



DISABILITY RIGHTS NEW YORK

New York's Protection & Advocacy System and Client Assistance Program

Report and Recommendations on the Treatment of Individuals with Intellectual, Developmental, and Mental Health Disabilities at Sullivan Correctional Facility

July 2016

725 Broadway, Suite 450
Albany, New York 12207
(518) 427-6561 (fax)

25 Chapel Street, Suite 1005
Brooklyn, New York 11201
(718) 797-1161 (fax)

44 Exchange Blvd, Suite 110
Rochester, New York 14614
(585) 348-9823 (fax)

mail@DRNY.org • www.DRNY.org

(800) 993-8982 (toll free) • (518) 432-7861 (voice) • (518) 512-3448 (TTY)

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EXECUTIVE SUMMARY

Disability Rights New York (“DRNY”) is the designated federal Protection and Advocacy System (“P&A”) for individuals with disabilities in New York State.¹ DRNY has broad authority to investigate incidents of abuse and neglect of individuals with disabilities.² DRNY also has the authority to monitor the service delivery systems for people with disabilities across the State.

Because of complaints received in November 2014, DRNY investigated allegations of abuse and neglect of incarcerated individuals with disabilities in the New York State Department of Corrections and Community Supervision (“DOCCS”) system, and monitored the specialized programs operated by DOCCS and the New York State Office of Mental Health (“OMH”). This report sets forth DRNY’s findings and recommendations concerning Sullivan Correctional Facility’s Correctional Alternative Rehabilitation Program (“CAR”), which DOCCS opened in May 2014.

DOCCS created CAR to address the needs of individuals with intellectual and developmental disabilities (“ID/DD”) and to serve as a rehabilitative alternative to punitive isolation in the Special Housing Unit (“SHU”). Individuals with ID/DD who receive punishment of isolation over 30 days in SHU are transferred to CAR, where they complete their punitive segregation sanction, but receive up to four hours of out-of-cell, therapeutic programming per day. CAR has available housing for up to 64 individuals. Although DOCCS designed CAR for individuals with ID/DD, participants in CAR may have a concurrent mental health diagnosis.

CAR is one element of SHU reforms that resulted from the *Peoples v. Fischer* litigation brought by the New York Civil Liberties Union about the use of solitary confinement.³ The creation of CAR is a crucial positive step in the development of progressive and therapeutic responses to the needs of incarcerated persons with ID/DD, many of whom have co-occurring mental health needs. The decision to establish CAR represents a significant commitment by the fifth largest corrections department in the country⁴ to re-align inmate management practices around

¹ DRNY is supported by the U.S. Department of Health & Human Services, Administration on Intellectual and Developmental Disabilities; Center for Mental Health Services, Substance Abuse & Mental Health Services Administration; U.S. Department of Education, Rehabilitation Services Administration; and the Social Security Administration. This report does not represent the views, positions, or policies of, or the endorsement of, any of these federal agencies.

² See generally Developmental Disabilities Assistance and Bill of Rights Act (“DD Act”), 42 U.S.C. § 15041 *et seq.*; Protection and Advocacy for Individuals with Mental Illness Act (“PAIMI Act”), 42 U.S.C. § 10801 *et seq.*; Protection and Advocacy for Individual Rights Act (“PAIR Act”), 29 U.S.C. § 794e; N.Y. Exec. Law § 558(b).

³ Settlement, *Peoples v. Fisher*, No. 11-cv-2694 (No. 137), available at http://www.nyclu.org/files/releases/20151216_settlementagreement_filed.pdf.

⁴ U.S. Dep’t of Justice, Office of Justice Programs, Prisoners in 2013, at 3, <http://www.bjs.gov/content/pub/pdf/p13.pdf>.

principles of rehabilitation and treatment, rather than punitive segregation that is associated with psychological harm.⁵

On November 20-21, 2014, DRNY visited Sullivan Correctional Facility's special programs, including CAR, SHU, the Residential Crisis Treatment Program ("RCTP"), the Sensorial Disabled Program ("SDP"), and the Special Needs Unit ("SNU").⁶ During this visit, CAR program participants complained to DRNY about excessive force and denial of treatment or services. Accordingly, DRNY returned to CAR on January 9, 2015 and August 11-13, 2015. DRNY spoke with executive staff and privately interviewed CAR program participants. DRNY also reviewed mental health and security records.

The participants described CAR as nothing more than a "slightly modified box."⁷ During DRNY's investigation and monitoring, DOCCS acted upon DRNY's feedback about CAR and made positive changes. Despite these positive changes, DRNY continues to find deficiencies in the structural framework, program design, and implementation of CAR.

Specifically, DRNY has found that:

1. **DOCCS has provided an appropriate physical space for programming.**
2. **DOCCS has designed an effective and well-received program curriculum.**
3. **DOCCS has established an under-inclusive eligibility process that fails to identify all CAR-eligible individuals.**
4. **CAR has an ill-defined program advancement system based on behavioral standards that do not adequately accommodate disability.**
5. **DOCCS policy allows program graduates to return to SHU.**

⁵ See, e.g., 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) (finding that people who were punished by solitary confinement were approximately 6.9 times as likely to commit acts of self-harm).

⁶ SHU is a 24-bed unit where DOCCS holds individuals in solitary confinement for 23 hours per day for punishment. DOCCS transfers individuals to this unit following the imposition of disciplinary sanctions or pending a disciplinary hearing (pre-hearing confinement). The RCTP is part of a satellite mental health unit at Sullivan Correctional Facility operated by OMH. The RCTP consists of eight crisis observation cells for individuals who require immediate mental health evaluation or observation. SDP is a unit designed to assist individuals who have been accommodated for visual and/or hearing impairments. As of April 18, 2016, SDP had a census of 57 individuals. SNU is 64-bed unit that provides long-term habilitative services to individuals who DOCCS has identified as developmentally disabled, or who have significant intellectual and/or adaptive deficits.

⁷ "Box" is prison slang for SHU.

6. **DOCCS places CAR eligible individuals in SHU outside the “exceptional circumstances” process.**
7. **DOCCS does not consistently utilize non-punitive alternatives to level regression and incentive removal.**
8. **DOCCS has imposed additional SHU sanctions and other punitive discipline upon CAR program participants.**
9. **CAR does not have clear or adequate standards for discharge from the program and DOCCS does not apply the existing discharge standards consistently.**
10. **DOCCS and OMH have not provided sufficient accommodations to enable participants with co-occurring mental health disabilities to access mental health services.**
11. **DOCCS and OMH have not utilized crisis intervention as a response to mental health crises resulting in neglect and an increased risk of harm.**
12. **DOCCS has subjected program participants to unnecessary use of force resulting in injuries and an increased risk of harm.**

If CAR is to succeed as an effective therapeutic alternative to SHU, DOCCS and OMH must address the deficiencies identified in this report. Although DOCCS and OMH do not jointly operate CAR, they share responsibility for ensuring that individuals’ well-known treatment needs are not ignored. DRNY makes the following key recommendations, which are discussed more fully in Section III of this report:

1. **DOCCS and OMH, in coordination with outside experts, must develop evaluative criteria that utilize best practices to properly identify and admit those eligible for CAR.**
2. **DOCCS and OMH must eliminate the “exit ramps” that lead back to SHU.**
3. **DOCCS and OMH must ensure that the structure and programming of CAR supports the habilitation of individuals with ID/DD and adaptive deficits by using non-punitive interventions and incorporating heightened manifestation determination procedures.**
4. **DOCCS and OMH must improve access to mental health services by providing reasonable accommodations to individuals who need assistance making requests for services.**
5. **DOCCS and OMH must adopt best practices in crisis intervention to improve treatment and assessment of individuals with mental health needs.**

6. **DOCCS and OMH must solicit technical assistance from independent experts to review the delivery of mental health services.**
7. **DOCCS and OMH must review patients who repeatedly transfer to and from the RCTP and CAR or SHU, and patients deemed to be “malingering.”**
8. **DOCCS must integrate best practices in crisis intervention by revising its use of force policy.**
9. **DOCCS and OMH must review the reasons for admission to the RCTP and the quality of treatment provided to mental health patients with lengthy and/or recurrent RCTP admissions, including individuals who have been involved in uses of force.**
10. **DOCCS and OMH must investigate and when appropriate remedy numerous, persistent, and credible complaints with regard to treatment, programming, and environmental conditions.**
11. **In consultation with an outside expert, DOCCS and OMH must develop and provide comprehensive training on recognizing signs of mental illness, managing and caring for populations with ID/DD and co-occurring mental illness, and crisis intervention practices.**
12. **DOCCS must collect, analyze, and make publicly available census data and statistical data on the CAR population.**

It is critical that DOCCS and OMH take these corrective actions to address problems with program design and implementation and, specifically, address the persistent and credible allegations of abuse that are detailed in DRNY’s letter dated September 3, 2015.⁸ DRNY is confident that its recommendations will assist DOCCS and OMH in realizing the mission of CAR and promoting a culture of respect for the rights and safety of persons with disabilities in DOCCS’ custody for the long term.

On May 24, 2016, DRNY sent this report to DOCCS and OMH and invited them to respond to DRNY’s findings and recommendations. See Addendum B. DOCCS provided its response in a letter dated July 12, 2016. See Addendum C. DRNY’s response to DOCCS’s July 12 letter can be found at Addendum D. OMH did not respond to DRNY’s May 24 letter.

⁸ The letter and the response dated November 5, 2015 from the DOCCS Assistant Commissioner are an addendum to this report. See Addendum A.

I. BACKGROUND AND SCOPE OF INVESTIGATION

On November 20-21, 2014, DRNY conducted monitoring and investigation of CAR, SHU, SDP, and RCTP pursuant to its federal authority.⁹ DRNY met with facility administrators and department officials, toured the program areas and housing areas, and spoke with program participants cell-side. DRNY spoke with over 30 CAR program participants, representing 46.8% of the CAR census at that time. Many participants complained of excessive force and wrongful denial of program and services.

During December 2014, DRNY reviewed DOCCS and facility policies and exchanged legal correspondence with program participants who complained of excessive force and wrongful denial of treatment and services.

On January 9, 2015, DRNY met privately with two CAR program participants.

On August 11-13, 2015, DRNY monitored CAR. During this visit, DRNY spoke with executive staff, toured CAR, and interviewed 49 program participants representing over 90% of the CAR census at that time.

Between January 2015 and February 2016, DRNY corresponded with CAR program participants and reviewed records.

As a result of its investigation and monitoring, DRNY identified the following issues and allegations that warranted further investigation:

1. Corrections staff are using force in the CAR housing area that is unnecessary for the situations or infractions at issue, and are verbally disrespectful toward program participants.¹⁰
2. Corrections staff are ill equipped to work with individuals with ID/DD, due to deficiencies in training.

⁹ See generally Developmental Disabilities Assistance and Bill of Rights Act (“DD Act”), 42 U.S.C. § 15041 *et seq.*; Protection and Advocacy for Individuals with Mental Illness Act (“PAIMI Act”), 42 U.S.C. § 10801 *et seq.*; Protection and Advocacy for Individual Rights Act (“PAIR Act”), 29 U.S.C. § 794e; N.Y. Exec. Law § 558(b); see also 45 C.F.R. § 1386.27.

¹⁰ DRNY notified DOCCS of allegations of excessive use of force and verbal abuse in a letter to Superintendent William Keyser dated September 3, 2015. DRNY has attached a redacted version of this letter as an addendum to this report, along with DOCCS’s reply. DRNY will not repeat its detailed accounting of the allegations of abuse in the body of this report, but incorporates it by reference. DRNY has not investigated these allegations, and has asked DOCCS to investigate, which it has promised to do. DRNY does note that the large number of such complaints, their consistency, and their specificity in identifying particular alleged perpetrators, makes these allegations credible and warrants thorough investigation. The complaints consistently note that many of the alleged assaults occurred in the CAR property room, and DOCCS should install audiovisual equipment in the property room and any other areas of CAR that are not currently subject to audiovisual recording.

3. CAR lacks a coherent behavioral management system informed by crisis intervention principles.
4. Corrections staff are issuing excessive “negatives” and misbehavior reports for imperfect adherence to rules.
5. Mental health staff disclose protected health information to corrections staff, placing program participants at risk of retaliation or abuse.
6. Mental health staff did not provide adequate treatment to CAR program participants.
7. DOCCS discharges program participants from CAR to SHU prior to their completion of the program and prior to their completion of their SHU sanction.
8. DOCCS transfers program participants out of CAR based on inadequate testing, and denies admission to CAR based on the same inadequate tests.
9. DOCCS transfers program participants out of CAR based upon misbehavior without the proper due process.

II. INVESTIGATIVE FINDINGS¹¹

DOCCS HAS PROVIDED AN APPROPRIATE PHYSICAL SPACE FOR PROGRAMMING

DOCCS HAS DESIGNED AN EFFECTIVE AND WELL-RECEIVED PROGRAM CURRICULUM

Maintenance of behavioral health is contingent upon the presence of a safe environment and access to supportive interventions. Safe spaces lead to the development of positive social and independent living skills, which improve the likelihood of successful community integration upon release. DRNY finds that the CAR program space is clean and bright. DOCCS allocated a room for private clinical interviews in the programming area, and program rooms were equipped with “Re-start chairs,” making the rooms feel like classrooms.¹² The majority of participants interviewed were pleased with the CAR program space.

Additionally, a majority of participants shared positive reviews of the CAR curriculum. Program participants stated that CAR teachers are helpful and committed. DRNY observed teachers engaging program participants in the curriculum and encouraging learning and development. Program participants consistently stated that the CAR classroom program has helped them manage anger, respond appropriately to conflict, and handle social situations effectively. Interviewees also stated that the CAR classroom program has improved their reading, writing, and math skills.

Recommended Action

DRNY encourages DOCCS to continue to develop classroom and congregate programming spaces throughout the state correctional system to expand the availability of therapeutic programming. DRNY also encourages DOCCS to continue to develop the CAR curriculum, and to devote the necessary resources toward the hiring of highly qualified staff year-round.

¹¹ Where appropriate, DRNY has included complaint examples throughout this report. These examples represent a small fraction of the complaints DRNY has received over the course of its investigation and monitoring. DRNY has assigned a pseudonym to each program participant because DRNY is required to keep the identity of complainants confidential. 45 C.F.R. § 1386.28(b)(1)(i)-(iv); 42 C.F.R. § 51.41(a).

¹² The “Re-start chair” uses a floor-level locking device to secure the program participant to the chair using ankle restraints. A desk connects to a small chair.

