NEW YORK CITY
BOARD OF CORRECTION

June 3, 2013

MEMBERS PRESENT
Gerald Harris, Esq., Chair
Alexander Rovt, PhD., Vice-Chair
Catherine Abate, Esq.
Pamela S. Brier
Greg Berman
Robert L. Cohen, M.D.
Pamela Silverblatt, Esq.

Excused absence was noted for Michael J. Regan.

DEPARTMENT OF CORRECTION
Dora B. Schriro, Commissioner
Evelyn A. Mirabal, Chief of Department
Mark Cranston, First Deputy Commissioner
Thomas Bergdall, Esq., Deputy Commissioner and General Counsel
Erik Berliner, Deputy Commissioner
Florence Finkle, Esq., Deputy Commissioner
Sara Taylor, Chief of Staff
Eldin L. Villafone, Press Secretary
Carleen McLaughlin, Legislative Affairs Associate

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Homer Venters, M.D., Assistant Commissioner, Correctional Health Services

OTHERS IN ATTENDANCE
Dilcio Acosta, Jails Action Coalition (JAC)
Agnes Baik, JAC
Katie Barry, NY1
Becca Broche, JAC
Rob Calandra, City Council
Dahianna Castillo, Office of Management and Budget (OMB)
Luis Cintron, MD, Corizon
Matthew Claiborne, Columbia University School of Journalism
Diane Cook, JAC
Megan Crowe-Rothstein, JAC
Laurie Davidson, Contract Administrator, Doctors Council SEIU
Allan Feinblum, JAC
Leah Gitter, JAC
David Gonzalez, JAC/**ISO**
Susana Guerrero, State Commission of Correction
Catherine Guzman, Solitary Watch
William Hongach, City Council
Sarah Kerr, Legal Aid Society

Lucas Koehler, OMB
Danielle C. Louis, OMB
Neil Leibowitz, M.D., Director, Mental Health, Corizon
Jeff Mailman, City Council
Kristin Misner, Deputy Mayor's Office
Jennifer Parish, Urban Justice Center/JAC
Felicia Reback, JAC
Regina Poreda Ryan, City Council
Rick Sawyer, JAC
Jane Stanicki, JAC
Marc Steier, Correction Officers Benevolent Association (COBA)
Jeng-Tying Hong, Columbia University School of Journalism
Eisha Wright, Finance Division, City Council
Sallina Yung, OMB
Michael Zuckerman, MD, Vice President of Operations, Corizon

Chair Gerald Harris called the meeting to order at 9:25 a.m. A motion to adopt the minutes from the Board's May 13th meeting was approved without objection. The Chair announced that Milton Williams resigned from the Board last week and requested that a resolution be adopted thanking Mr. Williams for his many years of dedicated service as a member of the Board and its gratitude for his diligent service, which was approved by all members.

Chair Harris requested that Department of Correction (DOC) Commissioner Dora Schriro provide a brief update on the progress of steps taken by the Department to address "issues that bear upon the question of punitive segregation".

The Commissioner handed out an updated report entitled "Alternatives to Punitive Segregation for Mentally Ill Inmates" (attached to the minutes), and stated that the mentally ill comprise almost 40% of the average daily population. Commissioner Schriro discussed the Department's plan to expand the Restrictive Housing Units (RHUs) for those inmates who are not seriously mentally ill, but have a mental health diagnosis. The Commissioner described the two existing RHUs, one for adolescents that began in May 2012 and the other for adult males at AMKC, as a behavior modification, self-paced program. She added that the expansion of new RHUs will begin on July 1, 2013 and will be completed by mid-August.

Commissioner Schriro mentioned that the Department was in the process of creating a "command within a command", recruiting for these positions, and once steady line officers and supervisors are selected, one to two weeks of training will be done in partnership with DOHMH. She also discussed the consolidation of the mental observation housing units for the acute and serious mentally ill male inmates, that are spread out over six facilities, but will be moved to one location and under one command. The Commissioner added that the Department will be able to pick-up 83 additional beds.

The Commissioner reported on the plans for a Clinical Alternative to Punitive Segregation (CAPS) program for the seriously mentally ill who have broken jail rules, which will provide enhanced clinical intervention, not punishment. Commissioner Schriro further stated that the infraction will be "set aside" and the goal of CAPS is for the participants to achieve compliance with their medication and develop skills so that they ultimately can be mainstreamed back to general population.

