

**Testimony by Jack Beck, Director, Prison Visiting Project,
The Correctional Association of New York
Before the Senate Standing Committee on Crime Victims, Crime and Corrections,
Senate Standing Committee on Mental Health and Developmental Disabilities, and
Senate Standing Committee on Health
March 17, 2009**

I am Jack Beck, Director of the Prison Visiting Project of the Correctional Association (CA), and I want to thank the Senate Committees for this opportunity to provide testimony about the SHU Exclusion Law and why, based upon our observations of the services provided to inmates with mental illness, full implementation of the Law should not be delayed or its rights limited. As many of you may know, the Correctional Association has statutory authority since 1846 to visit New York's prisons and to report to the legislature, other state policymakers and the public about conditions of confinement. Our access provides us with a unique opportunity to observe and document actual prison practices and to learn from inmates and staff what they believe to be the strengths and weaknesses of the prison operation. Overall, we believe that progress has been made to improve conditions for inmates with mental illness, but more needs to be done. Our findings clearly demonstrate that it is imperative that the SHU Exclusion Law be implemented as swiftly as possible and that its protections cover all inmates with serious mental illness (SMI).

I will be testifying about four issues: (1) why the protection of the Law is crucial to the wellbeing of inmates with mental illness and to the community; (2) why delay of the Law would be inappropriate, counterproductive and dangerous; (3) why it is important to apply the Law's protections inmates with SMI in Special Housing Units (SHUs) in prison designated as OMH level 3 and 4 prisons; and (4) why the executive's assertions of savings are exaggerated and illogical.

Throughout this testimony, I will be referring to the document, *Prison-Based Mental Health Services in New York, Rationale for Limited Delay of SHU Exclusion Law Requirements*, (hereinafter called the "Rationale Memorandum") as the articulation of the Executive's justification for delaying and amending the Law. We find the document grossly inadequate both in providing sufficient facts to support the claim for delay and in establishing a justification for the claim that significant saving would result from the proposed amendments.

SHU Exclusion Law is Necessary to Create Therapeutic Units to Adequately Treat Inmates with Serious Mental Illness

The fundamental objectives of the SHU Law are:

- (a) to remove inmates with serious mental illness from the extreme isolation and punitive environment of the SHUs, or the box as inmates and staff call these units, to a separate therapeutic environment called residential mental health treatment units (RMHTUs) that are not operated as disciplinary confinement housing areas;
- (b) to provide these inmates with adequate treatment on these therapeutic units including at least four hours of therapy conducted outside their cells;
- (c) to ensure through initial assessments and followup appointments that other SHU inmates who are not diagnosed with a serious mental illness are evaluated prior to placement in the SHU so that if their mental health status deteriorates in the box, these changes will be detected and they will be diverted to a residential mental health treatment program; and
- (d) to require that security staff in the RMHTUs are adequately trained so that they understand the illnesses, behaviors and treatments of inmates with mental illness and can appropriately respond to inmates' aberrant conduct consistent with the therapeutic mission of these units.

Each one of these components is crucial in order for the Department of Correctional Services (DOCS) and the Office of Mental Health (OMH) to meet the needs of inmates who have serious mental illness.

Inmates with SMI are Sent to the SHU Because They are Not Receiving Adequate Treatment in General Population in the State Prisons

The Rationale Memorandum illustrates that there are many more inmates with serious mental illness than there are residential mental health treatment program beds in the state prison system. With 8,659 inmates on the OMH caseload and 2,962 inmates with a diagnosis of serious mental illness, the demand for mental health services is great and ever increasing. Since 2003, the number of inmates on the OMH caseload has increased by 19%, even while the prison population has declined by about 8%. Despite these numbers, intense mental health therapy is mostly limited to the residential mental health units within the Department, the primary residential program being the Intermediate Care Programs (ICP) in the prisons. According to the Rationale Memorandum, as of March 31, 2010, there will only be 743 ICP beds, including 166 beds that are not yet operational. Adding the two other large residential treatment programs, the

Central New York Psychiatric Center (CNYPC) and the Transitional ICP with 209 and 217 beds, respectively, to the proposed ICP capacity, DOCS residential programs will only accommodate less than 40% of the inmates with SMI. Some of the other 5,697 inmates on the OMH caseload also have histories of significant mental health problems and may need a residential treatment program. In fact, some inmates not designated as an SMI case currently reside in a residential treatment program. Clearly, the 2009-10 expanded residential treatment programs cannot meet the demand within the prison population for these services. The vast majority of the other beds cited in the Rationale Memorandum as mental health treatment beds are not designed for, and do not confine, inmates with SMI; they simply cannot be counted as realistic alternatives for inmates requiring more intense mental health therapy. Given these statistics, it is obvious that most of the inmates with significant mental health needs are forced to live in general population.

