



February 10, 2026

BY EMAIL

Dwayne C. Sampson, Chair
Members of the Board
Board of Correction
2 Lafayette Street, Room 1221
New York, NY 10007

Re: Public Comment on Mental Health and Health Care Standards Rulemaking

Dear Chair Sampson and members of the Board:

The Jails Action Coalition and HALT Solitary Campaign submit this comment regarding the Board's proposed amendments to the Mental Health and Health Care Minimum Standards in New York City's jail facilities.

First, we urge the Board to conduct a comprehensive overhaul of the Mental Health and Health Care Minimum Standards and adopt amendments that provide clear requirements about the health care that must be provided to people incarcerated in New York City jails. The Board's current proposed amendments are unnecessarily limited in scope. We know that well over half of the people held in our City's jails have mental health conditions; that nearly a quarter are diagnosed with a serious mental illness; and that over a quarter are diagnosed with substance use disorders. Many people in our jails have chronic medical conditions, such as pulmonary, cardiovascular, and neurological conditions that require consistent medical care. As the Board knows, the Department of Correction (DOC) routinely fails to provide the mental and physical health care that people in custody need.

The proposed amendments do not ensure that appropriate care is reliably available and administered. Given the importance of this issue to the health and safety of persons in custody, we call on the Board to conduct a thorough, plenary review of the Mental Health and Health Care Minimum Standards. That review must include input from people in custody, health care experts, advocates, and other community members.

Second, we would like to request a meeting with you at your earliest convenience to discuss our comments below and how to more meaningfully address the mental and physical health needs of people in custody. The Minimum Standards are in need of significant revision to adequately address the many physical and mental health needs of the people in our City's jails, and we are eager to work with the Board as soon as possible to initiate those changes.

In addition to our comments regarding the specific substantive amendments proposed, below we provide our recommendations about how the standards can be strengthened.

I. THE BOARD MUST UPDATE THE MINIMUM STANDARDS ON MENTAL HEALTH AND HEALTH CARE IN THEIR ENTIRETY

The Board must commit to updating the Minimum Standards on Mental Health and Health Care in their entirety, rather than focusing on a small number of discrete topics at a time. In many areas, the standards lack clarity and uniformity, which can contribute to the provision of inadequate care, or even a failure to provide care at all. Below are some examples.

- A. The current standards are too vague and lack definitions for critical roles and functions. Terms like "close supervision" and "special housing" appear in the standards regarding treatment of people with mental or emotional health issues (Section 2-05(c)(1)), but lack a precise definition.
- B. The Board should review the timeframes for referrals, evaluations, and other practices and procedures. Throughout the Minimum Standards, these timeframes lack precision, which can lead to treatment delays. More clarity is needed to ensure that people who need treatment receive it as soon as possible, especially in emergent situations. For example, Section 2-04(b)(4) directs DOC to escort people in custody to mental health services staff on "the same day," and in all cases "within twenty-four hours" of the request for evaluation. This time limit must be shortened, and DOC must be directed to provide the requested mental health care "as soon as possible." Additionally, where the Minimum Standards require that DOC take an action "immediately," they should include a time limit, such as "but no longer than fifteen minutes," depending upon the circumstances, to ensure that DOC has concrete guidance on how quickly staff must act.
- C. The Board must address the lack of transparency and process for reviewing and revising required policies and procedures. In several sections of the Mental Health and Health Care Minimum Standards, the Board proposes changing the language requiring specific programs, policies, and

procedures from “design and implement” or “develop” to “maintain.”¹ Although the Board does not specify the reason for the amendment, the language change implies that the Board is satisfied that such a program, policy, or procedure already exists, and the requirement now is that it simply be maintained. Our concern is that this implication is incorrect, and that this change will condone a continued lack of transparency around those programs, policies, and procedures. Even if those programs, policies, and procedures exist, there is certainly no guarantee that they are adequate. The Minimum Standards should include a requirement that the relevant policies and procedures are provided to the Board so that the Board can consider whether they are adequate. In addition, the Health Authority and DOC should be required to review the policies annually, update them as needed, and inform the Board of all revisions.

