URBAN JUSTICE CENTER | Mental Health Project

PUBLIC COMMENTS ON PROPOSED SOLITARY CONFINEMENT REGULATIONS

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BY EMAIL

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Re: Proposed Rule Making on Special Housing Units, I.D. No. CCS-35-19-0001-P

The Urban Justice Center Mental Health Project strongly supports ending the torture of solitary confinement in local and state correctional facilities. Solitary confinement is detrimental to the health and well-being of those subjected to it. People with existing mental health concerns are particularly vulnerable to the harm of isolation and should be excluded from placement in solitary confinement entirely. Solitary confinement should certainly not be routine punishment for incarcerated individuals and, in no circumstances, should a person be isolated for more than 15 days. Solitary confinement that extends beyond 15 days constitutes torture and is therefore prohibited by the Standard Minimum Rules for the Treatment of Prisoners (known as the Mandela Rules), which the United Nations – with the support of the United States – adopted in 2015. The Department of Corrections and Community Supervision (DOCCS) should come into compliance with the Mandela Rules immediately.

The proposed rule published in the NYS Register on August 28, 2019, unfortunately not only fails to establish regulations that accord with international standards but also falls far short of bringing about the change that New Yorkers are demanding of the prison system. The Humane Alternatives to Long-Term Solitary Confinement Act (HALT Act) (S.1623/A.2500), which has the support of a majority of State Senators and Assembly Members, establishes meaningful restrictions on the use of isolation and promotes alternative ways of addressing problematic behavior. Although the proposed rule includes some provisions of the HALT Act, it leaves out critical requirements for replacing the current punishment paradigm with rehabilitative alternatives and permits the use of prolonged solitary confinement to continue. We encourage DOCCS to adopt regulations that include all aspects of the HALT Act:

- A total and absolute limit for all people on any and all forms of solitary (regardless of its name or location) of no more than 15 consecutive days and 20 days total in any 60-day period;
- Restricted criteria for who can be placed in solitary and alternative units;
- More humane and effective alternatives that actually provide for meaningful human engagement and congregate programming with at least seven hours out of cell every day and not restrictive units that are effectively solitary by another name;
- A complete ban on solitary for people with mental health needs, people aged 21 and younger or 55 and older, people with disabilities, and others, including a provision that all existing residential mental health treatment units have conditions at least as protective as the residential rehabilitation unit in the HALT Act;
- Clear, specific, and attainable mechanisms and time limits for release from all alternatives to solitary, including an absolute one-year limit except in extreme circumstances;
- Protective custody units that do not isolate individuals in solitary confinement but provide conditions at least as protective as alternatives to solitary; and
- Protection of incarcerated individuals' basic needs, training requirements, procedural protections, increased transparency, and outside independent oversight.

The Urban Justice Center Mental Health Project has advocated for people with mental health concerns involved in the criminal legal system for 20 years. We are deeply familiar with the difficulties people with mental health concerns have within correctional facilities and in accessing essential mental health services, housing, and benefits upon release. We represent the *Brad H.* Class, all incarcerated individuals who receive mental health treatment while in New York City jails. As Class Counsel, we conduct each week approximately 35 to 40 interviews of incarcerated individuals who have mental health concerns. We are extremely concerned that the jail environment, especially placement in solitary confinement, harms these individuals not only while they are incarcerated but after their release.

We have been involved in efforts to restrict the use of solitary confinement in New York State prisons and in New York City jails for the last 17 years. As a member of the Mental Health Alternatives to Solitary Coalition (MHASC), we advocated for legislation to end the placement of people with mental health concerns in solitary confinement in NYS prisons. The SHU Exclusion Law, which was enacted as a result of that advocacy, has been in effect for eight years. Despite the law, people with serious mental illness continue to be subjected to solitary for up to 30 days, and in some instances much more, and even those who are removed to residential mental health treatment units (RMHTUs) do not receive the therapeutic interventions that they require. In the last two years, MHASC has met with DOCCS and the NYS Office of Mental Health as well as the Governor's office about the serious inadequacies in the treatment of people with mental health concerns in DOCCS custody. We are deeply troubled that the proposed regulations do not expand protections for people with mental health concerns, provide for improving the operation of the RMHTUs, or adequately address the use of exceptional circumstances. (MHASC's summary of Mental Health Care Challenges in New York State Prisons, which was provided to the Governor's office in December 2018, is enclosed.)