Inmates with SMI and other inmates on the OMH caseload in general population get no group therapy and little one-on-one counseling; their therapy consists primarily of psychotropic medication and periodic meetings with OMH therapists. The security staff with whom they interact are not trained regarding the needs of individuals with mental health issues and often do not even know which inmates are diagnosed with significant mental health problems. If, due to their mental illness, these individuals act inappropriately or are disruptive with staff or other inmates, it is inevitable that they will receive a disciplinary infraction. This is the Department's response to almost any minor deviation of prison rules. The CA obtained disciplinary data from DOCS for the period January 2003 through August 2006, and during that time approximately 150,000 violations of prisons rules were issued each year resulting in a disciplinary sanction. Without adequate treatment and a prison staff that is instructed and trained to respond to aberrant conduct in a non-punitive manner, inmates suffering from mental illness will frequently be subjected to the disciplinary process. Although DOCS and OMH are making efforts to review disciplinary infractions of inmates with significant mental health problems, our observations and reports from inmates demonstrate that the SHU still remains the asylum of last resort for inmates with mental health needs who cannot conform to the rigid prison environment that is dominated by rules controlling all forms of behavior.

DOCS Has an Excessively Large SHU Population who are at Great Risk for Self-Harm

The Department has a very large SHU population with approximately 4,400 inmates confined in the nearly 5,000 SHU beds. New York has the highest percentage of inmates in disciplinary segregation in the country, representing 7.2% of its prison population. The national average for disciplinary confinement, as reported in *The Corrections Yearbook: Adult Corrections 2002*, was only 2.6%.

The risk of suicide and self-harm remains a major problem both for inmates in disciplinary confinement and for inmates who are mentally ill. The recent DOCS publication, *Inmate Suicide Report, 1998-2007*, notes that from 1998-2004, 34% of the suicides were in a SHU or disciplinary keeplock unit. Although the percentage declined to 18% for the period 2005-2007, this still represents a suicide rate that is more than twice the rate for general population inmates. The intersection of suicide and mental health is even more pronounced. Fifty-seven percent of DOCS suicide victims were classified as OMH level 1, 2 or 3 patients even though they represent only 15% of the prison population. Other acts of self-harm are also very prevalent in the prisons. In 2007, 88 unusual incident reports were filed in the prison system for instances of inmate self-harm and 57 reports were issued for attempted suicide. Of these, 10 self-harm incidents and 21 suicide attempts occurred in a special housing unit, representing 11% of the total self-harm reports and an astonishing 39% of suicide attempts in the Department. This latter figure is very disturbing and illustrates the dangers associated with disciplinary confinement and the need for suicide screening and continuous mental health monitoring of SHU inmates.

The CA has Observed and Documented the Suffering Experienced by Inmates with Serious Mental Illness and the Concentration of Inmates with SMI in Disciplinary Housing

In the CA reports, *Lockdown New York: Disciplinary Confinement in New York State Prisons*, published in 2003, and *Mental Health in the House of Corrections*, issued in 2004, we documented the terrible consequences for inmates with mental illness who are sent to the harsh isolation of the SHU—extremely high rates of suicide and self-harm, men who smeared themselves with feces or lit their cells on fire, individuals who were actively psychotic, manic, paranoid or seemingly overmedicated, extremely long disciplinary sentences that ranged up to 12 years in the box, and an overwhelming sense of isolation and sensory deprivation resulting in

depression and withdrawal even for those inmates without mental health problems prior to entering the SHU. We observed that inmates with mental illness represented almost one-fifth of the disciplinary population and many of these individuals had excessively long SHU sentences. Of the 162 SHU inmates on the mental health caseload we interviewed for those reports, the median SHU sentence was two years, one-third had been put on restrictive diets while in SHU, nearly half reported that they never or rarely went outside their cells even for recreation and over half reported that they had attempted suicide at least once while incarcerated. The pain and despair these individuals had experienced was obvious and overwhelming.

Subsequent to these reports, the CA has continued to monitor conditions in the SHU and to assess the new treatment programs developed by DOCS and OMH to deal with this population. The number of inmates with mental illness in the SHU has remained very high and inmates with mental illness are consistently overrepresented in the box and suffer serious harm as a result. Between December 2004 and November 2008, the CA visited nine OMH level 1 or 2 maximum security prisons with SHUs. These prisons contained 546 SHU cells and housed 515 inmates. At all of these prisons, nearly 50% of SHU inmates were on the OMH caseload.