II. COMMENTS ON THE PROPOSED AMENDMENTS

A. Psychotropic Medication (Mental Health Standard § 2-06(b)(2)(i-ii)²)

The Board’s proposed amendment is much broader than the variance which has been renewed repeatedly since it was first granted on November 10, 2005. In requesting the variance which the Board now seeks to codify, Correctional Health Services (CHS) made clear that the variance request was to allow “psychiatrists to see and evaluate stable adult patients on psychotropic medication in general population at least every 28 days, rather than every 14 days.”³ CHS policy requires that psychotropic medication orders be written for 14 days or less for people housed in mental observation units.⁴ According to CHS policy, a person in custody in general population is not considered “stable for a 28-day prescription until they have received a follow-up visit from a mental health provider who has determined

¹ See proposed §§ 2-02 (mental health program), 2-03(b)(3) (screening), 2-03(c)(3)(i) (training), 2-03(d)(2) (observation aides), 2-04(a) (evaluation and referral), 2-04(b)(4) (DOC escorts), 2-05(b)(1) (mental health staff, supplies, and equipment), 2-05(b)(2) (space for housing and treatment), 2-05(c)(1)(ii) (CO training curriculum), 2-05(c)(2) (mental observation housing admission and discharge), 2-05(c)(3)(iv) (treatment plan), 2-05(d) (informed consent), 2-05(e)(5) (treatment refusal), 2-06(b)(1) (medication), 2-06(c)(2) (storage of medication and supplies), 2-07(a), 2-08(b)(2) (correction personnel notification), 2-09(b)(1) (infractions in mental observation housing), 3-01(b) (health care program), 3-02(b)(8) (second medical opinions), 3-02(d)(3) (emergency services), 3-02(e)(2) (infirmaries), 3-02(f)(2) (special clinics), 3-02(g)(5) (medical isolation), 3-02(h) (special needs), 3-04(a) (screening procedures), 3-05(a) (pharmaceutical services), 3-06(d) (vision and eye care), 3-06(f)(1) (diagnostic services), 3-06(h)(1) (special diets), 3-06(m)(2) (HIV treatment and prevention), 3-10 (notification of deaths in custody), 3-12(a) (shackling), 3-14(a) (injuries).

² Throughout our comments, the Mental Health Minimum Standards in Title 40 of the Rules of City of New York are cited as proposed to be renumbered by the proposed rule.

³ January 6, 2026 letter from Joseph Otonichar, DO, Chief of Service, Mental Health, Correctional Health Services, to Jasmine Georges-Yilla, Executive Director, NYC Board of Correctional available at https://www.nyc.gov/assets/boc/downloads/pdf/BOC_Psych_Med_variance_JAN-2026_signed.pdf.

⁴ See, June 1, 2021 memo from Bipin Subedi, M.D., Co-Chief of Service, Mental Health, to Margaret Egan, Esq., Executive Director, NYC Board of Correction available at <https://www.nyc.gov/assets/boc/downloads/pdf/Meetings/2021/June/4a.%20CHS%20Psychotropic%20Meds%20Variance%20Letter.pdf/>

there is no need for a medication adjustment.”⁵ Thus, to codify this variance, the proposed amendment should be revised to specify that *only* people who are stable and housed in general population can be seen less frequently than required by the current standard.

We urge the Board to revise the proposed language as follows:

(2) Psychotropic medication shall be dispensed only when clinically indicated, consistent with the treatment plan:

(i) all prescriptions for psychotropic medication must include a stop order; no prescription for psychotropic medication shall be valid for longer than two weeks for persons in persons in custody in specialized mental health units and four weeks for persons in custody in general population;

(ii) every [inmate] person in custody receiving psychotropic medication shall be seen and evaluated by the prescribing psychiatrist, or, in cases of emergency when a physician other than a psychiatrist prescribes medication under 40 RCNY § [2-05(b)(1)(i)] 2-06(b)(1)(i) by the reviewing psychiatrist, at least once a week until stabilized and thereafter at least every two weeks for persons in custody in specialized mental health units and at least every four weeks for persons in custody in general population by medical personnel;

(iii) A person in custody in general population shall not be considered stabilized for the purpose of receiving a four-week prescription until they have received a follow-up visit from a psychiatrist who has determined there is no need for a medication adjustment and the person in custody agrees with that determination;

B. Psychiatric Provider (Mental Health Standard § 2-01(e))

The Board does not set forth the reason for defining “psychiatric provider” and substituting it for “psychiatrist” in several sections of the Mental Health Minimum Standards in its Statement of Basis and Purpose of Rules. Yet, the proposed rules include these amendments.⁶ Allowing professionals who have less training and medical expertise to provide treatment to people in custody is not a decision that should be taken lightly. In some circumstances a psychiatric nurse practitioner or psychiatric physician assistant may be qualified to carry out the responsibilities which the current standards reserve for psychiatrists to perform. However, the expertise that psychiatrists have regarding the provision of mental health care should be available to people in DOC custody, and the standards should include a required minimum staffing level for psychiatrists. The standards should also require that treatment teams in specialized mental health units include a psychiatrist and that psychiatrists provide secondary review of prescriptions for psychotropic medication in certain situations.