Specifically,

- **The proposed rule does not exclude from segregated confinement all incarcerated people with disabilities.** Instead, the disability must impair "the individual's ability to provide self-care within the environment of a correctional facility." Most people with mental disabilities do not meet this standard. In fact, this criterion for exclusion for segregated confinement is *more* restrictive than the definition of "serious mental illness" in the SHU Exclusion Law.[1] This means the more than 800 incarcerated individuals on the mental health caseload will continue to be subjected to the harms of isolation without any greater protection despite their mental health needs.
- **The rule does nothing to improve conditions in RMHTUs to make them more therapeutic.** In fact, under these regulations, individuals with serious mental illness incarcerated in the behavioral health unit (BHU) will receive much less time out of cell than individuals placed in residential rehabilitation units. In the BHU individuals are offered only two hours a day of structured out-of-cell therapeutic programming and/or mental health treatment, except on weekends or holidays, in addition to exercise. The residential rehabilitation units provide for "at least five hours of out-of-cell programming, activities, or recreation five days per week, excluding holidays, and at least two hours of recreation on the remaining days." Additional recreation on weekends is not required in any of the RMHTUs.
- **The rule includes no provisions to address the fact that the RMHTUs currently do not function as therapeutic units.** The residential mental health unit, therapeutic behavioral health unit, and the BHU have some of the highest rates of disciplinary tickets despite the statutory requirement that individuals in those units not be sanctioned with segregated confinement absent exceptional circumstances. The proposed regulations should provide guidance in determining "exceptional circumstances" so that eligible incarcerated individuals are allowed placement and programming in these units and can remain free from excessive discipline while there. "Exceptional circumstances" should be reserved for the most egregious and exceptional behavior and should not include violent conduct that occurs inside a person's cell, such as a cell extraction, or any other conduct that though offensive is strongly associated with mental illness.

Solitary confinement harms the mental health of *all* people. We support the HALT Act as a comprehensive approach to significantly reducing its use and creating humane alternatives to address harmful behavior and promote safety in jails and prisons. The proposed rule does not provide the necessary changes to end the torture of solitary confinement and create meaningful alternatives that foster rehabilitation.

1) **The rule does not end prolonged solitary confinement and unnecessarily delays introducing any time limits on its use.**

The proposed rule does not place any time limit on one's placement in segregated confinement, administrative segregation, protective custody, or keeplock status in a special housing unit until October 1, 2021, and only reaches the 30-day limit on October 1, 2022. There is no limit

[1] NY Corr. Law § 137(6)(e).

whatsoever on the amount of time that an individual can be placed in keeplock confinement in general population. Given that anything longer than 15 days amounts to torture, DOCCS should not permit any form of isolation beyond 15 days.

Even once the time limits provided in § 301.1 become effective, there is no guarantee that individuals released from solitary after 30 days will not be sent back to solitary within a day or two because there is no cap on the total amount of time one can spend in solitary in any given period. Without such a cap, incarcerated individuals can cycle in and out of solitary repeatedly.

The HALT Act not only includes a prohibition on holding a person in segregated confinement for more than 15 consecutive days; it also limits placement in segregation to 20 days total in a 60-day period. Once enacted, the law takes effect one year later – a much shorter implementation period than the timeframe set forth in the proposed rule.

2) The rule does not adequately limit the circumstances in which solitary confinement can be imposed.

Currently placement in segregated confinement or keeplock can be the sentence for violating one of a long list of institutional rules of conduct. A fundamental flaw in the proposed regulations is that it does little to change that approach. While the rule specifies the criteria for placing an incarcerated individual in segregated confinement, which includes disciplinary confinement in a special housing unit or in a separate keeplock unit, it does not set forth criteria for keeplock confinement. Moreover, the segregated confinement criteria that are included are overly broad allowing for placement in segregated confinement for non-violent conduct.

The criteria for placing an incarcerated individual in administrative segregation status are vague. Any incarcerated individual deemed to "pose an unreasonable and demonstrable risk to the safety and security of staff, incarcerated individuals, the facility or would present an unreasonable risk of escape" could be placed in a special housing unit, residential rehabilitation unit, or adolescent offender separation unit.

The HALT Act provides for "[d]e-escalation, intervention, informational reports, and the withdrawal of incentives [to] be the preferred methods of responding to misbehavior." It allows confinement for up to three consecutive days and no longer than six days in a 30-day period where a person violates department rules which permit segregated confinement. But, it limits placement in both segregated confinement, defined as any form of cell confinement for more than 17 hours a day, and residential rehabilitation units to circumstances in which an individual commits one of seven specific egregious acts.[2] Recognizing that people who engage in such behavior may need to

[2] The HALT Act amends Corr. Law § 137(6) to add the following provision:

> The department may place a person in segregated confinement beyond the limits of subparagraph (i) of this paragraph or in a residential rehabilitation unit only if, pursuant to an evidentiary hearing, it determines by written decision that the person committed one of the following acts and if the commissioner or his or her designee determines in writing based on specific objective criteria the acts were so heinous or destructive that placement of the individual in general population housing creates a significant risk of imminent serious physical injury to staff or other incarcerated persons, and creates an unreasonable risk to the security of the facility:

be separated from others, HALT allows for these individuals to be transferred to residential rehabilitation units where they will not be isolated from others but instead engaged in programming and treatment to address underlying causes of problematic behaviors.