Several of these prisons had very high numbers of SHU inmates requiring hospitalization in an OMH facility or transfer to a Residential Crisis Treatment Program (RCTP) due to mental deterioration. When we visited SHUs at Auburn and Elmira in 2004, we found that SHU inmates were 20 to 30 times more likely to require OMH hospitalization than general population inmates. During our recent visit to Five Points, we again found that more mental health crisis interventions occurred among SHU population than in the general prison population.

Sending inmates with SMI to the SHU and keeping them there for extended SHU sentences is also counterproductive for their long-term health and the prison system. We often encounter individuals with mental illness who have cycled from the box to Central New York Psychiatric Center (CNYPC) and back to the box, where their mental conditions deteriorate and the process is repeated over and over again. For example, we interviewed a man in Attica's Special Treatment Program (STP) in its SHU who reported that he had been to CNYPC 20 times during the eight years he had been in the SHU; his arms were scarred from numerous acts of self-injury and he was facing several more years of box time before he could return to general population. Clearly disciplinary confinement was not deterring his impulsive and self-destructive behavior. Recently, we met an inmate in the Five Points STP who had a 15-year

SHU sentence as a result of numerous disciplinary infractions. He had been in the SHU since 2002, had been to CNYPC approximately 20 times during his incarceration, including multiple times since being in the SHU, and now had been in the STP program for four years.

We documented in *Mental Health in the House of Corrections* that inmates with mental health problems spend extremely long times in the box, longer than the average SHU inmate. Because of their disciplinary record, these individuals generally are not granted parole or any form of early release, and therefore, remain longer in prison at greater expense to the state. Moreover, when they are released, they are going from the very restrictive and unnatural setting of SHU out to society where they are ill-equipped to deal with the challenges of ordinary living. Many are unable to cope with the numerous barriers of finding housing, a job, and appropriate health services, and end up returning to prison. This unfortunate scenario serves no one. The inmates suffer greatly from cycling through the SHU and crisis mental health interventions in the prisons, the prison staff repeatedly have to deal with their aberrant behavior as their mental health conditions deteriorates in the box, and the public is forced to pay for costly confinement that is not addressing these individuals' needs. Appropriate treatment that improves and maintains the patient's mental health status so that he/she can function in a non-disciplinary environment in prison will reduce the number of disruptive incidents in the prison, will better prepare the inmate for reentry to society, will result in release sooner from prison and will ultimately save the taxpayers money.

Inmates with SMI Respond to Intense Treatment but Need a Supportive Therapeutic Environment to Break the Pattern of Disruptive Behavior and Additional Prison Disciplinary Sanctions

The CA visited the Behavioral Health Units (BHU) at Great Meadow and Sullivan in 2006, and while we observed favorable aspects of the treatment program, we also found some disturbing evidence that a more therapeutic environment was needed. Great Meadow's BHU is the first phase of the BHU program and has a capacity for 38 inmates who receive two-hour group therapy sessions each weekday in a room with small cages in which each patient is confined for the entire treatment session. During our visit to this BHU, 83% of the residents responding to our survey rated mental health care as good or fair, and only 17% said it was poor. The inmates we interviewed seemed stable and more engaged than inmates in a typical SHU. We observed, however, that the relationship with the security staff was problematic, with 40% of

survey participants reporting relations with the officers as bad. Prior to placement in the BHU, these inmates had long and difficult SHU experiences. The median SHU sentence for these inmates was three years and half had been put on restrictive diets while in the box. Although the rate of disciplinary infractions for these inmates was reduced once in the BHU, half still received serious disciplinary infractions in the BHU and most did not go to recreation in part due to concerns about interacting with security staff. Moreover, many of these inmates were not progressing through the BHU program. A copy of our report on Great Meadow is attached.

At Sullivan's BHU, Phases Two and Three of the BHU are conducted and the unit has a capacity to serve 36 inmates in Phase Two and 24 in Phase Three. After an initial orientation period, Sullivan BHU inmates are given four hours of therapy in a classroom setting and their treatment is not restricted to the cages employed at Great Meadow. The Sullivan inmates responding to our survey had an even more favorable view of the mental health services than the Great Meadow BHU inmates, with 27% of Sullivan's BHU survey participants rating mental health services as good, 67% reporting them as fair and only one inmate saying they were poor. Clearly the patients we spoke with felt that they were benefiting from the therapy they were receiving. Although the view of security staff was also more positive at Sullivan than at Great Meadow, more than one-quarter of the survey respondents said relations with security personnel were poor. We also found that there was still a high incidence of additional disciplinary sanctions occurring on the unit, with half of the survey respondents receiving serious disciplinary sanctions while in the BHU. It was troubling to learn that there were more inmates who had their BHU phase lowered or had been removed from the program than inmates who had progressed. A copy of the Sullivan report is also attached.