Chair Harris asked when the CAPS unit will actually open. Commissioner Schriro responded that the unit will be opened on or before August 1st. She added that DOHMH received funding to hire additional staff, which will provide significant clinical presence in the CAPS unit, including the addition of two new positions, the mental health treatment aide and a senior mental health treatment aide.

Board Member Robert Cohen, MD, raised several concerns about the RHUs, including DOC's failure to provide steady officers who have received mental health training; admission to the unit is controlled by DOC rather than DOHMH; and that RHU is not a mental health unit, but rather a punitive one for inmates who have threatened to harm themselves. Dr. Cohen further stated that he also is concerned that once the Department appropriately moves the seriously mentally ill to a treatment program [CAPS], it will create the misimpression that inmates who are placed in the RHUs deserve punishment. Dr. Cohen urged the Commissioner to reconsider DOC's practice of placing all new admission RHU inmates in 23-hour lock-in during their first week and more out-of-cell time be given to the program participants particularly since these are inmates who have been diagnosed with a mental illness.

Chair Harris asked the Commissioner to discuss some of the other steps the Department is taking to reduce the punitive segregation population. She discussed the following measures:

- Sentencing guidelines piloted for a month at RMSC resulted in a 50% reduction in punitive segregation penalties, much better than the expected 40%.

- Conditional discharge in 2012 resulted in 562 individuals being discharged from punitive segregation after having completed 2/3 of their penalty and an additional 22 when having completed half of their penalty, and in 2013, there were 127 discharges after serving 2/3 and 18 after serving half.
- Temporary cell restrictions (TCRs) have resulted in 121 adolescent males at RNDC having avoided an infraction and instead being restricted to their cells for up to two hours.
- Historical expungement in 2012 resulted in 2,166 records being expunged out of a total of 2,200 records reviewed, and thus far in 2013, 834 were expunged.

Chair Harris discussed the Jails Action Coalition (JAC) petition that would require the Board within 60 days of its filing to either vote to initiate rulemaking or reject the petition and state the reasons for the rejection. The Chair continued as follows:

> Before that last meeting, four members of the Board had a meeting with the petitioners on and heard their issues and concerns. We all were furnished with copies of the petition… At the last meeting it was my recommendation to the Board that because we had the study in progress being made by our two experts and had not yet had the benefit of their review and because some of these reforms were being put in place by the Department of Correction, we wanted to have a chance to better assess their impact. We also needed to determine to what extent existing standards were being enforced or not being enforced. For that reason, I had urged that we reject the petition, but because we were concerned about the issues around the use of solitary confinement particularly as it related to those who are mentally ill and adolescents, we should create a committee of the Board to get the benefits of our expert study and take such other additional steps and then come back to the Board in September with a recommendation about whether or not we should formally begin the rule making process… at that time the Board felt there was a need to defer the vote on that proposed resolution until today to give them a little more of an opportunity to consider it and to have other members who weren't present on that occasion be here. Since the last meeting, we have continued to receive substantial volumes of correspondence, statements and declarations of support and other letters, which have been distributed to all members of the Board. I am sure everyone has carefully considered the arguments that were set forth in those communications. I know that I have…
>
> Chair Harris read the following resolution:
>
> The resolution provides that the Board has embarked on a process of examining the use of solitary confinement on Riker's Island, particularly with respect to mentally ill offenders. A central component of this effort is hiring two nationally recognized consultants to tour jail facilities, interview stakeholders and evaluate compliance with the Mental Health Minimum Standards.
>
> The Jail Action Coalition has petitioned the Board to adopt rules regarding the use of solitary confinement. Because the Board has not yet had a chance to review the findings from its consultants, it is the recommendation of this resolution should it be adopted that the petition be rejected.
>
> At the same time the Board wants to send a clear signal that it is concerned about the use and consequences of solitary confinement particularly as applied to those with mental illness and adolescents. Given this concern, it is recommended that the Board form a committee to weigh the findings of the consultants as well as the recent initiatives on the table by the Department of Correction to improve the treatment of mentally ill inmates. The committee would be charged with making a recommendation to the Board about

whether it should engage in rulemaking on the subject of solitary confinement and we would ask that that report be made at the September 9th meeting of the Board.