3) The rule creates alternatives that may function as restrictive, punitive units where individuals may be isolated in conditions comparable to solitary confinement.

Although the proposed rule purports to create "residential rehabilitation units," these units are quite restrictive, and the rule does not require the rehabilitative components needed to ensure that the units function as true alternatives to solitary. Individuals placed in these units are provided with limited out-of-cell time and can be isolated for 19 hours a day for five days a week and 22 hours a day on the other two days. The rule provides for "the most congregate setting available" but does not require that individuals in these units receive congregate programming and activities, so some individuals may spend their out-of-cell time without engagement with others. The rule also allows individuals to be discharged to solitary confinement if the individual is "chronically failing to comply with program objectives" or "poses an immediate and continuing unacceptable threat to the safety of staff or other incarcerated individuals or to the security of the facility." While both of these situations must be addressed, discharging individuals to an unspecified amount of time in solitary confinement is not the appropriate response.

Individuals on the residential rehabilitation unit can also be isolated in their cells on keeplock status with the same restrictions on property, visiting, packages, commissary, telephone calls, and correspondence as individuals isolated in segregated confinement. The rule contains no criteria for placing an individual in keeplock or limits on the amount of time they can spend there. Without restrictions on keeplock status in these units, individuals can potentially be isolated in conditions no different from current solitary confinement units.

Ensuring that alternative units are true alternatives and not solitary by another name is crucial. In New York, we have alternatives that continue to isolate individuals because they allow them to be confined to their cell without requiring interventions or time limits. In the RMHTUs discussed above, incarcerated individuals can be denied out-of-cell programming, and the massive amount of disciplinary infractions issued in these units perpetuate endless punishment. Incarcerated

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(A) causing or attempting to cause serious physical injury or death to another person or making an imminent threat of such serious physical injury or death if the person has a history of causing such physical injury or death and the commissioner and, when appropriate, the commissioner of mental health or their designees reasonably determine that there is a strong likelihood that the person will carry out such threat. The commissioner of mental health or his or her designee shall be involved in such determination if the person is or has been on the mental health caseload or appears to require psychiatric attention. The department and the office of mental health shall promulgate rules and regulations pertaining to this clause; (B) compelling or attempting to compel another person, by force or threat of force, to engage in a sexual act; (C) extorting another, by force or threat of force, for property or money; (D) coercing another, by force or threat of force, to violate any rule; (E) leading, organizing, inciting, or attempting to cause a riot, insurrection, or other similarly serious disturbance that results in the taking of a hostage, major property damage, or physical harm to another person; (F) procuring deadly weapons or other dangerous contraband that poses a serious threat to the security of the institution; or (G) escaping, attempting to escape or facilitating an escape from a facility or escaping or attempting to escape while under supervision outside such facility.

individuals cycle from one RMHTU to another without receiving the therapeutic interventions needed to enable them to return to general population or a specialized mental health unit.

Similarly, the Adolescent Offender Segregation Unit (AOSU) is supposed to be an alternative to solitary for young people, and it provides for some out-of-cell time, but on this unit, a 17-year-old with severe mental health needs spent ten consecutive days in 24-hour lockdown. A judge ordered that the young person be removed from the unit because of the irreparable harm and devastating mental health impacts that resulted from placement in AOSU. Creating units that replicate the harms of solitary confinement is not the solution.

The HALT Act creates residential rehabilitation units (RRUs) that provide for seven hours out of cell daily. This out-of-cell time must include six hours of "congregate programming, services, treatment, and/or meals," plus an additional hour for recreation in a congregate setting. The legislation limits the use of restraints during out-of-cell activities in the RRU. Individuals in RRUs would not be punished with limits on services, treatment, personal property, or basic needs such as clothing, food, and bedding. The legislation allows for restrictions but only in individual circumstances where allowing congregate recreation or provision of specific services, property, etc. would create "a significant and unreasonable risk" to the safety and security of other incarcerated persons, staff, or the facility.

The HALT Act does allow for restrictions on a person's participation in programming and out-of-cell activities, but only in limited circumstances and even in those instances still requires two hours of out-of-cell therapeutic programming and two hours of recreation. The legislation specifies time limits on restricting access to programming and requires the Commissioner personally to approve any restriction beyond 15 days and only when the person "poses an extraordinary and unacceptable risk of imminent harm to the safety or security of incarcerated persons or staff."

4) The rule does not protect vulnerable populations.

The rule excludes from segregated confinement and administrative segregation special populations, defined as individuals housed in adolescent offender facilities; individuals who are pregnant or in the first eight weeks of post-partum recovery or caring for a child in a correctional facility; and people who have a disability and the disability impairs their ability to provide self-care in a correctional facility, but it does not prevent them from being placed in keeplock confinement. The rule provides no protection for young people who are not housed in adolescent offender facilities. Nor does it protect older people or people who have a disability that makes them more vulnerable to the harms of solitary but are not so disabled that they cannot maintain basic self-care in the prison environment.

