order to comply with the various components of the PSA.
- In September 2009, DOCS and OMH will open a new, 100-bed service delivery model for inmates with mental illnesses who have been diverted from disciplinary confinement in SHU. The new unit, called a Residential Mental Health Unit (RMHU), will have 27 mental health staff to provide four hours of out-of-cell therapeutic programming and/or mental health treatment five days a week to inmates with SMI who would otherwise be in a SHU. Inmates in this unit will also be afforded enhanced access to services and exercise, including group exercise where appropriate.

- DOCS and OMH are creating additional new capacity for housing inmates with mental illness, including 166 Intermediate Care Program beds and 25 Special Treatment Program beds.
- The Joint Central Office Review Committee (JCORC) provides oversight and a key leadership role to ensure that the provisions of the PSA are followed throughout the DOCS system. The committee serves to reinforce both DOCS' and OMH's commitments to providing a heightened level of care for all inmates with a serious mental illness in disciplinary confinement - the goal being to ensure inmates are provided appropriate treatment in the least restrictive environment possible, where they can function effectively. To reinforce the authority and importance of the JCORC process for DOCS, each meeting is personally chaired by the Executive Deputy Commissioner, assisted by the OMH's Associate Commissioner for Forensic Services, and joined by a number of other high level staff from both DOCS and OMH.

Reduced SHU Confinement

As of December 31, 2008, there were 8,659 inmates on the active OMH caseload, indicating that they were receiving some level of mental health treatment. OMH had designated 2,962 of these inmates as SMI, the vast majority of whom were living in the general population.

Only 237 of these inmates with SMI were serving a SHU confinement sanction. Of that number, 205 had been assigned to a special program and offered a heightened level of mental health care. Seven had a sanction of less than 30 days. One was in a regional medical unit and 24 were in the referral/transfer process to a special program.

This success results from steps taken by DOCS and OMH beginning in 2007, designed to reduce the number of inmates with SMI serving a SHU confinement sanction, including:

- Joint training for all Superintendents and all Hearing Officers on the significance of OMH clinical testimony at an inmate's disciplinary hearing.
- Screening every inmate entering the DOCS system. Prior to the PSA OMH screened approximately 40% of incoming inmates. This enhancement is significant because at the earliest juncture it allows the system to place inmates with mental illnesses at those facilities with appropriate programs and services to best address their needs – namely, Level 1 or 2 correctional facilities.

- Expansion of Joint Case Management Committees (JCMCs) comprised of DOCS and OMH facility staff, to include all Level 2 correctional facilities. JCMCs review and monitor all active mental health caseload inmates housed in SHU. In addition, inmates housed in separate keeplock units now receive a JCMC review at least once every two weeks.
- Increased focus by Superintendents, who now personally review the hearings of all inmates for whom mental health was an issue, and where a disposition included a SHU sanction of over 60 days, or where the inmate is currently serving a SHU or keeplock sanction and any additional confinement time results in the accumulation of 120 days or longer.

As a result of these efforts, the number of inmates with SMI in SHU with more than 30 days confinement has continued to decline since January 5, 2009, and was last reported at 221.

Recent and Ongoing Improvements to Mental Health Programs for Inmates

The prison-based mental health system has been significantly expanded and improved since the initiation of the DAI lawsuit in 2002, and additional expansions will occur irrespective of the SHU Exclusion Law.

By March 31, 2010, DOCS and OMH plan to have a total of 2,523 beds/slots available for prisoners with mental illnesses in the NYS prison system, which include:

- 743 Intermediate Care beds (166 beds currently in development)
- 214 Residential Crisis Treatment beds
- 38 Intensive Intermediate Care beds
- 217 Transitional Intermediate Care beds
- 16 Therapeutic Behavioral Unit beds
- 48 Group Therapy Program slots
- 31 Community Orientation Re-Entry Program beds
- 166 Special Needs Unit beds
- 216 Merle Cooper beds
- 258 Assessment and Program Preparation Unit beds
- 32 Sensorially Disabled Unit beds
- 209 Central New York Psychiatric Center beds (20 beds under development)
- 102 Behavioral Health Unit beds
- 133 Special Treatment Program beds (25 beds are under development at Mid-State CF)

- 100 Residential Mental Health Unit beds (100 beds under development at Marcy CF due to be operational in Fall, 2009)

The vast majority of beds/slots dedicated to serving inmates with mental illnesses are designed to provide services to promote recovery and also assist the relatively small sub-population of inmates with SMI, whose conditions might otherwise result in a disciplinary infraction.