In response to the resolution, Board Member Pamela Brier stated that she would prefer that the Board vote on "something that's a little more action directed" and stated her concern about waiting three months for a report. Ms. Brier acknowledged the presence of attendees quietly standing holding signs with "WE CAN'T WAIT: END SOLITARY IN NYC" and the urgency of their concerns. Ms. Brier stated the following:

> …[T]hroughout this document there are a lot of things that say "may" or written in the passive voice. I'd like to see things very direct and clear so we know just what it is we're buying into if we vote for an extension…I want to make sure that DOC's timetable is on time …so that each and every project would have a time date on it, a projection, and provide a written report in July and in August that tells us that [the Department] is on time. I have some qualms about this, but I've been assured by the Deputy Mayor that people are working as hard as they can. I certainly hope that's true, but we'll make that assumption…I thought we were talking about an August date for a decision and a report...we need timetables and we have to be concrete.

Chair Harris responded that he proposed the September meeting only because there is much work that needs to be done and that the Board can be updated at the July meeting. Ms. Brier stated that the Board must have a report in August. Board Member Alexander Rovt expressed his agreement with Ms. Brier underscoring the importance of receiving the committee's report in August so that the Board can be prepared to vote in September. He stressed the urgency and importance of this issue.

Chair Harris agreed that there is no date set for the committee to report to the Board, but that he had assumed that the committee's report would be completed in advance of the September meeting. Ms. Brier responded that in order for her to support this motion, she must have "end dates and be very clear about what we are looking for … it's just too mushy…"

Board Member Catherine Abate stated the following:

> …In rational terms, one could argue to go forward sequentially - let's get a report, let's study it and then we'll look at rulemaking. I happen to believe that we can do both in a parallel fashion. I think that it will be very important to have the benefit of the experts, but the rulemaking does not mean that we're going to end up with any result and make any rule changes. It has to be clear to everyone involved there may be something adopted or maybe nothing, but it gives us an opportunity to go in a parallel fashion to even look at the existing rules to see if there's compliance. I don't even think it's about new rulemaking. It's also about existing as well as the new. I really do respect what the Commissioner is doing and the new reforms, but it may be the role of the Board to advocate that some of these reforms should be part of rules and it's going to take some time.
>
> I really appreciate the tools that the staff and the Commissioner of the department need to manage inmates and to reduce violence. It's critical. Our job is not to hamper these efforts, but to make sure that these efforts are carried out in the most effective way. That's why we are involved in rulemaking. One of the first steps in this parallel effort is to look at the existing rules and see that there's compliance and work with the Commissioner to see where there may be deficiencies or no deficiencies. That's going to take some time.

Chair Harris interjected the following:

That’s the point of having the committee. That’s what we would be asking them, among other things, to do and to come back with a report to us. It seems to me the responsible thing to do would be to get the report of our experts and have this committee take a look at that and the issues that you are raising and Pam has raised so that we can have a firmer course of action before us before we vote to commit to actually initiating the process. As I see it, it doesn't delay or slow the process. We all know that rulemaking is a long drawn out process and having a committee make these initial reviews and reports to the Board is not going to significantly elongate the period of rulemaking if the Board determines that that’s what has to be done.

Ms. Abate responded as follows:

But then on the other hand, to start rule making also does not determine what our outcomes will be. It's just another avenue for us to look at things separately. There are going to be different people looking at rulemaking and other people waiting for the expert’s report. I think they strengthen our efforts. Again, I don't want to in any way raise people's expectations that we're going to end up with one result or another. I just think we're at a point in time where we need as much fact finding as possible because there are some real concerns - not that punitive segregation isn’t warranted in certain situations - but how it is used, how often, for what reasons, what services are available, particularly with mental illness. It's so, so complex, even the diagnosis of someone whether they're suffering from severe mental illness or not severe and how people react and how their mental illness deteriorates in jail and how it deteriorates even in an RHU…that’s why I think starting this rulemaking process will really enhance this other committee's work.

