

Fordham Urban Law Journal

Volume 45

Number 2 *The Geography of Confinement*

Article 4

2018

Grassroots Challenges to the Effects of Prison Sprawl on Mental Health Services for Incarcerated People

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Stefen R. Short, *Grassroots Challenges to the Effects of Prison Sprawl on Mental Health Services for Incarcerated People*, 45 Fordham Urb. L.J. 437 (2018).

Available at: <https://ir.lawnet.fordham.edu/ulj/vol45/iss2/4>

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GRASSROOTS CHALLENGES TO THE EFFECTS OF PRISON SPRAWL ON MENTAL HEALTH SERVICES FOR INCARCERATED PEOPLE

*Stefen R. Short**

ABSTRACT

New York State's prison system is broken in several ways, many of which are linked to a fundamental geographical problem. Almost all of New York's fifty-four state prisons are located in rural, under-resourced communities. Prison units serving people with mental health needs are concentrated in communities with major physician shortages. Without a drastic influx of resources, New York's prisons will continue to over-utilize "half-measures," such as video teleconferencing, in a failed attempt to meet the mental health needs of incarcerated people. Lawyers continue to develop strategies—most of which are based in Eighth Amendment litigation—to either improve prison mental health care or increase prison mental health resources. But litigation is not the solution to every social problem and it most likely will not solve this problem on its own. Eighth Amendment litigation cannot change demographics, ameliorate physician shortages, or reverse prison sprawl.

Movement lawyers have known since time immemorial that grassroots approaches to major social problems—those that engage communities directly impacted and intentionally subsume the role of lawyers and legal work—create the most sustainable type of change. Grassroots approaches have successfully addressed prison and jail siting problems in New York. This Article argues that only through grassroots approaches can movement lawyers, activists, and advocates

* Staff Attorney, Prisoners' Rights Project of The Legal Aid Society of New York City; former Staff Attorney, Disability Rights New York. I wish to thank Joseph E. Short, Beverly Short, and Elena Landriscina for their steadfast pursuit of love and justice. This Article—and my life—is dedicated to my clients. God bless you all. Stay strong. See you on the other side someday. Abolition now!

address the underlying geographical problems causing the overuse of video conferencing, and other quality of care deficiencies, in New York State prisons. Though Eighth Amendment litigation will play a role, it will work only when combined with strong grassroots advocacy.

TABLE OF CONTENTS

| | |
|--|-----|
| Introduction | 438 |
| I. Deinstitutionalization and Resulting Deficiencies in New York's Prison Mental Health Care System..... | 449 |
| A. An Abridged History of the Deinstitutionalization Movement | 449 |
| B. The Scope of the System and the Availability of Mental Health Treatment in New York State Prisons | 454 |
| 1. Regional Catchment Areas | 461 |
| 2. VTC in New York Prisons: Implementation, Current Practices, and Shortcomings..... | 463 |
| II. The Insufficiency of Litigation Solutions Absent Grassroots Approaches..... | 472 |
| A. An Abridged Overview of the Eighth Amendment Framework..... | 473 |
| 1. Defendant Failed to Conduct an Adequate Examination, Take an Adequate History, or Ask Necessary Questions | 476 |
| 2. Defendant Failed to Remedy Known Systemic Deficiencies, such as an Institutional Lack of Access to Qualified Staff or Repeated Failures to Afford Proper Placement | 479 |
| B. A Grassroots Approach is Necessary to Correct the Systemic Problems Litigation Usually Cannot Address... | 486 |
| III. A Grassroots Solution to the Geographic Crisis Causing Subpar Prison Mental Health Treatment | 487 |
| Conclusion..... | 497 |

INTRODUCTION

During the mid-1950s, amidst burgeoning awareness among social justice activists of the abuse and neglect of individuals with mental health needs in psychiatric hospitals, the number of individuals

confined to those hospitals peaked.¹ Five hundred and sixty thousand patients were held in often brutal conditions, and scores of them were denied access to basic necessities of life, such as the right to form and maintain interpersonal relationships.² Rather than simply accept such severe restrictions upon their humanity, people who were confined to institutions told their stories.³ Due chiefly to their courage and the courage of their families and friends, a robust psychiatric deinstitutionalization movement emerged.⁴ That movement—at its peak during the 1960s and 1970s—forced psychiatric professionals, state governments, and the federal government to reckon with a treatment model that systematically devalued the lives of thousands of people.⁵ Although many states shuttered large psychiatric institutions in response to that movement, a large number of them—including New York—failed to devote necessary resources to the development of robust, community-based alternatives that could provide psychiatric care.⁶ Because the creation of a community-based care model, the chief goal of the deinstitutionalization movement, was not actualized, some scholars consider the movement a failure.⁷ Furthermore, many of those in need who stood to benefit from the movement wound up poor, destitute, or homeless as a result—arguably not much better off than they were before.⁸

1. William H. Fisher et al., *The Changing Role of the State Psychiatric Hospital*, 28 HEALTH AFFAIRS 676, 676–78 (2009); see also Deanna Pan, *Timeline: Deinstitutionalization and Its Consequences*, MOTHER JONES (Apr. 29, 2013), <http://www.motherjones.com/politics/2013/04/timeline-mental-health-america/> [<https://perma.cc/5BQM-82RN>] (describing population trends in psychiatric hospitals).

2. Pan, *supra* note 1; see also Walid Fakhoury & Stefan Priebe, *Deinstitutionalization and Reinstitutionalization: Major Changes in the Provision of Mental Health Care*, 6 PSYCHIATRY 313, 313 (2007).

3. See Albert Q. Maisel, *Bedlam 1946: Most U.S. Mental Hospitals Are a Shame and a Disgrace*, LIFE, May 6, 1946, at 102.

4. *Deinstitutionalization: A Psychiatric “Titanic,”* PBS FRONTLINE, <http://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html> [<https://perma.cc/SH7S-HPXU>].

5. See Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 CARDOZO L. REV. 1, 7 (2002) (discussing the successes and failures of the psychiatric deinstitutionalization movement).

6. Editorial, *Suffering in the Streets*, N.Y. TIMES (Sept. 16, 1984), <http://www.nytimes.com/1984/09/16/opinion/suffering-streets-deinstitutionalization-22-letter-mouthful-that-once-referred.html> [<https://perma.cc/6W65-WFJ4>].

7. See Hitesh C. Sheth, *Deinstitutionalization or Disowning Responsibility*, 13 INT’L J. PSYCHOSOCIAL REHABILITATION 11, 11–21 (2009) (discussing the growth of prisons and jails as de-facto mental health institutions due to a governmental failure to devote adequate resources to deinstitutionalization).

8. *Id.*

The “law and order” movement, which grew alongside the deinstitutionalization movement, led to the increasingly draconian criminalization of conduct often related to, or directly attributable to, mental health needs.⁹ Driven largely by establishment politicians increasingly buoyed by “tough on crime” rhetoric, the “law and order” movement produced significant regressive legal reforms.¹⁰ One such example are New York’s Rockefeller Drug Laws, enacted in 1973, which mandated harsher penalties for both the sale and possession of small amounts of banned narcotics.¹¹ The Rockefeller Drug Laws and other state and federal laws enacted during the “law and order” movement criminalized conduct often attributable to a manifestation of mental health needs.¹² For example, increased criminalization of substance abuse disproportionately impacts individuals with mental health needs, as over fifty percent of people

9. James Ridgeway & Jean Casella, *Criminalizing Mental Illness: The Story of Adam Hall*, SOLITARY WATCH (Mar. 14, 2012), <http://solitarywatch.com/2012/05/14/criminalizing-mental-illness-the-story-of-adam-hall/> [https://perma.cc/YV4S-ZJX4]; see also Nicholas Kristof, Opinion, *Inside a Mental Hospital Called Jail*, N.Y. TIMES (Feb. 9, 2014), <https://www.nytimes.com/2014/02/09/opinion/sunday/inside-a-mental-hospital-called-jail.html> [https://nyti.ms/2jL2Om3] (discussing growth of prison and jail mental health populations as a result of increasing arrests for “offenses that flow from mental illness”).

10. See NAT’L RESEARCH COUNCIL OF THE NAT’L ACADS., *THE GROWTH OF INCARCERATION IN THE UNITED STATES* 336 (2014) (“Across all branches and levels of government, the policies governing criminal processing and sentencing were reformed to expand the use of incarceration. Prison time was increasingly required for lesser offenses. Time served was significantly increased for violent crimes and for repeat offenses. Drug crimes, particularly street dealing in urban areas, became policed and punished more severely These changes in punishment policy—the enactment of mandatory sentence laws, long sentences for violence and repeat offenses, and intensified criminalization of drug-related activity—were the main and proximate drivers of the growth in incarceration.”).

11. Jeremy W. Peters, *Albany Reaches Deal to Repeal ’70s Drug Laws*, N.Y. TIMES (Mar. 25, 2009), <http://www.nytimes.com/2009/03/26/nyregion/26rockefeller.html> [https://nyti.ms/2lpaxoR].

12. See Press Release, N.Y. Civil Liberties Union, NYCLU Announces Findings About Statewide Impact of Rockefeller Drug Laws (Mar. 11, 2009), <https://www.nyclu.org/en/press-releases/nyclu-announces-findings-about-statewide-impact-rockefeller-drug-laws> [https://perma.cc/E7ZE-VZEZ] (finding that “[m]any of the thousands of New Yorkers in prison under these laws suffer from substance abuse problems; many others struggle with issues related to homelessness, mental illness or unemployment”). See generally Ellen Hochstedler Steury, *Specifying Criminalization of the Mentally Disordered Misdemeanant*, 82 J. CRIM. L. & CRIMINOLOGY 334 (1991) (discussing and specifying the definition of “criminalization” in the context of offenses related to mental health needs).

with mental health needs have a co-occurring and related substance use disorder.¹³

The results of these two movements cohered. As the “law and order” movement increasingly criminalized mental health-related conduct, the deinstitutionalization movement failed to shield individuals with mental health needs from the criminal justice system because it did not create the type of robust treatment model shown to prevent arrest and incarceration.¹⁴ Research has demonstrated that the increase in individuals with mental health needs in jails and prisons is directly correlated with the lack of mental health services available in community settings.¹⁵ Left to fend for themselves without access to robust treatment, individuals with mental health needs were ever more imperiled by New York’s emergent “law and order” ethos.¹⁶ That ethos’s harsh response to manifestations of mental health-related conduct, combined with New York’s lack of resources to treat such manifestations, led inexorably to an increase in the incarceration rate of individuals with mental health needs over several decades.¹⁷ Between 1991 and 2002, the percentage of

13. See B.C. Div., *Criminalization of Mental Illness*, CAN. MENTAL HEALTH ASS’N (Mar. 2005), http://www.antoniocasella.eu/archipsy/CMHA_march2005.pdf [<https://perma.cc/49FE-XXWU>] (“For a minority of people, usually those with multiple complex needs, deinstitutionalization combined with a lack of comprehensive community support systems has resulted in another type of ‘institutionalization,’ with prisons and jails rather than hospitals. This is only one of the factors leading to an increase in what is generally known as the ‘criminalization of mental illness,’ *i.e.* where a criminal, legal response overtakes a medical response to behaviour related to mental illness Over 50% of people with mental illness have a co-occurring substance abuse disorder. Co-occurring disorders (mental illness and substance use disorder) are more difficult to treat than either mental illness or substance abuse alone, and there are insufficient treatment programs for the growing demand.”).

14. *Access to Mental Health Care and Incarceration*, MENTAL HEALTH AM., <http://www.mentalhealthamerica.net/issues/access-mental-health-care-and-incarceration> [<https://perma.cc/Z5QX-KKH7>] (“In 2015, the Sentencing Project ranked the states based on the number of people incarcerated in state prison per 100,000 residents. Comparing state-by-state rates of incarceration with the access to mental health care ranking show a strong positive correlation between rates of adult[s] who are in the criminal justice system and lack of access to mental health care.”).

15. *Id.*

16. See discussion *infra* Part I.

17. E. FULLER TORREY ET AL., TREATMENT ADVOCACY CTR., THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY 73 (2014), <http://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf> [<https://perma.cc/WY77-24N3>] (“As the state mental hospitals have been downsized and closed, there has been a concomitant increase in mentally ill persons in the county jails and state prisons The state’s prisons, by default, have taken the place of psychiatric centers.”).

individuals receiving active mental health treatment in New York prisons increased by 73%.¹⁸ Over that same time period, the overall prison population increased by 14.6%.¹⁹ The increase in those incarcerated with mental health needs was five times greater than the increase in the overall prison population.²⁰ As recently as 2012, one-quarter of incarcerated individuals nationwide were diagnosed with mental health needs.²¹ These trends, along with a lack of fiscal resources, have burdened Central New York Psychiatric Center (“CNYPC”), the New York State Office of Mental Health (“OMH”) forensic hospital that is responsible for corrections-based mental health treatment in New York State prisons.²² The predicament at the CNYPC is a reflection of a nationwide crisis.²³

Activists, advocates, and lawyers have played a major role in responding to this crisis and improving psychiatric treatment in New York’s prisons over the last several decades.²⁴ For example, lawyers from Disability Advocates, Inc., Prisoners’ Legal Services of New York, and the Prisoners’ Rights Project of The Legal Aid Society of New York City negotiated a private settlement agreement in *Disability Advocates, Inc. v. New York State Office of Mental Health*,²⁵ expanding the circumscribed mental health services options in New York State prisons and increasing services for people with serious mental health needs housed in twenty-three-hour-per-day solitary confinement.²⁶ Although that settlement agreement has since expired, it led to the implementation of the Special Housing Unit

18. HUMAN RIGHTS WATCH, ILL EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 19 (2003), <https://www.hrw.org/reports/2003/usa1003/usa1003.pdf> [<https://perma.cc/Q26F-CQHJ>].

19. *Id.*

20. *Id.*

21. Robert D. Morgan et al., *Treating Offenders with Mental Illness: A Research Synthesis*, 36 LAW & HUM. BEHAV. 37, 37 (2012).