DOCCS HAS ESTABLISHED AN UNDER-INCLUSIVE ELIGIBILITY PROCESS WHICH FAILS TO IDENTIFY ALL CAR-ELIGIBLE INDIVIDUALS

The eligibility and evaluative process is under inclusive and excludes people with ID/DD who should be in CAR. DOCCS created CAR to “address the special needs of inmates with intellectual and adaptive deficits who are serving disciplinary sanctions in SHU.”¹³ Yet, even though CAR’s target population are individuals with adaptive deficits, DOCCS does not conduct adaptive assessments as part of the CAR eligibility process.¹⁴ The *Peoples* final settlement does not address this problem.

DOCCS conducts brief intelligence screening tests for all individuals entering its system at four reception centers. Thereafter, DOCCS conducts full-scale intelligence quotient (“IQ”) testing for individuals who have scored below 70 on the brief intelligence screening tests. DOCCS conducts full-scale IQ testing either at the receiving facility or at CAR upon referral.

DOCCS stated that it relies almost exclusively upon IQ testing as a method for determining CAR eligibility. In place of adaptive assessments, DOCCS relies on measures of reading and writing capability, observations, and inmate records. However, near-exclusive reliance on IQ testing is problematic because IQ testing is subject to a series of variables that may influence scores.¹⁵ Invalid scores result from the exclusive use of brief intelligence screening tests or group tests, invalid instruments, or the presence of co-occurring disorders that affect communication, language, and/or motor or sensory function.¹⁶ Even if DOCCS were to control for these issues by norming instruments for an individual’s socio-cultural background and native language, and ensuring that trained professionals conduct the testing, IQ scores will still be approximations and may be invalid or unreliable.¹⁷ For example, the WAIS-IV has a standard deviation of 15 and a margin of error of five points.¹⁸ Individuals who score above 70 on the WAIS-IV may still evince issues with verbal comprehension, working memory, perceptual reasoning, quantitative reasoning, abstract thought, or cognitive efficiency.¹⁹ IQ testing together with adaptive assessments will ensure that DOCCS does not erroneously screen eligible individuals out of CAR.

DOCCS has not acted upon earlier recommendations to incorporate adaptive assessments. In 1991, the New York State Commission on Quality Care for the Mentally Disabled (“CQC”)

¹³ Department of Corrections and Community Supervision, Correctional Alternative Rehabilitation (CAR) Program 5 (2014) (hereinafter “CAR Program Manual”).

¹⁴ While evaluators are encouraged to gather source material related to academic, vocational, and educational background, they are not required to do so.

¹⁵ AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 37 (David J. Kupfer, M.D., Task Force Chair, 5th ed. 2013).

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ Simon Whitaker, *Error in the Estimation of Intellectual Ability in the Low Range Using the WISC-IV and WAIS-III*, 48 PERSONALITY AND INDIVIDUAL DIFFERENCES 517 (2010). Due to its margin of error, a score of 75, for example, may not indicate a greater impairment than a score of 79.

¹⁹ DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, *supra* note 15, at 37.

published *Inmates with Developmental Disabilities in New York State Correctional Facilities*, which is the most recent public comprehensive assessment of DOCCS' services available to inmates with ID/DD. CQC determined that New York did not formally incorporate adaptive assessments into its screening processes and that, as a result, DOCCS did not identify or treat individuals with adaptive deficits appropriately. In 2016, DOCCS still faces this problem.

Recommended Corrective Action

As long as DOCCS uses IQ score as the sole quantitative method of eligibility, it will screen out those who, based on adaptive deficits or some combination of intellectual functioning and adaptive deficits, should be in CAR. DRNY recommends that DOCCS revise its eligibility process in collaboration with independent experts. During its August 11, 2015 visit, DRNY recommended that DOCCS look to best practices for assessing the adaptive functioning of incarcerated individuals. DOCCS was receptive to this idea. DRNY, therefore, provides the eligibility scheme adopted by California in Section III. This eligibility scheme may be improved upon in consultation with experts.

CAR HAS AN ILL-DEFINED PROGRAM ADVANCEMENT SYSTEM BASED ON BEHAVIORAL STANDARDS THAT DO NOT ADEQUATELY ACCOMMODATE DISABILITY

Once admitted to CAR, individuals participate in programming intended to address their social, academic, and rehabilitative needs. To advance, program participants must consistently attend this programming without displaying behavioral problems.²⁰ DRNY found, however, that CAR has ill-defined benchmarks for program advancement based on behavioral standards that do not adequately accommodate disability. To be effective, the CAR behavioral modification system must include realistic and obtainable goals. A successful behavioral modification system uses a 4:1 ratio of positive, affirming statements for every expression of disapproval, and treats interaction as an opportunity to model positive behaviors.²¹ Perhaps most importantly, a successful behavioral modification system does not punish inmates where negative behavior is a manifestation of disability.²²

DRNY received complaints that DOCCS holds program participants to unreasonably difficult standards of behavior and punishes participants when they do not meet those standards. DRNY investigated these complaints by reviewing the CAR rehabilitation level system and found that program advancement was contingent on refraining from behaviors that are common manifestations of ID/DD. For example, program participants must:

- (1) demonstrate an appropriate level of program participation;
- (2) demonstrate respectfulness to themselves, peers, and staff as evidenced by expressing themselves calmly in groups and other situations (*e.g.* not yelling, coercing, demanding, or threatening);
- (3) keep themselves and their cells clean and neat;
- (4) express negative emotions appropriately in all situations; and
- (5) move between groups and programs without being disruptive.²³

These criteria relate to verbal expression, self-care, attention, and emotion. Some criteria are subjective (*e.g.* demonstrating “appropriate” levels of participation), or leave little margin for error (*e.g.* participants must “attend and participate in all programming”).²⁴ Deficits in these areas may be manifestations of disability. With a clear and consistently applied behavioral modification system, program participants may learn to modify manifestations of their disability. As currently written, however, the standards do not foster widespread learning and rehabilitation,

²⁰ CAR Program Manual, *supra* note 13, at 13-20.

²¹ Frank Domurad and Mark Carey, *Implementing Evidence-Based Practices*, THE CENTER FOR EFFECTIVE PUBLIC POLICY, (2009), <http://www.cepp.com/documents/implementing%20evidence%20based%20practices.pdf>.

²² State education regulations operationalize this principle by requiring a behavioral intervention plan—not discipline—for an individual whose problematic behavior is a manifestation of a disability. *See, e.g.*, N.Y. COMP. CODES, R. & REGS. tit. 8, § 201.4 (requiring schools to review the relationship between a student’s disability and behavior subject to disciplinary action to determine whether the conduct is a manifestation of disability).

²³ CAR Program Manual, *supra* note 13, at 17.

²⁴ *Id.*

and leave too much discretion to CAR staff to treat behavior as a disciplinary issue rather than a manifestation of disability.

Program Participant A

Program Participant A stated that he was nearly promoted to level 2, but got one negative for fishing (exchanging items between cells using rope), and so was forced to do another 30 days at level 1. When Program Participant A challenged this strict punishment, officers allegedly told him, “this is our house; you are not going to win.”

Recommended Corrective Action

DRNY recommends that DOCCS revise its rehabilitation level system in collaboration with experts. During its August 11, 2015 visit, DRNY recommended that DOCCS look to best practices for creating a behavioral modification system for incarcerated individuals with ID/DD. DOCCS was receptive to this idea.

DOCCS POLICY ALLOWS PROGRAM GRADUATES TO RETURN TO SHU, AND DOCCS PLACES PROGRAM PARTICIPANTS IN SHU OUTSIDE THE “EXCEPTIONAL CIRCUMSTANCES” PROCESS

DOCCS executive staff informed DRNY that individuals who complete CAR before the expiration of their SHU or keeplock²⁵ sentence receive an automatic time cut. DOCCS policy, however, states that if a program participant completes CAR prior to the completion of his SHU or keeplock sentence, the Review Committee and Superintendent can decide to cut remaining SHU or keeplock time.²⁶ It is antithetical to rehabilitation to send a program participant back to SHU after successful completion of CAR. To the extent that DOCCS allows this to happen, it should amend its policies. Upon a program participant’s successful completion of CAR, DOCCS should cut all remaining SHU time and relocate the program participant to SNU, General Population (“GP”), or an appropriate specialized program. DOCCS should never discharge an individual to SHU after his completion of CAR.

Additionally, DOCCS should not place program participants in SHU without first utilizing the “exceptional circumstances” process. During DRNY’s August 11-13, 2015 visit, more than half of the 19 CAR program participants that DRNY privately interviewed stated that DOCCS subjected them to a “cooling off” period in SHU after their receipt of a misbehavior report. During DRNY’s meeting with executive staff, DOCCS confirmed that it subjects CAR program participants to “cooling off” periods in SHU, even when participants will likely return to CAR. One program participant stated that this happens with such regularity that “[CAR program participants] are the only people in the box.” Program participants complained that DOCCS curtails their progress through CAR by placing them in SHU, and uses SHU placement far too frequently as punishment for misbehavior. This practice undermines CAR’s rehabilitative mission. The touchstone of CAR should be the use of the least restrictive alternative at all times, including during the pre-hearing process.

Recommended Corrective Action

DRNY recommends that DOCCS revise its discharge and “cooling off” policies to bring them into compliance with the *Peoples* settlement. The *Peoples* settlement mandates the placement of eligible individuals in CAR unless there is a documented “exceptional circumstance.” DOCCS should eliminate the practice of using SHU to “cool people off.” CAR graduates should transfer to SNU, GP, or an appropriate specialized program. DRNY encourages DOCCS to utilize non-punitive approaches to maladaptive behavior.

²⁵ Keeplock is a form of punishment DOCCS imposes for less serious disciplinary infractions. Keeplock prisoners are subjected to 23 hours of isolation per day, often in a cell within general population or within a block of keeplock cells within a facility. Prisoners sentenced to keeplock may also be transferred to SHU to serve their keeplock time, where they are subject to the same restrictions as those sentenced directly to SHU. N.Y. COMP. CODES, R. & REGS. tit. 7, §§ 251-1.6, 253.7, 254.7. *See also* NEW YORK CIVIL LIBERTIES UNION, *BOXED IN: THE TRUE COST OF EXTREME ISOLATION IN NEW YORK’S PRISONS* 17 (2013) (describing the use of keeplock in New York State).

²⁶ CAR Program Manual, *supra* note 13, at 10.

In addition, whenever the Review Committee recommends that a participant be excluded from the program, a manifestation determination process, led by an appropriately trained and licensed clinician, should be used to determine whether the participant is being excluded on the basis of disability-related behavior. If so, the participant should not be excluded but instead should be evaluated to determine what supports are required to allow the participant to continue in the program.

DOCCS INAPPROPRIATELY USES LEVEL REGRESSION AND INCENTIVE REMOVAL INSTEAD OF NON-PUNITIVE ALTERNATIVES

The CAR program manual emphasizes that “relapses into inappropriate behaviors can result in the loss of incentives or . . . a return to a previous level.”²⁷ For the sake of clarity, DRNY has termed the “return to a previous level” system “level regression.” DRNY spoke with many program participants subjected to a reduction in incentives, level regression, or both.

Program Participant B

Program Participant B stated that he was a Progressive Inmate Management System (PIMS) level 3 in a SHU 200 prior to his transfer to CAR. A SHU 200 is a stand-alone SHU building on the grounds of a medium security prison. SHU 200 prisoners are subjected to 23 hours of isolation per day and are permitted one hour of recreation in a cage attached to their cell. SHU 200 inmates do not receive programming focused on developing or maintaining pro-social skills. Program Participant B stated that, after leaving a SHU 200 for CAR, he received six or seven tickets, lost several incentives, and was ultimately transferred to SHU for a “cooling off period.” Program Participant B stated that he tried his best to adhere to the manual, but it is “a big phony.” He does not know what to do to prevent further discipline, and he feels CAR officers targeted him.

For CAR to be successful, rehabilitation must be emphasized over punishment. However, its manual does not define “inappropriate behavior.” This lack of clarity may result in the imposition of discipline for disability-related behavior. Additionally, the touchstone of the *Peoples* settlement is the utilization of de-escalation and non-punitive alternatives as a first resort. DOCCS must exhaust non-punitive alternatives before it considers punitive measures.

Recommended Corrective Action

DRNY recommends that DOCCS, in consultation with appropriate experts, review the use of level regression and incentive removal in the CAR program and make necessary changes to assure that program participants are not punished for disability-related behavior and that appropriate behavioral supports are provided.

DOCCS also should consult with and seek advice from the Office of Persons with Developmental Disabilities (OPWDD) regarding best practices concerning providing behavioral and other supports to persons with developmental disabilities.

²⁷ *Id.* at 18.

DOCCS HAS IMPOSED ADDITIONAL SHU SANCTIONS AND OTHER PUNITIVE DISCIPLINE UPON CAR PROGRAM PARTICIPANTS

DRNY received complaints that program participants received excessive disciplinary sanctions in CAR. During its August 11-13, 2015 visit, DRNY spoke with 49 program participants cell-side and 19 program participants privately. All but one program participant expressed fears of discipline in CAR that is disproportionate to the offense.

DOCCS policy states, “[i]nfractions may result in additional disciplinary sanctions as outlined in DOCCS regulations.”²⁸ This is antithetical to the goals of CAR and sets up some program participants for failure. Many CAR program participants do not yet understand how to avoid infractions and require assistance in developing enhanced coping skills necessary to manage their behavior and conform to rules. DOCCS should not conflate punishment with rehabilitation. The CAR disciplinary system must reflect the tenets of the *Peoples* final settlement – to promote skill development as a rehabilitative alternative for SHU inmates with ID/DD.

DRNY finds that DOCCS’ practices of using SHU time, keeplock time, and deprivation orders violates the stated objectives of CAR as a rehabilitative alternative to SHU. DOCCS should never impose additional SHU time upon CAR program participants. By creating CAR, DOCCS has already demonstrated its understanding that individuals with ID/DD do not belong in SHU. SHU exposes people with ID/DD to psychological harm and runs directly against the rehabilitative goals of CAR. Furthermore, the imposition of SHU time upon CAR program participants may result in the continued occupation of a CAR cell, to the detriment of other individuals who may need CAR bed space.

