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Daniel J. O'Donnell, Chairperson  
Assembly Committee on Correction  
LOB 526  
Albany, NY 12248

Aileen Gunther, Chairperson  
Assembly Committee on Mental Health  
LOB 826  
Albany, NY 12248

Dear Chairperson O'Donnell and Chairperson Gunther:

Thank you very much for the invitation to address your committees concerning the critical matters of mental health treatment in prisons and jails. This summer will be the fifth anniversary of the SHU Exclusion Law. It is the right time to examine what works, and what does not work, and what more should be done to protect prisoners with serious mental illness (SMI) in New York's prisons and jails.

Disability Rights New York (DRNY) is an independent, non-profit agency, authorized under federal and state law to be the protection and advocacy (P&A) system for New Yorkers with disabilities. It provides statewide protection and advocacy for New Yorkers with physical disabilities, developmental disabilities, and mental illness. Prior to June 1, 2013, it was known as Disability Advocates Inc. (DAI). DAI was plaintiff in a 2002 prison mental health lawsuit which was settled in 2007. The settlement required out-of-cell programming for prisoners with serious mental illness sanctioned with more than thirty days SHU time and required the State to create secure treatment alternatives to SHU for prisoners with SMI. The SHU Exclusion Law further expanded these SHU diversion and treatment programs, and made these requirements permanent.

There has been much progress in the 12 years since the DAI prison mental health litigation commenced. Many dedicated mental health professionals are providing compassionate and respectful mental health care to inmate-patients who have difficult and complex mental health needs. Teamwork between OMH and DOCCS staff has been essential to this progress.

Many individuals have responded well to the mental health treatment alternatives created by the settlement of the lawsuit and the SHU Exclusion Law, and those people have received very significant SHU time cuts. But others have received additional disciplinary time while in the Residential Mental Health Treatment Unit's (RMTHU). Sanctioning an inmate with SHU time when the misconduct that has not posed an immediate threat to safety and security violates the SHU Exclusion Law's prohibition against SHU sanctions for people in the RMHTU.<sup>1</sup> To ensure compliance with this mandate, we urge enhanced Central Office oversight over any SHU or keeplock sanctions imposed against individuals in the RMTHU. In addition, there should be refresher trainings for both RMTHU staff and Tier 2 and Tier 3 hearing officers to re-enforce the principles of the SHU Exclusion Law.

Those individuals who succeed in the SHU diversion programs are most likely to maintain mental health stability if they are discharged to other mental health programming, such as the Intermediate Care Programs (ICP) or Transitional ICPs. Individuals who are discharged to general population are most likely to fail. Group programming for individuals with mental illness in general population is needed, with programs especially structured for inmates with significant disciplinary and behavioral histories, as well as added training for corrections officers working in these programs. In addition, expansion of programs for individuals with mental illness and substance abuse histories, who have completed the Integrated Dual Disorder Treatment (IDDT) in the RMHTU, is essential for their continued recovery.

### **Prisoners with Mental Illness in SHU: Underclassification of Serious Mental Illness**

The SHU Exclusion Law significantly protects some individuals with SMI, but many people with serious mental illness who do not meet the statutory definition of SMI continue to suffer and deteriorate in SHU, sometimes with devastating results. Even those who are classified as "S-designated" because of serious mental illness can be placed in SHU under the law if their disciplinary SHU or keeplock sentence is for fewer than 30 days.<sup>2</sup> S-designated inmates with longer sentences may also be placed in SHU or long-term keeplock for security or safety reasons, and if so must receive a "heightened level of care" of two hours out of cell programming daily.<sup>3</sup> But the risks of even short-term SHU confinement warrant expanding the law's requirements to require that this heightened level of care is provided to all S-designated inmates in SHU and long-term keeplock, even during the first 30 days.

A recent report in the Albany Times Union demonstrates this need. On October 30, Benjamin Van Zandt, a young man from Selkirk who had been S-designated, took his life after

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<sup>1</sup> N.Y. CORRECT. LAW § 401.5(a). For example, while monitoring the DAI settlement 2011, we found that individuals in the RMTHU received SHU sanctions for non-violent behavior, such as refusal to undergo urinalysis testing, obey direct orders, and for drug-related infractions. Please refer to the testimony submitted by the Correctional Association of New York, which discusses evidence of the continuing practice of imposing sanctions against individuals in the RMHTU.