The harm that solitary confinement causes young people whose brains continue to develop into their mid-twenties is well established. Chronic social isolation affects the regions of the brain related to learning, memory, and spatial awareness, and increases activity in the region that mediates fear and anxiety.[3] The effects of solitary on older people can also be dangerous. The lack

[3] Elena Blanco-Suarez, "The Effects of Solitary Confinement on the Brain: Neurobiology shows the need to make solitary confinement more humane." *Psychology Today*, Feb 27, 2019, available at https://www.psychology-today.com/us/blog/brain-chemistry/201902/the-effects-solitary-confinement-the-brain.

of sunlight, sensory deprivation, and limits on space in solitary confinement "increase the risk that older incarcerated people will develop or exacerbate chronic health conditions."[4] The harmful effects of solitary confinement on people with severe mental illness are so well documented that federal courts across the country have ruled that placing them in such conditions violates the Eighth Amendment prohibition on cruel and unusual punishment.[5] One court determined that placing people with mental health issues in solitary "is the mental equivalent of putting an asthmatic in a place with little air to breathe."[6]

The special populations delineated in HALT Act include all who are particularly vulnerable to the harms of solitary confinement, including people who are 21 years old and younger, who are 55 years old and older, and who have a disability as well as those included in the proposed rule. In addition, the HALT Act requires that the conditions and services in the RMHTUs must be at least comparable to those in the RRUs and that the protections afforded to those in RRUs be extended to people in the RMHTUs.

5) The rule lacks clear mechanisms and time limits for release from alternative units.

The rule provides that individuals will be released from a residential rehabilitation unit at the expiration of the sanction imposed or upon successful completion of a program, but individuals diverted to these units from administrative segregation do not have a clear path for release. Although the rule provides for periodic reviews of an individual's administrative segregation status, the review continues to weigh the reasons the individual was initially placed in administrative segregation and the individual's subsequent behavior. It does not require that the incarcerated individual be directed to complete a specific program to be released or demonstrate specific behavioral changes to qualify for release.

The HALT Act contains specific criteria to ensure that individuals who complete their disciplinary sanction or rehabilitation plan have a right to be discharged from the unit. The legislation also requires that staff state the reasons for any determination that a person is not ready for discharge from the unit and specify the requirements for the person to be discharged. The HALT Act also provides for people who have spent a year in the unit to be discharged, except under specific, extreme circumstances.

6) The rule does not end solitary confinement for people in protective custody.

The rule does not place any limits on the time that a person can be isolated in protective custody until October 1, 2021, and even after October 1, 2022, individuals in protective custody can continue to be isolated for 30 days.

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[4] Lucius Couloute, "Aging alone: Uncovering the risk of solitary confinement for people over 45," Prison Policy Initiative, May 2, 2017, available at https://www.prisonpolicy.org/blog/2017/05/02/aging_alone/.

[5] American Civil Liberties Union, *The Dangerous Overuse of Solitary Confinement in the United States* (ACLU Briefing Paper), Aug. 2014, available at https://www.aclu.org/sites/default/files/assets/stop_solitary_briefing_paper-_updated_august_2014.pdf.

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

The HALT Act prohibits isolating individuals in solitary confinement for protective custody and requires that all protective custody units provide at least the same out-of-cell time, congregate programming, and meaningful engagement as the RRUs.

7) The rule allows for the denial of basic needs.

Although the rule prohibits placing incarcerated individuals on a restricted diet as punishment, it adds a provision allowing individuals to receive "special management meals." It also permits the deprivation of essential services, including access to water in one's cell, in certain circumstances.

The HALT Act requires that individuals in segregated confinement and the alternative units be provided the same food as everyone else in the prison. The legislation prohibits the imposition of limitations on services, treatment, and basic needs as punishment. It permits them to be withheld only where providing them would "create a significant and unreasonable risk to the safety and security of incarcerated persons, staff, or the facility" and requires reinstatement as soon as the risk has ended.

8) The rule provides limited training to staff.

To create real culture change that results in rehabilitative units functioning as designed, staff must have the necessary training and supervision. The rule requires specialized training for hearing officers and staff assigned to special housing units, residential rehabilitation units, step-down units, and adolescent offender separation units, but it does not contain any requirements regarding the amount of training these staff members must receive. It also does not require staff to receive annual refresher training.

The HALT Act requires that hearing officers and staff working on segregated confinement units and RRUs receive substantial relevant training. Staff and supervisors working in these units, as well as hearing officers, are required to receive a minimum of one week of training before being assigned to the unit or presiding over any hearings, and then three days of additional training annually. In addition, all RMHTU staff must receive such training as well.

9) The rule does not enhance procedural protections.