These observations support the conclusion that treatment of SHU inmates with serious mental illness can be effective for both inmates and staff, but that it is very difficult to escape the entrenched practices of DOCS security staff to respond to aberrant behavior in a punitive manner. Moreover, we did not observe in 2006 that BHU inmates being release from disciplinary confinement went back to the general prison population. Although we believe this situation has somewhat improved, DOCS is very slow to reduce the level of restrictions placed on these inmates, and they frequently spend years in a disciplinary setting.

Special Treatment Programs (STP) for Inmates with SMI Confined in DOCS SHUs

In November 2008, the CA visited the STP at Five Points, where we spoke with OMH staff, interviewed 34 of the 43 inmates in Five Points' STP and received detailed surveys from 16 STP inmates. The Five Points STP program initially had a capacity of 25, but was increased to 50 in 2008. During the years 2006, 2007 and 2008 (thorough mid-November) 23, 42 and 55 inmates, respectively, were admitted to the program and 9, 26 and 18 were discharged. As with all STP programs, SHU inmates with SMI were housed in a SHU disciplinary unit, but each weekday were escorted to a group treatment room for approximately two hours, where up to five STP inmates were placed in small individual therapy cages, about the size of a phone booth, to speak with a group therapist or observe videos.

We talked to STP inmates in these small cages and obtained information about their situation. The population we observed appeared stable and coherent. We confirmed that group therapy was conducted five days a week for about two hours a day. We were pleased to learn that few inmates were going back to a regular SHU from this STP and most were not having problems getting the psychotropic medication. We were impressed that during the last three years, six STP inmates per year were sent to the ICP and in 2008, 13 STP residents had returned to the general population. We also have many concerns about the program.

(a) STP inmates had very long SHU sentences; the median SHU sentence for survey participants was two years, but over 40% of the STP inmates we interviewed had SHU sentences from 4 to 15 years. Forty percent of these inmates had already been in the SHU for more than three years at the time of our visit. This data shows that DOCS is still placing inmates with SMI in the box for extended periods of time and that many of these inmates have excessively long SHU sentences.

(b) Forty-four percent of the interviewed STP inmates had been to Central New York Psychiatric Center (CNYPC) during their current incarceration and 25% had been to CNYPC since they had been in the SHU. Even more prevalent was the need for crisis intervention for these inmates due to mental deterioration; 80% of STP inmates had been placed in a prison Residential Crisis Treatment Program (RCTP) for observation and evaluation and many had been to an RCTP 8 to 20 times. Overall, for the nearly three year period January 2006 through early November 2008, there were 128 admissions from the STP to the RCTP, four times the rate of admissions to RCTP from the prison's Intermediate Care Program.

(c) Sixty percent of our survey respondents reported that they had attempted to harm themselves since they were in the SHU, but only two said they had tried to hurt themselves since being in the STP.

(d) Some STP inmates spent a very long period of time in the STP program before they are transferred to a less restrictive setting. We interviewed several inmates who had been in the Five Points STP program for two to four years, receiving therapy in these small cages.

(e) More than one-third of the survey respondents had received disciplinary tickets while in the program and several had received additional SHU time of one to three years. For the nearly three year period January 2006 through early November 2008, 81 major disciplinary actions (Tier III disciplinary tickets) had been taken against STP inmates, for an entire STP population of 121 STP residents during this time period.

(f) Although 44% of the survey participants had reported some SHU time cuts, the median reduction in their SHU sentence was only a few months.

(g) There was very little one-on-one therapy; most inmates said they saw a therapist once or twice a month for an average of 10-15 minutes.

(h) Of the STP survey participants, 19% rated the mental health services as good, 38% rated them as fair and 44% rated them as poor. These survey respondents also assessed their relations with security staff; 44% said this relationship was very or somewhat bad, 43% said it was equally good and bad and 14% reported the relationship as somewhat or very good.

Overall, this data illustrated that: (1) STP provides significant group therapy, but very little one-on-one therapy; (2) many inmates enter the STP program only after receiving extensive SHU sentences; (3) some inmates spend a long time in this program before being transferred to less restrictive environments that does not entail 22-hour confinement to a cell or cage; (4) additional disciplinary actions against inmates in STP are very common; and (5) reductions in SHU sentences, although common, generally involved limited meaningful reductions in SHU sentences.

Based upon our observations during the last four years and the data provided by DOCS and OMH, it is clear that to enhance the therapy provided to SHU inmates with SMI, and to reduce the need for crisis interventions and incidents of self-harm, these patients must be treated in a more therapeutic environment. The therapeutic environment must first rely on treatment rather than punishment to modify uncooperative or even disruptive behavior. Moreover, educating security staff about the special needs of this population and developing protocols that

they can use to address unacceptable behavior without imposing more disciplinary sanctions is crucial. While DOCS and OMH are attempting to do this, more progress is needed to reverse the trend of mounting SHU sentences for these inmates.