<sup>2</sup> N.Y. CORRECT. LAW § 137(6)(d)(i).

<sup>3</sup> Wlock & Lilly, Central New York Psychiatric Center, "Active Mental Health Inmate-Patients Housed in Segregated Confinement: Fourth Quarter 2013."

two days in SHU.<sup>4</sup> Clearly, he slipped through the intended safety net for prisoners with SMI. Additional protections for prisoners with SMI who are in the SHU for fewer than 30 days are needed to prevent such tragedies.

According to the Correctional Association of New York's recent report on Clinton Correctional Facility at the time of their visit in July 2012, 22% in the Clinton SHU and long-term keeplock were on the OMH caseload, in contrast to 17% in the general population. Eight of those SHU inmates at Clinton, were determined to be at the highest level of mental health need, OMH Level 1,<sup>5</sup> with one of the 8 S-designated.<sup>6</sup> In the system overall, in the last month of 2013, 85 Level 1 patients were in SHU, a quarter of them S-designated.<sup>7</sup>

Inmates with SMI who are designated OMH Level 1 are permitted in SHU under the SHU Exclusion Law, but should be excluded. This is because meeting any of the criteria for Level I designation shows that the patient is psychiatrically vulnerable and likely to be harmed by SHU confinement. The Level I conditions which should preclude SHU confinement are:

Diagnosed with Serious Mental Illness (SMI) or significant behavioral disorder with at least six months of psychiatric stability, including continuous psychiatric medication compliance, if applicable;

OR Discharged from CNYPC within past 6 months;

OR Engaged in verified serious suicide attempt or engaged in significant/repeated self-injurious behavior with past year;

OR Currently prescribed Clozaril (prescribed for treatment-resistant schizophrenia);

OR Currently issued Court Ordered Psychiatric Medication COPM; (under a treatment over objection order);

OR Requires ICP/TrICP services;

OR Validated psychiatric de-compensation resulting in multiple RCTP admissions.<sup>8</sup>

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<sup>4</sup> Paul Grondahl, *Selkirk Man, 21, Takes own Life in Prison Cell*, ALBANY TIMES UNION, Nov. 5, 2014.

<sup>5</sup> OMH Level 1 is a service level designation that reflects the highest level of treatment need as determined by OMH treatment staff.

<sup>6</sup> CORRECTIONAL ASSOCIATION OF NEW YORK, CLINTON CORRECTIONAL FACILITY: 2012-2014 21 (2014).

<sup>7</sup> Wlock & Lilly, *supra* note 3.

<sup>8</sup> Central New York Psychiatric Center, Treatment Needs/Service Level Designation (Corrections-Based Operations), form 167 Med CNYPC (3/12)

All of these criteria indicate psychiatric vulnerability, but under the current law, only a few (the diagnosis of SMI and the serious suicide attempt) warrant an S-designation and therefore exclusion from SHU. The SHU Exclusion criteria should be expanded to encompass all persons who meet the Level 1 criteria. It would greatly simplify an overly complicated and subjective assessment process and meet the broader need for rehabilitation and treatment. Currently all OMH Level 1 inmates can remain in SHU 23 hours a day with no limit to their SHU time, which places them at great risk of suffering, injury, or death.

Under current law, inmates who do not meet one of the listed disorders of major depression, bipolar disorder, schizophrenia are unlikely to be excluded from SHU.<sup>9</sup> Establishing an “S” designation for inmates using the following criteria is extremely difficult and subject to the subjective judgments of OMH staff:

- (ii) he or she is actively suicidal or has engaged in a recent, serious suicide attempt;
- (iii) he or she has been diagnosed with a mental condition that is frequently characterized by breaks with reality, or perceptions of reality, that lead the individual to experience significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health;
- (iv) he or she has been diagnosed with an organic brain syndrome that results in a significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health;
- (v) he or she has been diagnosed with a severe personality disorder that is manifested by frequent episodes of psychosis or depression, and results in a significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health; or
- (vi) he or she has been determined by a mental health clinician to have otherwise substantially deteriorated mentally or emotionally while confined in segregated confinement and is experiencing significant functional impairment indicating a diagnosis of serious mental illness and involving acts of self-harm or other behavior that have a serious adverse effect on life or on mental or physical health.<sup>10</sup>