The HALT Act requires that incarcerated individuals have access to legal representation by pro bono attorneys, law students, or approved paralegals at hearings that could result in segregated confinement.

10) The rule does not provide transparency and independent outside oversight.

The rule includes some reporting requirements, but they are far too limited to provide an adequate understanding of how solitary confinement is used and whether the alternative units function effectively. For instance, there is no requirement to report data on keeplock confinement. Given the lack of limitations placed on use of keeplock confinement, it is crucial that the Department report on its use. Merely reporting the total number of individuals in the various units is insufficient. Given the racial disparities in the use of solitary confinement in NYS prisons, it is

especially important that the data regarding the individuals placed in the various units be broken down by race.

The HALT Act provides for transparency and accountability. Departments of correction must provide public reports on the number and categories of people in isolation and RRUs as well as lengths of stay. The report requires that the number of people in segregated confinement and RRUs be broken down by the following:

> (i) age; (ii) race; (iii) gender; (iv) mental health treatment level; (v) special health accommodations or needs; (vi) need for and participation in substance abuse programs; (vii) pregnancy status; (viii) continuous length of stay in residential treatment units as well as length of stay in the past sixty days; (ix) number of days in segregated confinement; (x) a list of all incidents resulting in sanctions of segregated confinement by facility and date of occurrence; (xi) the number of incarcerated persons in segregated confinement by facility; and (xii) the number of incarcerated persons in residential rehabilitation units by facility.

Under the HALT Act, the NYS Justice Center for the Protection of People with Special Needs and the State Commission of Correction would have authority to assess implementation of the law.

Conclusion

We urge you to amend the proposed rule to include all the provisions of the HALT Act. To end the torture of solitary confinement and create humane, effective alternatives, the Department must do the following:

- Limit the amount of time that a person can spend in any form of solitary confinement to 15 consecutive days or 20 days in a 60-day period;
- Limit the circumstances in which a person can be placed in any form of solitary confinement or any alternative;
- Provide alternatives to solitary confinement which allow for meaningful human contact and engagement and establish clear mechanisms for release;
- Exclude vulnerable populations from all forms of solitary confinement and end the solitary confinement of individuals in protective custody;
- Require staff training;
- Enhance procedural protections provided before placement in solitary confinement; and
- Require robust public reporting on the use of solitary confinement and independent, outside oversight.

New York should lead the way in ending the use of torture in jails and prisons. DOCCS regulations must require fundamental change in the way incarcerated people are treated. We encourage you to adopt regulations that will accomplish this goal.

Working to end solitary confinement
for people with psychiatric disabilities

MHASC

Mental Health Alternatives to Solitary Confinement

Mental Health Care Challenges in New York State Prisons

New York State over-criminalizes behavioral manifestations of mental health conditions, incarcerates large numbers of people with mental health conditions in Department of Corrections and Community Supervision (DOCCS) prisons, and fails to provide adequate mental health treatment in prison. The number of people in DOCCS custody receiving mental health treatment continues to rise despite the overall decrease in the prison population. In the last six years, from 2012 through 2017, the DOCCS population decreased by 9.6% while the number of people in prison on the mental health caseload increased by 26.8%.

Because of advocacy efforts, litigation, and legislative and agency reform, prison mental health services provided by the NYS Office of Mental Health (OMH) have significantly increased and improved in the state prisons over the past 15 years. However, serious challenges remain.

Most people with mental health needs receive inadequate mental health treatment in prison.
Treatment for people with mental health conditions who are not in specialized mental health programs is limited to brief monthly contacts with a therapist, and if needed, psychotropic medication and psychiatry appointments every three months. Enhanced services are available in specialized treatment programs, but only 44% of people diagnosed with a "serious mental illness" were served in such a program in 2017.

People in specialized mental health treatment units need improved quality of mental health care.
While specialized mental health treatment units provide significantly better access to and better quality of mental health services than is available in the prison general population, there is a lack of individually tailored treatment plans and, as a result, many people's needs are not met in the program model provided.

Residential mental health treatment units are not therapeutic environments free from abuse.
Many people housed in residential mental health treatment units report frequent security staff abuse, excessive force, overuse of disciplinary tickets, and a punitive and racially biased environment, all of which undermine the units' intended therapeutic nature. In September 2017, Disability Rights New York (DRNY), the federal Protection and Advocacy System for individuals with disabilities in New York State, found that DOCCS and OMH neglected and abused participants in Attica Correctional Facility's Residential Mental Health Unit (RMHU). In units designed to be therapeutic, DOCCS responds to behavioral issues with disciplinary tickets and additional segregation time, and too often officer brutality. The RMHUs, Behavioral Health Unit, and Therapeutic Behavioral Unit, have very high rates of disciplinary tickets (amongst the highest of any DOCCS units). During 2015-16, participants disciplined in these units received on average 206 to 811 additional segregation days. This is contrary to N.Y. CORRECT. LAW § 401.5(a) which states that people housed in an RMHTU "shall not be sanctioned with segregated confinement for misconduct on the unit … except in exceptional circumstances where such [incarcerated person's] conduct poses a

significant and unreasonable risk to the safety of [incarcerated persons] or staff, or to the security of the facility."