⁵ *Id.*

⁶ See §§ 2-05(c)(3)(i-ii), 2-06(b)(1)(i), 2-06(b)(2)(ii), 2-07(b)(iii), 2-07(c)(2-3), 2-07(c)(6-7).

As stated above, the Board should conduct a full review of the Mental Health Care Standards and propose comprehensive amendments. A thorough discussion of which responsibilities should be required solely of psychiatrists rather than psychiatric providers generally should be part of that rulemaking process. In addition, the Board should consider adopting limits on the number of persons in custody assigned to each psychiatric provider.⁷ The Board has not adequately considered its proposed amendments to replace psychiatrists with psychiatric providers. Thus, we urge the Board not to make these amendments at this time, but instead to consider them in the context of comprehensive changes to the Mental Health Minimum Standards as a whole.

C. Restraints and Seclusion (Mental Health Standard § 2-07)

1. Seclusion

We appreciate that CHS does not authorize or order the use of seclusion, which essentially is a form of solitary confinement, and we support the Board amending the standards related to this practice. However, simply removing the provisions that regulate the use of seclusion is inadequate. Unless the practice is explicitly prohibited, limits on its use must be preserved. To ensure that CHS' current practice of not using seclusion is maintained, the Board should adopt an amendment that clearly prohibits it.

We recommend that the Board amend Section 2-07 as follows:

- (a) Policy. The [Departments] Department of Correction and [Health] the Health Authority shall [develop and implement] maintain procedures [subject to the review of the Department of Mental Health, Mental Retardation and Alcoholism Services] governing the physical restraint [and seclusion of inmates] of people in custody being observed or treated for mental or emotional [disorders] health issues. Consistent with the New York State Mental Hygiene Law, restraints [or seclusion] shall not be used as punishment, for the convenience of staff, or as a substitute for treatment programs. The Health Authority shall not authorize or order the use of any form of seclusion under any circumstances.

In addition, we recommend the Board maintain the definition of seclusion in Section 2-07 (b) but eliminate (b)(i) and (b)(ii).

2. Restraints

The Board provides no justification for other amendments proposed to Section 2-07. However, two substantive changes are proposed:

- 1) an amendment to the definition section (2-07(b)(iii)) replacing “an inmate presents a clear and present danger to himself or others” with “an individualized determination is made that restraints are necessary to prevent an imminent risk of self-injury or injury to other people” and

⁷ Currently some psychiatric nurse practitioners are assigned to provide treatment to all persons in custody on two separate PACE units, which can total as many as 100 people.

2) an amendment to the procedures section (2-07(c)(3)(iii)) eliminating “these measures are absolutely necessary to avert the danger and will be therapeutically beneficial” as one of the four determinations that must be made before a person can be placed in restraints and changing the person making the determination from a psychiatrist to a psychiatric provider.

Amending the standards which limit the use of restraints should take place in the context of a comprehensive review of the Mental Health Minimum Standards. The Board certainly should not change the procedures without explaining the reason for the amendment.

D. Variances (Mental Health Standard § 2-10(b))

Regarding any application for a variance by the Commissioner of the Department of Correction or the Health Authority, the Board proposes to remove the requirement of an at-least-forty-five day notice period prior to the implementation date of any such requested variance. In its place, the Board proposed that any such application must be made “as soon as a determination is made that continued compliance will not be possible.”

In order to maintain at least some guarantee of a notice period, we propose the addition of language to require public notice of the requested variance and a minimum period of time -- *e.g.* 10 business days -- between the date of any application and the date on which the Board meets to hear from the requesting party and members of the public prior to any vote.

III. SPECIFIC ADDITIONAL CHANGES TO THE MINIMUM STANDARDS ON MENTAL HEALTH AND HEALTH CARE

The Minimum Standards seek to safeguard the provision of physical and mental health treatment in the jails. However, based upon the experience of people in custody and those who represent and advocate for them, we believe that a comprehensive overhaul of the standards should include the following discrete amendments to address persistent problems in practice.

A. The Need for Escorts Must Not Prevent People from Receiving Treatment

The current Health Care Minimum Standards bar the Department from delaying or denying health care as punishment and require adequate staffing to meet all minimum standards (Section 3-02(b)). They also require prompt escorts for people who need medical evaluation outside their housing area (Section 3-02(g)).