22. MARY BETH PFEIFFER, CRAZY IN AMERICA: THE HIDDEN TRAGEDY OF OUR CRIMINALIZED MENTALLY ILL 193 (2007).

23. Morgan et al., *supra* note 21, at 37 (“[T]reatment efforts for offenders with mental illness have been unable to keep pace with the incarceration rates in state and federal jail and prison facilities. In fact, the U.S. correctional systems have been criticized for failing to provide even minimally appropriate mental health services for prison inmates.”).

24. *See* discussion *infra* Parts I and II.

25. *See generally* Private Settlement Agreement, Disability Advocates, Inc. v. N.Y. State Office of Mental Health, No. 02 Civ. 4002 (GEL) (S.D.N.Y. Apr. 27, 2007) [hereinafter Private Settlement Agreement].

26. *Id.*

(“SHU”) Exclusion Law,²⁷ a New York State law that codified the expansion of treatment options and units for incarcerated individuals with serious mental health needs.²⁸ Among other requirements, the SHU Exclusion Law requires the New York State Department of Corrections and Community Supervision (“DOCCS”)—the agency that operates all New York State prisons—to “divert or remove inmates with serious mental illness . . . from [twenty-three-hour-per-day solitary confinement] when the period of [solitary confinement] could potentially be [longer than] thirty days.”²⁹ As a result, people with serious mental health needs—who, studies show, are far more susceptible to mental deterioration in solitary confinement—are diverted to a more treatment-rich environment.³⁰ Apart from the SHU Exclusion Law, the Constitution mandates that DOCCS and OMH provide mental health treatment to all other individuals with serious mental health needs, including mental health assessments by trained clinicians.³¹

27. Provisions of the law are codified as amendments to N.Y. EXEC. LAW § 553.24 (McKinney 2017) and N.Y. CORRECT. LAW §§ 2, 137.6, 401, 401-a (McKinney 2017).

28. *See generally* sources cited *supra* note 27.

29. N.Y. CORRECT. LAW § 137.6(d)(i).

30. *See* discussion *infra* Part I; *see also* Fatos Kaba et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 AM. J. PUB. 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); Joshua Manson, *New Report Documents Devastating Effects of Solitary Confinement on Mental Illness*, SOLITARY WATCH (Sept. 9, 2016), <http://solitarywatch.com/2016/09/09/new-report-documents-devastating-effects-of-solitary-confinement-on-mental-illness/> [<https://perma.cc/3LJT-J9UU>] (explaining solitary confinement’s acute impact upon individuals with preexisting mental health needs).

31. *See generally* NAT’L COMM’N ON CORR. HEALTH CARE, STANDARDS FOR MENTAL HEALTH SERVICES IN CORRECTIONAL FACILITIES (2015). *See also* *Brown v. Plata*, 563 U.S. 493, 502 (2011) (upholding a lower court population cap order under the Prison Litigation Reform Act based in part on California’s longstanding unconstitutional failure to provide needed mental health treatment and “specifically the severe and unlawful mistreatment of prisoners through grossly inadequate provision of medical and mental health care”). Prior to *Plata*, courts assumed that psychiatric care was included in medical care for Eighth Amendment purposes, but the issue had not been addressed at the Supreme Court level. *See* *Langley v. Coughlin*, 888 F.2d 252, 254 (2d Cir. 1989) (holding that “psychiatric or mental health care is an integral part of medical care. It thus falls within the requirement of *Estelle v. Gamble* that it must be provided to prisoners. The difference between the two varieties of care are simply factual and administrative”); *see also* *Eng v. Smith*, 849 F.2d 80, 82 (2d Cir. 1988) (upholding preliminary injunction on Eighth Amendment claim based on deliberate indifference to mental health treatment needs); *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977) (holding that there was “no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart”). Courts have since distinguished between “serious medical needs” and “serious mental health needs” for the purpose of Eighth Amendment

A memorandum of understanding between DOCCS and OMH details how the agencies work together to serve the needs of the population.³² Services are delivered primarily through mental health satellite units, which are units within the prisons providing mental health treatment.³³ Each satellite unit is headed by a mental health unit chief and is additionally staffed by nurses, social workers, and psychiatrists.³⁴

Almost all New York State prisons with mental health satellite units support local economies and serve as economic anchor institutions in fiscally depressed communities far from New York City's population center.³⁵ These prisons provide well-paying jobs in communities without many other employment options and maintain generational wealth through retirement packages and union protections.³⁶ Although a boon to local economies, the location of these prisons and the satellite units in them—specifically their geographic isolation—has negatively affected the quality of mental health care provided to incarcerated people.³⁷ For years, rural and suburban New York counties have experienced psychiatrist shortages:

deliberate indifference claims. For more on that distinction, see discussion on the Eighth Amendment framework *infra* Part II.

32. See generally Memorandum of Understanding between the New York State Office of Mental Health and the New York State Department of Corrections and Community Supervision (Sept. 14, 2016) [hereinafter Memorandum of Understanding] (on file with author).

33. *Id.* at 3–4. See generally N.Y. Dep't of Corr. & Cmty. Supervision, Directive # 4301: Mental Health Satellite Services and Commitments to CNYPC (Aug. 18, 2015) [hereinafter DOCCS Directive # 4301] (on file with author).

34. Memorandum of Understanding, *supra* note 32, at 7–8.

35. See, e.g., Ken Stier, *NYS Prison Budget Climbs, Despite Fewer Inmates*, CITY LIMITS (Nov. 10, 2015), <https://citylimits.org/2015/11/10/nys-prison-budget-climbs-despite-fewer-inmates/> [<https://perma.cc/C6L7-3A2W>] (“‘These are great, living-wage jobs in an area like Ogdensburg, in an area like Lyon Mountain, in an area like Lake Saranac,’ exclaims Mike Powers, president of the New York State Correctional Officer and Police Benevolent Association (NYSCOPBA), which represents 26,000 officers and retirees, most of whom live upstate, about or around the New York Thruway where there are few other well-paid jobs not requiring higher education levels. He makes no apology for aggressively working to retain as many of those posts as possible.”). Only two of New York’s fifteen prison units for individuals with serious mental illness are located in the New York City region. Almost all of the remaining thirteen units are located in rural areas with physician shortages. See discussion *infra* Part II.

36. See Stier, *supra* note 35.

37. See Joel A. Dvoskin et al., *The Structure of Correctional Mental Health Services*, in PRINCIPLES AND PRACTICE OF FORENSIC PSYCHIATRY 489, 496 (Richard Rosner ed., 2d ed. 2003) (“Complications surrounding geographic isolation and limited access to mental health professionals familiar with the correctional setting may, at times, compromise care for inmates.”).

for example, in 2017, fifty-four of sixty-two counties in the state reported shortages.³⁸ As such, the prison mental health satellite units in certain rural regions of New York State are under-staffed because DOCCS and OMH have difficulty hiring mental health clinicians in under-resourced, remote parts of the state that are experiencing those shortages.³⁹

Due to the dearth of qualified mental health clinicians in rural communities, DOCCS and OMH extensively utilize a video teleconferencing (“VTC”) model⁴⁰ for the provision of outpatient mental health services in many of the satellite units.⁴¹ Psychiatrists assess individuals through VTC to determine whether individuals who have reported a mental health crisis should be removed from suicide watch or discharged from an observation cell.⁴² Individuals incarcerated in New York State prisons are often assessed for their mental health condition—and even for their suicide risk—via VTC.⁴³ Individuals who receive ongoing mental health services, known as “being on the OMH case load,” also receive treatment from psychiatrists via VTC.⁴⁴ That treatment includes regular VTC appointments with individuals for the purpose of assessing mental health status, evaluating treatment regimens, and determining whether medications need to be adjusted.⁴⁵ Many correctional agencies throughout the nation have championed VTC as a method of responding to resource issues.⁴⁶

38. UNIV. OF THE STATE OF N.Y., REGENTS DESIGNATED PHYSICIAN SHORTAGE AREAS IN NEW YORK STATE 3–15 (2017).

39. *Id.* at 22.

40. “VTC” is often referred to in a mental health context as “telepsychiatry,” “telepsych,” or “tele-mental health.” For the purposes of this Article, “VTC” encompasses all these terms.

41. Memorandum of Understanding, *supra* note 32, at 7 (“In OMH Level 1 Satellite Units, there is a full time Unit Chief/Coordinator, and clinical staff working on site Monday through Friday sufficient to meet the needs of the mental health caseload. Under normal conditions there will be full time psychiatric coverage, by a psychiatrist or psychiatric nurse practitioner, either on site or by video teleconferencing.”).

42. See Cent. N.Y. Psychiatric Ctr., Corrections-Based Operations Policy # 4.2: Suicide Watches 1–2 (June 1, 2016) (on file with author); Cent. N.Y. Psychiatric Ctr., Corrections-Based Operations Policy # 2.9: Psychiatric Evaluation and Treatment via Video Tele-Conference (VTC) 1–2 (June 2016) [hereinafter CBO Policy # 2.9] (on file with author).

43. CBO Policy # 2.9, *supra* note 42, at 1–2.

44. *Id.*

45. *Id.*

46. Michael Ollove, *State Prisons Turn to Telemedicine to Improve Health and Save Money*, PEW CHARITABLE TRS.: STATELINE BLOG (Jan. 21, 2016),

Due to the geographic isolation of prisons and the resulting dearth of adequate local psychiatric services, DOCCS and OMH rely too heavily on VTC at the expense of the mental health of incarcerated persons. VTC is best suited to supplement, not supplant, in-person mental health services; it has been criticized as an ineffective medium for establishing trust and efficacy between clinicians and patients, and assessments performed by VTC may be unreliable or perfunctory.⁴⁷ Unfortunately, DOCCS and OMH have, in some cases, used it as a primary vehicle for the provision of mental health services in many state prisons, exacerbating the geographic isolation and psychosocial burden upon individuals with mental health needs incarcerated in those prisons.⁴⁸ Overreliance on VTC is merely one symptom of an overburdened prison mental health delivery system based in locations without sufficient resources.

Mental health treatment provided in New York State prisons will continue to suffer so long as prisons are sited in geographically isolated areas of the state. Unfortunately, decision makers in DOCCS, OMH, the governor's office, and the State Legislature have not acknowledged that reality. Geographic isolation and resulting resource issues are virtual non-factors in New York's discourse around prison siting and prison closures. That omission reveals gubernatorial, legislative, and agency priorities—state actors have prioritized supporting rural economies over tackling the geographic

<http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/01/21/state-prisons-turn-to-telemedicine-to-improve> [<https://perma.cc/UZK3-WDNX>].

47. See, e.g., Donald M. Hilty et al., *Clinical and Educational Telepsychiatry Applications: A Review*, 49 CAN. J. PSYCH. 12, 16 (2004) (finding that “[c]onsultee (that is, nurse, psychologist, or other) satisfaction with telepsychiatry was lower than satisfaction with in-person consultation in terms of ease with the process, ability to express oneself, and quality of interpersonal relationships One concern with telemedicine is that the technology may adversely affect communication and the development of a positive therapeutic alliance. Decreased ability to detect nonverbal cues in patient interviews has been reported during videoconferencing, which may limit mutual connections and understanding. In a physical environment, informational cues are incorporated without conscious awareness . . . the virtual environment created by telemedicine may differ”); see also Jeannine Monnier et al., *Recent Advances in Telepsychiatry: An Updated Review*, 54 PSYCH. SERVS. 1604, 1607 (2003) (citing studies that find that “telepsychiatric methods are not appealing to those providing treatment because these methods are perceived to make communication difficult and interfere with the therapeutic relationship”).

48. See Joseph Berger, *In Sing Sing's Hometown, Many Dream of Day 'the Big House' Closes*, N.Y. TIMES (Apr. 24, 2011), <http://www.nytimes.com/2011/04/25/nyregion/in-sing-sings-hometown-dreams-of-inmates-leaving-for-good.html> [<https://nyti.ms/2yCxiLk>] (noting that New York City-based lawmakers and advocates have emphasized the need for incarcerated individuals to maintain family ties, a problem when prisons are located “hundreds of miles away”).

issue that stands in the way of delivering robust mental health treatment to incarcerated individuals. This is a stark choice given the studies that find a lower recidivism rate among those who receive treatment while incarcerated.⁴⁹

Governor Cuomo has initiated the closure of minimum- and medium-security prisons to address budget issues, but has never proposed closing a large, maximum-security prison with a mental health satellite unit to address the failure of mental health treatment in such facilities.⁵⁰ His administration has never proposed moving mental health satellite units to better-resourced areas of the state to foster the provision of more robust, in-person mental health treatment. This omission is almost certainly not attributable to lack of knowledge on Governor Cuomo's part, as one of his most prized executive agencies, the New York Justice Center for the Protection of People with Special Needs, has decried the poor mental health treatment in New York's prisons and attributed that poor treatment to resources deficiencies.⁵¹ Governor Cuomo's omission may be due, in part, to pushback from state lawmakers. When Governor Cuomo decided to close minimum- and medium-security prisons in rural areas of the state, lawmakers responded by assailing the governor for one potential result—loss of jobs and damage to the local economy.⁵² It is safe to assume that the governor would face more vigorous pushback against any proposal to close a maximum-security prison, as

49. Morgan et al., *supra* note 21, at 37.

50. *Id.*

51. Governor Cuomo created the New York Justice Center for the Protection of People with Special Needs in response to federal government findings that its predecessor, the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities, was inadequate. Press Release, Office of the Governor, Governor Cuomo Announces Opening of the Justice Center for the Protection of People with Special Needs (June 29, 2013), <https://www.governor.ny.gov/news/governor-cuomo-announces-opening-justice-center-protection-people-special-needs> [<https://perma.cc/4RKA-2RMJ>]. The Justice Center has since found that DOCCS and OMH have failed to provide robust care to people with mental health needs incarcerated in state prisons, in part due to resources issues. *See* discussion *infra* Part II.