Recommended Corrective Action

DRNY strongly recommends that DOCCS discontinue the imposition of SHU time upon CAR program participants. DRNY recommends that DOCCS discontinue the imposition of additional keeplock time and deprivation orders, and DRNY recommends that DOCCS utilize de-escalation techniques and informational reports.²⁹

DRNY recommends that DOCCS develop a CAR manifestation determination process separate from the pre-existing hearing process designed solely to determine whether participant misbehavior relates to disability. During this manifestation determination process, a trained clinician – not a social worker or teacher – should assess the participant to determine whether the behavior relates to a disability. If the trained clinician determines that the behavior relates to a disability, DOCCS policy should preclude the Review Committee from recommending additional discipline and require the development of a behavioral intervention plan to help correct the problematic behavior. DOCCS should integrate the behavioral intervention plan into the participant’s CAR treatment plan.

²⁸ *Id.* at 19.

²⁹ Informational reports are reports used to convey positive or negative information to an inmate about his behavior. They are a communication tool and do not initiate formal discipline. *See* CAR Program Manual, *supra* note 13, at 13.

DRNY recommends that DOCCS solicit the assistance of an outside expert in training, staffing and design of CAR incentives and disincentives. Experts should train corrections and mental health staff on how to serve people with ID/DD.³⁰ Comprehensive training would enable staff to develop individualized rehabilitation plans that are well defined, appropriate, and utilize alternatives to discipline.

Executive staff informed DRNY that CAR staff attend a two-day annual training, which includes lessons on person-centered planning. However, DRNY was unable to assess the quality of training because DOCCS did not provide materials that DRNY requested. Currently, the CAR Program Review Committee consists exclusively of DOCCS staff, meaning that DOCCS exercises the only voices on the committee responsible for making all programmatic decisions that impact CAR program participants.³¹ Therefore, DRNY recommends that an outside expert have an advisory role on the CAR Program Review Committee.

³⁰ The *Peoples* final settlement agreement mandates de-escalation training; therefore, DRNY recommends training specific to individuals with ID/DD and co-occurring mental health needs.

³¹ CAR Program Manual, *supra* note 13, at 9.

CAR DOES NOT HAVE CLEAR OR ADEQUATE STANDARDS FOR DISCHARGE FROM THE PROGRAM

DOCCS DOES NOT APPLY DISCHARGE STANDARDS CONSISTENTLY

DOCCS FORMALLY DISCHARGES PROGRAM PARTICIPANTS TO SHU OUTSIDE OF THE “EXCEPTIONAL CIRCUMSTANCES” PROCESS

DOCCS executive staff stated the Review Committee has discharged program participants prior to their graduation or completion of SHU sentences. This means CAR program participants have left CAR with confinement time remaining. Several former participants complained that DOCCS discharged them from CAR to SHU based upon re-evaluations of full-scale IQ or individual misbehavior. In some cases, DOCCS allegedly discharged program participants back to SHU even though participants believed they were benefitting from and demonstrating success in the program. Some former participants complained that DOCCS transferred them to SHU and left them there to serve out their SHU sanctions.³²

The CAR guidelines make inappropriate discharges more likely. The Review Committee and Superintendent have unbridled discretion to discharge a program participant to SHU, with a discretionary review by DOCCS Central Office. Under the guidelines, the Review Committee and the Superintendent are free to determine that a program participant should serve the remainder of his disciplinary sanction in SHU. Therefore, DOCCS can remove “problem inmates” from CAR relatively easily. The wide discretion and undefined procedure regarding program completion and discharge undermine the purpose of CAR.

³² DRNY reviewed the records of some but not all of these former program participants. Records confirmed the complaints of program participants and the statements of DOCCS executive staff.

Program Participant C

DRNY met Program Participant C in November 2014. Program Participant C later wrote to inform DRNY that he was in danger of removal from CAR after receiving a misbehavior report for “being disruptive and yelling out of his cell making threats to officers on the block.” According to the misbehavior report, Program Participant C eventually obeyed a direct order to stop yelling, but he received a ticket anyway.

[One can] get a ticket for any little thing . . . which should not be happening in the CAR program. I'm here to try to better myself but how can that happen when CO's & higher ups don't want this program to work? All I ask is that these things be addressed professional.

Approximately two weeks later, Program Participant C wrote:

[Sullivan is not] letting me to go program anymore, because my I.Q. level is too high I need this program bad I can change in here if they move me it's not gonna help me better myself.”

Ultimately, Program Participant C was moved out of CAR to a SHU at another facility. He was discharged from the program due to five misbehavior reports and based on a review of his IQ score (IQ 77). On January 4, 2015, Program Participant C wrote:

I am 21 years old with bad coping skillz [sic] I have 5 years in the box, they are not trying to give me a program I'm going crazy.

Prior to CAR, Program Participant C accumulated 37 tickets over the span of 24 months. After receiving five tickets in seven months, DOCCS removed Program Participant C from CAR. After subjecting him to an almost one-year “cooling off” period,” and after months of advocacy from DRNY, DOCCS finally transferred Program Participant C back to CAR.

Recommended Corrective Action

DRNY recommends that DOCCS develop objective guidelines regarding discharge that support the rehabilitative mission of CAR, in consultation with independent experts. DOCCS should address individual misbehavior through therapeutic programming and person-centered intervention, rather than through discharge. Any discharge recommendation should be subject to a codified process of review by DOCCS Central Office.

DOCCS AND OMH HAVE NOT PROVIDED SUFFICIENT ACCOMMODATIONS TO ENABLE PARTICIPANTS WITH CO-OCCURRING MENTAL HEALTH DISABILITIES TO ACCESS MENTAL HEALTH SERVICES

DRNY received numerous complaints from CAR program participants regarding access to mental health services. Program participants complained that mental health rounds are infrequent and inconsistent, and that even when rounds are completed, there is no meaningful opportunity to engage with staff, as cell-side conversations are just minutes-long. Program participants complained that DOCCS and OMH instruct them to submit written requests for mental health services.³³ However, because some participants' disabilities affect their writing ability, and because staff refuse to provide assistance, some program participants are unable to access mental health services.

A procedure for access to mental health services that relies almost exclusively on written requests, without the provision of reasonable accommodations, precludes some program participants from accessing services, in violation of the American with Disabilities Act ("ADA"), 42 U.S.C. § 12132. Barriers to mental health services increase the risk of neglect.

Recommended Corrective Action

DRNY recommends that DOCCS and OMH take steps to ensure that they provide reasonable accommodations. Under the ADA, DOCCS and OMH are required to provide reasonable accommodations as well as auxiliary aids and services to "afford individuals with disabilities . . . an equal opportunity to participate in, and enjoy the benefits of, a service, program, or activity of a public entity." 28 C.F.R. § 35.160(b)(1); *see also* 28 C.F.R. §35.130(b)(7). DOCCS and OMH must permit oral requests from participants whose disability impairs the ability to make a written request, or provide aides to assist in making a written request.

³³ To obtain health services, CAR participants are required to "[o]btain a sick call slip from the Block Officer and fill out a slip with name, number, and locking location" and to "[i]ndicate the need for the appointment (examples: sick call, dental, medication renewal or medical supply renewal)." Department of Corrections and Community Supervision, Correctional Alternative Rehabilitation (CAR) Program at Sullivan Correctional Facility, Inmate Orientation Handbook 19 (2014) (hereinafter "CAR Inmate Handbook").

DOCCS AND OMH HAVE NOT UTILIZED CRISIS INTERVENTION TO RESPOND TO MENTAL HEALTH CRISES, RESULTING IN NEGLECT AND AN INCREASED RISK OF HARM

DOCCS and OMH have not applied essential principles of crisis intervention in CAR and the RCTP. Crisis intervention is an evidence-based method of responding to individuals who are in mental health crisis or who are a danger to themselves or others. A crisis intervention approach has certain essential values, including:

- Avoiding harm
- Intervening in person-centered ways
- Engaging and honoring the impacted individual in the process of crisis resolution
- Addressing trauma
- Establishing feelings of personal safety
- Addressing the whole person
- Respecting the individual as a credible source
- Promoting recovery and resilience
- Prevention.³⁴

Utilizing these principles, experts view recurring crises not as the product of an individual's bad behavior or a willful refusal to participate in treatment, but instead as deficiencies in assessment and treatment.³⁵ In correctional settings, access to adequate treatment ensures patient health and can eliminate the need for force by security staff to respond to crises.³⁶ Crisis intervention improves safety outcomes and is a best practice.³⁷

³⁴ U.S. DEP'T OF HEALTH & HUMAN SERVICES, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMINISTRATION, PRACTICE GUIDELINES: CORE ELEMENTS IN RESPONDING TO MENTAL HEALTH CRISIS 5-7 (2009). The Substance Abuse Mental Health Services Administration of the United States Department of Health & Human Services recommends that crisis intervention practices be based on the following principles: "access to supports and services is timely"; "services are provided in the least restrictive manner"; "peer support is available"; "adequate time is spent with the individual in crisis"; "plans are strength-based"; "emergency interventions consider the context of the individual's overall plan of services"; crisis services are provided by trained individuals; "individuals in a self-defined crisis are not turned away"; "interveners have a comprehensive understanding of the crisis"; "helping the individual to regain a sense of control is the priority"; "services are congruent" with the needs of the individual being served; "rights are respected"; "services are trauma informed"; "recurring crises signal problems in assessment or care"; and "meaningful measures are taken to reduce the likelihood of future emergencies." *Id.* at 7-12.

³⁵ *Id.* at 11.

³⁶ See HUMAN RIGHTS WATCH, CALLOUS AND CRUEL: USE OF FORCE AGAINST INMATES WITH MENTAL DISABILITIES IN U.S. JAILS AND PRISONS 23 (2015) ("Mental health services not only

During its monitoring visits, DRNY interviewed individuals who had been admitted to the RCTP from CAR or SHU after triggering suicide prevention procedures under Correction Law § 137(6)(d)(ii). Although DOCCS and OMH have crisis intervention policies (for example, procedures for referring patients to the RCTP and monitoring patient safety),³⁸ DRNY received complaints that mental health staff do not credit reports of symptoms before discharging individuals back to CAR or SHU. Individuals also complained that security staff antagonize patients or injure patients in uses of force. To investigate these allegations, DRNY reviewed hundreds of pages of security and clinical mental health records, as well as security videos, related to four individuals who were admitted to the RCTP from CAR or SHU.

The cases of Program Participants D and E, described below, illustrate the absence of effective crisis intervention. Mental health staff dismissed patient complaints as “agenda driven” to avoid CAR or SHU. This approach results in delayed services. For example, OMH eventually determined that Program Participant D has serious mental illness, but only after several months of documenting erratic behavior and evaluating Program Participant D after repeated uses of force.

Program Participant D

DRNY investigated the treatment of Program Participant D after interviewing him in the RCTP in November 2014. OMH admitted Program Participant D to the RCTP from SHU. Program Participant D is a teenager with a dual diagnosis of ID (IQ 66) and mental illness. He first arrived at CAR in the fall 2014 after serving approximately 380 days in SHU, some of that time as a juvenile. Prior to entering CAR, Program Participant D accumulated so many disciplinary sanctions that DOCCS planned to confine him in SHU through November 2017. Based on his diagnosis and history, his referral to CAR was appropriate. However, Program Participant D never advanced through CAR. Over several months, Program Participant D repeatedly transferred from CAR to SHU and then to RCTP after he demonstrated suicidal ideation and a desire to harm himself.

At one point, Program Participant D remained in the RCTP for crisis observation for 23 consecutive days before being returned to SHU. While in RCTP, Program Participant D complained about fear of harm from security staff, demonstrated suicidal ideation, engaged in self-harm, and smeared and ate feces. Mental health staff dismissed Program Participant D’s behavior as “behavioral,” “not psychotic,” and merely “agenda driven to . . . avoid SHU and CAR.” He continued to receive tickets in the RCTP, leading to more SHU sanctions. *(Continued on next page)*

can help improve the quality of individual prisoners’ lives, but they also promote safety and order within the prison by reducing rule-breaking and decreasing the need for custody staff to use force.”).

³⁷ Amy C. Watson & Anjali J. Fulambarker, *The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners*, 8 BEST PRACTICE MENTAL HEALTH 2, 5 (2012).

³⁸ Central New York Psychiatric Center, Policy #4.0: RCTP Observation Cells.

Program Participant D (continued)

Program Participant D repeatedly sought assistance from mental health staff in managing conditions in CAR. For example, in addition to reporting that he felt unsafe from staff, he expressed feelings of helplessness and complained that staff did not listen to or treat his requests seriously. Even as Program Participant D's behavior escalated with acts of self-harm and extremely unsanitary behavior, neither mental health staff in the RCTP nor the CAR administrators addressed his behavior from a crisis intervention perspective.

Despite signs of severe psychological distress, mental health staff and DOCCS staff concluded that Program Participant D was simply "acting out" for secondary gain. DRNY found little indication in Program Participant D's record that mental health staff worked with him to address his fears and his behaviors, or provided counseling on ways to access services or treatment.

DOCCS ultimately transferred Program Participant D out of CAR for being "repeatedly disruptive" and placed him in SHU at another facility. After months of continued advocacy by DRNY, Program Participant D was finally designated as an individual with serious mental illness and diverted to a residential mental health program under Correction Law § 137(6)(d).

DRNY determined that DOCCS and OMH failed to provide adequate care and treatment to address the root causes of Program Participant D's behavior and promote stabilization and long-term recovery. Despite Program Participant D's need for intervention, he was perceived by mental health staff to be manipulative and denied access to the mental health services he needed.

Program Participant E

Program Participant E was transferred from Southport, an all-SHU prison, to Sullivan's RCTP. He exhibited signs of severe decompensation when interviewed by DRNY. He described suicidal thoughts and hallucinations—a shadow sat on his bed and taunted him—and he explained that medications helped minimize the shadow's visits. He explained that he shared this information with RCTP staff, but they concluded that he was reporting psychiatric symptoms just to get out of SHU.

DRNY found that RCTP staff noted Program Participant E's serious symptoms, particularly his complaints about hallucinations and voices. Staff documented that he exhibited delays in responding to questions and exhibited an extremely poor ability to care for himself by not tending to his basic hygiene, leading staff to note he was "very malodorous" and to question him about his last shower. Staff also documented that Program Participant E continued to report suicidal ideation and thoughts of self-harm over a period of days. Mental health staff noted that Program Participant E requested Zyprexa, because it aided him in the past. *(Continued on next page)*

Mental health staff's preliminary assessment, however, was that Program Participant E was "feigning symptoms" to avoid being returned to Southport. After seven days in crisis observation, mental health staff finally prescribed Zyprexa "for impulsivity and verbal report of voices." After 14 days, noting that Program Participant E said he felt somewhat better and that the voices were reduced "a little bit," mental health staff discharged him back to Southport, noting "[t]here is no clinical evidence that psychotic symptomology is present other than his verbalization of voices" and hallucinations.