An additional provision is needed to address the particular staffing demands created by Department classification statuses that require special escorts. In particular, Department policy states that people assigned Centrally Monitored Case (CMC) status require a Captain escort, and we have repeatedly seen the Department fail to bring CMC-designated people to necessary hospital care because such escorts were not readily available.

B. People in Custody Should Be Allowed to Communicate Privately with Health Care Staff

The current Mental Health and Health Care Minimum Standards include protections about ensuring confidentiality and privacy in health care (Sections 2-08 and 3-08). However, in practice, often people in custody cannot communicate privately with their treatment provider as they are seen cellside and must share information about their condition through the cell door. Such encounters expose confidential information to people incarcerated in cells nearby and correction staff stationed in the housing area. The Board should amend the standards to require that health care staff ensure that people in custody can communicate about their physical and mental health conditions in private and that cellside encounters can be used only to inspect the person's cell and ask them to come out to speak privately with health care staff. In addition, the standards should give health care staff the authority to require DOC to escort a person in custody who wants to meet with health care staff to a location that allows for private communication between health care staff and the person in custody.

C. The Standards Should Monitor Dental Services for Over-reliance on Extractions

Dental care is governed by Section 3-06(c), which requires treatment when a person's health or comfort would otherwise be unreasonably affected and includes a non-exhaustive list of treatments that may be offered. The list includes "repair of injured or carious teeth."

We recommend adding a reporting requirement so the Health Authority tracks how often common services, and particularly tooth extractions, are performed. Extractions may be routine but they have long-term effects on employment, self-esteem, and successful reentry,⁸ and should be monitored to ensure alternatives are used whenever appropriate.

D. The Standards Must Improve Screening and Treatment of People with Developmental Disabilities or Cognitive Impairments

Due to longstanding issues with the screening, identification, and treatment of people with developmental disabilities and cognitive impairments in NYC jails, there are likely many people with developmental disabilities on Rikers who have not been diagnosed.⁹ For example, if someone was not diagnosed with a developmental disability at a young age, their medical records may not include this information. It can also be more difficult to identify individuals with developmental disabilities who do not have co-occurring mental health diagnoses. This hinders CHS' ability to provide proper care to these individuals and has led to instances in which the Department has failed to protect people with developmental disabilities.

⁸ See Eldridge, Taylor Elizabeth. "Another Hurdle For Former Inmates: Their Teeth." June 28, 2018, *The Marshall Project*. Available at <https://www.themarshallproject.org/2018/06/28/another-hurdle-for-former-inmates-their-teeth>.

⁹ Ben Hatttem, *NYC Jails Fail to Identify Prisoners With Cognitive Problems*, City Limits, Oct. 27, 2016, <https://citylimits.org/nyc-jails-fail-to-identify-prisoners-with-cognitive-problems/>.

We recommend that the Board review the current screening (Section 2-03(b)(3)) and staff training (Section 2-03(c)(1)(iv)) protocols regarding people with developmental disabilities.¹⁰ The Board should also consider whether there are other areas in the standards that inappropriately overlook people with developmental disabilities or improperly group them with people with mental health diagnoses.

E. The Standards Should Require Specialized Mental Health Units and Discharge Planning

Since the Mental Health Minimum Standards were implemented in 1985, the mental health treatment provided to people in the NYC jails has changed significantly. The standards require special housing areas for mental observation, specify staffing and treatment planning requirements, and give the mental health service responsibility for admission and discharge from special housing (Section 2-05(c)). For decades mental observation housing areas were the only alternative to general population for people with significant mental health treatment needs. But in 2015, CHS and DOC began developing PACE (Program to Accelerate Clinical Effectiveness) units which have a full complement of mental health staff stationed on the unit and offer a range of therapeutic interventions. Early evaluations of these units demonstrated that they had fewer uses of force and self-harm incidents and that they improved clinical outcomes. These units are essential to treat people in custody who need a higher level of mental health care. We are concerned that these units currently do not operate as originally designed. To restore them and ensure their continued operation, the standards should be amended to require this higher level of care and include staffing requirements and other essential components of the PACE model. The standards should also require a sufficient number of PACE beds to meet the needs of the jail population.

Similarly, discharge planning services were not available to people receiving mental health treatment in the jails until they were mandated, first as a result of a preliminary injunction and then through a settlement agreement, in *Brad H. v. City of New York*. Although CHS currently offers these services, nothing in the standards requires them to do so. The standards should be amended to require this fundamental component of mental health treatment as well as the specific services that must be offered.