DRNY has encountered numerous cases where OMH staff, perhaps overwhelmed or inured to prison conditions, view such suicidal or self-injurious individuals as attention-seeking and manipulative, and therefore do not consider an inmate to be actively suicidal or as having engaged in a “serious attempt.” Or OMH staff must determine whether an inmate who is

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<sup>9</sup> N.Y. CORRECT. § 137(6)(e).

<sup>10</sup> *Id.*

repeatedly self-harming is experiencing “breaks with reality” or is making rational statements. If OMH staff find that the inmate is rational or harming himself to achieve a goal, it does not matter how often she harms herself, she will not be excluded from SHU.

For example, one inmate we encountered on a monitoring visit to the Great Meadow SHU was disheveled and shouting loudly. His records revealed that he had been hospitalized repeatedly at Albany Medical Center for serious self-harm. OMH staff disagreed with Albany Medical Center’s diagnosis of schizophrenia and did not find the requisite “breaks with reality” or psychosis that would justify an SMI-designation and removal from SHU. He was designated OMH Level 1 but had no S-designation. OMH refused to provide an independent evaluation to review his diagnosis and SMI-designation, and he continued to self-harm, which required repeated hospital admissions throughout his two years in SHU.

Others individuals have been returned to SHU to serve long SHU sanctions even after extended hospitalizations at Central New York Psychiatric Center—hospitalizations that were precipitated by self-harm and attempted suicide. One of DRNY’s current clients was hospitalized at CNYPC for 40 days following a suicide attempt, then released back to SHU in September. He then cut himself and swallowed a piece of sharpened metal. He is currently in SHU on pen, headphones, and razor deprivation orders due to self-harm. He recently received his S-designation but remains in SHU pending RMHTU placement. This client will max out of prison in six months, and desperately needs programming to prepare him to succeed in the community.

We also have concerns about the quality of mental health services at certain all-SHU facilities, such as Upstate Correctional Facility. No individual with serious mental illness is to be housed at Upstate. Yet, at this all-SHU facility with limited mental health services, numerous individuals have complained of depression, feelings of panic and agitation, and difficulty tolerating the double-cell SHU conditions. If an inmate is off the mental health caseload, he will be seen by an OMH clinician at most every 90 days. For a psychiatric assessment, only telepsychiatry is available, i.e., the psychiatrist appears by videoconference from another location. In addition, psychiatric staffing continues to be a problem even at large maximum security OMH Level 1 facilities with hundreds of prisoners on the mental health caseload. For example, as recently as September 2014, only telepsychiatry was available at Attica Correctional Facility. Greater efforts should be made to provide psychiatric care on-site at these facilities.

### **Identification and SHU Exclusion of Inmates with Developmental Disabilities**

At present, the SHU exclusion law does not apply to individuals with intellectual and developmental disabilities (ID/DD). However, the scientific literature shows that prisoners with ID/DD are more likely to be unable to conform their behavior to the strictures of prison life, more likely to not understand what is expected of them in prison, and more likely to face SHU or keelock time as a result. Further, once placed in SHU, research shows that those with ID/DD

are less able to cope with deprivation and more likely to develop some form of mental illness as a result of the deprivation.<sup>11</sup>

It is well documented that deprivation causes those with ID/DD to “regress and lose vitally important life skills they previously possessed.”<sup>12</sup> The impact of SHU upon people with intellectual and developmental disabilities magnifies their disability and results in much higher rates of mental illness in comparison to individuals without disabilities.<sup>13</sup> This amounts to cruel and unusual punishment. The protections of the SHU Exclusion Law should be extended to people with ID/DD.

