



Mental Health Project

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
[coc@coc.nyc.gov](mailto:boc@coc.nyc.gov)

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

Dear Chair Sampson and Members of the Board:

We join with the Jails Action Coalition (JAC) and HALT Solitary Campaign (HALT) in calling on the Board to conduct a comprehensive review of the Mental Health and Health Care Minimum Standards, engage the expertise of a broad range of stakeholders, and amend the standards to improve access to and quality of care for people in Department of Correction (DOC) custody. The current rulemaking process is too narrowly focused, and as JAC and HALT point out, some of the amendments make substantive changes to the standards without any justification and without any engagement with people in custody, community members, advocates, or health care professionals regarding the consequences of these changes. Even the Board's proposed amendments regarding psychotropic medication (Mental Health Standard § 2-06(b)(2)(i-ii) (as renumbered in the Proposed Rules)), as currently drafted, do not accomplish the goal of codifying the long-standing variance, but instead reduce the standard of care for everyone receiving psychotropic medication. We urge the Board to revise this proposed change as indicated below.

For more than 25 years, the Urban Justice Center Mental Health Project has advocated for people with mental health concerns involved in the criminal legal system. We are deeply familiar with the difficulties people with mental health concerns have within correctional facilities and in accessing essential mental health services, housing, and benefits upon release. We represent the *Brad H.* Class, all incarcerated individuals who receive mental health treatment while in City jails. Currently the *Brad H.* Class includes almost 60% of the jail population.

The mental health treatment provided to people in custody has changed dramatically since the *Brad H.* litigation was filed in 1999, including the provision of discharge planning services. However, none of those advances are enshrined in the Mental Health Minimum Standards, and DOC and Correctional Health Services (CHS) are not required to maintain them. As a result,

some of the improvements to the specialized mental health units adopted more than a decade ago have been significantly eroded. In fact, many of the deaths of people in custody occurred in mental observation and PACE (Program for Accelerated Clinical Effectiveness) housing units. Moreover, these units have been the site of some of the most inhumane and restrictive uses of solitary confinement, in the form of deadlocking. It is vital that the Board ensure a level of mental health treatment that meets the needs of the jail population, especially people with serious mental illness which is now about 22% of people in custody. To do so, the Board should engage in a comprehensive rulemaking process.

We are eager to engage with the Board regarding various amendments to the standards which should be considered in such a rulemaking process, including the need for reporting requirements so that the Board can provide meaningful oversight of the standards.

In these comments we focus on the need for the Board to amend the proposed changes to Mental Health Standard § 2-06(b)(2)(i-ii).

The Board's proposed amendment to Mental Health Standard § 2-06(b)(2)(i-ii) is much broader than the variance first granted on November 10, 2005, and repeatedly renewed since then. Instead of limiting the circumstances in which people in custody who are prescribed psychotropic medication must be seen and evaluated by a psychiatrist, the proposed amendment reduces the required two-week evaluation to four weeks for everyone in custody.

This amendment to the standard is not in keeping with the approved variance. CHS limited its variance request to stable adult patients on psychotropic medication in general population. CHS policy requires that psychotropic medication orders be written for 14 days or less for people housed in mental observation units. 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 there is no need for a medication adjustment."¹ Because of the limited scope of the variance to people who had been stabilized on medication and housed in general population, the Board agreed to allow the required timeframe for seeing a psychiatrist for a medication reevaluation to be extended from two weeks to four weeks. Thus, to codify this variance, the standard should specify that *only* people who are stable and housed in general population can be seen less frequently than every two weeks.

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 custody in specialized mental health units and four weeks for persons in custody in general population;

¹ 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>.

(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;

The Board's proposed amendment also changes the requirement regarding who must provide the medication reevaluation. Rather than psychiatrists being responsible for this and many other obligations set forth in the Mental Health Minimum Standards, psychiatric providers, which include psychiatric nurse practitioners and psychiatric physician assistants, are authorized to provide this care. Such a change should not be adopted without more robust discussion of the role of psychiatrists in providing health care to people in custody. The Board should consider the circumstances when a psychiatrist should be involved in reviewing the care provided to people with the most significant mental health treatment needs. The standards may need to be amended to require a minimum level of staffing, such as a certain ratio of psychiatrists to people diagnosed with serious mental illness, or to require that a psychiatrist review prescribing practices in the mental observation and PACE units. Certainly, the Board should not simply replace psychiatrists wholesale with psychiatric nurse practitioners and psychiatric physician assistants without any explanation of this amendment in the notice of rulemaking. It seems that the Board has not fully considered the ramifications of such an amendment.

We encourage the Board to revise the amendments to Mental Health Standard § 2-06(b)(2)(i-ii) as indicated above and to defer adopting the change from "psychiatrist" to "psychiatric provider" until the Board conducts a comprehensive review of the Mental Health Minimum Standards and engages in a holistic rulemaking process that allows for the views of people in custody, their families, advocates, mental health care professionals, and the broader community to be considered.

Thank you for considering our comments. We look forward to a more substantive discussion about how mental health care can be improved for people incarcerated in the City jails.

Sincerely,



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