Delay of the SHU Exclusion Bill Is Inappropriate and Will Result in Unnecessary Suffering

The Governor's budget asks the legislature to delay implementation of the SHU Exclusion Law for an additional three years until 2014. This is outrageous, both because inmates with SMI will continue to suffer in SHUs during such a delay and because there is no persuasive reason to allow such harm to occur.

The SHU Law is currently scheduled for full implementation by July 2011, more than two years from now. In the interim, the DAI Settlement establishes the operative criteria for treatment of SHU inmates, significantly advancing the practices in the SHUs in the 1990s and early 2000s when almost no SHU residents were receiving consistent mental health services. The DAI Settlement requires that SHU inmates with serious mental illness (SMI) who will be in the SHU more than 30 days must get at least two hours of therapy five days per week. This has resulted in a significant increase in the number of SHU inmates with SMI receiving treatment; many of the SHU inmates with SMI were not receiving daily mental health care even at the time of the settlement in March 2007. However, this enhanced therapy is provided within the SHU and therefore, for the remaining 22 hours of the day, SHU inmates with SMI experience the oppressive environment and rules controlling these disciplinary units.

In contrast, the SHU Exclusion Law requires that SHU inmates with SMI be transferred to a residential mental health treatment unit (RMHTU) that is not a disciplinary area and mandates that RMHTU patients receive at least four hours of out-of-cell therapy. The Law requires that decisions about treatment and conditions of confinement on these RMHTUs be based upon a clinical assessment of the therapeutic needs of the inmate and the maintenance of adequate safety and security of the unit.

Our visits to SHUs with STPs reinforce our conclusion that the provisions of the Law that go beyond the relief mandated by the DAI Settlement are necessary and should not be delayed. The SHU Exclusion Law can improve the current situation by expanding the opportunities for therapy, reducing the restrictions on these patients' ability to participate in meaningful activities

in addition to therapy, and changing the oppressive disciplinary nature of current SHU confinement, replacing it with a more therapeutic milieu.

The Agencies Have Failed to Quantify the Need for Additional RMHTUs to Support Delay

The agencies urge the Legislature to delay the SHU Exclusion Law because they want to avoid the costly and time-consuming construction of some unspecified number of RMHTUs at this time given the fiscal crisis, and they need to assess the operation of the Marcy Residential Mental Health Unit (RMHU) to determine how to treat the remaining inmates with SMI. This argument assumes, without any data provided by the agencies, that many more RMHTUs are needed. Seriously undermining that assumption, however, is the agencies' presentation of the current demand for treatment slots for SHU inmates with SMI.

The agencies have been closely monitoring the number of SHU inmates with SMI, as the Rationale Memorandum details. It reports that there were 237 SHU inmates with SMI as of the end of 2008, a number it asserts has declined further during 2009. Given this census, it is unclear how many additional RMHTUs will be needed by 2011. Once the Marcy RMHU is opened, and including the BHUs and the Intensive ICP at Wende, DOCS will have 240 beds that would meet the Law's requirement for RMHTUs. This is greater than current demand.

We believe that by July 2011, the number of SHU inmates with SMI may be greater than it is today because of: (a) improved OMH assessments of newly admitted inmates and of SHU inmates with mental illnesses will likely identify more inmates with SMI in the prison system who may be sentenced to SHU time; and (b) the number of SHU inmates with SMI in the RMHTUs may be transferred out of these programs at a slower rate than the admission rate to SHU for other inmates with SMI. Other factors, however, such as reduced SHU sentences, diversion of inmates with SMI from any disciplinary sanction and the transfer of RMHTU patients to non-disciplinary status could reduce the demand for RMHTU beds. The crucial point is that the agencies are the only entities that have sufficient data at this time to assess these issues and other factors that could influence the future demand for additional RMHTU. At a minimum, they have an obligation to present their analysis of demand before they can request that the Law be delayed. Their failure to do so should justify a rejection of their request.

The Delayed Opening of the Marcy RMHU Does Not Justify Delaying the Law

The Rationale Memorandum asserts that the agencies must have an opportunity to open the Marcy RMHU and operate it for some unspecified period of time after which the agencies can assess the effectiveness of the RMHU program and determine: what type of additional treatment programs for SHU inmates with SMI should be provided; whether DOCS needs more RMHTUs; and if so, how many new beds will be necessary. This argument is faulty for several reasons.