In 1991, the New York State Commission on Quality of Care (CQC) estimated that as much as 3 percent of the New York prison population are individuals with ID/DD.<sup>14</sup> The CQC found that testing to identify these individual was insufficient and too few inmates were referred for extended classification due to possible ID/DD.<sup>15</sup> Although more incoming prisoners are now tested, the testing is still limited in scope and insufficient to identify all prisoners with ID/DD who are in need of services. Efforts to identify this population should be increased.

Services for individuals with ID/DD to help them manage prison life are limited. DOCCS has recently increased the capacity of the Special Needs Units (SNUs), so that there are now four units for male prisoners, one unit for women at Bedford Hills, and three “transitional” SNUs for men. However, the capacity is still far short of the total beds needed to serve up to 3% of the DOCCS population. The Correctional Alternative Rehabilitation, or CAR Program, recently implemented at Sullivan under the *Peoples v. Fischer* agreement, has a capacity of only 60 inmates. DRNY urges you to mandate additional treatment services for this vulnerable population.

### **Lack of Sufficient Trauma Treatment**

DRNY recently visited one of three trauma recovery programs for women located at Albion Correctional Facility. The Female Trauma Recovery Program is a specialized residential treatment program to assist women who have experienced the trauma of sexual abuse. Other

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<sup>11</sup> Orville Endicott, *Persons with Intellectual Disability Who are Incarcerated for Criminal Offences: A Literature Review*, CORRECTIONAL SERVICE OF CANADA REPORT 32-34 (1991); Craig Haney, *Mental Health Issues in Long-Term Solitary and Supermax Confinement*, 49 CRIME & DELINQ. 124 (2003).

<sup>12</sup> James W. Ellis & Ruth A. Luckasson, *Mentally Retarded Criminal Defendants*, 53 GEO. WASH. L. REV. 414, 482-85 (1985).

<sup>13</sup> *Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1, 7 (1981) (Pennhurst I); *Pennhurst State School & Hosp. v. Halderman*, 465 U.S. 89, 127-28 (1984) (Pennhurst II) (Stevens, J., dissenting); *New York State Ass'n for Retarded Children v. Rockefeller*, 357 F. Supp. 752, 756 (E.D.N.Y. 1973); Haney, *supra* note 11, at 124; Endicott, *supra* note 11, at 32. For additional citations to the scientific literature documenting institutional regression, see Ferleger, *Anti-Institutionalization and the Supreme Court*, 14 RUTGERS L. J. 595, 603 n.37 (1983); Teitelbaum & Ellis, *The Liberty Interest of Children: Due Process Rights and Their Application*, 12 FAM. L.Q. 153, 183-84 nn. 127-34 (1978).

<sup>14</sup> New York State Commission on Quality of Care for the Mentally Disabled, “Inmates with Developmental Disabilities in New York State Correctional Facilities” (1991) at 25.

<sup>15</sup> *Id.* at 17-18.

issues addressed are substance abuse, parenting, health issues, and building support networks. We were alerted to this program by an incarcerated woman who had been recommended for the program but could not participate because its location is inaccessible to women with mobility impairments. DRNY is aware of numerous other women qualified for and unable to access these services because they are physically inaccessible. We urge you to require that these programs be made accessible.

In addition, there is insufficient treatment for post-traumatic stress disorder. There is a very high prevalence of physical and sexual abuse histories among New York's incarcerated women.<sup>16</sup> Albion has 1,000 prisoners, but its trauma program has a capacity for only 19 women at a time. Another 800 prisoners are at Bedford Hills, a maximum security facility, and several hundred more are housed at Taconic. The small trauma treatment programs at these women's facilities are a tiny fraction of the intensive services needed to provide treatment and promote healing and recovery to New York's incarcerated women. We urge you to mandate the creation of additional treatment resources.

**More Supportive & Supported Housing for Ex-Offenders is needed and better efforts are needed to identify inmates needing such assistance.**

Many prisoners who need mental health housing upon release are not identified and referred for such housing. Even prisoners who have been S-designated pursuant to the SHU Exclusion Law are not necessarily identified. DRNY recently reviewed the records of an inmate who had spent years in special mental health programs and was S-designated. He reached his maximum release date, and was simply discharged with two weeks' medication, a bus ticket, and a motel reservation in Oswego County. Upon release, this prisoner went into crisis and was hospitalized before the county Department of Social Services located a bed in a rooming house. It is not unusual for SMI prisoners to be discharged to a homeless shelter or a motel. We are also aware of individuals with serious mental illness who have met their parole date, but have either remained in prison beyond that date because of a lack of supportive housing, or been discharged to a psychiatric center, a far more restrictive and costly setting than necessary. Ex-offenders with serious mental illness clearly need more supported and supportive housing. Stable housing is the bedrock for all efforts to build a productive life in the community.