Beyond disciplinary tickets, the extremely punitive and abusive approach to people with mental health needs in the residential units and throughout the prison system also manifests itself in correction staff treating people with mental health needs disrespectfully and even subjecting them to verbal and at times physical abuse. Mental health staff and correction staff should be promoting a safe, therapeutic environment rather than provoking residents who are known to have issues regulating their mood and behavior. As the most horrific outcome of such abusive treatment, Samuel Harrell and Karl Taylor – both Black men with serious mental health needs – were reportedly beaten to death by corrections officers in April 2015. MHASC is unaware of DOCCS or OMH taking any corrective actions in response to their deaths.

Many individuals are not properly assessed, diagnosed, and given appropriate treatment.
From 2008 to 2017, there was a 52% drop in the percentage of people diagnosed with schizophrenia and psychosis and a 110% increase in the percentage of people diagnosed with adjustment or personality disorders. Incarcerated individuals and their family members report that this drop is due to OMH clinicians re-diagnosing individuals with less serious impairments than are recognized by their community treatment providers, and as a result, they receive inadequate treatment for their serious impairments.

People in psychiatric crisis require more humane, therapeutic, and effective interventions.
DOCCS and OMH staff often fail to respond appropriately to individuals in mental health crisis. Individuals in crisis are not moved promptly to the Residential Crisis Treatment Program (RCTP), and security staff often subject people to verbal and sometimes physical abuse before, during, and/or after transfer. The RCTP remains a punitive environment rather than a therapeutic place of support to help people stabilize. It should be a short-term placement, where amenities are quickly restored to people who are stabilizing or where transfer to the psychiatric hospital is facilitated promptly. Instead, RCTP stays are far too lengthy – often weeks and at times even months - and OMH does not promptly send people in need of an inpatient level of care to Central New York Psychiatric Center (CNYPC). From 2007 to 2016, the number of people sent to the RCTP increased by 68%, while admissions to CNYPC dropped by 52% during the same period.

People in psychiatric crisis require fairness and should have their clinical needs considered foremost.
Currently, people who are in the midst of a mental health crisis are forced to face disciplinary hearings with no attorney or advocate on their behalf. In some cases, typically where people are held in RCTP for weeks or months, disciplinary hearings are held while the individual remains in crisis in the RCTP. We recognize that hearings may be held while an individual remains in RCTP either to ensure that the individual will have the support of RCTP staff at the time of the hearing or because staff feels they need a hearing disposition in place to move the person out of RCTP into an alternative placement. We are, however, concerned that a person in active psychiatric crisis is ill-prepared to exercise his or her due process rights at a disciplinary hearing. In other cases, people with pending disciplinary charges may spend days in a crisis observation cell in the RCTP, and then face a disciplinary hearing after discharge from the RCTP. In almost all cases, DOCCS isolates people in SHU while their disciplinary hearing is pending. A person subject to a disciplinary hearing while in psychiatric crisis in RCTP, or isolation in SHU shortly after discharge from RCTP, is deprived of a fair opportunity to mount a defense to the disciplinary charges: they have no help from a lawyer or mental health advocate and no meaningful chance to show they are not guilty of the alleged charges, they should not be disciplined at all due to their mental status at the time of the incident, or why mental health or programs are a better alternative to receiving further punishment for such behavior. Disciplining people in crisis is one of the many ways DOCCS and OMH prioritize punishment over people's needs for treatment.

Rates of suicide and self-harm are high, and they are concentrated in isolated confinement and residential mental health treatment units.
The suicide rate in New York prisons from 2010 to 2016 is 56% higher than the national average. Special Housing Units (SHU) only account for about 8% of the DOCCS population, but from 2014 to 2016, 32% of suicides occurred in SHU or keeplock. The Intermediate Care Program (ICP) and Transitional ICP, treatment units for people with mental illness, had a suicide rate 23 times that of the general prison population. Despite repeated tragic outcomes, DOCCS and OMH staff continue to view inappropriately those who self-harm or threaten self-harm as malingerers trying to game the system.

Thousands of people, including hundreds of people on the OMH caseload, are subject to solitary confinement each day, causing devastating mental health harm.
Holding any person for 22 to 24 hours a day in a SHU, keeplock, RMHTU without programming because of "exceptional circumstances," or any other solitary confinement cell has long been known to cause devastating mental health harm. This harm is especially exacerbated for people who have pre-existing mental health conditions prior to placement in solitary. Yet, thousands of people, and many hundreds on the OMH caseload, remain in solitary each day in NY prisons. While holding any person in solitary beyond 15 days is considered torture under international standards, and is banned in places including Colorado prisons, New York continues to hold people – including people on the OMH caseload – for months and years, and even decades.