The 2009-2010 Executive Budget represents no retreat from the Governor's commitment to keep New York at the forefront of prison-based mental health services. The Executive Budget supports continuing investments and services as described below:

- Of the total beds shown above, 266 are funded for the first time in the 2009-10 budget proposal, employing 115 new DOCS staff and 37 new OMH staff. These new beds will be located at Green Haven, Bedford Hills, Great Meadow, Albion, Mid-State and Marcy.
- All regular DOCS staff (including Correction Officers) working in SHUs in Level 1 and 2 correctional facilities will receive 8 hours of annual mental health training, providing them with an overview of mental illness and effective mental health treatment, with concentration on topics such as suicide prevention.
- The Commission on Quality of Care and Advocacy for Persons with Disabilities (CQCAPD) will receive funding for six additional staff and related costs to monitor prison-based mental health services and make recommendations to OMH and DOCS for improvements to prison-based mental health care.

Proposed Changes to the SHU Exclusion Law

The most important benefit of a delay in the Law would be the ability to evaluate the State's initial approach, and adjust that approach – as necessary – to ensure that it is safe and effective. The new 100-bed unit at Marcy is an untested model, for which no prior experience exists nationwide. The new unit will require a focused effort on the part of DOCS and OMH to open, staff, and operate. As implementation goes forward, DOCS and OMH are expected to identify changes needed to the physical layout, and the clinical and programmatic services offered, which would inform the development of subsequent facilities.

Delay will also give CQCAPD time to begin its new oversight responsibilities authorized by the SHU Exclusion Law to objectively assess the RMHU program and make recommendations for improvements of the prison-based mental health system before commencing this initiative. CQCAPD has begun making site visits

to correctional facilities in fulfillment of its new statutory responsibility to monitor the quality of mental health care provided to inmates, and the Executive has not proposed any statutory changes in CQCAPD's responsibility to perform this oversight function.

Absent Legislative approval to delay, the State must begin building new RMHUs *immediately* in order to have sufficient beds and treatment slots operational when the SHU Exclusion Law is scheduled to take effect. Funding for planning and design of the new RMHUs would total approximately \$88.8 million in capital construction costs. Providing sufficient time to evaluate the effectiveness of the new RMHU model would ensure that taxpayer dollars are spent on programs that provide the greatest success.

The Executive Budget also proposes to limit the frequency of mental health assessments for inmates in SHU at Level 3 and 4 facilities to the current policy. The Law requires significant assessments and screenings at these facilities, despite the fact that they house a minimal number of inmates with SMI.

Presently, all inmates admitted to a SHU in a Level 3 or 4 facility receive a suicide prevention screening at the time of their admission and receive ongoing monitoring. Under the Law, all inmates admitted to a SHU at a Level 3 or 4 facility will need to be assessed within 14 days. If an inmate with SMI is not diverted from the SHU, he or she will have to be re-assessed every 14 days thereafter. All inmates in a SHU at a Level 3 or 4 facility – even those without an SMI – must be offered an interview with a mental health clinician within 30 days of their initial assessment and every 90 days thereafter. This will require a significant number of ongoing screenings, when less than 50 inmates throughout the entire system of Level 3 and 4 facilities have SMI – and none of those are currently confined to SHU.

Fiscal Impact of Proposed Changes

The proposed changes will result in a reduction in OMH spending of \$8.6 million in 2009-10, \$12.5 million in 2010-11 and \$15.6 million in 2011-12 – reflecting the need to hire 86 new staff to begin the clinical assessments at Level 3 and 4 facilities. Spending in DOCS would be reduced by \$10.5 million in 2009-10, \$15 million in 2010-11 and \$15.1 million in 2011-12, primarily attributable to staffing reductions of 388 positions. Of those 388 positions, 105 were funded in the 2008-09 Budget and hiring was recommended to be delayed as part of achieving the required 3.35 percent Financial Management Plan savings target. The remaining 283 staff were associated with the planned opening of additional RMHU capacity in 2009-10 -- intended to allow the State to make aggressive progress toward implementation of the SHU Exclusion Law.