**Application of SHU Exclusion Law to Jails**

The principles of the SHU Exclusion Law should apply to jails. Suicide is the leading cause of death for jail inmates in the United States and in New York State, and the majority of jail suicides – 64 percent -- occur within the first month of incarceration.<sup>17</sup> When coupled with the known risk of placement in isolation, the risk is even higher. Despite the known risks, many jails lack basic mental health services and screening, and no State Commission of Correction

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<sup>16</sup> Angela Browne et al., *Prevalence and Severity of Lifetime Physical and Sexual Victimization Among Incarcerated Women*, 22 Int'l J. L. & Psychiatry 301, 310-22 (1999).

<sup>17</sup> U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, MORTALITY IN LOCAL JAILS 2000-2007, NCJ 222988.

standards exist for mental health screening or the provision of mental health services in the New York jails.<sup>18</sup>

DRNY receives complaints from county jail inmates in New York State, and in these cases mental health staff triage scarce county-level resources. The United States Department of Justice has had to intervene to address systemic deficiencies in suicide prevention and mental health screening and treatment in Erie County,<sup>19</sup> mental health treatment and solitary confinement of juveniles in Westchester County,<sup>20</sup> and mental health treatment in Nassau County.<sup>21</sup> We urge the Legislature to commit resources to an in-depth survey of jail mental health needs, including suicide prevention protocols and training, before further federal intervention becomes necessary.

### **Rikers Island**

DRNY is concerned about the overrepresentation of individuals with disabilities in local jails, incidents of serious physical injuries, prolonged segregation, and tragic cases of extreme neglect in the provision of mental health services. We are particularly concerned about the quality of care in the New York City Department of Correction. New York City has one of the largest jail systems in the country, with an average daily population of approximately 11,800 people.<sup>22</sup> Currently, nearly 40 percent of the New York City jail population has a mental health diagnosis.<sup>23</sup> That number climbs to 51 percent for adolescents.<sup>24</sup> Approximately 800 to 900 people in the New York City jails have serious mental illness. While the average stay for any individual at Rikers Island is 61 days, an individual with mental illness on average stays 112 days.<sup>25</sup> Thus, there is no question that the New York City jail system is burdened with the difficult task of delivering mental health care and treatment to jail inmates, many of whom should be diverted to more cost-effective treatment programs outside of the criminal justice system.<sup>26</sup>

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<sup>18</sup> N.Y. COMP. CODES R. & REGS. TIT. 9, §§ 7000-7070.

<sup>19</sup> *United States of America v. Erie Cnty., New York*, “Stipulated Order of Dismissal,” Case 1:09-cv-00849-WMS – JJM, Filed August 18, 2011.

<sup>20</sup> U.S. Dep’t of Justice, Civil Rights Division, Findings Re: CRIPA Investigation of the Westchester County Jail, Valhalla, New York (Nov. 19, 2009).

<sup>21</sup> Nassau County and the U.S. Department of Justice entered into a consent decree pertaining to medical and mental health care, as well as use of force at Nassau County Correctional Center. The Department of Justice monitored the jail until 2008. See *Marone, Nantista, NYCLU v. Nassau County & Mangano*, Index No. 003630-2012 (reviewing history and ordering the County to appoint a Board of Visitors).

<sup>22</sup> New York City, Preliminary Mayor’s Management Report – FY2014 15 (2014), available at <http://www.nyc.gov/html/doc/downloads/pdf/MMR-2014.pdf>.

<sup>23</sup> *Id.* at 16.

<sup>24</sup> U.S. Dep’t of Justice, CRIPA Investigation of the New York City Department of Correction Jails on Rikers Island 6 (Aug. 4, 2014).