Family members and loved ones have great difficulty engaging with OMH staff.
Family members and loved ones provide invaluable support to incarcerated persons and useful information to OMH and DOCCS staff. Yet, some staff exhibit callous attitudes toward family members, and some staff fail to provide information to, or receive information from, them.

Many people who receive mental health treatment are not provided with adequate discharge planning services.
Discharge planning services for people who have received OMH care while incarcerated are severely lacking. The Community Orientation & Re-entry Program (CORP) aims to provide comprehensive mental health discharge planning for people returning to New York City, but CORP is a 31-bed program. In 2015, more than 4,100 people on the OMH caseload were released from incarceration.

Recommendations

- DOCCS and OMH should expand treatment opportunities for people in general population and SHU, including cognitive behavioral therapy, trauma treatment, group therapy, and peer support. DOCCS and OMH should also expand Integrated Dual Disorder Treatment (IDDT) for people with both mental health and substance abuse issues, and enhance OMH collaboration in all prison substance abuse programs. We recommend group therapy for people with mental health conditions in general population, but these services should not be a substitution for mandated monthly one-on-one counseling, but rather an addition to individual counseling.
- OMH should enhance for all people on the OMH caseload individual needs assessments and treatment plans, individual and group therapy, cognitive behavioral therapy, trauma treatment, IDDT, and peer support for each person. OMH should also use ADL and other habilitative programs to increase people's capabilities upon reentry to the community.
- DOCCS and OMH must create a more therapeutic environment in the disciplinary and non-disciplinary residential units by ending staff abuse, decreasing the use of tickets, and utilizing non-punitive individualized therapeutic interventions in response to difficult behavior.
- DOCCS must curtail its use of "exceptional circumstances" to ensure that all eligible incarcerated people are afforded placement and programming in specialized mental health units and remain free from excessive discipline while in those units.
    - The requirement in N.Y. CORRECT. LAW § 401(5)(a) of no imposition of additional segregated confinement for misbehavior in residential mental health treatment units (RMHTU) unless there are "exceptional circumstances where such [incarcerated person's] conduct poses a significant and unreasonable risk to the safety of [incarcerated persons] or staff, or to the security of the facility" must apply to all confinement sanctions, including those that are expected to be served in an RMHTU.
    - Where additional segregated confinement is imposed at a Tier III disciplinary hearing based on conduct in an RMHTU, the hearing record must include a finding as to the presence of exceptional circumstances, and a statement of reasons and facts in support of the finding.
    - "Exceptional circumstances" as described in 401(5)(a) should be reserved for the most egregious and exceptional behavior. In light of the statutory standard, exceptional circumstances should not be found unless an incarcerated person outside of his or her assigned cell initiates aggression that either causes or could reasonably be expected to cause serious harm to another person. Violent conduct that occurs inside an incarcerated person's assigned cell, such as a cell extraction, should not be defined as meeting the exceptional circumstances threshold.
    - Lewd exposure which occurs inside an RMHTU cell should not be viewed as meeting the exceptional circumstances standard of 401(5), since despite the obvious offensive qualities of such behavior, it is strongly associated with mental illness. Other conduct which occurs in a cell but which may directly and physically affect people outside of the cell, such as throwing bodily fluids, may warrant a confinement sanction under 401(5).
    - Any period of segregated confinement imposed for misbehavior in an RMHTU pursuant to 401(5)(a) should be imposed to run concurrently with all prior confinement sanctions.

- Incarcerated persons housed in an RMHTU must not be restricted from out-of-cell programming unless they have engaged in *violent* conduct during program that demonstrates that they pose an *imminent* risk to safety and security of other incarcerated people or staff. "Exceptional circumstances" as defined in N.Y. CORRECT. LAW § 401(2)(a)(i) should be reserved for only the most egregious behavior.
- Incarcerated people who are restricted from programming in an RMHU must receive meaningful alternate programming pursuant to their individualized treatment plan.
- DOCCS must significantly restrict its practice of retaining people with serious mental illness in segregated confinement for over 30 days. "Exceptional circumstances" as defined in N.Y. CORRECT. LAW §§ 137(6)(d)(ii)(E) and 401(5)(a) should be reserved for situations where no less-restrictive response would ameliorate an *imminent* and *substantial* safety risk to other incarcerated people or to the facility.
- DOCCS and OMH must significantly restrict their practice of failing to provide a "heightened level of care" to people with serious mental illness who remain in segregated confinement. "Exceptional circumstances" as defined in N.Y. CORRECT. LAW § 137(6)(d)(iii)(B), must be limited to situations where an incarcerated person engaged in *violent* conduct while receiving a "heightened level of care" in the Group Therapy Program, and where that conduct demonstrates that the person poses an *imminent* risk to safety and security of other incarcerated people or staff.
- DOCCS and OMH must comply with statutory requirements that they document all "exceptional circumstances" findings in writing and review them at least every fourteen days. Those reviews must not function as a *fait accompli* aimed at indefinitely continuing a program restriction, retaining a person in segregated confinement, or restricting a person's receipt of a "heightened level of care."