52. State Senator Betty Little has often complained about job loss due to prison closures. *See, e.g.*, Paul Post, *Closed Prisons in Rural Areas Are a Tough Sell*, N.Y. TIMES (Apr. 10, 2017), <https://www.nytimes.com/2017/04/10/nyregion/closed-prisons-new-york.html> [<https://nyti.ms/2ojPfMI>] (“When the decision is made to close a prison in a rural community, that community loses hundreds of jobs that aren’t going to be absorbed by the private sector It’s a huge blow that someone from a populated area of New York State wouldn’t understand.”).

such facilities are larger than minimum- and medium-security facilities and provide greater economic benefits.⁵³

The political paradigm therefore remains. The discourse around prison closures and prison siting in New York State remains intensely focused on the needs of small, rural communities rather than the needs of incarcerated individuals, particularly those with mental health needs. The conversation has steadfastly omitted difficulties recruiting and retaining mental health staff to meet the needs of incarcerated individuals in those rural communities, and the resulting impact on rehabilitation. Advocacy organizations such as the Correctional Association of New York and the Alliance of Families for Justice have repeatedly called for the closure of large prisons in rural areas and the re-directing of resources to facilities closer to large population centers where more humane treatment is feasible.⁵⁴ This Article argues that due to the convergence of the above-mentioned social phenomena, this is the only way to improve mental health treatment in New York State prisons.

Part I of this Article provides a brief history of the deinstitutionalization movement and its impact upon the development of an infrastructure for psychiatric care in the New York State prison system. Part I also evaluates the effectiveness of that system's use of VTC as a response to resource and geographic issues affecting the quality of psychiatric care. Part II provides an overview of the dearth of Eighth Amendment litigation involving VTC, and posits that Eighth Amendment litigation is an inadequate vehicle through which to address VTC and other resource problems attendant to the provision of mental health treatment in rural prisons. Part III argues that, in addition to any litigation strategy, activists, advocates, and movement lawyers must build on an already existing grassroots movement to shrink the prison population and shift psychiatric resources and incarcerated persons in need of such resources to facilities near urban centers. The widespread use of

53. *But cf.* DANA KAPLAN, IMPACTS OF JAIL EXPANSION IN NEW YORK STATE: A HIDDEN BURDEN 1 (2007) https://www.prisonpolicy.org/scans/ImpactsofJailExpansion_NYS.pdf [<https://perma.cc/2NSS-JSSC>] (explaining the costs of prison construction as opposed to the economic benefits borne by the communities in which prisons are located).

54. *Current Topic: Close Attica*, CORR. ASS'N OF N.Y., http://www.correctionalassociation.org/current_topics/attica [<https://perma.cc/7ABP-ELX4>]; *March for Justice: From New York City to Albany!*, ALL. OF FAMILIES FOR JUSTICE (Apr. 27, 2017), <https://afj-ny.org/blog/2017/4/27/march-for-justice-from-harlem-to-state-house-in-albany> [<https://perma.cc/C9T6-Q25W>].

VTC in prisons is reflective of a fundamental geographic problem and, as such, requires a geographic solution.

I. DEINSTITUTIONALIZATION AND RESULTING DEFICIENCIES IN NEW YORK'S PRISON MENTAL HEALTH CARE SYSTEM

As explained above, the deinstitutionalization and “law and order” movements unintentionally caused a large increase in the number of individuals with mental health needs in prisons. In response to that increase, DOCCS and OMH have changed their corrections-based mental health treatment modalities and increased the number of prison-based units that provide mental health treatment.⁵⁵ Despite those changes, need has far outstripped resources.⁵⁶ As a result, DOCCS and OMH rely heavily on VTC.⁵⁷ Part I provides an overview of the results of the deinstitutionalization movement,⁵⁸ the subsequent changes in DOCCS and OMH's mental health care delivery system,⁵⁹ and an explanation of DOCCS and OMH's use of VTC.⁶⁰ Part I ultimately concludes that deficiencies in VTC have combined with other factors to cause poor outcomes for people with mental health needs. Due to VTC's deficiencies, DOCCS and OMH should not rely on VTC to improve mental health treatment in state prisons. That improvement will come only after the agencies reckon with underlying geographic and resources problems.

A. An Abridged History of the Deinstitutionalization Movement

Though many critics consider the deinstitutionalization movement to have been a “disaster” because of its inability to achieve more robust community integration of individuals with mental health needs, the facts paint a far more complicated picture.⁶¹ The deinstitutionalization movement was certainly a partial success in that it caused a drastic decrease in the number of individuals with mental

55. See discussion *infra* Section I.B.

56. See discussion *infra* Section I.B.

57. See discussion *infra* Section I.B.

58. See discussion *infra* Section I.A.

59. See discussion *infra* Section I.B.

60. See discussion *infra* Section I.B.

61. See generally E. FULLER TORREY, *OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS* (1998) (identifying systemic flaws in America's mental health treatment model and linking those flaws to failures of the deinstitutionalization movement); Amitai Etzioni, “*Deinstitutionalization*”: *A Public Policy Fashion*, 3 *EVALUATION*, no. 2, 1976, at 9; Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s*, 9 *OHIO ST. J. CRIM. L.* 53, 54 (2011).

health needs confined to institutional settings.⁶² In 1955, the number of individuals in large psychiatric hospitals peaked at approximately 560,000 individuals.⁶³ As of 2012, that number had dropped to approximately 50,400, around nine percent of what it was at its peak, and continued to drop.⁶⁴ This was a great achievement, as it removed individuals from dilapidated and under-resourced facilities to, in some cases, community alternatives.⁶⁵

However, deinstitutionalization also came at a cost to some individuals with mental health needs. The overriding criticism of the deinstitutionalization movement focuses on its incompleteness.⁶⁶ Although deinstitutionalization brought down the raw number of individuals with serious mental health needs confined to institutions, it also shifted a significant portion of that population onto the streets and into jails and prisons, due largely to an increase in arrests for manifestations of mental health needs.⁶⁷ As Professor Bagenstos writes, “there is . . . little doubt that, in the wake of deinstitutionalization, a significant number of people were left to fend for themselves.”⁶⁸ As a result, today nearly fifteen percent of men and thirty percent of women booked into jails nationwide have a serious mental health need.⁶⁹

62. Fisher et al., *supra* note 1, at 676 (“State hospitals were once the most prominent components of U.S. public mental health systems. But a major focus of mental health policy over the past fifty years has been to close these facilities. These efforts led to a 95 percent reduction in the country’s state hospital population.”).

63. See TORREY, *supra* note 61, at 9; Harcourt, *supra* note 61, at 54.

64. See TORREY, *supra* note 61, at 9; Harcourt, *supra* note 61, at 54.

65. See generally Ronald W. Manderscheid et al., *Changing Trends in State Psychiatric Hospital Use from 2002 to 2005*, 60 PSYCH. SERVS. 29 (2009).

66. See Bagenstos, *supra* note 5, at 3; Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 94–97 (1991).

67. BRENDAN O’FLAHERTY, MAKING ROOM: THE ECONOMICS OF HOMELESSNESS 235 (1998) (“After 1975, the movement out of state and county mental hospitals was more than offset by the movement into nursing homes and correctional institutions, and after 1980 homelessness rose among mentally ill because housing conditions got worse.”); E. Fuller Torrey, *Jails and Prisons—America’s New Mental Hospitals*, 85 AM. J. PUB. HEALTH 1611, 1611 (1995) (“Quietly but steadily, jails and prisons are replacing public mental hospitals as the primary purveyors of public psychiatric services for individuals with serious mental illnesses in the United States.”); *Jailing People with Mental Illness*, NAT’L ALL. ON MENTAL ILLNESS, <https://www.nami.org/Learn-More/Public-Policy/Jailing-People-with-Mental-Illness> [https://perma.cc/7S8E-ZYFP] (“In a mental health crisis, people are more likely to encounter police than get medical help. As a result, 2 million people with mental illness are booked into jails each year. Nearly 15% of men and 30% of women booked into jails have a serious mental health condition.”).

68. Bagenstos, *supra* note 5, at 3.

69. *Jailing People with Mental Illness*, *supra* note 67.

The movement's failure to achieve more robust community integration rather than a shift in the *type* of institutionalization was not driven by flawed movement strategies and tactics. Instead, it was driven by the failure of the federal government and local and state governments to devote the necessary resources to establishing a true community-based treatment model for individuals with serious mental health needs.⁷⁰ Many of the programs that benefited individuals with mental health needs, most notably those authorized specifically to effectuate deinstitutionalization, were not fully implemented or were entirely eliminated under a succession of several presidential administrations. In some cases, the executive branch scuttled those programs by failing to spend the monies Congress authorized to fund them.

The Nixon Administration, for example, refused to expend \$289.5 million of the \$340 million authorized to support community mental health centers and mental health research initiatives between 1970 and 1973.⁷¹ That funding had been authorized as an extension of, and an amendment to, the Community Mental Health Act of 1963.⁷² President Ford, after succeeding President Nixon in scandal, vetoed an expansion of that Act.⁷³ That veto was later overridden⁷⁴ and although the law survived under President Carter after two reauthorizations, expenditures remained meager.⁷⁵

70. HUMAN RIGHTS WATCH, *supra* note 18, at 20.

71. James M. Cameron, *A National Community Mental Health Program: Policy Inflation and Progress*, in HANDBOOK ON MENTAL HEALTH POLICY IN THE UNITED STATES 121 (David A. Rochefort ed., 1989). Prior to Congress's passage of the Budget and Impoundment Control Act of 1974, 2 U.S.C. §§ 601–688, and the Supreme Court's interpretation of that Act in *Train v. City of New York*, 420 U.S. 35 (1976), presidents maintained virtually unbridled authority to impound—or refuse to spend—monies appropriated by Congress. President Nixon impounded with impunity. See generally Gerald A. Figurski, *Presidential Impoundment of Funds: A Constitutional Crisis*, 7 AKRON L. REV. 107 (1974). Presidents now maintain a circumscribed power to interfere with the executive branch's expenditure of appropriated funds. Some scholars maintain that such interference runs afoul of the Constitution's "Take Care Clause." U.S. CONST. art. II, § 3, cl. 5. For a more robust explanation of the presidential power, as it exists today, to interfere with expenditures, see generally David E. Lewis, *Political Control and the Presidential Spending Power* (Vanderbilt Univ. Ctr. Study of Democratic Insts., Working Paper No. 1, 2017), https://www.vanderbilt.edu/csdi/includes/WP_1_2017_final.pdf [<https://perma.cc/9JJ9-AJSH>].

72. See generally Community Mental Health Act of 1963, Pub. L. No. 88-164, 77 Stat. 282 (codified as amended in scattered sections of 42 U.S.C.).

73. *Health Bill OK'd in Congress: Ford Veto Is Upset 1st Time in '75*, CHI. TRIBUNE, July 30, 1975, at 6.

74. *Id.*

75. See generally *id.*

After President Carter's Commission on Mental Health produced a preliminary and later final report that nominally supported deinstitutionalization,⁷⁶ Congress passed another law, the Mental Health Systems Act of 1980, to support such efforts.⁷⁷ That law was never implemented, however, as Congress largely repealed it during the heady early days of the Reagan Administration.⁷⁸ In the bill repealing the Mental Health Systems Act of 1980, Congress also block-granted to the states the remaining money authorized by the Community Mental Health Act of 1963, thus transferring responsibility for the implementation of mental health services and programming to state governments.⁷⁹ Over the next decade, most states developed what are best termed "minimum benefit mental health [programs],"⁸⁰ and passed legislation—most of which was not ambitious—to fund only basic necessities for individuals with mental health needs.⁸¹ Most of the community mental health centers authorized by Congress were never built.⁸²

76. Gerald N. Grob, *Public Policy and Mental Illnesses: Jimmy Carter's Presidential Commission on Mental Health*, 83 MILBANK Q. 425, 442 (2005) ("The report affirmed a commitment to the goal of making high-quality mental health care at reasonable cost available to all who needed it. Personal and community supports had to be strengthened, and a responsible mental health service system had to be created that provided the most appropriate care in a least restrictive setting. The report endorsed a federal program designed to encourage the creation of new community mental health services, particularly in underserved areas.").

77. See generally The Mental Health Systems Act of 1980, Pub. L. No. 96-398 (codified as amended in scattered sections of 42 U.S.C.) (repealed 1981).

78. See generally The Omnibus Budget Reconciliation Act of 1981, Pub. L. 97-35 (codified as amended in scattered sections of 20 U.S.C.).

79. See Cameron, *supra* note 71, at 121. This was but one tactic in the Reagan Administration's new federalism/devolution strategy, which initiated a swift and radical transfer of power from the federal government to state governments. New federalism/devolution, which was based on an overbroad reading of the Tenth Amendment to the United States Constitution, unsurprisingly harmed traditionally marginalized groups that relied on federal government intervention to secure basic civil rights. For an illustration of the manner in which "new federalism" harmed traditionally marginalized groups, specifically African-Americans, the working class, and the poor, see generally Anthony Cook, *The Ghosts of 1964: Race, Reagan, and the Neo-Conservative Backlash to the Civil Rights Movement*, 6 ALA. C.R. & C.L. L. REV. 81 (2015).

80. Olga Loraine Kofman, *Deinstitutionalization and Its Discontents: American Mental Health Policy Reform 38* (2012) (unpublished B.A. thesis, Claremont McKenna College), http://scholarship.claremont.edu/cgi/viewcontent.cgi?article=1348&context=cmc_theses [<https://perma.cc/JS74-9ERH>].

81. *Id.* at 33.

82. See generally Michelle R. Smith, *50 Years Later, Kennedy's Vision for Mental Health Not Realized*, SEATTLE TIMES (Oct. 20, 2013), <https://www.seattletimes.com/nation-world/50-years-later-kennedys-vision-for-mental-health-not-realized/> [<https://perma.cc/B4T7-DVYX>].