<sup>25</sup> DAVID CLOUD & CHELSEA DAVIS, TREATMENT ALTERNATIVES TO INCARCERATION FOR PEOPLE WITH MENTAL HEALTH NEEDS IN THE CRIMINAL JUSTICE SYSTEM: THE COST SAVINGS IMPLICATIONS 1 (Feb. 2013), available at <http://www.vera.org/sites/default/files/resources/downloads/treatment-alternatives-to-incarceration.pdf>.

<sup>26</sup> *Id.*; Michael Schwirtz & Michael Winerip, *Rikers Jail Costs Soared Despite Fewer Inmates, Comptroller Finds*, N.Y. Times, Oct. 16, 2014.

*Violence against individuals with mental illness*

Incarcerated individuals with mental illness are deeply vulnerable. At Rikers Island, they experience a shocking number of serious injuries from corrections staff. Seventy-seven percent of serious physical injuries—fractures, wounds requiring stitches, head injuries—are suffered by individuals with a mental health diagnosis.<sup>27</sup> In some cases, corrections staff have beaten individuals following suicide attempts.<sup>28</sup> In one case reported by the *New York Times*, a man who attempted to hang himself was beaten so badly by staff that his small bowel was perforated and feces began to leach into his abdomen.<sup>29</sup> Excessive force is often used against young people with mental illness for minor or perceived acts of noncompliance.<sup>30</sup>

To its credit, the New York City Department of Correction under Commissioner Joseph Ponte has promised reform—including, significantly, reviews of how force is used,<sup>31</sup> additional mental health training for new recruits,<sup>32</sup> and the removal by the end of this year of 16- and 17-year olds from punitive segregation.<sup>33</sup> In addition, both the Department of Correction and Department of Health & Mental Hygiene have committed to redesigning mental health observation units to improve care.<sup>34</sup> These reforms build on the creation of a mental health program that was established late last year. However, much more needs to be done to address the violence and improve the quality of treatment that has led to the abuse and neglect of individuals with mental illness.

*Solitary confinement of individuals with mental illness & mental health programs*

DRNY is greatly concerned about the culture in the New York City jails, where individuals with mental illness face excessive use of force and harsh disciplinary action, including punitive segregation, rather than mental health treatment and other services and interventions. Such reliance on long-term segregation, without sufficient access to needed services and supports, is fundamentally contrary to the integration mandate required by the Americans with Disabilities Act<sup>35</sup> and may result in constitutional rights violations.

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<sup>27</sup> Michael Winerip & Michael Schwartz, *Rikers: Where Mental Illness Meets Brutality in Jail*, N.Y. TIMES, July 14, 2014.

<sup>28</sup> *Id.*

<sup>29</sup> *Id.*

<sup>30</sup> U.S. Dep't of Justice, *supra* note 22, at 75-76.

<sup>31</sup> Michael Schwartz & Michael Winerip, *Head of Jails Is Criticized on Violence at Rikers*, N.Y. TIMES, Oct. 8, 2014.

<sup>32</sup> Hearing Before the New York City Council Comm. on Fire & Criminal Justice Services & Comm. on Finance (June 2, 2014) (Statement of Joseph Ponte, Comm'r of Dep't of Corr.).

<sup>33</sup> Michael Schwartz, *Solitary Confinement to End for Youngest at Rikers Island*, N.Y. TIMES, Sept. 28, 2014.

<sup>34</sup> New York City Bd. of Corr. Minutes (July 8, 2014), *available at* [http://www.nyc.gov/html/boc/downloads/pdf/Minutes/BOCMinutes\\_20140708.pdf](http://www.nyc.gov/html/boc/downloads/pdf/Minutes/BOCMinutes_20140708.pdf).

<sup>35</sup> See 28 C.F.R. § 35.130(d) (“A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”).