Chair Harris responded as follows:

I don't see how labeling it rulemaking detracts from the fact that we are in fact starting the process if we created this committee and charged them with the responsibility of reviewing all these issues that you’ve been raising and throwing it in a report that the Board could then get its hands around when it next meets. We're not proposing to delay or deny the potential need for rulemaking. We're simply saying let's do the responsible thing and get our facts together before we simply commit to initiate process.

Dr. Cohen stated the following:

I am going to vote in favor of the Jails Action Coalition petition to initiate rulemaking regarding solitary confinement in jails. I want to go through the reasons why it's important. The first is because prolonged solitary confinement is cruel. Solitary confinement is dangerous, particularly for adolescents and mentally ill and during the past three years, the percentage of prisoners languishing in solitary confinement has increased dramatically without benefit in terms of decreased violence or increased safety on Rikers Island. I have regularly visited solitary confinement areas on Rikers Island over the past three years. On any given day, the vast majority of prisoners spend 24 hours a day in their cells. They have the option to go out to the yard, but most of them spend the entire day in their cell, except for showers. In the Central Punitive Segregation Unit the majority of prisoners are lying on their bed with their head under a blanket. Mentally ill prisoners in solitary confinement on Riker's Island are at substantially increased risk for

experiencing serious injury. Overall, in the New York City jails, 14.7% of verified injuries are DOC-related. In the Central Punitive Segregation Unit, 49% and in MHAUII, 58% of the verified injuries are DOC-related. The rate of serious injuries occurring in MHAUII is approximately 170 per thousand persons; the rates in other facilities on Rikers Island are dramatically less: approximately 50/1000 in RNDC, and between 40/1000 25/1000 in most of the other jails. At the present time, between 20 and 25% of all adolescents on Riker's Island are confined in solitary confinement. I visited these boys and they had their blankets over their head and they have never seen a teacher. The Department of Correction has never demonstrated increased safety, decreased injuries, or any other benefit of its policy of increasing the use of solitary confinement for the mentally ill, but it has increased the number of solitary confinement beds for this population dramatically.

I'm just echoing Catherine's point that rule making is not a punishment of the Department of Correction or the Department of Health by the Board of Correction. The Mental Health Minimum Standards were established in the 1980s when I worked on Riker's Island running the medical services, and then the mental services. They weren't written as punishment, but to improve, and they did improve the situation dramatically in terms of people not dying from suicide.

In the 1990s, the Health Care Minimum Standards of the Board of Correction were written not to punish the Department of Health for its medical care that it oversees, but to support it. I know that the Commissioner has worked in this field a long, long time and in so many instances rulemaking or decisions by courts have been very, very helpful to the Commissioner…

It is the Board's statutory responsibility "to establish minimum standards for the care, custody, correction, treatment, supervision and discipline of all persons held or confined under the jurisdiction of the Department of Correction". That is our job. In 2007, the Department of Correction came to the Board and asked us - I wasn't on the Board at the time, but several of us were - to undertake rulemaking. The Board received their request and initiated a process to review their rules request. Some of the rules requested by the Department were accepted, but a number were rejected and among those requests made by Commissioner Horn that were rejected by the Board, were the request to increase crowding of prisoners in dormitories by decreasing the number of square feet from 60 to 50. The Board rejected this proposal because it felt that the crowding was not going to make things better. It was going to make the chance of violence more likely. There was also a request by Commissioner Horn to modify the Board's standards to legitimize the use of prolonged, up to 23 hours, of lockdown of prisoners in closed units, which the Department had established in violation of the Board's standards. In 2010 the Supreme Court of New York ruled that the Department was in violation of our standards and that Commissioner Schriro closed down those units.

I am confident that the Board of Correction will soon initiate a process, which will establish minimum standards and issue rules defining the use solitary confinement in the New York City Department of Correction, but really now is the time. Thank you.

Mr. Rovt stated that the committee should prepare its report to the Board as quickly as possible so that the members can properly study this important issue. He added that the members might consider making site visits to the facilities on Rikers Island.