DRNY has identified a pattern of complaints about the denial of mental health services at Sullivan. Specifically, staff often determine that patients "malingering"—feign symptoms and seek treatment to avoid disciplinary confinement—even when records indicate past treatment history and even when patients supply a reason for mental distress, such as neglect of medical needs, trauma, or abuse.³⁹

DRNY finds that some mental health staff treat behavioral incidents as volitional and manipulative, rather than as a manifestation of disability or a response to environmental factors. For example, while a nurse attempted to explore the reason for Program Participant D's behavior ("*Feces smeared on all the walls. P[atient] got up from cot and said he was going thru something when I asked him why he was smearing.*"), the following day, a clinical social worker misstated the nurse's report, framing Program Participant D's behavior as aggressive and volitional. The clinical social worker noted:

Patient still unhygienic, with feces in his cell, smeared on walls. He is not hygienic to come out for interview. Per Nursing last night, he was saying he was going to throw something. This morning per Nursing, he was mute to Nurse. He is eating and drinking. No acts of self-harm. He is not psychotic. He does not want to go to CAR or SHU and he is apparently willing to remain in fecal matter to avoid everything.

Mental health policy requires that "[a]ll patients will be offered private clinical interviews in a confidential area outside of their RCTP cell."⁴⁰ Even though Program Participant D evidenced troubling behavior, the progress note shows that the clinical social worker did not offer an interview or otherwise engage Program Participant D in an effort to motivate his participation in counseling and therapy. Instead, the clinical social worker treated Program Participant D's behavior as volitional and manipulative.

The clinical social worker also assessed Program Participant E to be manipulative, rather than in need of services. Specifically, clinical notes show that the clinical social worker did not consider that mental illness affected Program Participant E's ability to communicate and behave in accordance with directions. A day after OMH admitted Program Participant E to the RCTP, the clinical social worker noted:

³⁹ Ineffective crisis intervention is not unique to Sullivan. Through monitoring and investigation, DRNY has identified the same pattern at other prisons.

⁴⁰ Central New York Psychiatric Center, Policy #4.0: RCTP Observation Cells.

Patient talks in a very low tone. He was asked numerous times to speak louder and although he said he would, he never did.

The following day, the clinical social worker noted:

Just as he did yesterday, he speaks in a whisper. He was asked again to speak loud enough to be heard but he did not. Per UCR progress notes in the past, patient has the ability to speak louder as well as yell. The fact that he is not communicating loud enough to be heard indicates that he is uncooperative, noncompliant, resistant to [mental health services].

When OMH staff evaluate patients without any exploration of what their complaints indicate about mental health status or capacity for tolerating their environment, staff place patients at risk of neglect. Timely, person-centered care, coupled with the provision of a safe environment, would reduce the need for crisis services and free up mental health resources for ongoing treatment. For months, Program Participant D continued to cycle between the RCTP, CAR, and SHU, before he was eventually diverted to a residential mental health treatment program, and ultimately to Central New York Psychiatric Center for inpatient hospitalization.

Sullivan's mental health treatment lacks important elements of crisis intervention—particularly, person-centered engagement and intervention, respect for the individual as a credible source, and the development of personal safety. When mental health staff fail to establish or implement an appropriate treatment plan, or provide a safe environment, staff place individuals at risk of injury or death. DRNY finds that Program Participants D and E experienced neglect due to delayed care and treatment and the lack of appropriate mental health interventions.

Doctors who lead the New York City jail mental health system have taken a different approach to assessing patients in isolated confinement.⁴¹ These administrators urge frontline staff to engage in person-centered interventions and to recognize, not dismiss, adaptive behavior as potential manifestations of patients' mental distress and deterioration in isolation settings.

One area of dual loyalty merits special consideration: the role of health care providers in punishment of patients. It is problematic for health professionals to become part of the security staff's punishment infrastructure and *to clear* patients for solitary confinement or other punishment settings that may pose health risks to patients, as they are sometimes asked to do. . . . The punitive environment often presents such a severe stress that patients will respond by feigning illness (most commonly paralysis or non-epileptic seizure) or causing self-harm to try to

⁴¹ See Sara Glowa-Kollisch, Jasmine Graves, Nathaniel Dickey, Ross MacDonald, Zachary Rosner, Anthony Waters, and Homer Venters, *Data-Driven Human Rights: Using Dual Loyalty Trainings to Promote the Care of Vulnerable Patients in Jail*, 17 HEALTH & HUMAN RIGHTS JOURNAL (2015), available at: <http://www.hhrjournal.org/2015/03/data-driven-human-rights-using-dual-loyalty-trainings-to-promote-the-care-of-vulnerable-patients-in-jail/> (explaining that “incarcerated patients experience new morbidity and mortality related to their incarceration, ranging from medication interruption to injury to worsening mental health during solitary confinement”).

remove themselves to a safer, more desirable medical setting. This puts the medical provider in an ethically difficult situation, where they are charged with using their diagnostic skill to identify whose illness is “fake.” In these circumstances, what is essentially adaptive behavior by patients seeking to avoid the stressor of solitary confinement is often labeled as *goal oriented* or *malingering* behavior by medical staff.⁴²

Further, the NYC jail administrators have noted:

Those inmates who appear to self-harm to escape solitary confinement are often judged to exhibit “volitional” or “goal-oriented” behavior, as opposed to suffering from psychosis, mania, or another more recognized mental health symptom. . . . [E]ven “goal-oriented” acts of self-harm can have severe consequences.⁴³

With respect to Sullivan’s RCTP, DRNY echoes the concerns raised by CQC in a 2013 review of care and assessment in the RCTPs.⁴⁴ CQC found that mental health staff failed to explore individuals’ underlying issues and that there was a lack of continuity of care, which impacted the adequacy of treatment.⁴⁵ CQC recommended that DOCCS and OMH’s Joint Case Management Committee (JCMC) review patients who are deemed to be “malingering” and document the outcome of those reviews in an individual’s clinical record.⁴⁶

Recommended Corrective Action

DRNY recommends that DOCCS and OMH review assessment and treatment procedures to improve the quality of care in CAR and the RCTP. DRNY recommends that DOCCS and OMH solicit technical assistance from independent experts to conduct a comprehensive review of the delivery of mental health treatment to RCTP patients, with a focus on patients who repeatedly transfer to or from the RCTP and CAR or SHU, and those who staff determine are “malingering.” JCMC and the Joint Central Office Review Committee (“JCORC”) should review these two populations periodically. In addition, in consultation with experts, DOCCS and OMH should develop additional training for corrections and mental health staff on crisis intervention and care for people with ID/DD and co-occurring mental illness. This program should be provided in addition to the de-escalation training mandated by the *Peoples* final settlement agreement.

⁴² Ross MacDonald, Amanda Parsons, and Homer Venters, *The Triple Aims of Correctional Health: Patient Safety, Population Health, and Human Rights*, 24 JOURNAL OF HEALTH CARE FOR THE POOR AND UNDERSERVED 1226, 1229-1230 (2013).

⁴³ Kaba et al., *supra* note 5, at 446.

⁴⁴ New York State Commission on Quality of Care and Advocacy for Persons with Disabilities, Residential Crisis Treatment Program(s) Follow-up Review, June 14, 2013, <http://www.justicecenter.ny.gov/sites/default/files/documents/FOR003-Final-RCTP-Review-Report-6-24-13.pdf>.

⁴⁵ *Id.* at 5-7.

⁴⁶ *Id.* at 14.

DOCCS AND OMH HAVE SUBJECTED PROGRAM PARTICIPANTS TO USE OF FORCE RESULTING IN INJURIES AND AN INCREASED RISK OF HARM

DRNY found that CAR program participants who complained about inadequate treatment were also subject to multiple incidents of force, including cell extractions and chemical agents. Because of the adverse consequences of using force against people with disabilities, DOCCS and OMH should eliminate such incidents.⁴⁷ Implementation of crisis intervention principles will eliminate the need for force, reduce injuries to CAR program participants, and make the environment safer and more therapeutic.

A “cooling off” period can obviate the need for force if potentially threatening behavior terminates.⁴⁸ Recognizing the special needs of people with mental illness and ID/DD, experts recommend corrections policies include at least the following essential elements. First, mental health staff and others who have received specialized training in crisis intervention must be involved in defusing incidents. Second, crisis intervention staff must engage determinedly and at length with the individual, if necessary, with the goal of deescalating a situation and working cooperatively to find a resolution.⁴⁹

[C]risis intervention cannot be brief *pro forma* visits to the inmate’s cell front. Mental health staff or other negotiators must be given the time and have the determination to connect with the individual to determine what is prompting his distress, what he is seeking, and how the situation can be resolved without violence.⁵⁰

Third, staff must consider that, due to mental illness or ID/DD, an individual may not be able to understand an order or may have difficulty conforming his or her behavior to an order.⁵¹ Staff

⁴⁷ See HUMAN RIGHTS WATCH, *supra* note 36, at 62 (noting that trauma from use of force can trigger psychotic episodes, increase hallucinations, and exacerbate other mental health symptoms); *see id.* at 63 (noting the dangers of chemical agents and stun devices because a disability may impact a person’s ability to understand that complying with orders “is the fastest way to avoid pain” and “the infliction of pain may strengthen paranoid delusions”).

⁴⁸ According to human rights standards and corrections experts, use of force must be used as a last resort (i.e., used only when necessary and other interventions have been exhausted); have a legitimate objective; be the minimal amount necessary and objectively reasonable to overcome resistance; and be terminated as soon as possible and deescalated if resistance decreases. *Id.* at 47. See also *Coleman v. Brown*, No. 2:90-cv-00520, Defendants’ Plans and Policies Submitted in Response to April 10, 2014 and May 13, 2014 Orders at 30 (E.D. Cal. Aug. 1, 2014) (“A decision to use chemical agents for the extraction should be based on more than passive resistance to placement in restraints or refusal to follow orders. If the inmate has not responded to staff for an extended period of time, and it appears that the inmate does not present an imminent physical threat, additional consideration and evaluation should occur before the use of chemical agents is authorized.”).

⁴⁹ Experts recommend that “interventions ideally should be without time limits, but should last at a minimum 40 minutes before force is initiated.” *Id.* at 50.

⁵⁰ *Id.* at 49.

⁵¹ *Id.* at 50.

must consider the risk of psychological harm or decompensation that may result from a use of force.⁵²

DRNY received a shocking number of complaints about excessive force in the CAR housing unit. DRNY shared many of these complaints in its September 3, 2015 letter to Superintendent William F. Keyser.⁵³ For some program participants, fears about safety impeded full participation in the program. For example, staff used force against Program Participant F when he exited his cell after the control booth staff mistakenly opened his door. Because of force, Program Participant F received a bloody nose and other injuries. Afterwards, Program Participant F was so anxious about his personal safety that he refused to leave his SHU cell, foregoing all CAR programming, until his maximum release date from prison.

Program Participant G had similar complaints about abuse from security staff. Program Participant G is a 20-year-old man who DOCCS transferred from CAR to Upstate Correctional Facility, an all-SHU facility. He found that he had been benefitting from CAR classroom programming and was making progress on his behavioral issues with the CAR program counselor. He stated, however, that security staff were not reinforcing classroom lessons. After being “gassed” out of his cell (exposed to chemical agents), he no longer wanted to be in CAR.

Program Participant D complained about harassment by CAR staff and SHU staff. DRNY investigated his complaint of injury in SHU by reviewing videotapes of the incident. After an officer collected a meal tray, Program Participant D kept his hands in the “hatch” area where the trays are passed. The officer ordered Program Participant D to remove his hands, but within one second of issuing this order, the officer slammed the hatch door on top of Program Participant D’s hands. The Superintendent subsequently reviewed the use of force and approved it as “appropriate.”

Some participants’ preference for SHU over the perceived risk of CAR reflects a failure to create a safe environment to carry out the therapeutic mission of the program. More importantly, the pattern of complaints about excessive force indicates a systemic failure to use crisis intervention strategies. Crisis intervention is an absolute necessity for people with ID/DD, especially people with co-occurring mental illness or serious behavioral disorders. People in special programs such as CAR have a great need for interventions on a day-to-day or possibly minute-by-minute basis. Instead, DRNY found that staff used force in a manner contrary to best practices in crisis intervention.

⁵² *Id.* at 51. This latter principle is reflected in OMH policy for inpatient settings, where staff are required to consider the risk of harm prior to the use of force such as mechanical restraints. *See, e.g.,* Central New York Psychiatric Center, Policy #3.0 – Seclusion/Restraint (2010) at 7 (“In assessing the need to use seclusion/restraint, *the potential for any negative impact of the procedure on the patient shall be considered.* A. In the case of patients/residents who are known or reasonably believed to have a history of trauma (physical and/or sexual abuse.”) (emphasis added). *See also* Coleman, *supra* note 47, at 8-9 (describing controlled use of force policy that (1) requires mental health practitioner to evaluate inmate’s ability to understand and comply with orders, and whether use of force poses a threat of decompensation, (2) mandates a cool-down period, (3) mandates de-escalation via verbal persuasion by mental health staff).

⁵³ *See* Addendum.

DOCCS's current policy provides too much discretion to use force against persons with disabilities and not enough guidance on how to incorporate crisis intervention practices to defuse crises and obviate the need for force.⁵⁴ The policy does not expressly require a crisis intervention team or a de-escalation period for an individual with a mental disability. It also does not require consultation with mental health staff regarding the risk of decompensation from using force. Without a policy that is consistent with best practices, individuals will continue to be at risk of abuse and neglect, because they will remain housed in an unsafe environment and be at risk of unnecessary uses of force and injury.

⁵⁴ For example, it states that chemical agents must be used “only when and to the extent that the employee reasonably believes such use is necessary.” Department of Corrections and Community Supervision, Directive #4944 – Use of Physical Force (2012).

Program Participant D

Program Participant D, a teenager dually diagnosed with ID and serious mental illness, was subjected to multiple planned uses of force involving chemical agents. In late December 2014, Program Participant D was in the RCTP when he refused to cooperate with a nurse. After he spat at officers and allegedly clenched his fist, corrections staff tackled him, slamming him “face first” onto the floor, causing a severely swollen black eye. Program Participant D told DRNY that he was experiencing hallucinations at the time. Afterwards, he became self-abusive and said he felt unsafe from security staff and wanted to kill himself. He also requested therapeutic care: “I want to go Hospital. Hospital might help me.” Staff treating Program Participant D nevertheless concluded: “No abnormalities of behavior are noted. He is agenda driven. He wants to avoid SHU sanctions as well as CAR program. He will remain in RCTP for further stabilization.”