First, the agencies have operated mental treatment programs for SHU inmates for almost a decade and have treated hundreds of patients during these years. The STP at Attica has existed since 1999, the Five Points STP opened in 2002 and expanded in 2008, the Behavioral Health Units (BHUs) at Great Meadow and Sullivan have operated for at least four years and the Group Treatment Program (GTP) has existed for three years. The Intensive ICP, established at Wende in October 2007, developed additional treatment modules for inmates with SMI. Each of these programs has an operations manual describing the treatment modalities and every program has some form of quality improvement mechanism to assess program compliance and effectiveness. It is not credible to assert that now, after all of these efforts, DOCS and OMH do not have a clear picture of the treatment plan they will use to address the mental health needs of this population. Moreover, if additional efforts are needed to refine the treatment model, they have more than two years to develop an updated program.

Second, there is sufficient time to incorporate any program modifications resulting from an evaluation of the Marcy RMHU, which opens 21 months before the SHU Exclusion Law takes effect. Moreover, the agencies have delayed the opening of the RMHU for many months, and they should not be encouraged to continue that delay by being given even more time to decide how to address the pressing needs of SHU inmates with SMI. This problem has been litigated and studied for years, and prompt remedial action is required now, not five years from now.

Third, the need for additional RMHU beds is a function of the number of inmates with SMI in the system and should not be significantly impacted by the Marcy RMHU, which may influence program curriculum but not its capacity. The demand for RMHTUs will primarily be driven by the number of inmates with SMI sent to the SHU. The agencies have failed to articulate any rationale for how the Marcy RMHU will impact on the need for additional beds.

New Construction is Not Necessarily Required to Establish Additional RMHTUs

The Rationale Memorandum also assumes without explaining that the creation of additional RMHTUs will require costly construction of new facilities in DOCS' prison system. This assumption should not be accepted without a comprehensive, detailed explanation by the agencies of their criteria for assessing existing space for the program, how they reviewed current facilities and why no existing space is appropriate. The law defining a RMHTU addresses the program's content and does specify any physical space requirements or mandate any construction to occur. It is reasonable to assume that RMHTU inmates will be confined in cells and then go to treatment program space near their housing area. The treatment area will likely consist of small classrooms and some individual treatment rooms. At present, there are more than 600 SHU beds that are not in use. More importantly, there are more than 19,000 cells in OMH level 1 maximum security prisons and an additional 2,800 cells in OMH level 2 maximum security prisons that could be used for a RMHTU. Although not all housing units in a maximum security prison could be used for these units, it defies logic to say that there are no units that could be modified to create a secure housing area and some treatment space. It is reasonable to assume that the most construction necessary to create a new RMHTU would be some additional treatment areas adjacent to existing cell areas; but this would entail expenditures that are significantly less than what the Rationale Memorandum suggests.

Given the current demands for RMHTU program beds, it would be reasonable to assume that only a limited number of additional beds are necessary to meet demand in the next two years. We believe one or two moderate sized RMHTUs, on the order of 30 to 60 beds, could be developed within existing prison structures. In addition, as the Department downsizes prison space, additional empty housing areas could become available and, consequently, open cell space for an RMHTU. Given the fiscal crisis, creative use of existing space would seem to be the more responsible approach to adding needed program services, rather than denying this vulnerable group essential care simply because an elaborate construction plan is not feasible in the current budget cycle.

There is No Justification for Denying Care to Inmates with SMI in the SHUs in OMH level 3 and 4 Prisons or for Curtailing Mental Health Assessments on these Units

The Executive's proposal would restrict the application of the SHU Exclusion Law to only inmates with SMI who are confined in a SHU in an OMH level 1 or 2 prison. The amendments would eliminate both the right of inmates with SMI to be transferred to a RMHTU and the rights of all inmates in SHUs in OMH level 3 and 4 facilities to receive an initial mental health assessment and followup appointments or assessments. Both restrictions are inappropriate and the rationales for the amendments are specious.

There is no justification for the proposition that an inmate with SMI who meets the criteria for treatment under the Law while in a SHU in an OMH level 3 or 4 facility should not be transferred to a RMHTU. The need for treatment is based upon an inmate's mental status, not where that individual is housed. The Rationale Memorandum suggests that inmates with SMI generally are not in these prisons, although the document admits that some inmates with SMI are housed in general population at these prisons. But once a SHU inmate with SMI is identified he/she needs care as much as any SHU inmate with SMI in a level 1 or 2 prison. This aspect of the amendment is illogical and must be rejected.

Eliminating the application of the Law to assessments of inmates in SHUs in OMH level 3 and 4 prisons would also significantly reduce the scope of the Law. Although exact data on the number of SHU beds in these prisons is not available, we have identified at least 2,887 SHU beds in OMH Level 3 and 4 prisons of the 4,997 SHU beds in the system, representing 58% percent of the total SHU capacity.

