NYS Assembly Standing Committee on Correction
NYS Assembly Standing Committee on Mental Health
Mental Illness in Correctional Settings Public Hearing
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Written testimony submitted by Anthony J. Annucci, Acting Commissioner, New York State Department of Corrections & Community Supervision

Chairman O'Donnell and Chairwoman Gunther, thank you for the opportunity to submit written testimony to the Assembly Standing Committee on Correction and the Assembly Standing Committee on Mental Health, on the very important topic of Mental Illness in Correctional Settings.

To begin with, the mission of the New York State Department of Corrections and Community Supervision is to improve public safety by providing a continuity of appropriate treatment services in safe and secure facilities where offenders' needs are addressed and they are prepared for release, followed by supportive services under community supervision to facilitate a successful completion of their sentence. The following summarizes the Department's commitment to provide for the safe and humane confinement of every individual committed to its custody, including those who have been diagnosed as having a mental illness.

The Department, in partnership with the Office of Mental Health (OMH), the agency responsible for providing psychiatric care and treatment of the inmate population, settled a complex class action lawsuit a number of years ago pertaining to the care and treatment of mentally ill inmates. The lawsuit was resolved by the signing of a 31-page Private Settlement Agreement (PSA). Beginning in 2007, both agencies embarked on a major joint initiative in order to meet the requirements of this court-approved PSA with Disabilities Advocates Inc. (DAI), and have now established what has become a national model in the treatment of inmates who have mental health concerns. Thereafter, the SHU Exclusion Law, which was enacted as Chapter 1 of the Laws of 2008, imposed additional responsibilities on both agencies with respect to the care and treatment of inmates with mental illness.

As a result of the PSA, every inmate is screened by OMH upon admission in reception at DOCCS. Prior to the PSA, OMH screened approximately 40% of the incoming inmates. This is a significant enhancement because at the earliest juncture, it allows the system to place inmates with mental illness at those facilities with appropriate programs and services to best address their needs.

In addition, the PSA resulted in the following:

- The expansion of Joint Case Management Committees (JCMC's), comprised of DOCCS and OMH staff from OMH Level 1 facilities, to include all OMH Level 2 facilities, like Southport. JCMC's review and monitor all active mental health caseload inmates housed in Special Housing Units and Separate Keeplock Units at least every two weeks. This vibrant process includes input from various line staff, as well as supervisors, who deal with these inmates on a regular basis.

- The formation of the Joint Central Office Review Committee (JCORC), which consists of high level staff from both DOCCS and OMH and provides oversight and a key leadership role to ensure the provisions of the PSA were and are still followed throughout DOCCS system. JCORC serves to reinforce both DOCCS' and OMH's commitments to providing a heightened level of care for all inmates with a serious mental illness (SMI) and to providing appropriate treatment in the least restrictive setting where they can function effectively. Each month, JCORC connects by televideo to the JCMC's of two selected facilities to jointly review with them all of the cases that are on the schedule.

- To comply with the PSA and then transition to compliance with the SHU Exclusion Law, DOCCS invested over $157 million in capital expenditures in both rehab of existing residential and program space, as well as new construction. Beyond these expenditures for construction and renovation, DOCCS had to significantly increase its staff in order to escort and supervise inmates as well as to provide the Department's portion of the four hours of out-of-cell therapeutic treatment and/or programming each day, Monday through Friday. There are currently 1,005 residential mental health treatment unit beds jointly operated with OMH for the seriously mentally ill. These include 781 Intermediate Care Program beds (ICP) that provide the heightened level of care in general population for those inmates with major mental disorder and who have demonstrated difficulty functioning in a general population setting. There are also 224 residential beds for inmate-patients who are designated SMI and who have disciplinary confinement sanctions in excess of thirty days. These beds consist of Residential Mental Health Units, the Behavioral Health Unit and the Therapeutic Behavioral Unit for females at Bedford Hills.

- As part of the PSA, 253 Transitional Intermediate Care Program beds were created for those inmates transitioning back into general population.