Ms. Brier stated that she was intrigued by Ms. Abate's statement about looking at compliance with existing minimum standards as part of the rulemaking process and confirmed that Board staff had a good understanding of those issues. Furthermore, she stated that if she was going to vote to delay the rulemaking process, the Department should provide "deliverables" on an interim basis to the Board. After some discussion, Ms. Brier recommended that the Chair's original motion be amended as follows: the committee report to the Board by August 22nd regarding its recommendation as to whether the Board should engage in rulemaking and that on the first day of each month beginning on July 1st, the Department of Correction will provide to the Board monthly written progress reports regarding the status of every initiative listed in the Commissioner's hand-out ["Alternatives to Punitive Segregation for Mentally Ill Inmates"] and all other reforms initiated to improve programming for adolescent inmates.

Chair Harris moved that the Board adopt the motion with the understanding that it will be amended to reflect the additions made by Ms. Brier. Chair Harris and Members Rovt, Berman, Brier and Silverblatt voted in favor and Members Cohen and Abate voted against the motion.

Chair Harris requested that the following Board Members serve on the committee: Catherine Abate, Greg Berman, Pamela Silverblatt and Dr. Cohen, who would serve as Chair. All agreed.

The Chair requested that Commissioner Schriro update the Board on the status of any action taken by the Department regarding several deaths and incidents of violence on Rikers Island. The Commissioner responded that she is prepared to update the Board; however, because these matters are under investigation and also deal with personnel matters, she requested that it be done in executive session. The Chair adjourned the meeting at 10:40 a.m. The Board remained in executive session until 11:00 a.m.

ALTERNATIVES TO PUNITIVE SEGREGATION FOR MENTALLY ILL INMATES

Introduction

In CY2012, the NYC Department of Correction (DOC) incarcerated an average of 12,100 inmates daily and over the course of the year, processed approximately 83,000 new admissions and incarcerated about 60,000 individuals. The NYC Department of Health and Mental Hygiene (DOHMH) provides the medical and mental health care for the inmates in DOC custody.

Today, 39 percent of DOC's average daily population has a mental health diagnosis. About one third of the inmates with mental illness meet established criteria for serious mental illness.[1] Concern about the increasing prevalence and severity of mental illness in the city's inmate population led Mayor Bloomberg to establish the Steering Committee on the Justice Involved Mentally Ill, and to immediately accept its recommendation to establish a resource hub in each of the five boroughs to divert eligible diagnosed defendants from jail to the community. These hubs will open in the fall 2013. It was also the impetus for the DOC in partnership with DOHMH to develop a two-pronged approach to address inmates with mental illness who engage in jail-based misbehavior:[2] 1) by distinguishing those with serious mental illness and responding in keeping with evidence-based practices, and 2) for those who are not seriously mentally ill and subject to disciplinary sanctions[3] by operating a disciplinary system that is also data driven and based upon the field's best practices.

Current Practices

National Landscape: Considerable attention to long term solitary confinement[4] has led to improvements in conditions in a number of state correctional systems including the closing of death row housing in Mississippi, revisiting super max in Illinois, and decreasing utilization of administrative segregation housing in Colorado, Ohio, Washington, Massachusetts and Maine. Although there is widespread recognition of the impact of long term solitary confinement on the mentally ill, few of these reforms are specifically tailored to address their needs and risks and none that distinguishes between the seriously mentally ill and those who are not.

NYC: DOC operates both punitive segregation units for infracted inmates who are well and alternatives to punitive segregation for infracted inmates with mental illness. The 200-bed alternative unit is called the Mental Health Assessment Unit for Infracted Inmates (MHAUII). Both non-SMI and SMI inmates are assigned to the Unit. DOHMH oversees and can override DOC placements. Length of time in the unit is based upon the penalty imposed. Inmates who participate in the limited counseling services and maintain good institutional conduct may reduce the time imposed by one-third. A year ago in May 2012, DOC piloted an alternative to MHAUII for adolescent males with infractions who are not seriously mentally ill. Last October 2012, DOC expanded the pilot to include adult males. These units are called Restrictive Housing Units (RHU). Since then DOC and DOHMH have developed alternatives to MHAUII for both the seriously mentally ill with infractions and those who are not.