Program Participant D was eventually discharged from RCTP to SHU and then transferred to CAR. Then, in late January 2015, force was used again, this time to extract Program Participant D from his CAR cell. Program Participant D had been yelling out of his cell and was deeply agitated, “in a rage, yelling, cursing, volatile, potential danger to self and others,” and had tied a sheet obscuring visibility into his cell. He complained to the clinical social worker that he had not gotten proper medical care for eye injuries after the December incident, described above. Staff concluded that he should be brought to the RCTP for observation. Corrections staff ordered Program Participant D “to calm down” and exit his cell for an evaluation in RCTP, but he did not.

Security staff initially justified using force because Program Participant D was obstructing the view into his cell and was refusing a direct order to exit. However, by approximately 10:13 a.m., when the extraction team arrived at Program Participant D’s cell, no sheet obscured the view into his cell. Rather, Program Participant D peered out his cell door window, while security staff ordered him to exit, warning him that chemical agents would be used.

Thus, one of the two justifications for force had dissipated by the time the extraction team began to expose Program Participant D to a total of eight bursts of chemical spray over the course of 10 minutes. After the first two bursts, Program Participant D moved to the farthest corner of his cell to stand by the window, which he opened for air. When he did this, a lieutenant called to him: “Hey, that ain’t gonna help you, fella, trust me. Come back to the gate for cuffing up, that’s a direct order, or another application of chemical agents will be used.” Program Participant D eventually lay face down on his bed before the extraction team rushed in, pressed shields against him, restrained him, and escorted him out to RCTP.

DRNY found that Program Participant D experienced abuse when he was subjected to force in the CAR housing unit. 42 U.S.C. § 10802(1)(D). By no objective measure was it necessary or proportionate to subject a teenager with an IQ of 66 and serious mental illness to chemical agents merely to gain compliance with an order to leave his cell.

Recommended Corrective Action

DOCCS and OMH should revise use of force policies and training programs in consultation with independent experts. Training programs should incorporate best practices in crisis intervention and be mandatory for all staff working with individuals with ID/DD and mental illness. DOCCS and OMH should document all crisis intervention strategies used to defuse an incident.

DOCCS and OMH should establish a Central Office committee to review incidents where force was used against individuals with ID/DD and mental illness. The members of the review committee should be independent of the staff who were involved in the use of force incident. The review should focus on identifying how force could have been avoided and what steps will be taken to prevent the recurrence of incidents.

Finally, DOCCS and OMH should develop quality improvement reviews of the management and treatment provided to individuals with recurrent and/or lengthy RCTP admissions from CAR or SHU, including individuals who have been involved in uses of force. These reviews should include data collection and analysis concerning admissions, lengths of stay, and factors precipitating admissions. DOCCS and OMH should investigate circumstances precipitating crisis situations, such as complaints about inadequate medical and mental health treatment, the environment in CAR, and poor relationships with staff. This report has collected examples of individuals going to extreme measures to avoid CAR, such as choosing to forego all programming to remain in SHU. At least one member of the mental health staff believed that Program Participant D was eating feces and living for days in fecal matter simply to avoid CAR. DOCCS and OMH should immediately investigate the circumstances and conditions in CAR that lead to such events. Furthermore, DOCCS and OMH must take appropriate steps to remediate these problems and ensure that the housing and program environment respects the basic human rights of all participants.

III. KEY RECOMMENDATIONS AND PROPOSED RESOLUTIONS

DRNY makes the following recommendations to DOCCS and OMH:

- **Develop appropriate eligibility criteria and assessment procedures to identify individuals with ID/DD and individuals with adaptive deficits for CAR, in consultation with experts. Specifically, DOCCS should look to best practices for program eligibility, including the eligibility practice adopted by the California Department of Corrections and Rehabilitation as a result of *Clark v. California*, 739 F. Supp. 2d 1168 (N.D. Cal. 2012). DRNY recommends the following eligibility scheme, which is based upon the *Clark* settlement and CQC’s previous recommendations:**

Measurement of Cognitive Functioning

DRNY has been informed that only individuals who score 70 or below on the BETA-III (BETA), Kaufman Brief Intelligence Test, Second Edition (KBIT-2) and Welscher Adult Intelligence Scale – Fourth Edition (WAIS-IV) qualify for CAR. DOCCS should conduct IQ testing during the first two phases of its evaluative process, as outlined below.

Phase I: DRNY recommends that during Phase I of the eligibility determination process, DOCCS perform a BETA and/or KBIT-2 on each inmate entering the DOCCS system. This will allow for a rapid estimate of cognitive function. Both the BETA and KBIT are “quick tests,” and are not dispositive of full intellectual acuity. However, by conducting these tests, DOCCS can screen out individuals who *are not* eligible for SNU or CAR based upon intellectual acuity. DOCCS should refrain from informing inmates of their estimated IQ and should ensure that accommodations are available for individuals with limited English skills and/or other disabilities.

Phase II: If an individual scores below 80 on the BETA and/or KBIT-2, a WAIS-IV should be administered. The WAIS-IV is a more extensive cognitive measure and will generate a full-scale intelligence quotient. DRNY recommends that individuals with a full-scale intelligence quotient score of 70 or below, as measured by the WAIS-IV, secure eligibility by virtue of intelligence quotient alone. Individuals who score between 70 and 75 should be referred for Phase III of the evaluative process, which will assess adaptive functioning.

Measurement of Adaptive Functioning

DRNY recommends that anyone who scores between 70 and 75 on the WAIS-IV be referred for full testing of adaptive functioning, to include the Adaptive Behavior Assessment System, Second Edition (ABAS-II) or the Vineland Adaptive Behavior Scales, Second Edition (Vineland-II). These evaluations are the gold standard, and OPWDD accepts both as valid measures of adaptive functioning. With the proper collaboration with experts in the field and necessary revisions, however, DOCCS can properly utilize these assessments in a prison setting.

Phase III: The ABAS-II is a complete assessment of adaptive skills, in accordance with the American Association on Intellectual and Developmental Disabilities (“AAIDD”) guidelines. The Vineland-II is similar in that it measures the social presentation and social skills of individuals from birth through adulthood. Individuals who score between 70 and 75 in Phase II should be referred for an ABAS-II or Vineland. The results of these evaluations will assist DOCCS in identifying whether the individual has adaptive functioning deficits in a correctional setting and, in turn, will assist DOCCS in making the prison environment safer and more manageable for inmates and staff. As recommended by CQC in its 1991 report and implemented by other states, DOCCS should broaden eligibility to include those with (1) measured adaptive deficits in two domains and a full-scale intelligence quotient below 75; or (2) adaptive deficits measured at two standard deviations below the norm, across all domains. This eligibility criterion would take into account both measured substantial limitations and the WAIS-IV’s margin of error.

Phase IV: Individuals who score between 70 and 75 in Phase II and are not initially found to have adaptive deficits in Phase III should be re-evaluated between 120 and 210 days after the initial Phase III evaluation. The secondary evaluation will account for any changes in adaptive functioning as a result of incarceration. Any evaluation conducted after the completion of Phase III should be considered a Phase IV evaluation. DRNY recommends that DOCCS conduct Phase IV testing as needed and, at most, once a year in accordance with a documented change in individual behavior as assessed by a trained clinician. DOCCS should not use Phase IV testing as a means of removing individuals from CAR.

Other Methods of Eligibility: DOCCS should be mindful of the fact that the proposed Phases I and II assess individuals only for ID, and Phases III and IV require, at minimum, below average cognitive functioning. Therefore, individuals with developmental disabilities that do not manifest in intellectual deficits are not captured by these eligibility criteria. An individual with Cerebral Palsy or Epilepsy, for example, would not be eligible for CAR under these criteria. These diagnoses are reflected only by an adaptive assessment with a prior diagnosis of the condition. DOCCS should consider expanding therapeutic housing options for other individuals with developmental disabilities that do not manifest in intellectual deficits.

In summary, DRNY recommends that DOCCS revise its eligibility criteria so that individuals secure CAR eligibility if:

- (1) they are found to have a full-scale IQ of 70 or below; or
- (2) they are found to have a full-scale IQ between 70 and 75 with concurrent adaptive deficits in two domains; or
- (3) they are found to have adaptive deficits two standard deviations below the norm, across all domains.

If DOCCS conducts all evaluations upon an individual’s arrival at one of the four reception centers throughout the state, it will only need to conduct re-evaluations in accordance with the foregoing Phase IV process. This will save DOCCS time and resources, and will ensure

that CAR serves all individuals who cannot function in SHU because of low cognitive functioning and/or adaptive deficits.

- **Ensure that the structure and programming of CAR supports the habilitation of individuals with ID/DD and adaptive deficits by:**
 - Developing and clarifying appropriate behavioral standards and milestones for CAR program participants;
 - Eliminating all remaining SHU or keeplock time for individuals who successfully complete CAR and are discharged from CAR;
 - Discontinuing the level regression system for all but the most severe circumstances and using level regression only in connection with a manifestation determination procedure that is designed to identify and address behavior that is connected to a disability;
 - Discontinuing the imposition of SHU sanctions on CAR program participants;
 - Using non-punitive interventions to address misbehavior in CAR;
 - Revising disciplinary policies and procedures to incorporate a manifestation determination process, mitigation of sanctions, development of behavioral intervention plans where conduct is related to an individual's disability;
 - Conducting a review of discharges from CAR, examining the circumstances and justification for the discharges; and
 - Eliminating pre-hearing confinement for CAR program participants.
- **Improve access to mental health services by providing reasonable accommodations to individuals who need assistance making requests for services.**
- **Integrate crisis intervention consistently through all aspects of care and treatment by:**
 - Reviewing staff compliance with the RCTP Observation Cell Policy requirements related to confidential interviews;
 - Ensuring on-going compliance with RCTP Observation Cell Policy;
 - Requiring documentation of how staff intervened in person-centered ways, addressed trauma, worked with the patient to establish feelings of personal safety, respected the patient as a credible source, and promoted patient recovery and resilience;
 - Soliciting technical assistance from independent experts to conduct a comprehensive review of the delivery of mental health services;

- Revising use-of-force policies to expressly require: de-escalation, intervention by staff trained in crisis intervention, use of “cooling off” periods, and evaluation by mental health staff of the potential negative psychological impact of use of force;
 - Requiring DOCCS and OMH staff to document all crisis intervention strategies used to defuse an incident;
 - Establishing a Central Office committee to review incidents where force was used against individuals with ID/DD and mental illness, with a focus on identifying how force could have been avoided and what steps will be taken to prevent the recurrence of incidents;
 - Reviewing management and treatment of CAR program participants with recurrent and/or lengthy RCTP admissions from CAR and SHU, including by collecting and analyzing data on admissions following use of force and factors precipitating admissions, and by identifying steps to address patterns of complaints with regard to treatment, housing, program, and environmental conditions; and
 - Providing additional training for corrections and mental health staff on: recognizing the signs of mental illness; managing and caring for populations with ID/DD and co-occurring mental illness; and crisis intervention practices.
- **Consult with an outside expert regarding training for corrections and mental health staff in CAR.**
 - **Collect and publish data on the population and outcomes measures, including but not limited to:**
 - CAR monthly census;
 - Average length of SHU sanction for a CAR program participant, broken down by rule violation/disciplinary infraction;
 - If the eligibility criteria are revised, census data regarding the number of individuals who attain CAR eligibility in each of the “phased” evaluative areas;
 - Census data regarding the number of CAR program participants who successfully progress through the CAR level system, broken down by level;
 - Census data regarding the number of CAR program participants subject to level regression, broken down by level;
 - Census data regarding the number of CAR program participants who are subject to additional disciplinary sanctions, broken down by the type of sanction and whether the sanction resulted in additional SHU or keeplock time;

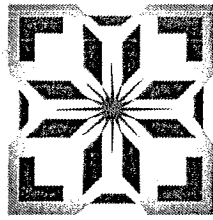
- Census data regarding the number of CAR program participants discharged from the program prior to program completion;
- Census data regarding CAR program participants' admissions and discharges, broken down by facility and type of unit (*e.g.*, Great Meadow SHU);
- Census data regarding the number of CAR program participants who are on the OMH case load, by OMH level;
- Census data regarding CAR program participants in the RCTP, by OMH level, diagnosis, race, age, involvement in use of force, length of stay, and factors precipitating admissions.

IV. CONCLUSION

DOCCS should not confine individuals with ID/DD in SHU for any length of time under any circumstance. During this investigation, DRNY interviewed over 100 individuals with ID/DD, many of whom complained that they deteriorated in isolation. DRNY supports the final settlement in *Peoples v. Fischer*, but DOCCS and OMH should go beyond the terms of the agreement. The recommendations in this report serve as a guide for corrective action to eliminate the risk of abuse and neglect of individuals with ID/DD and co-occurring mental illness.

DRNY commends DOCCS and Superintendent William F. Keyser for being receptive to DRNY's concerns throughout this investigation. DRNY will continue to work cooperatively with DOCCS and OMH to improve the care and treatment of individuals with ID/DD.

ADDENDUM A



DISABILITY RIGHTS NEW YORK

New York's Protection & Advocacy System and Client Assistance Program

September 3, 2015

Superintendent William F. Keyser
Sullivan Correctional Facility
325 Riverside Drive
Fallsburg, NY 12733

Re: **Correctional Alternative Rehabilitation (CAR) Misconduct Complaints**

Dear Superintendent Keyser:

I write to follow up on my August 11 – 13, 2015 visit to Sullivan Correctional Facility (“Sullivan”) and my interviews with Correctional Alternative Rehabilitation (“CAR”) Program Participants. As I stressed during our August 12 and 13, 2015 meetings, I received overwhelmingly positive reviews about the CAR classroom component. Despite this, I received voluminous complaints about misconduct by Corrections Officers. I am hopeful that this misconduct can be remedied so that every program participant can remain safe and fully avail themselves of CAR programming.