- Before the PSA and SHU Exclusion Law, inmates with a serious mental illness who received a disciplinary confinement sanction would find themselves confined for up to 23 hours a day with one hour of out-of-cell exercise. The PSA required that such inmates be offered a heightened level of care which consisted of at least two hours of out-of-cell therapeutic programming and/or mental health treatment per day, five days per week, in addition to exercise. The central component of the SHU Exclusion Law increased that required out-of-cell therapeutic programming/mental health treatment to 4 hours per day for virtually all SMI inmates with a disciplinary confinement sanction in excess of thirty days. Furthermore, in the absence of exceptional circumstances, such programming and treatment must occur in one of the Department's Residential Mental Health Treatment Units, which, as the SHU Exclusion law specifies, are not special housing units.

- The SHU Exclusion Law requires that upon admission to segregated confinement in a facility designated as OMH Level 1, 2, 3 or 4, a suicide prevention screening instrument is to be administered by a trained employee in order to identify inmates who may be at risk. DOCCS Sergeants, the first line supervisors, are trained to conduct this screening of all inmates upon admission

to an SHU or a separate keeplock unit. The screening tool contains 14 separate items for the Sergeant conducting the screening to enter the inmate's responses as well as the Sergeant's observations of the inmate's behavior/appearance. There is also a box for the security supervisor to enter the observations made of the inmate by the officer who escorted the inmate to SHU. Seven of the 14 response boxes for the questions/observations are marked with asterisks which means if the box is checked, an immediate referral of the inmate must be made to OMH for their assessment. If an inmate is identified to be at risk of suicide, DOCCS will notify OMH and take appropriate safety precautions. Many of the questions on this suicide prevention screening instrument were modified based on suggestions by National Suicide expert Lindsay Hayes. A completed form is filed with four different units.

In addition to the suicide prevention screening requirement and the expansion of residential mental health treatment unit beds mentioned above, the law resulted in the following:

- *Assessments by OMH* – All inmates are assessed by OMH within one business day of admission to SHU at a facility designated as an OMH level 1 or 2. All inmates are assessed by OMH within 14 days of admission to SHU at a level 3 or 4 facility. In order to ensure that the Department is in compliance with the American Correctional Association (ACA) Standard 4-4256, any inmate in SHU at a facility with no OMH services is assessed by OMH within 30 days of admission. This is arranged by the Offender Rehabilitation Coordinator.

- *Reassessments by OMH* – All inmates are offered at least one interview with a mental health clinician within 14 days of their initial assessment and at least every 30 days thereafter, in an OMH level 1 or 2 facility SHU. All inmates in an OMH level 3 or 4 facility SHU, are offered one interview with a mental health clinician within 30 days of their initial assessment and at least every 90 days thereafter. These 90-day reassessments are also done by OMH for inmates who are housed in an SHU, which has no OMH services (Level 6) (ACA Standard 4-4256).

- *Oversight* – The SHU Exclusion Law, Correction Law 401-a, assigned oversight responsibilities to the former NYS Commission on Quality of Care and Advocacy for Persons with Disabilities (CQCAPD), which now is the NYS Justice Center, with regard to monitoring the quality of mental health care provided to inmates and ensuring compliance with Correction Law 137 relative to inmates who are designated as SMI, being removed from SHU. Staff of the Justice Center have direct and immediate access to all areas where inmates are housed and to clinical and Department records relating to inmates' clinical conditions.

- Training – All new correction officers and all DOCCS staff, who regularly work in programs providing mental health treatment for inmates, receive eight hours of training about the types and symptoms of mental illness, the goals of mental health treatment, the prevention of suicide, and training in how to effectively and safely manage inmates with mental illness. This training is provided annually as long as the staff work on the unit.

In addition to the above training, DOCCS employees who work in an SHU at a facility designated as an OMH level 1 or 2, receive 4 hours of training annually by OMH. The training topics include Understanding, Identifying & Treating Inmate-Patients with Mental Illness, Suicide Assessment & Prevention and Communication.

All new Sergeants, Lieutenants and Captains receive a two-hour presentation on their role in mental health. All elements of the SHU exclusion law are reviewed to ensure that the supervisors are aware of and understand their responsibilities.

In 2012, DOCCS provided a two-hour training module covering Suicide Prevention for DOCCS Supervisors. This was delivered to every facility executive team and all supervisors and covered: i) the prevention of suicide and understanding how that relates to the goals of the Department's mission; ii) the formal tools used to document observations of an inmate's mental status; and, iii) the completion of the formal suicide prevention screening instrument, which is administered to all inmates upon admission to a Special Housing Unit or Separate Keeplock Unit. It also covered the actions required should an inmate be identified as being at risk of suicide.