---

[1] Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, panic disorder, post traumatic stress disorder and borderline personality disorder. A person must be 18 years of age or older before receiving a SMI diagnosis. See also, New York State Office of Mental Health Criteria for Serious Mental illness, available at: http://www.omh.ny.gov/omhweb/guidance/Serious_Persistent_Mental_Illness.htm. Generally speaking, non-serious mental illnesses include behavioral, personality and adjustment disorders, minor depression, seasonal affective disorder, and general anxiety disorder.

[2] People with mental illness are more likely to be involved in jail incidents and have difficulty navigating the justice system. See, the Report at http://consensusproject.org/jc_publications/improving-outcomes-nyc-criminal-justice-mental-health.

[3] Inmates who are well and have no mental illness and those who are not seriously mentally ill are both subject to sanctions.

[4] Administration Segregation is the separation of prisoners from the general population typically in a cell for 23 hours a day. It is generally long-term; that is, not fixed, either indefinite or renewable, and 30 or more days in duration. It is not punitive, disciplinary or protective. See Long Term Isolation: Policies and Practices, Liman Program at Yale Law School (2013).

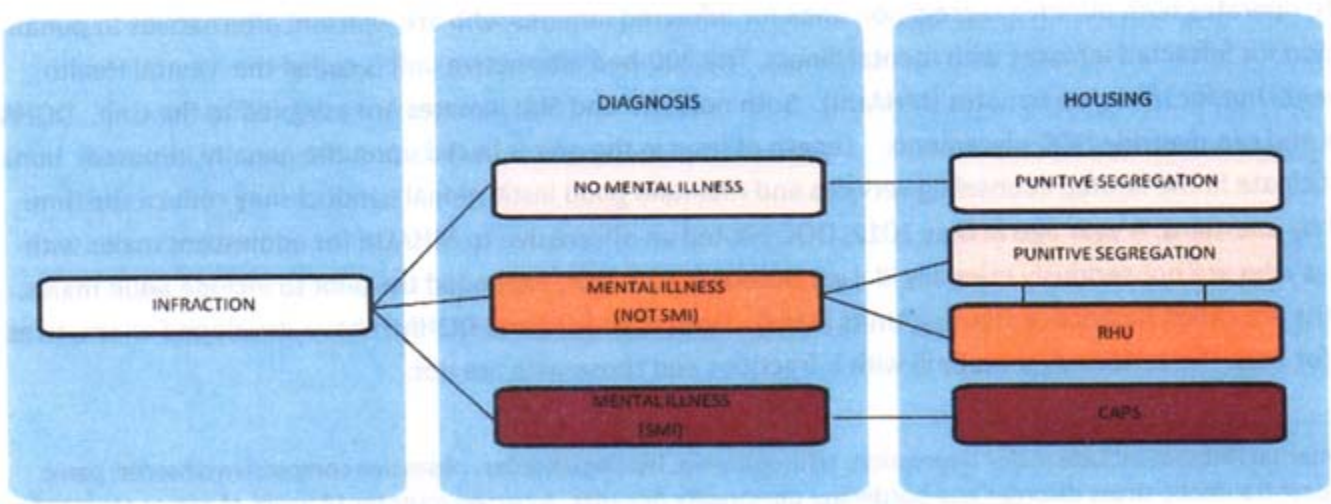
NYC DOC Reforms: Improved Practices in Process

Overview[5]: Most inmates do not have a mental health diagnosis. When warranted, they may continue to be placed in punitive segregation for rule violations. Inmates with mental illness who are not seriously mentally ill will be assigned to Restricted Housing Units (RHU) co-operated by DOC and DOHMH. The RHU features a three-phase behavioral modification program and opportunity for earned early release. Inmates who are seriously mentally ill will be transferred to the Clinical Alternative to Punitive Segregation (CAPS), a secure clinical setting in jail operated DOHMH. Its focus is treatment: DOC will set aside the penalty that is imposed; the length of time spent in this unit will be clinically determined by DOHMH. Additionally, DOC has adopted and is implementing a number of sentencing reforms described on the next page.

Punitive Segregation: Inmates, who do not have a mental health diagnosis and incur infractions, may be reassigned temporarily to punitive segregation to serve the penalty imposed. Those with good behavior can earn conditional release. DOHMH rounds daily; any inmate that it determines to evidence symptoms warranting removal is reassigned immediately by DOC.