Between this shift of responsibility to the states and cuts to preexisting social safety net programs during the 1980s and 1990s, the federal government essentially abdicated its role in promoting community integration.⁸³ Not until the 1990s and the passage of the Americans with Disabilities Act (“ADA”) were individuals with mental health needs the focus of any *major* federal legislative efforts.⁸⁴ Even then, the ADA is largely rights-based, not services-based.⁸⁵ In 1990, the Public Citizen Health Research Group and the National Alliance for the Mentally Ill conducted a nationwide study and found that public psychiatric services were in “near total breakdown,” both underfunded and understaffed.⁸⁶

Left with the major responsibility, state governments did little.⁸⁷ New York is very much a microcosm of the national trend away from confining individuals with serious mental health needs to psychiatric

83. See Michael L. Perlin, *Book Reviews*, 8 N.Y.L. SCH. J. HUM. RTS. 557, 568 (1991).

84. See *generally* SOC. SEC. ADMIN., OFFICE OF POLICY, TRENDS IN THE SOCIAL SECURITY AND SUPPLEMENTAL SECURITY INCOME DISABILITY PROGRAMS 73–81 (2006), https://www.ssa.gov/policy/docs/chartbooks/disability_trends/trends.pdf [<https://perma.cc/W3ST-BFLG>].

85. A rights-based statute, such as the Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241 (codified as amended in scattered sections of 42 U.S.C.), is one that guarantees a group’s basic civil legal rights. The Americans with Disabilities Act fulfilled that function for people with disabilities. See *generally An Overview of the Americans with Disabilities Act*, ADA NAT’L NETWORK (2017), https://adata.org/sites/adata.org/files/files/ADA_overview_final2017.pdf [<https://perma.cc/DUT5-625U>]. Because of the ADA, people with disabilities can access services and public accommodations to which non-disabled people have always had access. By contrast, a services-based statute, like the Community Mental Health Act of 1963, provides an entitlement to, or appropriates funds for, a service for a marginalized group. In the case of the Community Mental Health Act of 1963, those services were community health centers. Rights-based statutes create legal parity between traditionally marginalized groups and their privileged counterparts. Services-based statutes, by contrast, expand entitlements in an affirmative attempt at equity. As such, they are usually more ambitious.

86. See Phillip J. Hiltz, *U.S. Returns to 1820’s in Care of Mentally Ill, Study Asserts*, N.Y. TIMES (Sept. 12, 1990), <http://www.nytimes.com/1990/09/12/us/us-returns-to-1820-s-in-care-of-mentally-ill-study-asserts.html> [<https://perma.cc/F29D-9NCL>].

87. Kofman, *supra* note 80, at 32 (“States were not pleased to support mental health programs and little more than custodial care was provided. Major gaps in service were never addressed, particularly the lack of rehabilitative and aftercare services for the chronically mentally ill. Poor coordination between state hospitals and community mental health centers also made continuous care for the chronically mentally ill patchy at best. Worse yet, states divested themselves of responsibility for the mentally ill by transferring patients to private nursing homes or board-and-care facilities away from state facilities as a result of Supplemental Security Income (SSI) and Medicaid offering financial support The seriously mentally disabled were quietly ignored . . .”).

institutions and toward confining them in prisons.⁸⁸ As a result of a great increase in the sheer numbers of individuals incarcerated in the state of New York throughout the 1980s and 1990s,⁸⁹ and the number of those individuals who came into the system with mental health needs,⁹⁰ DOCCS bolstered its mental health services system.⁹¹ That shift occurred in part so that DOCCS and OMH could avoid Eighth Amendment⁹² or medical malpractice liability for the failure to provide those individuals with constitutionally mandated medical—and now mental health—treatment.⁹³ The shift mirrored similar shifts in the medical care priorities of corrections agencies across the country.⁹⁴

B. The Scope of the System and the Availability of Mental Health Treatment in New York State Prisons

Integral to understanding the way that geographic factors and lack of resources have undermined the efficacy of mental health treatment in New York State prisons is understanding the full scope of the system and the nature of the programs and therapy it provides. Mental health treatment in DOCCS is provided by OMH through CNYPC, which provides inpatient treatment at its hospital in Marcy, New York, and outpatient treatment at state prisons.⁹⁵ All

88. See HUMAN RIGHTS WATCH, *supra* note 18, at 19. See generally KACEY HEEKIN & LARRY POLIVKA, THE CRIMINAL JUSTICE SYSTEM AND MENTAL HEALTH (2015), http://coss.fsu.edu/subdomains/claudepeppercenter.fsu.edu_wp/wp-content/uploads/2016/02/The-Criminal-Justice-System-and-Mental-Health.pdf [<https://perma.cc/569N-F2H4>]; Michael Winerip & Michael Schwirtz, *For Mentally Ill Inmates at Rikers Island, a Cycle of Jail and Hospitals*, N.Y. TIMES (Apr. 10, 2015), <https://www.nytimes.com/2015/04/12/nyregion/for-mentally-ill-inmates-at-rikers-a-cycle-of-jail-and-hospitals.html> [<https://nyti.ms/2jBuiYF>].

89. See discussion *supra* Introduction.

90. See discussion *supra* Introduction.

91. Lisa W. Foderaro, *The Mentally Ill Overwhelm New York's Prisons*, N.Y. TIMES (Oct. 6, 1994), <http://www.nytimes.com/1994/10/06/us/the-mentally-ill-overwhelm-new-york-s-prisons.html> [<https://perma.cc/3G3H-ULFF>].

92. For a fuller explanation of the Eighth Amendment's applicability to prison mental health care, see discussion *infra* Section II.A.

93. See, e.g., Stipulation, Eng v. Goord, No. 80 Civ. 385S (W.D.N.Y. June 12, 2000) (barring DOCCS and OMH from placing individuals with serious mental illness in solitary confinement at certain state prisons and mandating procedures for assessing suicide risk and guaranteeing quality of mental health treatment).

94. See generally HUMAN RIGHTS WATCH, CALLOUS AND CRUEL: USE OF FORCE AGAINST INMATES WITH MENTAL DISABILITIES IN US JAILS AND PRISONS (2015), https://www.hrw.org/sites/default/files/reports/usprisoner0515_ForUpload.pdf [<https://perma.cc/T5M8-YQYL>] (discussing the evolution of the provision of mental health care in United States prisons and the quality of that care).

95. Memorandum of Understanding, *supra* note 32, at 10–12.

incarcerated individuals are screened for mental health treatment needs as part of the DOCCS reception process.⁹⁶ Incarcerated individuals can also request mental health services during their incarceration, though many complain that those requests are not always met.⁹⁷ Where necessary, incarcerated individuals can be voluntarily or involuntarily transferred from a state prison to CNYPC.⁹⁸ Involuntary commitment to a hospital occurs through the “two physician certificate” process outlined in New York Mental Hygiene Law section 9.27.⁹⁹ OMH also utilizes an emergency admissions procedure where a patient is an imminent danger to themselves or others and therefore requires a heightened level of care in shorter order than is feasible through the “two physician certificate” process.¹⁰⁰

Each individual whom OMH and DOCCS have identified as requiring mental health treatment at reception or during some other point in their incarceration is designated a mental health “service level” pursuant to OMH policy.¹⁰¹ OMH can change this service level based upon the person’s acuity, or severity of their symptoms.¹⁰² There are five OMH service levels—one, two, three, four, and six.¹⁰³ A person designated service level six has been identified as “not in

96. *Id.* at 10; *see also* Cent. N.Y. Psychiatric Ctr., Corrections-Based Operations Policy # 1.2: Reception Mental Health Screening 1–3 (Apr. 8, 2015) (on file with author); Cent. N.Y. Psychiatric Ctr., Corrections-Based Operations Policy # 2.0: Screened – Admitted to Services 1–3 (June 1, 2016) (on file with author).

97. *See* DOCCS Directive # 4301, *supra* note 33, at 3–5; N.Y. Dep’t of Corr. & Cmty. Supervision, Form # 3150: Mental Health Referral (July 2016) (on file with author); Cent. N.Y. Psychiatric Ctr., Corrections-Based Operations Policy # 1.3: Mental Health Referrals 1–2 (May 20, 2016) (on file with author).

98. *See* DOCCS Directive # 4301, *supra* note 33, at 9–10.

99. *See generally* N.Y. MENTAL HYG. LAW § 9.27 (McKinney 2017).

100. Cent. N.Y. Psychiatric Ctr., Corrections-Based Operations Policy # 7.4: Admissions to Inpatient Services 1, 4–5 (May 13, 2014) (on file with author). In the emergency procedure, where a patient is “mentally ill and dangerous to self or others and requires immediate transfer to an inpatient facility,” the two physician certificate process proceeds, but without the court order requirement imposed under normal circumstances. *Id.*; *see also* N.Y. MENTAL HYG. LAW § 9.39 (McKinney 2017); N.Y. CORRECT. LAW § 402 (McKinney 2017).

101. *See* Cent. N.Y. Psychiatric Ctr., Corrections-Based Operations Policy # 1.12: Mental Health Service Level 1 (May 20, 2016) [hereinafter CBO Policy # 1.12] (on file with author); Cent. N.Y. Psychiatric Ctr., Treatment Needs/Service Level Designation (Outpatient) 167 MED CNYPC (Mar. 2012) [hereinafter MED CNYPC] (on file with author).

102. *See* CBO Policy # 1.12, *supra* note 101, at 1; Cent. N.Y. Psychiatric Ctr., Corrections-Based Operations Policy # 9.12: Treatment Needs/Service Level Designation Form 1–3 (May 6, 2015) [hereinafter CBO Policy # 9.12] (on file with author); MED CNYPC, *supra* note 101.

103. CBO Policy # 9.12, *supra* note 102, at 1–3.

need of services” and is therefore not on the OMH case load.¹⁰⁴ An individual who has been designated service level one is considered in highest need of treatment.¹⁰⁵ Individuals with serious mental health needs, as defined in New York state law as opposed to simply OMH policy, receive a 1-S or 2-S designation (referred to as “S-designation”).¹⁰⁶

OMH also assigns each state prison a service level, which denotes the number and type of OMH staff and clinical space available to meet the treatment needs of incarcerated individuals.¹⁰⁷ Because not every prison has the staff or resources to serve high-need individuals, those individuals with a service level one, two, three, or four, or an S-designation may only be housed at prisons with a corresponding service level.¹⁰⁸ In practice, this means that individuals with an S-designation cannot be housed at a level three facility, because such facility does not have the necessary resources to treat that individual.¹⁰⁹

In addition to affording specified treatment to individuals based upon their particular service level, DOCCS and OMH afford certain people access to specialized units in which more intensive mental health treatment is provided.¹¹⁰ Those units grew out of a combination of forward-thinking action by DOCCS and OMH, litigation, legislation, and grassroots mobilization by advocates and activists.¹¹¹ Such a specialized unit that serves individuals with serious

104. CBO Policy # 1.12, *supra* note 101, at 1.

105. CBO Policy # 9.12, *supra* note 102, at 1–3.

106. N.Y. CORRECT. LAW § 137(6)(d)–(e) (McKinney 2017). State law defines persons with “serious mental illness” as “individuals who meet criteria established by the commissioner of mental health, which shall include persons who are in psychiatric crisis, or persons who have a designated diagnosis of mental illness under the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and whose severity and duration of mental illness results in substantial functional disability.” N.Y. MENTAL HYG. LAW § 1.03(52) (McKinney 2017); *see also* Cent. N.Y. Psychiatric Ctr., Corrections-Based Operations Policy # 1.13: Serious Mental Illness Designation 1–5 (Mar. 16, 2015) (on file with author).

107. N.Y. Dep’t of Corr. & Cmty. Supervision, Directive # 4302: Transfers to Health/Mental Health Care Units 7 (May 9, 2017) [hereinafter DOCCS Directive # 4302] (on file with author); *see also* CBO Policy # 1.12, *supra* note 101, at 1.

108. DOCCS Directive # 4302, *supra* note 107, at 7.

109. *See id.* (noting that individuals are “assigned to facilities where that level of service is available”).

110. *Id.* at 4–6.

111. For example, in 2016, DOCCS and OMH expanded treatment options for people with histories of mental health-related violence of their own volition, rather than in response to litigation. For more information on those units, see discussion concerning the Discharge and Enhanced Intermediate Care Programs *infra* Section I.B. As mentioned above, however, DOCCS and OMH did not expand

mental health needs is called a Residential Mental Health Treatment Unit (“RMHTU”).¹¹² The RMHTUs are organized into two types. The first type of RMHTU serves individuals who would otherwise be housed in general population, or those who do not have solitary confinement sanctions of any type.¹¹³ Those units are called the Intermediate Care Program,¹¹⁴ Transitional Intermediate Care

treatment options for people with S-designations housed in solitary confinement until it settled civil rights litigation. *See* Private Settlement Agreement, *supra* note 25, at 3–7. DOCCS and OMH did not make many of those options permanent until the SHU Exclusion Law was codified. *See* N.Y. EXEC. LAW § 553.24 (McKinney 2017); N.Y. CORRECT. LAW §§ 2, 137.6, 401 & 401-a (McKinney 2017). The SHU Exclusion Law was codified largely due to advocacy by Mental Health Alternatives to Solitary Confinement, a grassroots advocacy organization dedicated to the development of therapeutic approaches to mental health crises in the DOCCS system. For more information about Mental Health Alternatives to Solitary Confinement and its push for the SHU Exclusion Law, see generally *Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences, Hearing Before the Sen. Judiciary Subcomm. on the Constitution, Civil Rights, and Human Rights*, 112th Cong. (2012) (statement of Mental Health Alternatives to Solitary Confinement), <http://solitarywatch.com/wp-content/uploads/2012/06/mental-health-alternatives-to-solitary-confinement.pdf> [<https://perma.cc/36PT-5BXN>].

112. N.Y. CORRECT. LAW § 137(6)(d)(1). Although most of these units serve exclusively people with S-designations, some serve individuals with a service level of one or two. To be sure, those individuals have been diagnosed with serious mental illness despite the fact that OMH has not afforded them an S-designation.