As you know, Disability Rights New York plans to issue detailed feedback about the CAR Unit as a whole. This letter serves only to summarize complaints about officer misconduct so that the proper investigation can be initiated. I received consistent complaints about four areas of broad officer misconduct: (1) assaults in the CAR property room; (2) abuse of “cool off” periods in the Special Housing Unit (“SHU”); (3) pat frisk violations; and (4) level two retaliation threats. The following is a summation of these complaints:

Assaults in Property Room

Of the 17 Program Participants I spoke with privately, over 75% shared unsolicited complaints about assaults in the property room. I observed the property room when I toured the CAR housing area, and noted that cameras are not installed there. Many program participants informed me that officers instigate brutal force in the property room, and are not held

725 Broadway, Suite 450
Albany, New York 12207
(518) 427-6561 (fax)

25 Chapel Street, Suite 1005
Brooklyn, New York 11201
(718) 797-1161 (fax)

44 Exchange Blvd, Suite 110
Rochester, New York 14614
(585) 348-9823 (fax)

mail@DisabilityRightsNY.org • www.DisabilityRightsNY.org

(800) 993-8982 (toll free) • (518) 432-7861 (voice) • (518) 512-3448 (TTY)

accountable due to a lack of evidence. One program participant informed me that officers “use hands and feet” in the property room specifically because they know they will never be “caught.” DRNY has not conducted a full investigation of each of these allegations. The frequency of complaints, however, reveals that program participants do not feel safe in the property room. DRNY recommends that the Department of Corrections and Community Supervision (“DOCCS”) conduct a thorough investigation of these allegations and install audiovisual equipment in the property room to obviate future concerns.

“Cool Off” Periods in SHU

Of the 17 Program Participants I spoke with privately, over half had been subjected to a “cooling off” period in SHU after receiving misbehavior reports in CAR. One Program Participant said of Sullivan SHU, “[CAR program participants] are the only people down there.” Program Participants reported that their progress through the CAR program was curtailed by their placement in SHU, and that SHU placement is used far too frequently as a punishment for CAR misbehavior. DRNY is concerned that this practice, due to its lack of codification and its disproportionate impact upon individuals with intellectual and/or developmental disabilities, is likely to be abused. DRNY recommends that DOCCS consider discontinuing this practice. DRNY will provide more substantive feedback on this practice, and additional recommendations, in the near future.

Pat Frisk Violations

Of the 17 Program Participants I spoke with privately, nearly all reported violations of DOCCS Directive #4910 related to pat frisk procedures. Program Participants named particular officers and stated that they are often sexually groped during pat frisks. Program Participants were extremely indignant with this practice, and feel violated. As you know, pat frisks must be conducted professionally “in a manner least degrading to all involved.” Overtly sexual pat frisks fall outside the bounds of both decency and legality. DRNY recommends that DOCCS conduct an investigation into the pat frisk procedures of Officer [REDACTED] (see below), and retrain officers in pat frisk procedures, as needed.

Level Two Retaliation Threats: Of the 17 Program Participants I spoke with privately, several reported that particular officers have threatened them with violence if they progress through the program. These threats have dissuaded Program Participants from working hard during program and have created a fear of unnecessary and unimpeded violence.

In addition to the foregoing broad complaints, I received several specific complaints about Corrections Officers [REDACTED]

Officer [REDACTED]

Of the 17 Program Participants I spoke with privately, 15 shared unsolicited complaints about Corrections Officer [REDACTED]. Program Participants reported variations of the same complaints. Nearly all Program Participants reported that Officer [REDACTED] uses racial slurs and targets individuals who are profoundly disabled. It has also been reported that Officer [REDACTED] is an

“action junkie” who provokes individuals with aggression issues so that he can use force against them. The following is a summation of the complaints I received concerning Officer [REDACTED]:

Program Participant A: Program Participant A has resided in CAR since February of 2015. He reported that many CAR officers are “talking s*** and not acting professional” and alleges that officers on the 3:00 PM to 11:00 PM shift are “eating take out on the block, slapping each other on the [buttocks], and randomly searching people’s cells.” Program Participant A informed me that Officer [REDACTED] makes fun of people with disabilities frequently, referring to them as “retarded” and “idiot,” and provoking them toward violence. Program Participant A is adamant that CAR should be “shut down” due solely to officer behavior.

Program Participant B: Program Participant B has moved back and forth between CAR and SHU five times since he got to CAR. He states that he would rather deal with SHU officers than CAR officers, and informed me that “[SHU Officers] walk [the unit] and leave. They only bother you if you bother them. In CAR, [officers] look for trouble.” For this reason, Program Participant B stated that he feels safer in the box.

Program Participant B reports that Officer [REDACTED] has a pro-ticket, pro-negative bias, and hands out tickets and negatives with relative ease. Rather than counsel Program Participants on rule compliance, Program Participant B reported that Officer [REDACTED] yells at Program Participants and hands out frivolous tickets. Program Participant B reported that, during an August 2015 extraction, Officer [REDACTED] directed several racial slurs towards him. Program Participant B stated, “[t]his is not supposed to be this way. [The program is] supposed to be built to deal with people like us.”

Program Participant C: Program Participant C began our interview by stating, “[t]he program is good and you can learn; it’s just the officers.” He informed me that Officer [REDACTED] does “little things” to antagonize Program Participants. For example, Program Participant C reported that on June 18, he went to commissary and purchased peanut butter. Later that day, Program Participant C’s cell was searched by Officer [REDACTED]. When Program Participant C returned to his cell at the conclusion of the search, he discovered that his peanut butter had been tampered with, allegedly by Officer [REDACTED].

Program Participant C reported that Officer [REDACTED] has violently pushed him into his cell during cuff up, and has addressed him rudely and aggressively, with racial slurs and insults toward his family. Additionally, Program Participant C reported that Officer [REDACTED] tightens his cuffs too tight and aggressively pulls his waist chain, in an effort to unnerve him. When Program Participant C threatened Officer [REDACTED] with a grievance, Officer [REDACTED] replied, “[y]ou can write all day. I’ve never lost.”

Program Participant D: I met with Program Participant D in SHU after he was allegedly provoked toward violence by several CAR officers. Program Participant D reported that he “had issues” for the entire month he was in CAR. He reported that for the last month, officers, including Officer [REDACTED] have been verbally harassing him and attempting to provoke him to remove him from the unit. When I asked why officers had done this, Program Participant D stated, “I don’t know. They just don’t like me.”

Program Participant D stated that Officer [REDACTED] has repeatedly harassed him by making fun of his disability, calling him a "retard," "worthless," "no good piece of s***," "low-life" and other slurs. Program Participant D informed me that he reported this conduct to a Sergeant and a Lieutenant, neither of whom adequately addressed his concerns. Program Participant D reported that constant harassment by Officer [REDACTED] led to his behavioral outburst, which resulted in a ticket and subsequent SHU sanction. Program Participant D reported that he feels safer in SHU because "the officers do not mess with people as much in SHU."

Program Participant E: When I met with Program Participant E, he had finished his first volatile week in CAR. Program Participant E reported that when he got to CAR, Officer [REDACTED] stated, "[t]his is my house and you're going to follow my rules." Two days later, after observing that Program Participant E's pants were "too low," Officer [REDACTED] remarked, "do you want to give me a massage?" That same day, an unprovoked Officer [REDACTED] slapped Program Participant E and stated, "I will split you in half if you disrespect my officers." Program Participant E reported that during his first week in CAR, he heard Officer [REDACTED] call other program participants "princess" and "f*****," and deny people showers without justification.

Program Participant F: I met with Program Participant F in SHU after he was allegedly "set up" by Officer [REDACTED] on the 30th of July. Program Participant E stated that he has not had a hearing and has not been informed when he will return to CAR. Program Participant F reported that Officer [REDACTED] referred to him as a "towel head" and other slurs for Arab-Americans during the July 30 incident, and referred to his wife as his "n***** wife." Program Participant F reported that Officer [REDACTED] consistently uses these slurs. Program Participant F reported that he was informed by Superintendent Keyser that he would return to the CAR program. Since he was informed of this, he has repeatedly asked mental health staff and corrections officers about his status. When he asked a mental health staff member about his status recently, he was informed that he would be returned to CAR "when [Sullivan Correctional Facility Staff is] good and ready." He informed mental health staff that Disability Rights New York would contact the facility to follow up, and mental health staff replied "I don't give a f*** what Disability Rights thinks."

Program Participant H: Program Participant H arrived at CAR from Marcy SHU on June 22. Program Participant H reported that everything was laid back when he first arrived at CAR, but as the program progressed, things became "different." Program Participant H reported that as program participants move to and from the unit, corrections officers "try to make issues out of little things." He reported that he has been involved in altercations with Officer [REDACTED] on several occasions in the past. When he first got to CAR, he observed that Officer [REDACTED] treats program participants who are not fluent in English poorly. He has heard Officer [REDACTED] ask non-fluent English speakers if they are "f***** dumb" when they failed to reply to him. Program Participant H reported that he has observed Officer [REDACTED] flip cells for no reason, and intentionally drop program participants' food trays.

Program Participant J: Program Participant J arrived in CAR from Upstate Correctional Facility. He reported that he has been involved in two altercations with Officer [REDACTED] since his transfer to CAR. Officer [REDACTED] "flipped" his cell after reprimanding him for hanging up a clothesline.

Program Participant J also reported that Officer █████ consistently marks him as a program refusal for imperfect adherence to the rules, even when he clearly states that he is not refusing and wants to go to program. As a broad matter, Program Participant J reported that correctional officers, particularly Officer █████, view program participants as “less than human.”

Program Participant K: Program Participant K arrived in CAR from Upstate Correctional Facility, where he had already completed his SHU time and had additional keeplock time. Program Participant K reported that Officer █████ is doing his job “way off board.” Program Participant K reported that in July of 2015, he was writing in his cell and an officer asked to view his writing. Program Participant K refused to hand his writing over to the officer, and indicated that he was going to rip up the writing and flush it down the toilet. The officer told Program Participant K that “if you do that, I am going to have an officer give you a ticket.” Program Participant K eventually handed over his writing. Program Participant K reported that later that day, Officer █████ visited his cell and asked him to apologize. When Program Participant K refused to apologize, Officer █████ “flipped his cell” and “attacked him.” Program Participant K reported that Officer █████ hit him three times in the back, and wrote him a ticket for assault and creating a disturbance. Program Participant K stated that “[officers] can do anything to you here. Also, the way officers write tickets needs to change. You got guys who come here with 30 days [SHU time] and they get more and more.”

Program Participant L: Program Participant L arrived in CAR last summer from Attica Correctional Facility. Program Participant L reported that within three weeks of arriving in CAR, he got a cell shield order and several tickets. Program Participant L alleged that he was dragged into the property room shortly thereafter and “beaten profusely.” Program Participant L reported that he has written to the Inspector General about this incident numerous times, and specifically named Officer █████. Program Participant L reported that since this incident, he has been singled-out by Officer █████ and is fearful of him. Program Participant L reported that Officer █████ and Sergeant █████ have allowed for Officer █████ conduct to continue, and have “backed him up” on several allegations.

Program Participant L reported that in July of this year, he confronted Officer █████ about his relationship with Officer █████. Two days later, Officer █████ held Program Participant L back from program and demanded an apology. When Program Participant L refused to apologize, Officer █████ got vulgar with him and threatened him with a ticket. Program Participant L stated that “[e]ven though the program is a good program, you got guys like █████. A lot of the problems start with the officers here.”

Program Participant N: Program Participant N is a Level Two inmate in CAR. Program Participant N reported that “the officers need more training so they can handle us. If you are locked up in here, your mind is not functioning right.” Program Participant N reported that while he has not observed Officer █████ “beat people up,” he believes Officer █████ “sets people up a lot.” Program Participant N reported that Officer █████ targets individuals who do not speak English fluently. Program Participant N emphasized that once Officer █████ instigates confrontations, he and other officers respond disproportionately. Program Participant N reported that Officer █████ and other officers overuse chemical agents and put “hands on” when unnecessary. At the conclusion of our conversation, Program Participant N reported that

“[program participants] are mental health patients, and that’s why we have a problem with the officers. They don’t understand the anger and rage that we got.”

Program Participant O: Program Participant O began our conversation by stating, “[t]his program helps a lot of us but we are not going to better ourselves if we keep dealing with these a***** officers.” Program Participant O immediately reported that Officer [REDACTED] “uses his hands and feet off camera in the medical room and property room.” Officer [REDACTED] has told Program Participant O that if he grieves this alleged conduct, Officer [REDACTED] will write him up, beat him again, and send him to SHU. Program Participant O reported that Officer [REDACTED] continues to make fun of him for his case, and intentionally pushes his buttons. Program Participant O reported that Officer [REDACTED] has threatened him by stating, “[y]ou don’t bruise easily, so I can slap you around all day.”

Program Participant P: Program Participant P informed me that he arrived in CAR from Clinton Correctional Facility after receiving a dirty urine ticket. Program Participant P showed me a facial scar he received from Officer [REDACTED] during an alleged illegal use of force incident. Program Participant P reported that Officer [REDACTED] continually picks on people for their disabilities and calls people derogatory names. Program Participant P reported that he has anger issues, Attention Deficit Hyperactivity Disorder, and significant difficulty reading and writing. Officer [REDACTED] continually picks on him for his reading and writing difficulty, and has stated, “you can’t grieve any of this because you’re retarded.”

Program Participant Q: Program Participant Q remarked that Officer [REDACTED] is “superseding his authority and is an action junkie.” Program Participant Q primarily reported that Officer [REDACTED] “eggs individuals on” and provokes confrontation to make his job “more exciting.” While Program Participant Q reported that “a lot of [program participants] bring problems on themselves,” he reported that many officers are overly aggressive and cannot deal with the CAR population.

Program Participant R: Program Participant R stated that Officer [REDACTED] grabs his testicles and gropes him when searching him. This occurs on a daily basis. Program Participant R stated that the CAR program was a good program but that these correction officers undermine the program. He has read the manual three times, but when he tells the officers they are not following the manual, they tell him that “this is our house” and “you are not going to win.”

Officer [REDACTED]

Of the 17 Program Participants I spoke with privately, seven shared unsolicited complaints about Corrections Officer [REDACTED]. Program Participants reported variations of the same complaints. Program Participants reported that Officer [REDACTED] is verbally aggressive, at times physically violent, and often intoxicated on the job.¹ The following is a summation of the complaints I received concerning Officer [REDACTED]:

¹ Over 75% of the Program Participants I interviewed privately stated that Officer [REDACTED] often drinks hot toddy out of a Stewart’s Cup while at work, and has arrived at work with alcohol on his breath on multiple occasions.