RHU: Infracted inmates with mental illness determined not to be seriously mentally ill will be placed in Restricted Housing Units (RHU). All placements require joint approval by DOC and DOHMH. Inmates are encouraged to participate in a three-phase behavioral program in a group setting staffed by DOHMH. The program is self-paced and takes about eight weeks to complete. With each phase, inmates earn additional time out-of-cell and limited access to commissary. Steady officers are assigned to the unit and receive special training before their assignment. Inmates who successfully complete the program may earn up to a one-half reduction in the penalty imposed.

CAPS: Infracted inmates who are seriously mentally ill are not placed in either punitive segregation or RHU. The infraction is set aside and the seriously mentally ill inmate is assigned instead to a secure clinical setting, the Clinical Alternative to Punitive Segregation (CAPS) within DOC, for treatment. The length of time in the unit is clinically informed by the inmate's diagnosis and progress. When DOHMH determines s/he has acquired sufficient skills and is in compliance with medication to reside with others incident-free, the inmate is returned to general population.



[5] DOC also operates Administrative Housing units however unlike other correctional systems, these units are not restrictive in nature; the conditions of detention are identical to those in effect in the general population.

FACT SHEET RECAP

Mentally Ill Inmates

1. Expand the Restricted Housing Units (RHU) from pilot of 60 beds to 175 beds: start July 1, complete August 15
   - RHU offers progressive behavioral modification programming using dialectical behavioral therapy
   - Inmates who engage in their clinical treatment plan and maintain good behavior on the unit earn additional time out of cell for enhanced clinical care and structured activities
   - Inmates who complete the program are eligible for a reduction up to 50 percent in the time imposed for the infraction incurred
2. Open the Clinical Alternative to Punitive Segregation (CAPS) unit for seriously mentally ill inmates who commit infractions, capacity 60 beds: August 1
   - Infractions will be adjudicated but no penalty imposed
   - Hospital-style clinical treatment environment with clinical programming by mental health staff
   - Each inmate is provided and expected to complete an individualized clinical treatment plan
   - Length of time in the unit guided by clinical assessment of inmate's fitness to rejoin the general population
   - Full range of clinical staffing (unit chief, psychiatrists, mental health clinicians, secure treatment aides, nurses, clinical supervisors and activity therapists) on unit will provide intensive clinical care
   - Specially selected uniformed staff will receive enhanced training and be permanently assigned to the unit
3. CAPS will operate as a 'command within the command' with a dedicated commanding officer and assigned staff
4. DOC will close MHAUII and repurpose these housing areas for the general population: complete August 31
5. The National Institute of Corrections will assist DOC and DOMHM in the development of an evaluation model
6. Consolidate existing Mental Observation housing and expand by 83 beds: start July 1, complete August 31

System-wide Reforms, all inmates with infractions

1. Sentencing guidelines
   - Sets guidelines to standardize the range of days sentenced for individual infractions
   - Incorporates progressive discipline approach in which first offenses are treated less severely than subsequent offenses in most instances
   - Affirms a 'zero tolerance' policy for certain infractions notably, assaults on staff, inmate-on-inmate assaults with serious injury, and assaults with weapons that do or may reasonably result in serious injury
   - Expected to reduce demand for punitive segregation capacity by as much as 40 percent
   - The guidelines were implemented at RMSC on a pilot basis on 5/1 and will be adopted department-wide in CY13. During May, an average of 13 days per infraction was imposed; in comparison, in April an average of 29 days per infraction was imposed.
2. Conditional Discharge
   - Inmates infracted for non-violent offenses may be conditionally discharged from punitive segregation after serving two-thirds of their sentence with sustained good behavior and program participation in the unit
   - Potential to earn conditional release sooner, case-by-case basis. There have been 127 discharges at 67 percent and 18 at 50 percent, CY13 through April 30.
3. Historical Time Expungement
   - Inmates returning to DOC custody with previously imposed punitive segregation time not served in full, may be eligible to expunge that time if it has been a) two years from the date of an assault on staff, inmate on inmate assault with serious injury, and assault with weapons that does or may reasonably result in an injury, or b) one year from the date of any other infraction. A total of 834 records have been expunged during CY13 to date; in CY12, 2,166 records were expunged.