113. What is often colloquially referred to as “solitary confinement” is referred to in New York State Law as “segregated confinement,” or “the disciplinary confinement of an inmate in a special housing unit or in a separate keeplock housing unit. Special housing units and separate keeplock units are housing units that consist of cells grouped so as to provide separation from the general population, and may be used to house inmates confined pursuant to the disciplinary procedures described in regulations.” N.Y. CORRECT. LAW § 2(23).

114. The Intermediate Care Program (“ICP”) operates on a “step system.” Each step, of which there are four, promotes increased proficiency at activities of daily living and provides for increased privileges, such as increased access to work or education assignments, additional program offerings, structured work programs, increased property privileges, and increased access to other parts of the facility. Individuals incarcerated in the ICP are provided with programming pursuant to an individualized treatment plan developed by ICP staff. Each ICP is also expected to develop its own program incentives, designed to secure rule compliance, support positive behaviors, improve treatment compliance, improve program success, and ultimately [allow] for integration into a less restrictive environment. N.Y. STATE DEP’T OF CORR. SERVS. & N.Y. STATE OFFICE OF MENTAL HEALTH, INTERMEDIATE CARE PROGRAM MANUAL 3–40 (2009) [hereinafter INTERMEDIATE CARE PROGRAM MANUAL]. *See generally* DOCCS Directive # 4302, *supra* note 107. DOCCS and OMH suggest several program incentives, including basic items such as extra personal hygiene products, snack prizes, an additional shower, headphones, and access to movies. Although advocates receive many complaints about conditions in the ICPs, many of their clients have successfully transitioned from an ICP to general population and reported improvement in their ability to cope with the prison environment and manage the manifestation of their mental health needs. ICPs operate at several maximum-security prisons, including Attica, Auburn, Bedford

Program, Enhanced Intermediate Care Program, and Discharge Intermediate Care Program.¹¹⁵ All of those units serve individuals with S-designations or those designated service level one.¹¹⁶ Individuals in those units are provided with four hours of structured, out-of-cell programming five days per week.¹¹⁷ That programming is designed to promote their eventual release into the general population setting.¹¹⁸ The Transitional Intermediate Care Program provides two groups per week with programming aimed at assisting individuals who have been in an Intermediate Care Program to remain successfully in general population, hence the “transitional” moniker.¹¹⁹ The Enhanced Intermediate Care Program and Discharge Intermediate Care Program serve people with histories of violence who are within 18–48 months of their approved release date and 9–12 months of their approved release date, respectively.¹²⁰ Those units provide substantially the same programming as the regular Intermediate Care Program.¹²¹ As a result of litigation, some Intermediate Care Programs, which were once located exclusively at maximum-security prisons, are now located at medium security facilities.¹²²

Hills, Clinton, Elmira, Five Points, Great Meadow, Green Haven, Mid-State, Sing Sing, and Sullivan Correctional Facilities. DOCCS Directive # 4302, *supra* note 107, at 5; *see also* Cent. N.Y. Psychiatric Ctr., Corrections-Based Operations Policy # 9.40: Intermediate Care Program Referral 1 (December 5, 2013) (on file with author); *supra* INTERMEDIATE CARE PROGRAM MANUAL, at 3 (“The goal of the ICP is to improve inmate-patients’ functioning while reducing the impact that symptoms of mental illness and behavioral instability can have on adjustment during incarceration. The ICP is a therapeutic community that provides mental health services and promotes development of self-regulation, symptom management, social, recreational, and rehabilitative skills. In addition to traditional clinic services, the ICP provides case management, crisis intervention, adaptive skills training, self-help, and peer support.”).

115. DOCCS Directive # 4302, *supra* note 107, at 4–6.

116. *Id.*

117. *Id.* at 8.

118. *Id.* at 4.

119. *Id.* at 5.

120. *Id.*

121. *See id.*

122. *Id.* at 5. Before the private settlement agreement in *Disability Advocates, Inc. v. New York State Office of Mental Health* required expanded treatment options for individuals incarcerated in general population and solitary confinement, DOCCS had already established ICPs in certain maximum-security state prisons. In response to *Disability Advocates, Inc. v. New York State Office of Mental Health*, which challenged DOCCS’s and OMH’s placement of the ICPs at only maximum-security prisons, DOCCS and OMH opened ICPs at Albion Correctional Facility and Fishkill Correctional Facility, both of which are medium-security prisons. Private Settlement Agreement, *supra* note 25, at 7–11 (“Defendants will add ninety (90) new beds in the

The second type of RMHTU serves people with certain solitary confinement sanctions.¹²³ As a result of *Disability Advocates Inc. v. NYS Office of Mental Health*,¹²⁴ DOCCS and OMH created new units to serve individuals with S-designations who receive a solitary confinement sanction of thirty days or more.¹²⁵ Those individuals are diverted from solitary confinement to a Behavioral Health Unit,¹²⁶ a Residential Mental Health Unit,¹²⁷ an Intensive Intermediate Care Program, or a Therapeutic Behavioral Unit¹²⁸ to serve their segregated confinement sanction. Individuals in the Behavioral Health Unit are afforded two hours per day of structured, out-of-cell therapeutic programming five days per week, whereas individuals in

Intermediate Care Program . . . in addition to the 572 current . . . beds and the 118 additional . . . beds covered by the previously approved 2004 and 2005 initiatives.”); see also DOCCS Directive # 4302, *supra* note 107, at 5.

123. See *supra* text accompanying note 122.

124. See generally Private Settlement Agreement, *supra* note 25.

125. *Id.* at 8.

126. The Behavioral Health Unit affords incarcerated individuals two hours per day out-of-cell therapeutic programming and is located at Great Meadow Correctional Facility. The Behavioral Health Unit operates similarly to the Intermediate Care Program in that incentives are afforded and advancement is obtained through program compliance, attendance, and positive behavior. N.Y. DEP’T OF CORR. & CMTY. SUPERVISION, BEHAVIORAL HEALTH UNIT ORIENTATION HANDBOOK 2–5 (2015) (on file with author) (“The Behavioral Health Unit . . . is a therapeutic program designed to teach you the skills necessary to solve problems and cope with stress in a healthy, nonviolent way. By acquiring and practicing these skills, you may reduce or eliminate the behaviors that lead to Misbehavior Reports. This will help you re-enter general population of a DOCCS facility, another special program, or the community. This is accomplished through Mental Health and DOCCS treatment/programming that allows for interaction within groups, and individual counseling.”).

127. If a participant successfully graduates to stage two in a Residential Mental Health Unit, they are offered “at least four hours a day structured out-of-cell therapeutic programming and/or mental health treatment . . . and . . . additional out of cell activities consistent with mental health needs.” DOCCS Directive # 4302, *supra* note 107, at 8. Residential Mental Health Units are located at Attica Correctional Facility, Five Points Correctional Facility, and Marcy Correctional Facility. *Id.*

128. The Therapeutic Behavioral Unit, which is the Residential Mental Health Unit for women, is located at Bedford Hills Correctional Facility. Not only do individuals in these units receive therapeutic treatment, but they can work their way toward receiving property, services and privileges similar to those available in general population. They are assessed on essentially the same scale that is used in the Behavioral Health Unit, but the program is divided up into three stages with attendant “milestones.” Each milestone is associated with additional privileges, with the third being associated with discharge to an alternate program. N.Y. DEP’T OF CORR. & CMTY. SUPERVISION & N.Y. OFFICE OF MENTAL HEALTH, ATTICA RESIDENTIAL MENTAL HEALTH UNIT INMATE-PATIENT ORIENTATION HANDBOOK 5–10 (Nov. 2016) (on file with author).

the other three aforementioned units are afforded four hours of such programming per day.¹²⁹ The existence of these units, and criteria for when DOCCS must divert or remove individuals to them, are now codified in the SHU Exclusion Law.¹³⁰

In circumstances satisfying certain codified requirements, DOCCS and OMH are entitled to retain individuals with S-designations in solitary confinement for over thirty days.¹³¹ First, DOCCS and OMH must demonstrate that “exceptional circumstances” justify placing the individual in a more restrictive environment.¹³² Where DOCCS and OMH have satisfied that requirement, they must provide a heightened level of care to those individuals.¹³³ DOCCS and OMH often provide such care in the Group Therapy Program, in which they offer individuals two hours of structured, out-of-cell programming five days per week in the Special Housing Unit itself.¹³⁴

As of December 31, 2015, 1205 individuals diagnosed with serious mental health needs were housed in an RMHTU.¹³⁵ Of those individuals, 987 were in a general population RMHTU, such as an Intermediate Care Program.¹³⁶ That number represented 39.2% of the total DOCCS population diagnosed with serious mental health needs.¹³⁷ Of those diagnosed with a serious mental health need, 210 individuals were confined to an RMHTU for people with solitary confinement sanctions of over thirty days, such as the Residential Mental Health Unit.¹³⁸ That number represented 8% of the total DOCCS population diagnosed with serious mental health needs.¹³⁹ These figures need some qualification, however. Prisoner rights advocates receive frequent complaints from incarcerated persons,

129. DOCCS Directive # 4302, *supra* note 107, at 4.

130. *See* N.Y. CORRECT. LAW § 137.6(d)(i) (McKinney 2017) (requiring DOCCS to divert or remove individuals with serious mental illness from segregated confinement where the period of such confinement could be longer than thirty days).

131. *See* N.Y. CORRECT. LAW §§ 2.21, 137.6(d)(ii)(E) (McKinney 2017).

132. *Id.*

133. *Id.*

134. DOCCS Directive # 4302, *supra* note 107, at 5.

135. CENT. N.Y. PSYCHIATRIC CTR., N.Y. STATE OFFICE OF MENTAL HEALTH, 2015 ANNUAL CORRECTIONS-BASED OPERATIONS STATISTICAL REPORT 3 (2015) (on file with author).

136. *Id.* at 7–9.

137. *Id.*

138. *Id.* at 7–9, 15.

139. *Id.*

alleging that they have been erroneously classified or misdiagnosed, sometimes in retaliation for alleged misbehavior.¹⁴⁰

1. Regional Catchment Areas

The DOCCS system is divided into “Regional Catchment Areas,” or “hubs,” which facilitate the transfer from one facility to another of individuals who require mental health services, evaluations, or treatment.¹⁴¹ There are fourteen main mental health hubs, which generally have mental health offices, private interview rooms, and observation cells for people who are experiencing a crisis.¹⁴² DOCCS’s crisis observation unit is called the Residential Crisis Treatment Program.¹⁴³ People may be admitted to the Residential Crisis Treatment Program if they trigger a suicide screen upon admission to segregated confinement,¹⁴⁴ if they manifest behavior

140. See *Mental Health Services in NY Prisons, Hearing Before the Assemb. Comms. Corr. & Mental Health 4* (2014) (statement of Jack Beck, Dir., Prison Visiting Project, Corr. Ass’n of N.Y.) (“Related to patients in [solitary confinement], there has been a major shift in diagnoses in the last six years from schizophrenia and psychoses (35% drop) to adjustment, anxiety, and personality disorders (72% rise). With a related 36% drop in the number of S-designations, less people are eligible for [diversion from solitary confinement], raising serious concerns about whether the SHU Exclusion Law’s provision of a sharp line above which people receive intensive services and below which people remain in [solitary confinement], are leading to improper diagnoses. These concerns are even more stark given that the percentage of the total OMH caseload designated as Level 1 has risen in recent years.”).

141. DOCCS Directive # 4301, *supra* note 33, at 1–3.

142. *See id.*

143. *Id.* at 3.

144. *Id.* at 4–7. Although the Residential Crisis Treatment Program and the “hub” structure predate *Disability Advocates, Inc. v. New York State Office of Mental Health* and the subsequent codification of the SHU Exclusion Law, that law established the requirement that DOCCS or an OMH clinician must perform a suicide screening on all individuals upon their admission into solitary confinement and a full mental health assessment within one day of the imposition of a solitary confinement sanction. If a suicide risk is identified, an OMH clinician must be consulted and precautions must be taken to mitigate the potential for suicide. These requirements were initially imposed by settlement in *Disability Advocates, Inc. v. New York State Office of Mental Health*. See Private Settlement Agreement, *supra* note 25, at 14. It is now codified. N.Y. CORRECT. LAW § 137.6(d)(ii)(A)–(B) (McKinney 2017). If the incarcerated individual is placed in solitary confinement at a service level 1 or service level 2 facility, they must be fully assessed for the presence of serious mental illness within one business day of their placement. *Id.* If they are placed in solitary confinement at a service level 3 or service level 4 facility, they must be assessed for the presence of serious mental illness within fourteen days of their placement. *Id.*

that triggers a mental health referral,¹⁴⁵ or if they report suicidal ideation or thoughts of self-harm.¹⁴⁶

As a precaution, individuals who are admitted to the Residential Crisis Treatment Program are afforded constant clinical supervision for stabilization.¹⁴⁷ Residential Crisis Treatment Programs consist of both individual cells and dorm beds.¹⁴⁸ Upon transfer to a Residential Crisis Treatment Program cell, individuals are provided with “amenities” commensurate with their suicide risk level as assessed by OMH, including one specialized tear and fire resistant mattress, two specialized tear resistant mats, one specialized tear resistant safety smock, one pair of rubber sandals, and certain hygiene products and eating utensils (which they are not allowed to keep in their cells and must return after use).¹⁴⁹ They are often unable to receive mail or otherwise communicate with the outside world.¹⁵⁰ OMH gives clinicians increased access to their patients in order to extensively document the individuals’ status during their stay in the Residential Crisis Treatment Program.¹⁵¹ In the event of a stay longer than seven calendar days, additional approval by a clinical director is required or a transfer to CNYPC is initiated.¹⁵² Individuals in the Residential Crisis Treatment Program are to be transferred out only where one of several criteria are met, as determined and documented by a psychiatrist.¹⁵³ DOCCS and OMH have developed

145. See N.Y. Dep’t of Corr. & Cmty. Supervision, Directive # 4101: Inmate Suicide Prevention 2, 3 (Jan. 1, 2016) (on file with author).