Individuals with mental illness are overrepresented in the punitive segregation units in the New York City jails. For example, in a one-day snapshot of the population in January 2014, 513 of 11,251 prisoners were in some form of punitive segregation—in either the Central Punitive Segregation Unit (“CPSU”) or a “Restricted Housing Unit (“RHU”).<sup>36</sup> Out of those 513 individuals in punitive segregation, nearly 63 percent had received a mental health diagnosis.<sup>37</sup> A study of self-harm published in March 2014 in the *American Journal of Public Health* found that individuals in Rikers Island who were “punished by solitary confinement were approximately 6.9 times as likely to commit acts of self-harm.”<sup>38</sup> The use of segregation for individuals with serious mental illness has led to devastating results.<sup>39</sup> We remain concerned that individuals with mental health diagnoses continue to be placed both in CPSU and the RHUs. DRNY conducted a monitoring visit to a RHU at the George R. Vierno Center in August 2014. While staff appeared committed to the success of the unit, the highly restrictive conditions in the RHU are counterproductive to assisting individuals in mental health recovery.

The Department of Correction and the New York City Department of Health & Mental Hygiene have worked jointly to establish new mental health programs to reduce the use of solitary confinement for some of the most vulnerable individuals. The Clinical Alternative to Punitive Segregation (“CAPS”) program is one such therapeutic program, designed for 36 men and 12 women with serious mental illness who have committed rule infractions and would otherwise be punished in punitive segregation. Preliminary data from the Department of Health & Mental Hygiene indicates that incidents of self-harm and violence dropped with the creation of this alternative-to-segregation program.<sup>40</sup> Research repeatedly shows that treatment—not prolonged segregation—enhances safety, both within prison and in the community when people return home.<sup>41</sup> After a monitoring visit to the CAPS unit at the Anna M. Kross Center, DRNY

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<sup>36</sup> New York City Board of Correction, Fact Sheet No. 2014/01, Infracted Mentally Ill Prisoners in NYC Department of Correction Custody: One-day Snapshot (Jan. 13, 2014).

<sup>37</sup> *Id.* In CPSU, individuals are confined to their cell between 20 and 23 hours a day. The RHU is operated jointly by corrections and mental health staff. It is a punitive segregation unit for individuals with mental illness, where individuals have the ability to gain out-of-cell time as they progress through a level system.

<sup>38</sup> Fatos Kaba, Andrea Lewis, Sarah Glowa-Kollisch, James Hadler, David Lee, Howard Alper, Daniel Selling, Ross MacDonald, Angela Solimo, Amanda Parsons, & Homer Venters, *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 AM. J. PUBLIC HEALTH 442, 445 (2014).

<sup>39</sup> For example, in 2012, Jason Echevarria, who was diagnosed with bipolar disorder, was placed in a punitive segregation unit for individuals with mental illness after swallowing a battery and attempting suicide. While in punitive segregation, he then swallowed a toxic soap ball, and as the inner lining of his throat burned away, his pleas for medical assistance were ignored, and he died. Press Release, U.S. Attorney’s Office for the Southern District of New York, Manhattan U.S. Attorney and FBI Announce Charge Against Rikers Island Correction Officer for Deliberately Ignoring Urgent Medical Needs of Inmate Who Later Died (Mar. 24, 2014), *available at* <http://www.justice.gov/usao/nys/pressreleases/March14/TerrencePendergrassPRComplaintPR.php>; Michael Schwirtz, *U.S. Accuses Rikers Officer of Ignoring Dying Plea*, N.Y. TIMES, Mar. 24, 2014.

<sup>40</sup> *Oversight: Examination of Violence and the Provision of Mental Health and Medical Services in New York City Jails Before the New York City Council Comm. on Fire & Criminal Justice Services, the Comm. on Health, and the Comm. on Mental Health, Developmental Disability, Alcoholism, Substance Abuse & Disability* (June 12, 2014) (statement of Mary T. Bassett, Commissioner New York City Dep’t of Health & Mental Hygiene), *available at* <http://www.nyc.gov/html/doh/downloads/pdf/public/testi/testi20140612.pdf>.