As a follow-up, we are working with OMH on a new two-hour training module for supervisors at facilities with part-time or no OMH services. This training will cover signs and symptoms of mental illness, the mental health referral process, and responsibilities of supervisors with regard to the prevention of suicide. This training will begin in December 2014.

Following a recommendation by CQCAPD after their review of all Residential Crisis Treatment Programs (RCTP), training for all staff working in RCTPs was developed. In 2014, all employees regularly assigned to RCTPs received 8 hours of training which was jointly developed and delivered by OMH and DOCCS. This training covered not only operational issues, but communication with inmate-patients in RCTP, Recovery and Treatment of Inmate-Patients. This training will be delivered annually.

Additionally, all DOCCS employees receive 1 hour of training in the prevention of suicides annually.

As a result of a request from the Public Employees Federation (PEF) during a DOCCS labor-management meeting with PEF, OMH has developed training to be delivered to those DOCCS employees who do not work in residential mental health treatment units, but who do work in the general population of facilities that are designated as OMH level 1 and 2. The training covers such topics as signs and symptoms of mental illness, recognizing abnormal behavior, communication and the mental health referral process. We plan to have this begin in early 2015.

As of September 30, 2014, the total number of inmates who were on the OMH Caseload was 9,311, representing 17% of the DOCCS under-custody population (53,650).

In addition to the 1,005 RMHTU beds and 253 Transitional ICP beds mentioned above, there are also 214 Residential Crisis Treatment Program beds, located at DOCCS facilities designated as OMH level 1. These beds provide crisis services, medication monitoring and potential commitment to the Central New York Psychiatric Center (CNYPC). DOCCS provides security supervision in these units.

There is also a 31-bed program jointly operated by OMH and DOCCS (Community Orientation and Re-entry Program - CORP) located at Sing Sing Correctional Facility which provides discharge planning for inmates with mental illness who are close to being released to the New York City community. There also is a similar program for female inmates called the Safe Transition and Empowerment Program (STEP), that is located at Bedford Hills Correctional Facility. OMH provides services in these programs, while DOCCS provides guidance and supervision. Also, there is in-reach from the community in and around New York City (NYC).

As described above, there are a total of 1,503 mental health beds in the prison system. We do not feel we need more at this time. DOCCS and OMH work cooperatively on utilization reviews. Both agencies support the concept of housing inmate-patients in the least restrictive environment where they can function effectively.

For persons with Serious Mental illness who are under Community Supervision, cases are reviewed by OMH and referred for community-based mental health services in accordance with their identified level of care required prior to release. This may include a referral to single point of access services (SPOA), Assisted Outpatient Therapy (AOT), mental health care, psychotropic medication, case management services and or residential services in the community.

Additionally, such individuals will be supervised by parole officers who will support these individuals with community reentry issues and with developing strategies to remain crime free in the community. Parole Officers will coordinate with other professionals (OMH and community-based providers), and with support persons (family, loved ones and care-givers) involved in a case to ensure a comprehensive approach to the delivery and management of supervision and treatment plans.

DOCCS also welcomes the support of OMH to assist with the further development of post release coordination activities between the community supervision staff and community based mental health service providers.

DOCCS most recent report “Profile of SMI Inmates” from January 2013, indicates the median minimum sentence for inmates designated as SMI was 128 months compared to 62 months for non-SMI inmates. It should be noted that 80% of inmates designated as SMI under DOCCS custody have committed violent felony offenses as compared to 64% for non-SMI designated inmates under DOCCS custody. In fact, one-third of SMI inmates had been committed for murder, attempted murder or manslaughter compared with 19% for non-SMI inmates.

Unquestionably, it is a daunting, complex and labor-intensive challenge to provide effective care and treatment to mentally ill individuals who are sentenced to state imprisonment; a challenge that exists throughout their confinement in a correctional

facility, as well as throughout their supervision in the community upon release. Among other things, it is critical while undergoing treatment, that they be protected from harm, and that they also be prevented from harming staff, visitors, other inmates, other parolees, and any members of the general public. Though the challenge is a formidable one, nevertheless, both the Department and OMH are committed to doing everything within their power to provide a network of treatment and services that can serve as a model for the entire country.