146. See *id.* at 15.

147. Cent. N.Y. Psychiatric Ctr., Corrections-Based Operations Policy # 4.0: RCTP Observation Cells & Dormitory Beds 1 (June 1, 2016) [hereinafter CBO Policy # 4.0] (on file with author) (“Observation cells should be utilized only for inmate-patients who may be psychiatrically unstable, unpredictable and/or a danger to themselves or others.”).

148. *Id.*

149. N.Y. Dep’t of Corr. & Cmty. Supervision, Directive # 4308: Residential Crisis Treatment Program (RCTP) 4, 5 (Jan. 2, 2018) (on file with author); see also CBO Policy # 4.0, *supra* note 147, at 3.

150. See generally CBO Policy # 4.0, *supra* note 147.

151. *Id.* at 4–7.

152. *Id.* at 7.

153. *Id.* (“Transfers out of an RCTP Observation Cell/Dormitory Bed can occur when the crisis precipitating the transfer to RCTP has been resolved, the psychiatric assessment suggests the patient is capable of meaningfully participating in programming and that return to a lower level of care represents the least restrictive and appropriate means of treatment, the psychiatrist assessment determines the need for an increased level of treatment, e.g. transfer to CNYPC, the need for an observation cell level of care is no longer met, and a step-down to a Dormitory Bed is warranted.”).

these policies as a safeguard against tragic, avoidable suicides and incidents of self-harm.

2. *VTC in New York Prisons: Implementation, Current Practices, and Shortcomings*

Though DOCCS and OMH have created a reasonable infrastructure for the delivery of mental health treatment in New York State prisons, that infrastructure is undermined by resource deficiencies caused by the geographic siting of New York's prisons. One manifestation of those resource issues is DOCCS's and OMH's use of VTC.

As early as the late 1990s, it was clear to much of the practicing psychiatric community that VTC, and telemedicine more broadly, could help close the prison resource gap.¹⁵⁴ Although it was unclear when or whether VTC could or would replace in-person psychiatric evaluations,¹⁵⁵ practicing psychologists wrote positively about the then-existing jail and prison VTC programs.¹⁵⁶ That said, psychiatrists have also been vocal about the potential for negative effects of such technology and the need to control for those negative effects, in particular stressing the importance of clear and robust policies and procedures for the implementation and use of the technology.¹⁵⁷

154. Nat'l Comm'n on Corr. Health Care, *Position Statement: Use of Telemedicine Technology in Correctional Facilities*, 6 J. CORR. HEALTH CARE 129, 134 (1999) [hereinafter *Position Statement*] ("The use of telemedicine affords correctional facilities many opportunities for reducing operational costs associated with providing health care to confined individuals.").

155. See Steven E. Hylar et al., *Can Telepsychiatry Replace In-Person Psychiatric Assessments? A Review and Meta-Analysis of Comparison Studies*, 10 CNS SPECTRUMS 403, 411–12 (2005) ("Telepsychiatry seems to be a reasonable alternative in situations in which it is difficult or impractical to arrange for I-P assessments Telepsychiatry could be viewed as a necessity in situations in which the alternative might be that no psychiatrist or psychiatrist sub-specialist would be available Whether telepsychiatry can replace [in-person] for ongoing therapy requires more study.").

156. See, e.g., Even Lynn Nelson et al., *A Comparison of Psychiatrist Evaluation and Patient Symptom Report in a Jail Telepsychiatry Clinic*, 10 TELEMEDICINE J. & E-HEALTH S-54, S-54 (2004) (touting the quality of prison VTC programs and prospects for expansion).

157. *Position Statement*, *supra* note 154, at 134–35 ("Policies and procedures must clearly define the purpose and instances in which telemedicine may be used in a correctional facility. Regardless of the type and combination of technologies used to provide medical care, the basic principals [sic] governing the physician/patient relationship must remain intact. This responsibility can be met in large part by ensuring that telemedicine policies and procedures comply with the National

Since VTC's implementation, both DOCCS and OMH have relied heavily on its use for the provision of psychiatric treatment. The reliance on VTC is an outgrowth of the challenges of staffing mental health satellite units that are located in rural parts of New York.¹⁵⁸ It is a natural response to resource issues and one method by which the State can avoid liability for failure to provide specialty care or crisis intervention services.¹⁵⁹ Unfortunately, VTC's use is not governed by robust DOCCS and OMH policy.¹⁶⁰ It is therefore unclear how DOCCS or OMH control for the potential drawbacks of VTC or whether the agencies evaluated the potential negative consequences of its use before promulgating VTC policies.¹⁶¹

Although DOCCS and OMH have promulgated policies concerning the use of VTC in state prisons, those policies are not particularly detailed.¹⁶² Pursuant to CNYPC policy, OMH maintains a VTC coordinator at each facility that hosts a satellite unit.¹⁶³ Before any VTC appointment, CNYPC staff at the facility where the incarcerated patient is located must send copies of certain medical documentation to the VTC unit.¹⁶⁴ The same is true of any follow-up VTC appointment.¹⁶⁵ To ensure that the VTC Unit has sufficient time to review pertinent documents, all documents must be sent at

Commission on Correctional Health Care's Standards for Health Services that have been developed for prisons, jails, and juvenile detention and confinement facilities.").

158. See Letter from Donna Hall, Ph.D, Assoc. Comm'r, Div. of Forensic Servs., N.Y. Office of Mental Health, to Melissa Finn, MSW, Facility Review Specialist II, N.Y. Justice Ctr. for the Protection of People with Special Needs (Mar. 22, 2016) (on file with author).

159. See *generally Position Statement*, *supra* note 154.

160. CNYPC Corrections-Based Operations policies and DOCCS Directives cited herein represent all DOCCS and OMH policies on the provision of VTC, specifically. The author confirmed this by Freedom of Information Law requests to DOCCS and OMH. Letter from Riele J. Morgiewicz, Records Access Officer, N.Y. State Office of Mental Health, to author (Oct. 26, 2017) (on file with author); Letter from David J. Harvey, Assistant Counsel, N.Y. Dep't of Corr. & Cmty. Supervision, to author (Oct. 27, 2017) (on file with author).

161. See *generally supra* note 160 and accompanying text.

162. See CBO Policy # 2.9, *supra* note 42, at 1; Cent. N.Y. Psychiatric Ctr., Corrections-Based Operations Policy # 3.11: Telepsychiatry Orders 1 (Mar. 16, 2016) [hereinafter CBO Policy # 3.11] (on file with author).

163. CBO Policy # 2.9, *supra* note 42, at 1.

164. *Id.* (Documentation includes the chronological record, diagnosis record, core history, Comprehensive Suicide Risk Assessment (CSRA), screening/admission note, initial psychiatric evaluation, last three psychiatric progress notes, last three primary progress notes, termination/transfer progress note, last physician's order, most recent medication treatment record and pharmacy print out, and most recent laboratory results (if applicable).).

165. *Id.*

least twenty-four hours prior to the appointment.¹⁶⁶ Upon the completion of the appointment, the VTC psychiatrist is required to fax new medical documentation to the facility where the incarcerated patient is located.¹⁶⁷ CNYPC staff at that facility are then required to discuss the treatment plan with the incarcerated patient following the VTC session “when needed.”¹⁶⁸ Policies provide no guidance regarding the determination of “need.”¹⁶⁹ DOCCS and OMH have also promulgated a policy concerning medication orders following a VTC session.¹⁷⁰ That policy largely concerns documentation requirements.¹⁷¹ No DOCCS or OMH policy addresses staffing, quantity, or quality of VTC services afforded to incarcerated individuals.¹⁷²

While VTC may appear a convenient and efficient option to close the resource gap, it comes with many drawbacks. Perhaps the biggest of those drawbacks is VTC’s potential to undermine trust, rapport, and communication between physicians and patients.¹⁷³ With respect to communication, practitioners posit that VTC may undermine a physician’s ability to assess non-verbal communication, and that patients may be unable to adapt their communication style to suit the medium.¹⁷⁴ Whereas non-verbal communications are often interpreted naturally during in-person interactions, VTC interactions do not foster the same natural understanding of non-verbal cues.¹⁷⁵ Assessing non-verbal communication is an important aspect of any

166. *Id.* at 2.

167. *Id.*

168. *Id.*

169. *Id.* For more on the importance of discussing treatment plans with patients, see generally F.J. Fowler, *Informing and Involving Patients to Improve the Quality of Medical Decisions*, 30 HEALTH AFFAIRS 699 (2011) (discussing best practices for involving patients in treatment decisions and treatment planning).

170. CBO Policy # 3.11, *supra* note 162, at 1–2.

171. *See id.*

172. These are areas any correctional VTC policy should address, as contemplated by the National Commission Standards. *See Position Statement, supra* note 154, at 135.

173. Melissa Lee et al., *The Doctor Is Online: An Introduction to Text-Based Telepsychiatry*, 8 UNIV. B.C. MED. J. 33, 33 (2017) (stating that “[s]ome clinicians are concerned that the absence of face-to-face interaction and non-verbal cues could undermine communication during therapy” and reasoning that those losses are only “partially” offset where clinicians take remedial measures).

174. Jay H. Shore et al., *Cultural Aspects of Telepsychiatry*, 12 J. TELEMEDICINE & TELE CARE 116, 117 (2006).

175. Hilty et al., *supra* note 47, at 18.

reliable psychiatric assessment, particularly where a clinician is assessing the presence of potential suicidality or suicidal ideation.¹⁷⁶

Some practitioners posit that it is much more difficult for a patient to establish a connection with a medical professional over VTC.¹⁷⁷ Patients may feel disconnected because of the medium itself, regardless of the qualifications of the physician or the degree of attention paid to dignifying the patient and fully assessing the patient's needs.¹⁷⁸ The implications of a lack of trust are particularly acute where a physician is assessing a patient for suicidality.¹⁷⁹ Patients are far less likely to tell the truth about their feelings where a robust therapeutic relationship has not been established.¹⁸⁰

Another danger of VTC is its potential to endanger the effectiveness of diagnoses and treatment. Scholars repeatedly reported during the late 1990s and early to mid-2000s that deficiencies in technology undermined the efficacy of VTC and patients' confidence in the medium.¹⁸¹ As recently as 2004, some psychiatrists tempered their positive review of VTC's potential with concerns about its prospective effectiveness in a carceral setting.¹⁸² Three years earlier, several scholars published a study that indicated that reliability results were consistently lower for VTC evaluations that required visual observation rather than a simple self-report.¹⁸³ As a precaution, some scholars have advocated that VTC practitioners

176. Khushminder Chahal, *The Utility of Assessing Nonverbal Communication in the Psychiatric Evaluation*, 12 AM. J. PSYCH. RESIDENTS 3, 3 (2017); Gretchen N. Foley & Julie P. Gentile, *Nonverbal Communication in Psychotherapy*, 7 PSYCHIATRY 38, 44 (2010). In the author's experience interviewing incarcerated individuals with mental health needs and intellectual disabilities, a twitch of the leg, a forlorn countenance or a rapid eye movement may indicate an otherwise non-obvious disposition.

177. Lee et al., *supra* note 173, at 33.

178. Hilty et al., *supra* note 47, at 16 ("One concern with telemedicine is that the technology may adversely affect . . . the development of a therapeutic alliance.").

179. See Linda Ganzini et al., *Trust Is the Basis for Effective Suicide Risk Screening and Assessment in Veterans*, 28 J. GEN. INTERNAL MED. 1215, 1215 (2013).

180. Jessica Sun Choi, *Mental Health Services via Skype: Meeting the Mental Health Needs of Community College Students Through Telemedicine*, 25 S. CAL. REV. L. & SOC. JUST. 331, 344 (2016).

181. See Christopher J. Caryl, *Malpractice and Other Issues Preventing the Development of Telemedicine*, 12 J. L. & HEALTH 173, 201 (1998); Choi, *supra* note 180, at 351; Barbara M. Rohland et al., *Acceptability of Telepsychiatry to a Rural Population*, 51 PSYCH. SERVS. 672, 673 (2000); Shore et al., *supra* note 174, at 119; Kathleen Vybony, *Legal and Political Issues Facing Telemedicine*, 5 ANNALS HEALTH L. 61, 62–63 (1996).

182. Nelson et al., *supra* note 156, at S-84.

183. Monnier et al., *supra* note 47, at 606.

forego diagnosis where they believe that, due to the medium, they have insufficient data.¹⁸⁴

Finally, a third danger is VTC's potential to undermine patient privacy. However, this concern may be alleviated as technology improves. Though today's technology is by no means beyond issues of hacking and privacy protection, it is nonetheless better suited to ensure the confidentiality of digital medical records.¹⁸⁵ Many agencies—though neither DOCCS nor OMH—have moved to an entirely digital storage model for medical and mental health records.¹⁸⁶

As of 2015, twenty percent of Americans lived in an area that has a shortage of primary care physicians.¹⁸⁷ That percentage was expected to increase.¹⁸⁸ This year, every prison with a mental health satellite unit was found to be located in a city, town, or village with a shortage of mental health professionals.¹⁸⁹ Therefore, it would be disingenuous to suggest that VTC should not be used in prisons to close the resources gap, particularly as that gap widens. It is not disingenuous, however, to suggest that DOCCS and OMH should control for concerns about the use of VTC by developing more robust policies concerning issues such as effectiveness of communication over VTC and confidentiality of VTC communications. That suggestion is bolstered by the findings of oversight agencies such as the New York Justice Center for the Protection of People with Special Needs (“Justice Center”), Disability Rights New York, and Mental Health Alternatives to Solitary Confinement, some of which crystallize the above concerns.¹⁹⁰

184. Caryl, *supra* note 181, at 201.

185. Laurinda B. Harman et al., *Electronic Health Records: Privacy, Confidentiality, and Security*, 14 *AMA J. ETHICS* 712, 712 (2012).

186. Darrelle Knight, *Electronic Medical Records: Moving Jails Forward*, *CORRECTIONS* (Oct. 19, 2009), <http://www.corrections.com/news/article/22296-electronic-medical-records-moving-jails-forward> [<https://perma.cc/KV9D-V5QF>].