Equally important, many of these SHU beds are in long-term SHU facilities. Six of the eight 200-bed S-Blocks are in OMH level 3 and 4 prisons and Upstate Correctional Facility, an OMH level 3 prison that is the largest SHU in the state, has 1,200 disciplinary beds. Combined, these seven prisons can house 2,400 SHU inmates, nearly half of the SHU population. The S-Blocks and Upstate were specifically designed (1) to house disciplinary inmates in the most secure areas in the system with improved surveillance, and (2) to minimize the circumstances when SHU inmates are out of their cells, thereby reducing contact with staff and other inmates and the opportunity for staff-inmate or inmate-inmate confrontation. Because of these attributes, DOCS uses these facilities to house inmates with more aberrant behaviors with longer SHU sentences. SHU inmates from many other prisons who receive longer box time are sent to these

units to serve their SHU sentence. Inmates can spend many months to more than a year at these facilities and generally will have been in the box weeks or even months before they get to an S-Block or Upstate. At Upstate, 323 of its 1,303 inmates, representing 25% of its population, were at the prison more than one year and 148 inmates were there for more than two years. When we visited Upstate in 2006, we obtained surveys from 98 residents; 28% of those inmates had been at Upstate for more than a year, 8 inmates had been there for more than three years. When we visited Lakeview's S-Block in 2007, the median SHU sentence for the inmates we surveyed was 12 months, and 15% had SHU sentences of three to seven years.

The Rationale Memorandum argues that the protections of the SHU Exclusion Law are not necessary for OMH level 3 and 4 prisons because inmates with SMI are not sent to SHUs in these facilities. This is not true, but more importantly, ignores the essential facts that (1) inmates' mental health status frequently deteriorate once they are placed in the stressful environment of the SHU; (2) an SMI designation is a reflection of current functioning not an indication of a diagnosis or history of mental illness; and (3) inmates' mental health status are not regularly monitored in general population and therefore, without a prompt assessment upon placement in the box as required by the Law, inmates with serious mental illness could be sent to a SHU in OMH level 3 and 4 facilities even though they currently are exhibiting symptoms of an SMI.

Based upon our visits to several OMH level 3 and 4 SHUs, it is clear that many inmates with mental illness are placed in these units and some experience significant adverse consequences as a result of their mental health status. A few examples demonstrate that the Law's protections must be extended to these prisons:

(a) During our visit to Upstate in 2006, we learned that of the 918 inmates in disciplinary segregation, 89 (almost 10%) were on the OMH caseload. Of the 98 inmates we surveyed, over one-third reported that they had been on the OMH caseload at some point during their incarceration, indicating, as we find throughout the state, that individuals in disciplinary segregation suffer disproportionately from mental health problems. Moreover, in 2005, 38 of Upstate's SHU inmates were transferred to an RCTP and two were transferred to CNYPC for treatment for severe psychiatric distress. Additionally, over 80% of the survey respondents told us that self-harm or suicide attempts occur at the prison, and over one-third reported that such occurrences are frequent.

(b) We visited Gouverneur's S-Block in 2008 where 45 of the 197 residents, representing 23% of the SHU population, were on the OMH caseload. Of the S-Block

inmates we surveyed, one-third stated that they had received or been recommended for mental health services while incarcerated, and 68% rated mental health services as poor, and only 4% rated the services as good. During the period 2005 through 2007 there were 104 admissions to a RCTP from this S-Block, a rate that is almost four times higher than the RCTP admission rate for general population inmates at the prison.

(c) We visited Greene's S-Block in 2008 and obtained surveys from its residents. Thirty-three of its 174 residents, representing 19% of the S-Block population, were on the OMH caseload. Thirty-eight percent of the S-Block inmates who participated in our survey said they had received or been recommended for mental health services while incarcerated. In 2006 and 2007, 35 Greene S-Block inmates had been sent to a RCTP, an admission rate that was 17 times higher than the admission rate for the prison's general population.

It would be unconscionable to declare a majority of the SHUs exempt from the Law and to withdraw all protections for a large SHU population that needs mental health services unless the agencies can provide a compelling reason to do. The Rationale Memorandum fails to meet this burden and simply relies on the asserting that no harm will occur. Our experiences in these facilities demonstrate just the opposite and illustrate the need for the Law at these facilities.

The Agencies' Assertion that Delay of the SHU Exclusion Law Will Result in Significant Savings This Fiscal Year is Unsupported and Presents Staffing Data that Grossly Exaggerate the Need for Staff Increases

The Rationale Memorandum asserts that DOCS could save \$10.5 million in Fiscal Year 2009-10 by eliminating 388 positions and OMH could save \$8.6 million by not hiring 86 staff to perform assessments in OMH level 3 and 4 prisons. The agencies provide no additional data to support these savings and fail to articulate what these staff will be doing, where they will be deployed and for what specific programs. A simple analysis of the agencies' proposal, however, shows that these figures grossly exaggerate the number of new positions needed to serve inmates with SMI under the Law.