F. The Requirements for Observation Aides Should Be Expanded

The requirement that the NYC jails have an observation aide program that employs persons in custody trained to monitor individuals identified as potential suicide risks was a key element of the Mental Health Minimum Standards when they were adopted. The program was credited with reducing suicides in NYC jails and was replicated in other systems. The proposed rule expands the housing areas in which observation aides must operate, but additional amendments are needed to improve and modernize the observation aide program.

¹⁰ For example, the Board could consider whether the Department and Correctional Health Services are employing the best practices put forth by the Council of State Governments Justice Center. Jazmone Wilkerson, Felicia Lopez-Wright, and Leigh Ann Davis, *Improving Outcomes for People in Contact with the Criminal Justice System Who Have Intellectual or Developmental Disabilities*, Council of State Governments Justice Center (April 2022), <https://csgjusticecenter.org/publications/improving-outcomes-for-people-in-contact-with-the-criminal-justice-system-who-have-intellectual-or-developmental-disabilities/>.

The standards should specify how CHS and DOC provide supervision and support for these peer workers as well as require mandatory debriefing for observation aides who witness suicides and suicide attempts. Observation aides should also carry and be trained to administer naloxone. The standards should require procedures for periodic refresher training and for observation aides to report staff misconduct or retaliation. Considering the level of responsibility observation aides are given, they should be paid at least the NYC minimum wage for their work, and when appropriate, given a letter of recommendation or some other certification toward future employment. The Board should survey persons in custody about the observation aide program to determine additional amendments needed to strengthen the program.

G. The Standards Should Require Data Collection and Review to Promote Compliance

The current standards include many important requirements related to physical and mental health care that are not being followed. For example, Section 2-03(c)(3) of the Mental Health Minimum Standards requires training for all correction officers, and Section 2-05(c)(1)(ii) requires additional training for correction officers assigned to steady posts in the mental observation housing areas. Proper training equips staff to handle situations effectively, promoting the safety and well-being of all involved. When staff are well-prepared, they can respond to crises more efficiently and provide better care for people in custody, leading to improved outcomes. Enhancing these standards by focusing on continuous education and support for the staff can further improve the quality of care in mental health units. Ongoing training sessions and workshops can help staff stay updated with the latest practices and techniques. This not only boosts their confidence but also enhances their ability to manage complex situations with greater ease.

To ensure that the Department provides training, continuing education, and steady staffing, regular data reporting and monitoring should be required. This is especially crucial in places like mental health units, where having a stable team of correctional staff is necessary. Consistency in staffing ensures that the team can work smoothly together and understand the needs of the individuals they serve. Ensuring that staff receive thorough training and are prepared to deal with the unique challenges that arise in these environments is another critical requirement that needs attention.

The Board's Elimination of Sexual Abuse and Sexual Harassment in Correctional Facilities Minimum Standards include robust data reporting and monitoring requirements (Section 5-40). Similar requirements to collect and report data on key elements of the Mental Health and Health Care standards should be adopted.

IV. THE BOARD MUST ENGAGE IN AN INCLUSIVE PROCESS TO UPDATE THE MENTAL HEALTH AND HEALTH CARE STANDARDS

To effectively address pressing health care issues, it is essential to engage in a comprehensive process. The people whom the Minimum Standards are intended to protect must have a central role in this process. This process should blend insights from both external experts and the concerns of those directly involved, including people in custody, families of people in custody, and advocates. By doing so, we can tackle these challenges more thoroughly. It is important to listen to these varied voices, as they provide a

range of perspectives that contribute to crafting well-rounded and effective solutions. The key to overcoming health care challenges lies in fostering a collaborative environment where diverse viewpoints are not only heard but valued. By incorporating the knowledge of professionals from outside the health care system and considering the experiences and apprehensions of those within it, we create a foundation for meaningful change. This collaborative approach ensures that the solutions we develop are not one-sided but instead reflect a balanced understanding of the issues at hand.

* * * * *

In conclusion, JAC and the HALT Campaign urge the Board to recognize the need for a large-scale revision of the Minimum Standards on Health Care and Mental Health. In addition to the suggestions above, the Board must commit to closely monitoring and enforcing DOC's and CHS' compliance with the Minimum Standards to ensure that every New Yorker in our City's jails receives the care that they need and deserve. We welcome any questions the Board has, and are eager to meet with you to discuss our suggestions further.