Program Participant A: Program Participant A's allegations against Officer ██████ were very similar to his allegations against Officer ██████. Program Participant A reported that Officer ██████ was involved in an assault against him on March 10, 2015 in the hallway outside the program area, adjacent to the therapy rooms. Program Participant A reported that Officer ██████ refers to program participants in an extremely vulgar manner and makes fun of program participants for their disabilities. Program Participant A also reported that Officer ██████ gives out far too many tickets and negatives for conduct that is not particularly serious. For example, Program Participant A reports that he was on a cell shield order for a long period of time for throwing a bar of soap on the gallery.

Program Participant C: Program Participant C did not assert that Officer ██████ was physically violent, but corroborated allegations that Officer ██████ is extremely verbally aggressive. Program Participant C reported that Officer ██████ is rude, yells at people, and makes fun of people for their disabilities. Program Participant C stated that he has "written this up," and informed the Commissioner and Lieutenant ██████, to no avail.

Program Participant H: Program Participant H reported that Officer ██████ is verbally aggressive towards him and has become the rudest officer on the unit. Program Participant H reported that Officer ██████ is vulgar and calls him names "every single day." Program Participant H reported that he believes Officer ██████ takes advantage of him because he is unstable, and believes that Officer ██████ has identified him as a "problem person" without justification. Program Participant H reported that Officer ██████ gives him tickets after "intentionally riling [him] up."

Program Participant J: Program Participant J corroborated complaints about Officer ██████ manner of addressing individuals. Additionally, Program Participant J reported that Officer ██████ targets "dudes that can't read, speak, and write, or do not know how to talk or grieve." Program Participant J reported that Officer ██████ often refuses him supplies. During a Saturday round, Program Participant J asked Officer ██████ for toilet tissue after another officer ignored him on a supply round. Officer ██████ refused. Program Participant J asked, "what if I had to go to the bathroom right now?" Officer ██████ replied, "So?" Program Participant J remarked, "I am not being spiteful and I do not have a personal problem with the COs, but right is right and wrong is wrong."

Program Participant O: Program Participant O reported that Officer ██████ instigates him frequently, often by referring to his case. Program Participant O reported that Officer ██████ has a habit of instigating verbal confrontation and issuing tickets when inmates respond. For example, Program Participant O reported that he was recently issued a ticket after Officer ██████ made fun of his case for an extended period of time, and Program Participant O told Officer ██████ he would "[have sex with his] wife and daughter." Program Participant O stated that Officer ██████ knows he has anger issues which he is actively working on. Program Participant O called it "unfair" that Officer ██████ intentionally provoked his anger in this manner.

Program Participant P: Program Participant P reported that Officer ██████ is involved in verbal taunting along with Officer ██████. Specifically, Program Participant P informed me that

Officer [REDACTED] has called him several derogatory names and made fun of him for both his disabilities and his case.

Program Participant Q: Program Participant Q began our conversation by stating, “[t]hey need to scrutinize staff that is [sic] being placed here. The staff needs to be re-evaluated and trained more, especially Officer [REDACTED].” Program Participant Q stated that some security staff are holding the program back. Program Participant Q first reported to me that Officer [REDACTED] “walks around with a Stewart’s cup drinking hot toddy all day,” and often issues blanket negatives to the entire unit for the conduct of one program participant.

Program Participant R: Program Participant R said that, in late July, he was penalized for having his light off and his food was thrown away. When he requested his meal, he was taken to the property room, and beaten by Officers [REDACTED]. He filed grievances but nothing resulted from these grievances. He stated that, “They beat you up whenever you say something.”

Officer [REDACTED]

Of the 17 Program Participants I spoke with privately, six shared unsolicited complaints about Corrections Officer [REDACTED]. Nearly all Program Participants reported that Officer [REDACTED] is violent, and follows the direction of Officer [REDACTED]. I have been informed that Officer [REDACTED] often uses force unnecessarily and is extremely uncomfortable around individuals with disabilities. The following is a summation of the complaints I received concerning Officer [REDACTED]:

Program Participant C: Program Participant C reported that Officer [REDACTED] works with Officers [REDACTED] and [REDACTED] to intentionally instill fear in CAR program participants. Program Participant C informed me that he stopped going to program partially because Officer [REDACTED] instigates violence on the way to program, at the direction of Officer [REDACTED]. Program Participant C referred to Officer [REDACTED] as Officer [REDACTED] “enforcer.”

Program Participant H: Program Participant H echoed the concerns of Program Participant C, stating that Officer [REDACTED] instigates violence to and from the unit. Program Participant H stated that when traveling to and from the unit, Officer [REDACTED] takes advantage of individuals with low comprehension.

Program Participant J: Early in our conversation, Program Participant J referred to Officer [REDACTED] as a “problem.” Program Participant J reported that Officer [REDACTED] has ignored him on supply rounds and instigated violence both on and off the housing unit. Program Participant J referred to Officer [REDACTED] specifically when he stated that “the [officers] look at us as less than human.”

Program Participant O: Program Participant O reported that Officer [REDACTED] “uses his hands and feet off camera in the property rooms” and to and from program. Program Participant O echoed the sentiments of the above-referenced Program Participants, stating that he does not feel safe moving to and from program due to Officer [REDACTED] instigation.

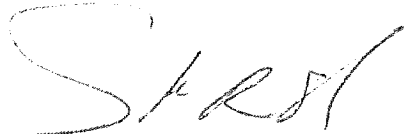
Program Participant P: Program Participant P reported that Officer [REDACTED] told him that if he “makes it to Level Two, we are going to fight.” Program Participant P also reported that he feels

unsafe moving from program to the housing unit and that Officer ██████ penchant for instigating violence dissuades him from going to program.

Program Participant Q: Program Participant Q reported that Officer ██████ is verbally aggressive and has a tendency to conduct fraudulent and unnecessary cell searches.

DRNY is concerned that systemic and individual officer misconduct threatens to derail what is otherwise a promising CAR program. DRNY recommends that Sullivan initiate a thorough investigation of the foregoing complaints, through the DOCCS Office of Special Investigation., and requests an update on any corrective action taken upon the conclusion of this investigation. Additionally, DRNY will include the foregoing information in its upcoming report, and continue to conduct individual advocacy on behalf of CAR program participants. I look forward to a telephone call with you to discuss this letter, and I welcome any opportunity to clarify the foregoing complaints. Thank you for your prompt attention to these matters.

Sincerely,



Stefen Russell Short, Esq.
Staff Attorney

cc: *Stephen Maher, Chief*
Department of Corrections and Community Supervision
Office of Special Investigations

Further correspondence regarding this matter should be directed to the Brooklyn office of Disability Rights New York.



Corrections and Community Supervision

ANDREW M. CUOMO
Governor

ANTHONY J. ANNUCCI
Acting Commissioner

November 5, 2015

Stefen Russell Short, Esq.
Staff Attorney
Disability Rights New York
725 Broadway, Suite 450
Albany, N.Y. 12207

Re: Sullivan Site Visit

Dear Mr. Short:

This is in response to your recent letter regarding your site visit to Sullivan Correctional Facility on August 11 - 13, 2015. You have expressed systemic and staffing misconduct within the Correctional Alternative Rehabilitation (CAR) program.

The Office of Special Investigations (OSI) has investigated a number of complaints and currently there are pending investigations. Upon completion of the investigations and review of the program, necessary steps will be taken in order to preserve the program's integrity. This program is essential in addressing those inmates with deficits and limited adaptive functioning and all matters are taken seriously and addressed appropriately.

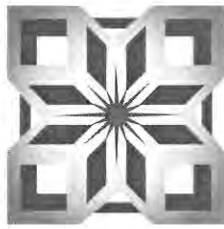
If you have further questions or concerns, please feel free to contact me at 518-485-0010.

Sincerely,

A handwritten signature in cursive script that reads "Bryan Hilton".

Bryan Hilton
Assistant Commissioner

ADDENDUM B



DISABILITY RIGHTS NEW YORK

New York's Protection & Advocacy System and Client Assistance Program

May 24, 2016

William F. Keyser
Superintendent
Sullivan Correctional Facility
325 Riverside Drive
Fallsburg, New York 12733

El Hadji Gueye
Unit Chief
Mental Health Unit
Sullivan Correctional Facility
325 Riverside Drive
Fallsburg, New York 12733

Dear Superintendent Keyser and Unit Chief Gueye:

Enclosed is Disability Rights New York's report following its 2014-2015 monitoring and investigation of the Correctional Alternative Rehabilitation Unit ("CAR") at Sullivan Correctional Facility. The report includes findings and recommendations for DOCCS and OMH. DRNY intends to publicly release this report. Before releasing the report, DRNY will consider any responses received by June 17, 2016. Please do not hesitate to contact DRNY with questions or concerns at (518) 432-7861. We look forward to working with you.

Sincerely,

Stefen Russell Short
Staff Attorney

Elena Landriscina
Staff Attorney

Encl.: *Report and Recommendations Concerning the Treatment of Individuals with Intellectual,*

725 Broadway, Suite 450
Albany, New York 12207
(518) 427-6561 (fax)

25 Chapel Street, Suite 1005
Brooklyn, New York 11201
(718) 797-1161 (fax)

44 Exchange Blvd, Suite 110
Rochester, New York 14614
(585) 348-9823 (fax)

mail@DRNY.org • www.DRNY.org

(800) 993-8982 (toll free) • (518) 432-7861 (voice) • (518) 512-3448 (TTY)

Developmental, and Mental Health Disabilities at Sullivan Correctional Facility

cc: Anthony Annucci, Acting Commissioner, DOCCS
Bryan Hilton, Assistant Commissioner, DOCCS
Ann Marie T. Sullivan, Commissioner, OMH
Deborah J. McCulloch, Executive Director, CNYPC
Nancy Heywood, Deputy Counsel, DOCCS
Margaret Drake, Senior Attorney, OMH

ADDENDUM C



Corrections and Community Supervision

ANDREW M. CUOMO
Governor

ANTHONY J. ANNUCCI
Acting Commissioner

July 12, 2016

Stefen Russell Short, Esq.
Staff Attorney
Suite 450
725 Broadway
Albany, N.Y. 12207

Re: Sullivan Site Visit

Dear Mr. Short:

This is a response to your May 24, 2016 report on the Sullivan Correctional Facility, Correctional Alternative Rehabilitation (CAR) Program. CAR is an initiative developed by Department of Corrections and Community Supervision (DOCCS) to address the special needs of inmates with intellectual and adaptive deficits, who are serving disciplinary sanctions. DOCCS understands the importance of this initiative as an element of the *Peoples v. Annucci* Settlement Agreement, but more importantly, this program assists inmates with special needs to develop skills and supports their integration into general population.

The CAR program opened in May of 2014 and is a relatively new program that has demonstrated success for inmates with developmental disabilities. In your report, you acknowledge the majority of participants shared positive reviews of CAR. Currently, DOCCS feels the CAR program is adequately serving our population with ID/DD with disciplinary sanctions more than thirty days. The CAR curriculum is reviewed and revised on an ongoing basis.

Criteria

The current eligibility criteria and assessment procedures used to identify individuals with ID/DD and individuals with adaptive deficits is in accordance with NYCLU agreement. Those criteria and procedures capture more than those individuals with a "severe" and "chronic disability" required to meet the definition of DD found in 42 U.S.C.A. § 15002(8).

Despite your understanding to the contrary, a number of inmates with a WAIS score above 70 have been admitted to the CAR program. Currently, our census has 46% of participants with an IQ above 70, but have demonstrated some adaptive functioning difficulty. For instance, one inmate in the CAR program has an IQ of 96, but has an extreme lack of social skills that impacts his functioning ability.

Phase I recommendation has been in place since the 2007 Private Settlement Agreement (PSA). OMH screens all inmates coming into our system. This screening includes IQ testing. Before 2007, inmates without IQ test scores were referred to OMH for such testing. Inmates with an IQ below 80 receive a WAIS, if a referral is made, despite the logistical issues associated with having to arrange for a psychologist to complete the WAIS in each such case. DOCCS has an automated list generated for

all inmates with WAIS/BETA score below 75 and more than 30 days of confinement sanctions. This produces immediate referral to the CAR program.

However, to improve our ability to identify those inmates with limitations in adaptive functioning in daily living skills, DOCCS will explore adopting an adaptive functioning assessment tool as suggested in the Phase III of your recommendation. Your suggested use of Vineland II was reviewed with Office for People With Developmental Disabilities (OPWDD), as was the use of Adaptive Behavior Assessment System II (ABAS II). Use of these tools, however, would present an undue burden on the Department to hire staff with the necessary educational qualifications and training to administer them. OPWDD did not identify an instrument to use in a correctional setting, but instead suggested that it is sufficient that an adaptive functioning assessment is being made.

With regard to your Phase IV recommendation, facilities hold Joint Case Management Committee (JCMC) meetings to review all inmates on the OMH caseload in Special Housing Units or Long Term Keeplock Units. The consideration of inmates with developmental disabilities have been included in this process since 2014. The Joint Central Office Review Committee (JCORC) reviews two facilities a month and facilities are reminded to refer any inmates with limited adaptive functioning using the "SNU Inmate Referral Form." Staff at any time can make a SNU referral to CAR for any inmate showing adaptive functioning difficulty.

Structure of the Program

A) Your report includes comments on the structure of the CAR programming. As you note there are milestones established for the program. OPWDD indicated that the milestones can be consistently applied to all inmates, with the ability to individualize as needed. On more than one occasion, I have consulted with Washington State Department of Corrections, which has a similar smaller program to address inmates with intellectual disabilities. The recommendations from Washington State Department of Corrections Chief Psychologist were: 1) allow the Program Committee to be individualized so that all factors can be taken into consideration and that overly strict adherence with the milestones may not allow other factors, such as manifestation of disability to be taken into account; 2) The current curriculum is adequate and the Chief Psychologist was impressed with how routinely new curriculum is added, like the Brave Series. In fact, Washington State Department of Corrections implied it would be implementing aspects of our model.

B) An inmate successfully completing the CAR program prior to his confinement sanctions being completed will either have the entire remaining confinement time expunged, or will have half the remaining confinement time expunged and half suspended. If the inmate later receives a misbehavior report and a suspended confinement sanction is imposed, this will automatically trigger a review by the Office of Special Housing. This practice has been in place since the CAR program opened.

After conducting a review of all the inmates transferred out of the CAR program since its inception, there has not been a single case of an inmate, who successfully completed the program, being transferred directly to a Special Housing Unit (SHU). The goal of the CAR program is to assist inmates with developing the skills for successful re-integration back into general population or a specialized program within general population, like the Special Needs Unit (SNU) or Transitional SNU.