- DOCCS should promulgate regulations implementing the SHU Exclusion Law's "presumption against discipline" and "exceptional circumstances" provisions, or at a minimum, add a meaningful standard to the applicable directives.
- OMH should enhance assessments for all people with mental health needs; increase reliance on individuals' mental health history, past treatment, and family input to determine accurate diagnoses; and develop more appropriately individualized treatment plans. OMH should utilize its own information about past difficulty experienced by people while in the SHU or any residential mental health treatment program, and evaluate their concerns about misdiagnosis and changes in diagnosis, to ensure these individuals are appropriately diagnosed and diverted from the SHU when required.
- DOCCS and OMH must enhance RCTP services, ensure it is a therapeutic environment free of staff abuse, house people in crisis in the least restrictive setting given their mental health needs, and hasten their transfer to CNYPC or an appropriate residential mental health treatment program.
    - DOCCS and OMH should utilize RCTP dorms, and develop stepdown units to serve people who require a transition from the heightened care and monitoring of the RCTP.
    - DOCCS and OMH should develop procedures to ensure people experiencing a mental health crisis or requiring respite care are not isolated in RCTP single cells for an excessive period, establishing a goal of no more than four days in the RCTP.
    - In assessing the person's needs, both agencies should coordinate an evaluation that, in addition to the mental health assessment concerning risk of self-harm, also considers the

person's overall mental health status and factors that are contributing to the person's request for crisis intervention. Following this consultation, the agencies should jointly develop a holistic response that reduces conditions that exacerbate the person's mental health status.

- DOCCS and OMH should ensure that people are not held in RCTP observation for excessively long periods of time, such as more than seven days, and should make greater use of CNYPC in order to discharge from RCTP people who are not sufficiently stable to return to their prior housing units;
- OMH should bring its policies into compliance with the new DOCCS RCTP directive affording greater access to "privileges" and "amenities," and both agencies should amend all RCTP policies to create a presumption that people receive certain "privileges" and "amenities."

- DOCCS and OMH must work together to reduce the length of RCTP stays, create a mechanism to consider dismissal of disciplinary charges that are pending while a person is in an RCTP, and assign counsel or an advocate at any hearing held while a person is in RCTP or held shortly after discharging a person from RCTP.
- DOCCS and OMH must better prevent and respond to self-harm. Staff must recognize these acts as indications of crisis, not penalize them, and respond appropriately through counseling, treatment, and/or transfer to an RMHTU or CNYPC. Staff must also address the traumatic impact of self-harm on others through individual and/or group discussions.
- DOCCS and OMH should work together to eliminate the use of solitary confinement for people with mental health needs and stop placing any person in any form of solitary beyond 15 days. At the very least, DOCCS and OMH should utilize empty bed space in the RMHTUs for people without an S-designation on the OMH caseload who are in SHU and stop placing people with S-designations in keeplock or in SHU even for periods up to 30 days. DOCCS and OMH should be using existing and new rehabilitative and therapeutic alternatives to solitary confinement, modeled off successful programs like the CAPS Units in New York City Jails, Resolve to Stop Violence Project in San Francisco jails, and the previous Merle Cooper program at Clinton C.F.
- DOCCS and OMH must work to stop all staff brutality against people with mental health needs and all people in prison, and must account for past and future incidents and deaths. Staff must use approaches emphasizing de-escalation, crisis intervention, and therapeutic responses. Much more needs to be done to protect and support people with mental health needs, and to ensure at a minimum that staff physical abuse and even homicide never again occurs in New York's prisons.
- OMH should work more collaboratively with family members and loved ones. OMH should clarify protocols for what information can be shared, widely distribute those protocols, and provide staff training on them. The agencies should also expand training to ensure staff respectfully listen to, consider, and offer feedback on information from family members. Staff should also facilitate communication by proactively obtaining consent to release information. OMH should ensure that staff can easily determine who may receive patient information regardless of facility transfers.
- DOCCS and OMH should expand CORP, and other OMH discharge planning services throughout the system. Staff should adequately document individuals' mental health needs, past courses of treatment, and the level of services needed; help them locate and enroll in community mental health treatment, apply for public benefits, and obtain housing; and prepare people mentally and emotionally for return to their communities.

- DOCCS and OMH should expand mental health training for security and civilian staff, including by requiring Crisis Intervention Team training.

- DOCCS and OMH should collect data and conduct assessments of the effectiveness of mental health and special programs serving people with mental and behavioral health needs, including by engaging and surveying the population served by these programs, in order to improve outcomes.