<sup>41</sup> See Reassessing Solitary Confinement: the Human Rights, Fiscal and Public Safety Consequences: Hearing Before the Subcomm. on the Constitution, Civil Rights and Human Rights of the S. Comm. on the Judiciary, 112th

believes that the CAPS program—though in some respects a work in progress—is a good model that the Department of Correction and the Department of Health & Mental Hygiene should be looking to expand to serve a greater number of individuals given the amount of need in the system. In fact, both agencies have committed to redesigning Mental Observation Units (“MOUs”), which have been the site of deaths of individuals with serious mental illness in the last year,<sup>42</sup> to create four new units called Programs for Accelerated Clinical Effectiveness (“PACE”).<sup>43</sup> The goal of the PACE units is to provide enhanced services to individuals with mental health needs *before* individuals engage in problematic behavior. We support the city’s efforts to expand therapeutic programs and urge their continued expansion.

DRNY is encouraged by the commitment to take concrete and necessary steps to remedy abuse and neglect of individuals with mental illness. These initiatives, however, are not enough to address systemic deficiencies in the delivery of mental health services at Rikers Island. Moreover, we are deeply concerned about the Department of Correction’s recent request for authorization from the New York City Board of Correction to establish a new 250-person housing unit for indefinite solitary confinement.<sup>44</sup> Based on information presented to the Board about the criteria for placement in this unit and the lack of any exclusions for individuals with mental illness, vulnerable individuals are at risk of placement in this new unit. Individuals with mental illness should be excluded from the unit. While systemic violence at Rikers Island must be addressed, reforms must not occur at the expense of the health and safety of individuals with mental illness.

### **Training for Community Law Enforcement**

Police officers and other law enforcement officers frequently come into contact with individuals with mental illness. It is critical that these officers feel comfortable during these interactions and understand how to use appropriate techniques to de-escalate a situation or respond to a person in crisis. The New York City Police Department alone responds to about 150,000 “emotionally disturbed persons” calls per year; almost all officers will encounter this type of case at least once in their careers. Training for these situations has been undervalued,

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Cong. 2-3 (2012) (Written testimony of Michael Jacobson, President & Director, Vera Institute of Justice) (noting Mississippi’s experience in reducing segregation was accompanied by a 70 percent decrease in prisoner-on-prisoner and prisoner-on-staff violence); *see* Mississippi DOC’s Emmitt Sparkman on Reducing the Use of Segregation in Prisons, Vera Institute of Justice Blog, Oct. 31, 2011, <http://www.vera.org/blog/mississippi-docs-emmitt-sparkman-reducing-use-segregation-prisons> (noting reduction in violence in segregation unit with the use of programming and incentives); *see* David Lovell & Clark Johnson, *Felony and Violent Recidivism Among Supermax Prison Inmates in Washington State: A Pilot Study* 19 (2004) (finding that individuals released directly from segregation to the community had “significantly higher rates of felony recidivism than those who had some prerelease period in social prison settings”).

<sup>42</sup> Jake Pearson, *2 Deaths Put NYC Jail System Under Scrutiny*, ASSOCIATED PRESS, May 22, 2014.

<sup>43</sup> Letter from Joseph Ponte, Comm’r of the New York City Dep’t of Corr., to Gordon Campbell, Chair, New York City Bd. of Corr. (Nov. 4, 2014).

<sup>44</sup> The Board of Correction has direct oversight authority under the New York City Charter § 626.

and failure to appropriately understand and respond to these cases can result in physical harm to all parties involved.

Some states, as well as some towns and cities within New York, have taken the proactive step of requiring officers to learn crisis intervention techniques that can be used during interactions with mentally ill individuals. Crisis Intervention Training, or CIT, is an example of a program designed to specifically assist law enforcement officials on how to respond to a person in crisis. This form of training works through various scenarios during which a law enforcement official may encounter an individual with a mental illness, and provides tools and guidance in addressing the situation. Officers learn how to recognize signs and symptoms of mental illness and how to respond appropriately. Most importantly, officers are taught de-escalation techniques to use in cases where individuals become agitated. These techniques can be life-saving, as they allow an officer to maintain control of a tense situation without resorting to potentially dangerous physical restraint.

Crisis Intervention Training should be a required part of educating law enforcement officials about appropriate interactions with individuals with mental illness, and New York should require this training for new officers and as a refresher to veteran law enforcement officials.

Thank you very much for the opportunity to submit this testimony. Thank you for your consideration.

Respectfully submitted,

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