You recommend eliminating the practice of using SHU as a "cooling off period." Your position, however, does not fully appreciate that fact that an inmate is not moved to SHU unless the inmate presents an unacceptable risk to the safety of staff or other inmates or to the security of the facility. Inmates are returned once he no longer presents as unacceptable risk.

All inmates are reviewed by the CAR Program Committee on a daily basis. The Deputy Superintendent for Security consults with the Program Committee (which includes social workers and a psychologist) prior to finding an inmate on exceptional circumstance. Any inmate removed from the program due to an exceptional circumstance is reviewed by Central Office for return to CAR program.

C) DOCCS recognizes that disciplinary measures must never be indiscriminate or overly severe. Under the NYCLU agreement, comprehensive guidelines have been established and those guidelines will be further modified downward in the coming year. The NYCLU agreement discourages the imposition of additional confinement sanctions, however, the agreement does permit the imposition of confinement sanctions for inmates that present an unacceptable risk to safety of staff, other inmates or the security of the facility. The CAR program encourage practices that seek to address behavior in an effort to improve rehabilitation.

The Program Committee reviews every case on a daily basis to address misconduct and encourage inmate's progression through the program. In addition, the Program Committee considers the overall operation and impact on other inmates in the program. Program Committee can recommend a level regression for inappropriate behavior in the CAR program. Individuals with intellectual disabilities are affected by their environment and actions of other inmates around them. They can be easily influenced and need to understand that there are consequences to certain behavior. The more serious behavior does result in immediate regression. Other less serious behavior does not always result in regression, but could result in loss of other incentives. If the less serious behavior continues, then regression can occur. This approach follows the cognitive behavioral approach of re-focusing repetitive negative behavior to more constructive behavior. A staff psychologist assigned to the CAR program monitors, evaluates and adjusts these practices in an effort to improve the development of behavioral compliance skills.

The CAR program involves sanctions and incentives that are applied to inmates. Program participation does not exempt those enrolled in the program from the disciplinary system. As noted in the *Peoples v. Fischer* settlement agreement, misbehavior reports can only be issued for serious offenses or where similar behaviors persist. Informational reports are utilized in the CAR program to convey information about (positive or negative) behavior to the Program Committee and used as a tool to implement progressive discipline short of the disciplinary process for less serious misconduct. Over a six month period there were a total of 512 informational reports written. Of those informational reports, 170 were positive, 336 were negative and 6 fell in the category of other. This demonstrates the use of this affective tool in the CAR program. Imposing confinement sanctions are avoided absent serious offenses that demonstrate a threat to the safety of other inmates, staff or the operation of the facility. A Superintendent review occurs before any confinement sanction is imposed. In addition, the Office of Special Housing reviews any sanctions imposed upon an inmate in the the CAR program. In addition, with the full implementation of the amended *Peoples* guidelines, some of your concerns will be addressed.

As an incentive, time cut reviews occur every two weeks for all inmates, giving the inmates an opportunity to earn a time cut for positive behavior and participation. This allows a mitigation of sanctions through the duration of the inmate's participation in the program. CAR psychologist develops behavioral intervention plans for any inmate showing difficulty adjusting or continuously displaying inappropriate behavior. In addition, other psychologists not working in the program assist with developing interventions for difficult CAR inmates to assist them in modifying their behavior in order that they may benefit from the program.

There have been 147 inmates discharged from the CAR program from October 2014 to January 2016. Four inmates were discharged from the program following admission after further testing and

monitoring led a psychologist to conclude that these inmates did not meet the established criteria for CAR. Their IQs tested above 70 and they displayed no adaptive deficit.

There were 26 inmates removed from the program for presenting as unacceptable risk to the safety of other inmates, staff or to the operation of the facility. Two inmates were discharged due to protective custody issues; 18 inmates have been readmitted to the program, with six of those inmates successfully completing the program; two inmates have been moved to mental health programs; and four inmates remain in SHU, two of which are scheduled to be re-admitted to CAR. Those that remain in SHU are evaluated every 14 days by Central Office Review Committee for appropriateness to return to CAR. All recommendations by the Program Committee to discharge for exceptional circumstances are sent to the Superintendent. The Superintendent recommendations are, in turn, reviewed by Central Office.

D) Under the *Peoples v. Fischer* Settlement Agreement, DOCCS will implement revised guidelines for disciplinary sanctions. As part of the disciplinary system, for approximately ten years, an inmate's mental state and intellectual disability, when deemed at issue, is taken into consideration as mitigating factor when imposing sanctions. All sanctions for inmates in CAR are reviewed by the Superintendent for appropriateness.

E) Inmates admitted to CAR are evaluated and assessed for appropriateness for the program. A staff psychologist conducts testing and an inmate is monitored and assessed for his adaptive functioning for the period of time he is in the program. If determined that inmate is not appropriate for the program, this recommendation is forwarded to Central Office Committee for approval. Once the inmate has been discharged, he can be referred again if he shows adaptive functioning difficulties, for re-evaluation and possible readmission to CAR. This is part of DOCCS' responsibility to ensure the integrity of the program and the safety and security for those inmates in the program.

F) Your recommendation to eliminate placing inmates on pre-hearing confinement is based on inaccurate information. Inmates are not placed on pre-hearing for sole purpose of making a determination regarding the effect of a disability on behavior. Inmates are required to program four hours a day and pre-hearing confinement is not a practice in CAR. Programming is always offered unless the inmate presents as unacceptable risk to the safety of staff, other inmates or to the security of the facility. If the inmate presents as unacceptable safety and security risk, he can be placed on exceptional circumstance and that status ends once the inmate no longer presents an unacceptable risk. Inmates are not placed on pre-hearing confinement.

Mental Health Access

The Office of Mental Health (OMH) is not required to conduct daily rounds on the housing unit because it is not a mental health program. However, OMH routinely is on the housing unit based on referrals submitted on the inmates' behalf. DOCCS guidance staff assist inmates on the block and in the program area when requesting OMH services. Security staff also submit call-out requests for OMH services, when requested, because of their understanding of the limitations of this population. For example, in checking with OMH at Sullivan, they conducted 20-25 call-outs a week based on referrals made by staff working in the CAR program. OMH reports this is pretty consistent. In addition, OMH staff are utilized as consultants on difficult cases in the CAR program. Over the last several months OMH has consulted on 26 cases and the designation of 10 inmates were changed to seriously mentally ill and transferred to a mental health program. I think this demonstrates not only the accessibility to mental health services, but also the routine use of OMH professionals to help manage this population. OMH has been consulted in developing behavioral/treatment plans to assist inmates in their coping skills. Notwithstanding the foregoing, I will check with OMH regarding the referral process for obtaining mental health services and discuss any need to improve access.

Crisis Intervention

You recommend enhancing our crisis intervention strategies. Crisis intervention is an essential component to managing this population. Crisis Intervention strategies are utilized throughout the program even to the point that highest level facility staff, such as a Captain and Assistant Deputy Superintendent, will talk with inmates in an attempt to de-escalate a situation. There is a group that works with every inmate after an incident to evaluate how other approaches could have been used to avoid the incident. Our crisis intervention strategies are part of our training provided by OPWDD. This is a population with disabilities and can be very volatile, therefore every effort is made to handle a situation in the best way for all involved.

Once again, OMH is a resource to assist in managing this population. In your report you mention incidents where you thought OMH did not assess inmate's symptoms properly nor comply with Residential Crisis Treatment Program (RCTP) protocol. Your report has been shared with OMH for their analysis of your recommendations. However, DOCCS has social workers and a psychologist that see inmates every business day and routinely will refer inmates to OMH for consultation or further evaluation. DOCCS employs crisis intervention strategies and understands the importance dealing with the manifestation of emotional distress.

In addition, the person-centered approach is at the heart of all of our Special Needs Programs. As a result of a grant received in 2003, Cornell University assisted and trained DOCCS in person-centered planning for a five year period. Even though Cornell University is no longer assisting DOCCS, the Department has continued the person-centered planning approach because it recognizes its effectiveness. Again, OPWDD is periodically consulted on new treatment modalities and best practices in crisis intervention.

Establishing a Committee

All incidents where force is used are reviewed by the facility Executive Administration and can be sent to Central Office for review by a number of separate divisions. If there is an issue with the use of force, Office of Special Investigation (OSI) will investigate and, if appropriate, further action will be taken. There have been incidents, some referenced in your report, that have been investigated and disciplinary action has been taken. Our Department has implemented a new use of force policy that includes actions to be employed prior to the use of force when the situation allows. Other strategies are being explored to ensure proper response to incidents.

Training

Prior to the opening of the CAR program in May of 2014, all staff were trained on such topics as: De-escalation and dealing with aggressive behavior, crisis intervention, how to deal with individuals with disabilities, Trauma Informed Care (TIC) and effective communication. OPWDD was consulted and OPWDD staff were presenters at the training. DOCCS continues to conduct annual training to all DOCCS staff working in CAR utilizing OPWDD resources.

Our de-escalation training included recommendations made by National Institute of Corrections (NIC). Most recently a Massachusetts Police Department expert assessed our de-escalation process, toured several facilities, and made recommendations on how to improve our training.

Our Department has and will continue to reach out to other resources to advance our training of staff.

Consult with Outside consultants/experts

The Department works with OPWDD and other agencies and experts to periodically review our program and best practices. In addition, NYCLU experts have conducted site visits and made recommendations, some of which have been accepted and implemented. Staff at facilities have utilized SAMSHA and made several recommendations to Central Office for enhancing the program.

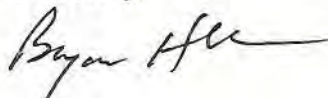
DOCCS employs professionals such as Masters level social workers and a Masters level psychologist who are trained and educated in assessing inmates in relation to mental illness and intellectual disabilities. Also, as mentioned above, a psychologist item is designated for CAR as well as a DOCCS Doctoral level Psychologist oversees and assists with the program.

Collect Data

As part of the outcome measures, monitoring of the program data is collected in a number of areas that are reviewed by Central Office staff.

If you have further questions or concerns please feel free to contact me at 518-485-0010. Thank you.

Sincerely,



Bryan Hilton
Assistant Commissioner

ADDENDUM D



DISABILITY RIGHTS NEW YORK

New York's Protection & Advocacy System and Client Assistance Program

DRNY RESPONSE TO DOCCS'S JULY 12, 2016 LETTER

Criteria

While DOCCS has agreed to “explore” adaptive functioning assessment tools, it provided no information about how adaptive functioning assessments will be conducted without using the assessment tools DRNY recommended. Therefore, DRNY’s remains concerned that the eligibility and evaluative process will be under-inclusive and fail to identify individuals who are eligible for CAR. In addition, DOCCS’s reliance on “remind[ers] to refer any inmates with limited adaptive functioning” does not address DRNY’s concerns if facility staff have neither special training nor an assessment tool to identify eligible individuals.

Structure of the Program

B) “Cooling off” transfers to SHU undermine the rehabilitative mission of CAR and should not occur. DOCCS acknowledges that it may place a CAR participant in SHU for a “cooling off period” when “the inmate presents an unacceptable risk” to safety and security and that the CAR program participant will be “returned once he no longer presents an unacceptable risk.” That practice should be amended to require completion of “Exceptional Circumstances” documentation which triggers the related Central Office review.

C) DOCCS acknowledges that four individuals from CAR “remain in SHU, two of which are scheduled to be re-admitted to CAR.” DOCCS stated that CAR participants in SHU are evaluated every 14 days to determine whether they should be returned to CAR. DRNY remains concerned that during this period in SHU, which can last 14 or more days, a CAR program participant receives no programming (DOCCS Letter, subsection F: “Programming is always offered unless the inmate presents as unacceptable risk”). DRNY reaffirms its position that individuals with ID/DD should not be in extreme isolation, where there is no meaningful programming, for any length of time under any circumstance. DOCCS should maintain individuals with disabilities in the least restrictive setting possible and move individuals to an integrated environment and deliver programming and pro-social skill development opportunities as promptly as possible.

725 Broadway, Suite 450
Albany, New York 12207
(518) 427-6561 (fax)

25 Chapel Street, Suite 1005
Brooklyn, New York 11201
(718) 797-1161 (fax)

44 Exchange Blvd, Suite 110
Rochester, New York 14614
(585) 348-9823 (fax)

mail@DRNY.org • www.DRNY.org

(800) 993-8982 (toll free) • (518) 432-7861 (voice) • (518) 512-3448 (TTY)

F) DRNY reiterates its recommendation that DOCCS develop a manifestation determination process when a CAR program participant is alleged to have broken a disciplinary rule. A manifestation determination process is designed to determine whether problematic behavior is a manifestation of a disability. If a trained clinician determines that the behavior relates to a disability, DOCCS should be precluded from imposing additional confinement sanctions and, instead, should develop a behavioral intervention plan to address the problematic behavior. DOCCS's current disciplinary system does not include a manifestation determination process, because disability is only a factor considered for mitigating penalties.

Mental Health Access

DOCCS stated that the Office of Mental Health is not required to conduct daily rounds in CAR, and that DOCCS and OMH will discuss referral processes and improvements to accessing mental health services. The large number of transfers to mental health programs underscores the need for greater access to mental health services for CAR program participants, many of whom have a dual diagnosis of ID/DD and mental illness.

Crisis Intervention

Based on DOCCS's response, DRNY anticipates that DOCCS and OMH will conduct a further analysis of DRNY's recommendations on crisis intervention, including an independent, comprehensive review of the delivery of mental health services; periodic review by the Joint Case Management Committee and Joint Central Office Review Committee of patient populations; and additional training for staff. DRNY will seek additional information from DOCCS and OMH regarding the analysis and any changes that have occurred as a result of DRNY's recommendations.

Training and Expert Consultation

DOCCS stated that OPWDD participated in CAR staff training, reviewed the program, and provided assistance regarding best practices. DOCCS also stated that it will seek out other resources to advance additional training for staff. This is very positive. However, DOCCS has not produced training materials DRNY requested in September 2014, which makes it impossible to evaluate the adequacy of the training. Notwithstanding the training and consultation with OPWDD, DRNY's investigation revealed deficiencies in DOCCS and OMH staff's management and care and treatment of individuals with ID/DD, and DRNY reiterates its recommendations for additional training and for further consultation with experts on how to best address the needs of individuals with ID/DD.

Data Collection

DOCCS should publish data on the CAR population and outcomes measures. The publication of this data will assist the public in understanding and evaluating DOCCS's programs and its commitment to eliminating the use of solitary confinement for people with disabilities in New York State.

July 22, 2016