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The Correctional Association of New York
Before the Hearing of the Assembly's Corrections and Mental Health Committees
Mental Health Services in NY Prisons – November 13, 2014

EXECUTIVE SUMMARY

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

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

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

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

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

The Torture of Solitary Confinement. The torture of solitary or isolated confinement can exacerbate pre-existing mental illness and create new mental health challenges for any person. Yet, six years after passage and three years after full implementation of the SHU Exclusion Law, each day around 3,800 people, including 650-700 people on the OMH caseload and disproportionately people of color, continue to remain in Special Housing Units (SHU). People in isolated confinement in New York prisons in SHU or keeplock spend 22 to 24 hours per day locked in a cell, with generally no meaningful human interaction, programs, jobs, therapy, group interactions, or even the ability to make phone calls. The sensory deprivation, lack of normal human interaction, and extreme idleness have long been proven to lead to intense suffering and physical and psychological damage for any person. A recent study found that people in solitary confinement were seven times more likely to harm themselves and more than six times more likely to commit potentially fatal self-harm. The United Nations Special Rapporteur on Torture has concluded that isolated confinement beyond 15 days amounts to cruel, inhuman, or degrading treatment, or torture. Yet, each year DOCCS imposes an average of more than 10,000 individual SHU sentences, nearly 8,000 of which are for three months or more and nearly 3,900 SHU sentences of six months or more. Moreover, because people often accumulate additional SHU time while in isolation, people regularly spend years in isolation, some people have been in solitary confinement in New York for more than two decades.

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

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

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

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

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

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

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

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

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

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

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

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