187. Avery Schumacher, *Telehealth: Current Barriers, Potential Progress*, 76 *OHIO ST. L.J.* 409, 413 (2015).

188. *Id.*

189. *UNIV. OF THE STATE OF N.Y.*, *supra* note 38.

190. *See* Letter from Melissa Finn, MSW, Review Specialist II, N.Y. Justice Ctr. for the Protection of People with Special Needs, to Donna Hall, Ph.D, Assoc. Comm'r, Div. of Forensic Servs., N.Y. State Office of Mental Health, and Anthony J. Annucci, Acting Comm'r, N.Y. State Dep't of Corr. & Cmty. Supervision (March 3, 2016) (on file with author); Letter from Deborah McCulloch, Exec. Dir., Cent. N.Y. Psychiatric Ctr., to Elena Landriscina, Staff Attorney, Disability Rights N.Y. (Dec. 12, 2016) (on file with author); Minutes, Meeting Between the N.Y. Justice Ctr. for the Protection of People with Special Needs and Mental Health Alternatives to

Over the last two years, the Justice Center¹⁹¹ has issued findings to both DOCCS and OMH regarding psychiatric staffing in several state prisons and has informed advocates that staffing problems are related in part to the relative isolation of state prisons. For example, the Justice Center issued a findings letter to DOCCS and OMH on March 3, 2016 concerning its investigation of a suicide at Attica Correctional Facility.¹⁹² The Justice Center found in relevant part that due to staffing shortages, the deceased individual had only one opportunity over a thirty-day period to meet with a psychiatrist prior to his death, and did not receive the psychiatric evaluation he was supposed to have been afforded within one day of his admission to the Residential Crisis Treatment Program.¹⁹³ DOCCS and OMH afforded the individual only one psychiatric evaluation, which was facilitated via VTC and occurred immediately before his discharge from the Residential Crisis Treatment Program.¹⁹⁴ During that VTC evaluation, a psychiatrist cleared the individual's discharge from Residential Crisis Treatment Program so that he could call his wife.¹⁹⁵ The Justice Center found "no documentation to support that [the

Solitary Confinement (Jan. 20, 2017) [hereinafter 2017 Meeting Minutes] (on file with author).

191. The Justice Center is responsible for monitoring the quality of mental health care provided to incarcerated individuals pursuant to the SHU Exclusion Law, N.Y. CORRECT. LAW § 401-a (McKinney 2017). In exercising that responsibility, the Justice Center conducts monitoring in segregated confinement units throughout the state to ensure that all SHU Exclusion Law benchmarks are being met. *Id.* The Justice Center ensures that SHU mental health screenings and assessments are being conducted in a timely fashion and that DOCCS and OMH meet the other SHU Exclusion Law benchmarks such as the mandate to "[divert and remove] inmates with serious mental illness from segregated confinement to residential mental health treatment units." *Id.* The Justice Center also assesses the general population mental health units, and the quality of care afforded to incarcerated individuals in all Residential Mental Health Treatment Units. *Id.* The Justice Center occasionally takes on an advocacy posture, recommending that certain incarcerated individuals be placed into an Residential Mental Health Treatment Unit or be afforded additional attention. *Id.* The Justice Center has been an integral watchdog to ensure that mental health services are expanded upon and reinforced for individuals incarcerated throughout the state. *See id.*; 2017 Meeting Minutes, *supra* note 190; *see also Forensic Oversight Unit*, N.Y. JUSTICE CTR. FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS, <https://www.justicecenter.ny.gov/oversight-and-monitoring/forensic-oversight> [<https://perma.cc/86UA-FJDJ>].

192. *See* Letter from Melissa Finn, *supra* note 190. Due to heavy redactions in the Justice Center's letter and both DOCCS's and OMH's response, it is impossible to ascertain how long the individual was in the Residential Crisis Treatment Program, how many appointments he should have had, and whether he was otherwise cared for in accordance with applicable policy and law. *See id.*

193. *Id.* at 3.

194. *Id.* at 1.

195. *Id.* at 3.

individual] . . . received any mental health assistance between his discharge from the [Residential Crisis Treatment Program], and when he died by suicide on [redacted].”¹⁹⁶

These findings raise serious questions about the quality of care provided. Were warning signs present but missed due to the quality of the VTC medium? Would the individual have engaged more readily with the psychiatrist if the evaluation had been conducted in person? And if so, would he have received more careful attention? Would the psychiatrist have approved the individual’s discharge after an in-person evaluation? These questions cannot be answered, but these are valid inquiries given the above-cited literature.¹⁹⁷

The Justice Center raised the issue of psychiatric staffing very directly in its findings by referencing a previous finding it issued to DOCCS and OMH regarding “the lack of psychiatrists in the Attica [Correctional Facility].”¹⁹⁸ The Justice Center stated that both agencies had acknowledged the problem, reporting that Attica Correctional Facility added an additional VTC Unit to “enhance the number of hours for assessments via VTC, and recruitment strategies were continuing.”¹⁹⁹ Despite these measures, the Justice Center found that the deceased man had not received care consistent with the applicable OMH policy.²⁰⁰ The Justice Center also found that the individual was not afforded a step-down from the Residential Crisis Treatment Program,²⁰¹ contrary to best practices.²⁰² In consideration of those findings, the Justice Center requested an update from the respective agencies on the “current status of an on-site psychiatrist at the Attica Correctional Facility, and the current number of available hours per week of VTC assessments.”²⁰³ In response, the Associate Commissioner of OMH stated that the agency “continues to actively

196. *Id.*

197. *See* sources cited *supra* notes 173–86.

198. *See* Letter from Melissa Finn, *supra* note 190.

199. *Id.*

200. *Id.*

201. *Id.* at 4. Individuals who are afforded a “step down” from Residential Crisis Treatment Program are not immediately discharged upon a finding that they are no longer a suicide risk, but are phased back to their original placement more gradually. For some, this will mean that they are discharged not from the Residential Crisis Treatment Program back to their cell immediately, but are discharged first to a Residential Crisis Treatment Program dorm bed for less frequent observation than they would have been afforded in a Residential Crisis Treatment Program cell placement, but more frequent observation than they would have been afforded in their cell. CBO Policy # 4.0, *supra* note 147, at 7–8.

202. Letter from Melissa Finn, *supra* note 190, at 4.

203. *Id.*

recruit for an on-site psychiatrist at Attica Correctional Facility. The current number of available hours per week for VTC assessments is 60–68 hours. An additional VTC unit was added, along with continued recruitment strategies to date, as indicated in the August correspondence.”²⁰⁴ OMH still relies heavily on VTC for the provision of such services at Attica.²⁰⁵ Unfortunately, neither the Justice Center nor OMH extended their findings to the quality of VTC itself or to its impact upon the relevant suicide.

The Justice Center has continually reiterated similar staffing concerns to Mental Health Alternatives to Solitary Confinement. In June 2013, the Justice Center reported to Mental Health Alternatives to Solitary Confinement that certain Intermediate Care Programs were experiencing staffing shortages, and that others—including Fishkill and Green Haven, both Intermediate Care Programs located closer to New York City—were considered “model [Intermediate Care Programs]” for staffing, documentation, and programming.²⁰⁶ During that meeting the Justice Center emphasized that the drop in admissions to the Intermediate Care Program likely had to do with staffing issues.²⁰⁷ The Justice Center subsequently reported to Mental Health Alternatives to Solitary Confinement a serious shortage of psychiatrists, doctors, and providers in the prisons, and posited that the vacancies exist due to the location of the facilities.²⁰⁸ Although the Justice Center informed Mental Health Alternatives to Solitary Confinement that it has not “focused on” the shortages issue, it reported that it encouraged OMH to be “more creative in recruitment and retention” initiatives.²⁰⁹ Similarly, the Justice Center reported to Mental Health Alternatives to Solitary Confinement that appointments are often missed because staff is not available.²¹⁰ Attica Correctional Facility was used as an example, where there was one psychiatrist on site and four days of VTC despite the large size of Attica’s mental health case load.²¹¹

204. Letter from Donna Hall, *supra* note 158, at 1.

205. 2017 Meeting Minutes, *supra* note 190.

206. Minutes, Meeting Between the N.Y. Justice Ctr. for the Protection of People with Special Needs and Mental Health Alternatives to Solitary Confinement (Nov. 14, 2013) (on file with author).

207. 2017 Meeting Minutes, *supra* note 190.

208. *Id.*

209. *Id.*

210. *Id.*

211. *Id.*; CORR. ASS’N OF N.Y., 2014 UPDATED CORRECTIONAL ASSOCIATION REPORT ON ATTICA 16–17 (2014), <http://www.correctionalassociation.org/wp-content/uploads/2015/02/Attica-2014-CA-Updated-Report-Final.pdf> [<https://perma.cc/37BM->

In late 2016, OMH shared similar findings with Disability Rights New York, New York State’s Protection and Advocacy System for individuals with disabilities. Disability Rights New York has the federal statutory responsibility to protect and advocate for individuals with disabilities,²¹² and has devoted a significant amount of its resources to advocacy for individuals with mental health needs incarcerated in New York State prisons.²¹³ Disability Rights New York was informed via letter that “[g]iven the limited psychiatric resources at Elmira [Correctional Facility], cases are clinically prioritized with the VTC psychiatrists in an effort to effectively serve all of the inmate-patients receiving mental health treatment in that unit.”²¹⁴ In this case, Disability Rights New York was concerned with OMH’s failure to afford an incarcerated individual with a psychiatric assessment upon his transfer to the Residential Crisis Treatment Program, in accordance with the applicable policy.²¹⁵ That individual was not seen by a psychiatrist for an evaluation until long after his transfer to the Residential Crisis Treatment Program, and was seen by VTC rather than in person.²¹⁶ OMH excused its failure to provide a prompt assessment as a “clinical oversight,” and closed by reporting its “continue[d] efforts to recruit and retain psychiatric staff, and to

BLDX] (“As of July 2013, the latest available data, there were 456 people at Attica, or roughly 21% of Attica’s total population, on the Office of Mental Health (OMH) caseload. Seventy-five of those individuals were in an Intermediate Care Program (ICP)—a residential treatment program for patients with “serious mental illness,” 37 were in a Transitional ICP, and an additional nine people were in a Residential Mental Health Unit—an alternative placement to the SHU for people with serious mental illness sentenced to disciplinary confinement. The remaining 335 people, at least 34 of whom were diagnosed with a “serious mental illness,” were in general population or SHU, facing the same conditions documented throughout this report. The presence of such large numbers of people with mental health needs at Attica, and particularly in Attica’s general population, raises concerns about these individuals’ safety and well-being.”) (internal citations omitted).

212. NEW YORK EXEC. LAW § 558 (McKinney 2017). *See generally* The Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. § 15043 (2012); The Protection and Advocacy for Individuals with Mental Illness Act of 1986, 42 U.S.C. § 10801 (1986); The Protection and Advocacy for Individual Rights Act, 29 U.S.C. § 794e (1992).

213. Protection & Advocacy for Individuals with Mental Illness Program, *PAIMI Priorities*, DISABILITY RTS. N.Y., <http://www.drny.org/p-a-for-people-with-mi-paimi.html> [<https://perma.cc/B74S-9KEN>] (“Priority VII: Advocate to ensure that people in prisons and jails receive appropriate mental health services in the least restrictive environment, including reducing and eliminating solitary confinement for individuals with mental illness and assuring that appropriate discharge planning is provided for individuals returning to the community.”).

214. Letter from Deborah McCulloch, *supra* note 190, at 1.

215. *Id.*

216. *Id.* at 1–2.

maximize the resources currently available at Corrections Based Operations.”²¹⁷

If VTC is properly viewed as a second-best measure, there should be a commitment towards identifying the ways to bring services in line with people’s needs. This necessarily means analyzing whether incarcerated people are better served by remaining closer to the communities they come from, and what commitment New York must make to investing more resources in those communities.²¹⁸ The most salient questions for movement lawyers to ask are: what resources can we bring to bear to force that conversation upon DOCCS and OMH? Can litigation force DOCCS to correct VTC so that it can continue to be used as a means to address the broader resources problems, or are other approaches more promising? And even if movement lawyers correct deficiencies in DOCCS and OMH’s VTC program, what does that do to address the broader geographical problems that prompted the agencies to use VTC in the first place?

II. THE INSUFFICIENCY OF LITIGATION SOLUTIONS ABSENT GRASSROOTS APPROACHES

Movement lawyers have long used Eighth Amendment impact litigation as a tool to expand and improve medical and mental health services in prisons.²¹⁹ It is unclear, however, whether such litigation is the best tool to address deficiencies in VTC as a medium, or the geographic and resources problems that caused the expansion of VTC in prisons. Part II provides a brief overview of some of two potential avenues for improving VTC through Eighth Amendment litigation.²²⁰

217. *Id.* at 2.

218. Similar ideas have inspired New York State’s new approach to juvenile justice. *See, e.g., Close to Home Initiative*, N.Y. STATE OFFICE OF CHILDREN & FAMILY SERVS., http://ocfs.ny.gov/main/rehab/close_to_home/ [<https://perma.cc/7SHM-DGH7>] (explaining New York State’s juvenile justice reforms aimed at “keep[ing] youth close to their families and community”).

219. *See generally* Theodore Eisenberg, *Litigation Models and Trial Outcomes in Civil Rights and Prisoner Cases*, 77 GEO. L.J. 1567 (1988) (discussing and appraising theoretical models of prisoners’ rights litigation).

220. Section II.A does not provide an exhaustive list of *all* litigation options for addressing the problems identified in this Article. Other Eighth Amendment theories may be useful in addressing the problems identified in this Article, as may state law causes of action including medical malpractice and negligence. State law solutions are beyond the scope of this Article, as it narrowly examines certain reported decisions involving VTC and/or mental health care in prisons. For more information on other potentially relevant or useful Eighth Amendment strategies and state law causes of action, refer to the materials cited in Section III.A, particularly JOHN BOSTON & DANIEL MANVILLE, *PRISONERS’ SELF-HELP LITIGATION MANUAL* (4th ed. 2010).