The most obvious deficiency in the agencies' assertion is that they are proposing a massive staffing increase even though the Law does not take effect until more than two years from now. They provide no explanation of why security staff should be hired now for a program that will not be fully operational until so far in the future. Even if implementation would be phased in, this surely would not occur until the next fiscal year, which ends well before the July 2011 deadline for full implementation. Given the anticipated reduction in the prison

population, there would seem to be many qualified staff that could be shifted to these projects in the next fiscal year if some additional staff is needed. Clearly no DOCS hiring is mandated now.

Concerning the hiring of new OMH staff, it has been suggested that OMH has had some difficulty recruiting professional staff to work in the prisons. Even if this is true, hiring staff now, 27 months before full implementation is not reasonable.

Finally, if some additional staff is needed to implement the Law, the numbers proposed by the two agencies seem well beyond any reasonable projection of need. DOCS states that implementation of the Law requires hiring 388 additional employees. The Department has failed to say where these individuals will work and to what mental health program they will be assigned, making it impossible to analyze specific staffing needs. But under any reasonable assessment of the projected need for additional RMHTU beds, this staff estimate is grossly exaggerated. In the current fiscal year, the Rationale Memorandum states that 266 new mental health service beds will be opened. For these beds, the Department will hire 115 additional DOCS employees. If the future additions had a DOCS staffing ratios at a rate similar to that used for the 2009-10 additional mental health beds, the 388 additional staff would mean that DOCS would be adding approximately 900 beds for the Law. This is ridiculous. Even if the staff ratio for the RMHTU was double the rate needed for the 266 treatment beds scheduled in 2009-10, that would still mean that 450 additional beds would be added in 2009-10; this clearly is not going to occur. There is no projection of need that approaches numbers such as these. Without presenting a clear picture of what additional RMHTU beds are needed, DOCS projections of new hires must be rejected.

The estimate that 86 new OMH staff positions are needed to perform assessments in the OMH level 3 and 4 SHUs is also flawed. Again, the agency has failed to say where these individuals will be assigned, how many additional assessments are needed, and how many assessments each employee can perform during the normal course of his/her duties. On its face, these numbers seem grossly exaggerated. At present, it is OMH's policy that any inmate admitted to a SHU will be assessed within 30 days. The Law has moved the time period for an initial assessment to 14 days for OMH level 3 and 4 facilities, but this means that the only additional initial assessments that will occur will be for individuals who would be leaving the SHU before the 30-day assessment currently employed. Given the mean SHU sentence is 124 days for a single infraction and there are few SHU sentences that are shorter than 30 days (in

contrast to keeplock sanctions which are shorter and generally do not trigger the Law), we believe any additional assessments under the Law would not entail substantially more work for OMH staff if they are currently complying with their own regulations.

A second requirement of the Law dealing with assessments is that if an inmate in the SHU in an OMH level 3 or 4 prison determined during an initial assessment to not meet the criteria for an SMI designation, they have a right to request an interview with OMH staff thirty days after the initial assessment and then every 90 days thereafter. Note that the Law does not mandate re-assessments for all SHU inmates, it only permits an inmate to request an interview. At present, inmates in the SHU can ask to see a mental health person, and it is our understanding that they will be seen. The Law only mandates that they have to be seen at least on this 30- and 90-day schedule if requested by the inmate. It is unclear how many additional interviews will be required by the Law, but the difference between the number of mandated interviews required by the Law compared to the number of OMH interviews currently conducted as a result of SHU inmate requests or scheduled OMH treatment sessions would seem to be small. Certainly it cannot justify a large infusion of staff without extensive analysis and justification. No projections of additional initial assessments and followup interviews have been made by the agencies and consequently, their assertion that a large number of additional staff should be hired now for an obligation that will not start for 27 months seems ludicrous.

Conclusion

The state has taken steps to improve the treatment provided inmates with mental illness primarily in response to litigation brought on behalf of these patients, pressures from prison and mental health advocates and, most importantly, action by the legislature. But more needs to be done as inmates with serious mental illness continue to cycle between the SHU and crisis treatment as their mental health status inevitably deteriorates in the box's oppressive environment. The SHU Exclusion Law mandates the next steps that must be taken to ensure that this needless suffering ends for this most vulnerable population. It would be tragic to retreat from our advancements and return to the days when these patients were effectively tortured by isolation, sensory deprivation and mental deterioration. The Law makes clear what needs to be done, and we ask the legislature to remain resolute in making the state a leader in the care of inmates with serious mental illness by not delaying the Law's implementation.