It ultimately concludes that litigation is not the answer, but only part of a larger grassroots strategy to reverse the sprawl of the prison system and bring resources closer to home. Litigation has a role to play, but it will not create sustainable change without a coexisting grassroots movement.

A. An Abridged Overview of the Eighth Amendment Framework

The Eighth Amendment prohibition of cruel and unusual punishment²²¹ forbids the denial of treatment for serious medical needs²²² of prisoners, including serious mental health needs.²²³ A *prima facie* case for the denial of mental health treatment in violation of the Eighth Amendment requires a plaintiff to meet a two-pronged test.²²⁴ First, the plaintiff must establish that they have a serious mental health need.²²⁵ The first prong is considered the “objective prong.”²²⁶ As such, the defendant must prove the existence of their serious mental health need through evidence of prior diagnosis and treatment or the obviousness of the need for treatment.²²⁷ Not every

221. U.S. CONST. amend. VIII.

222. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (“[D]eliberate indifference to serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain’ proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner’s needs, or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. Regardless of how evidenced, deliberate indifference to a prisoner’s serious illness or injury states a cause of action under § 1983.”).

223. *Brown v. Plata*, 563 U.S. 493, 502 (2011) (upholding a lower court population cap order under the Prison Litigation Reform Act based in part on California’s longstanding unconstitutional failure to provide needed mental health treatment, pointing to “the severe and unlawful mistreatment of prisoners through grossly inadequate provision of medical and mental health care”). Prior to *Plata*, courts treated psychiatric care as part of medical care for Eighth Amendment purposes, and the issue had not been addressed at the Supreme Court level. See *Langley v. Coughlin*, 888 F.2d 252, 254 (2d Cir. 1989) (“[P]sychiatric or mental health care is an integral part of medical care. It thus falls within the requirement of *Estelle v. Gamble*, that it must be provided to prisoners. The difference between the two varieties of care are simply factual and administrative.”); *Eng v. Smith*, 849 F.2d 80, 82 (2d Cir. 1988) (upholding preliminary injunction on Eighth Amendment claim based on deliberate indifference to serious mental health treatment needs).

224. *Conn v. City of Reno*, 591 F.3d 1081, 1094–102 (9th Cir. 2010), *cert. granted on other grounds and case remanded*, 563 U.S. 915 (2011), *opinion reinstated on remand*, 658 F.3d 897 (9th Cir. 2011).

225. *Conn*, 591 F.3d at 1095.

226. *Id.*

227. See, e.g., *Johnson v. Busbee*, 953 F.2d 349, 351 (8th Cir. 1991) (holding that a serious medical need is one that has been diagnosed by a physician as requiring

mental health need is considered serious.²²⁸ The Second Circuit considers several questions in determining whether a need is serious, including “whether a reasonable doctor or patient would perceive the need in question as important and worthy of comment or treatment, whether the medical condition significantly affects daily activities, and the existence of chronic and substantial pain.”²²⁹

The Supreme Court added the second prong, the deliberate indifference standard, in *Farmer v. Brennan*.²³⁰ To meet the second prong, the plaintiff must establish that the defendants were deliberately indifferent to that need because they knew of, and disregarded, a substantial risk to the plaintiff’s health and safety.²³¹ The second prong is considered the “subjective prong.”²³² As such, a prison official cannot be found liable under the Eighth Amendment for denying humane conditions of confinement unless the official was aware of facts from which the inference could be drawn that a substantial risk of harm existed, and actually drew that inference.²³³ A defendant who did not treat an incarcerated individual properly because he or she did not realize how sick they were, or what the problem was, may not be deliberately indifferent due to a lack of actual knowledge.²³⁴

It is unclear how courts will evaluate deliberate indifference claims that turn predominantly on a question about the quality of VTC care because federal courts have not yet examined the use of prison VTC as the gravamen of an Eighth Amendment claim.²³⁵ They have examined its use only tangentially and, even then, the issue has never

treatment, or one that is so obvious that even a lay person would recognize the necessity of a doctor’s attention).

228. See *Tillery v. Owens*, 719 F. Supp. 1256, 1286 (W.D. Pa. 1989), *aff’d*, 907 F.2d 418 (3d Cir. 1990) (holding that a serious mental health need is one “that has caused significant disruption in an inmate’s everyday life and which prevents his functioning in the general population without disturbing or endangering others or himself”).

229. *Brock v. Wright*, 325 F.3d 158, 162 (2d Cir. 2003) (internal quotation marks omitted); see also *Tillery*, 719 F. Supp. at 1286.

230. 511 U.S. 825, 837–38 (1994).

231. *Id.*

232. *Conn v. City of Reno*, 591 F.3d 1018, 1095 (9th Cir. 2010).

233. *Id.*

234. *Id.*

235. See generally, e.g., *Gutwein v. Taos Cty. Det. Ctr.*, No. 1:15-cv-00672, 2017 WL 3602028 (D.N.M. Jan. 20, 2017); *Cantazaro v. Mich. Dep’t of Corr.*, No. 08-11173, 2009 WL 2139210 (E.D. Mich. July 14, 2009); *Rouse v. Caruso*, No. 06-10961, 2009 WL 891728 (E.D. Mich. Mar 31, 2009); *Thomas v. Seago*, No. G-05-0431, 2009 WL 242311 (S.D. Tex. Jan. 30, 2009); *MacDonald v. Schriro*, No. CV 04-1001-PHX-SMM, 2008 WL 2783472 (D. Ariz. July 17, 2008); *Coyle v. Cambra*, No. 02-1810 SBA, 2005 WL 2397517 (N.D. Cal. Sept. 26, 2005).

reached a circuit court of appeals.²³⁶ Additionally, as scholars frequently acknowledge, Eighth Amendment medical and mental health care cases are highly fact specific and can be difficult to win.²³⁷

Federal court challenges to VTC, which have thus far focused only on medical care, are not particularly promising for plaintiffs.²³⁸ In those cases, courts have not second-guessed a corrections department's reliance on the VTC.²³⁹ Instead, courts have been silent on VTC or passingly concluded that it did not pose a quality of care concern as applied to the plaintiff.²⁴⁰ Most courts that have addressed prison VTC have framed any disagreement with its use as a disagreement about "course of treatment," insufficient to support an Eighth Amendment claim.²⁴¹

Although absent clear precedent for such a challenge, it is useful to examine two potentially applicable Eighth Amendment theories. Both of these theories may help a plaintiff overcome a dispositive motion, as has happened in one case involving VTC. Similarly, these theories may help a plaintiff combat a defendant's assertion that a reasonable mental health judgment was made during a VTC evaluation.²⁴² Ultimately, however, even where these strategies are

236. See generally cases cited *supra* note 235. In each of these cases, the losing party did not appeal.

237. See, e.g., Doretha M. Van Slyke, *Hudson v. McMillian and Prisoners' Rights: The Court Giveth and the Court Taketh Away*, 42 AM. U. L. REV. 1727, 1754 (1993) (reasoning that "by creating legal barriers to Eighth Amendment claims through high standards of proof, the Supreme Court makes upholding these rights increasingly difficult"); see also Lori A. Marschke, *Proving Deliberate Indifference: Next to Impossible for Mentally Ill Inmates*, 39 VAL. U. L. REV. 487, 531 (2004) (stating that "proving a 'serious medical need' and subjective deliberate indifference poses exceptionally high hurdles for mentally ill inmates to overcome when attempting to obtain a remedy for a violation of their Eighth Amendment right to adequate mental health care").

238. See generally cases cited *supra* note 235. It is still instructive to examine these cases, however, because courts apply essentially the same test to evaluate cases concerning deliberate indifference to serious medical needs and deliberate indifference to serious mental health needs. *BOSTON & MANVILLE*, *supra* note 220, at 64 n.453 (stating that "[m]ental health care is subject to the same constitutional standard as other forms of prison medical care: deliberate indifference to serious mental health needs violates the Eighth Amendment or, for pretrial detainees, the Due Process Clause").

239. See generally cases cited *supra* note 235.

240. In *MacDonald v. Schriro*, for example, the court held that the plaintiff's right to medical care was not violated without opining on VTC, despite the fact that plaintiff's claim turned on a perfunctory VTC evaluation. 2008 WL 2783472, at *3. In *Coyle v. Cambra*, the court framed plaintiff's disagreement with VTC as a mere disagreement over a course of treatment. 2005 WL 2397517, at *3.

241. See *Coyle*, 2005 WL 2397517, at *3.

242. See *BOSTON & MANVILLE*, *supra* note 220, at 41 n.274.

successful, Eighth Amendment litigation cannot address the geographic problems raised in this Article without a concomitant grassroots approach.

1. *Defendant Failed to Conduct an Adequate Examination, Take an Adequate History, or Ask Necessary Questions*²⁴³

As explained above, scholars have found that VTC hampers communication between physicians and patients and interferes with the development of a therapeutic alliance. Those endemic problems may inform an Eighth Amendment claim under one theory in particular—a plaintiff may bring a claim that the corrections officials were deliberately indifferent to the plaintiff’s serious mental health needs where those officials failed to “inquire into essential facts.” A long line of Eighth Amendment cases has established that such a claim is cognizable if an incarcerated plaintiff was not fully evaluated by prison mental health staff for a known, serious mental health need and was therefore harmed.²⁴⁴

One of the few cases involving VTC at the district court level, *MacDonald v. Schriro*,²⁴⁵ turned on a “failure to inquire into essential facts” theory.²⁴⁶ In *MacDonald*, the plaintiff, Allan S. MacDonald, brought a deliberate indifference claim after a prison physician performed on him an extremely perfunctory VTC knee exam and therefore failed to fully assess his knee injury.²⁴⁷ The court denied the physician defendant’s motion for summary judgment. Although the *MacDonald* court did not squarely address the quality of VTC medical services, one could reasonably conclude from the facts of the case that VTC enabled defendant’s perfunctory approach to MacDonald’s reported ailment.

243. This theory is based upon a theory articulated in *BOSTON & MANVILLE*, *supra* note 220, at 44.

244. *See, e.g.*, *Steele v. Shah*, 87 F.3d 1266, 1271 (11th Cir. 1996) (denying summary judgment to Defendant physician who discontinued plaintiff’s psychotropic medication without reviewing plaintiff’s chart or conducting a proper psychiatric interview); *see also Comstock v. McCrary*, 273 F.3d 693, 711 (6th Cir. 2001) (holding that psychologist’s failure to follow up on clear suicidal ideation supported a deliberate indifference claim).

245. No. CV 04–1001–PHX–SMM (MHB), 2008 WL 2783472, at *3 (D. Ariz. July 17, 2008).

246. *Id.* at *3 (“Therefore, the crux of Plaintiff’s claim against Defendant rests upon his November 6, 2003 telemedicine appointment. Plaintiff asserts that (1) Defendant failed to examine Plaintiff’s knee and ignored Plaintiff’s reported symptoms; (2) Defendant failed to read or obtain a copy of the June 11, 2003 MRI, despite the fact that Plaintiff told Defendant he was reading an outdated MRI . . .”).

247. *Id.*

The record in *MacDonald* reflects that MacDonald received a subpar medical consult chiefly because that consult was conducted via VTC. MacDonald presented evidence that during the course of the VTC consult, the physician never asked him to remove his long pants (which obscured his knee) or stand up.²⁴⁸ The physician instead recommended that MacDonald continue with the previously prescribed course of treatment—a knee brace and inflammatory drugs for pain—despite never having examined the knee or evaluated its health.²⁴⁹ MacDonald implored the physician to conduct a more thorough evaluation and to obtain and review his most recent MRI, to no avail.²⁵⁰ MacDonald saw the physician three years later and ultimately underwent knee surgery shortly thereafter.²⁵¹ During that procedure, the surgeon noted possible recurrent left meniscus tears and a loose bone fragment.²⁵²

MacDonald asserted, among other claims, that the physician acted with deliberate indifference to his serious medical needs by failing to adequately examine his knee during the VTC consult and by ignoring the symptoms he reported during that consult.²⁵³ MacDonald alleged that he attempted to convey to the physician what he was experiencing, and the results of his most recent MRI.²⁵⁴ Instead, the physician refused to review the new MRI or credit MacDonald's report of his condition.²⁵⁵ Although MacDonald did not squarely challenge VTC, he made clear that VTC enabled the physician to all but ignore his assertions.²⁵⁶ One could easily posit that it is much harder to ignore reported symptoms during a one-on-one assessment than it is to ignore them during a VTC consult, particularly where a treating physician is not in the room with the patient and where the patient is not encouraged to develop any real rapport with the VTC consultant.

248. *Id.* at *1.

249. *Id.*

250. *Id.* at *3.

251. *Id.* at *1.

252. *Id.*

253. *Id.* at *3.

254. *Id.*

255. *Id.*

256. The court noted this in finding that the crux of MacDonald's claim against the defendant rested upon his telemedicine appointment. *Id.*

MacDonald did not receive a merits decision in this case, but the court did deny the physician's motion for summary judgment, reasoning that:

A jury could infer that Defendant did not perform a physical examination on Plaintiff's knee on November 6, 2003, did not listen to Plaintiff's symptoms, and did not obtain or review Plaintiff's June 2003 MRI that revealed multiple bone infarcts. The jury could also infer that these actions were deliberate, based on Plaintiff's testimony that he tried to explain to [Defendant] that his injury was new and that a new MRI had been performed, but that Defendant refused to listen.²⁵⁷

The court also found that a reasonable jury could conclude that the defendant's deliberate indifference caused a three-year delay in the plaintiff's surgery, which was sufficient to impose liability.²⁵⁸

MacDonald reifies many concerns about VTC, even as applied to mental health evaluations. Although psychiatrists do not perform physical examinations, they nonetheless must make observations that can be missed over VTC, such as observations of rapid movements and body language.²⁵⁹ Those observations are crucial to proper diagnoses, effective treatment, and the development of an understanding and a rapport between the clinician and the patient.²⁶⁰

MacDonald's legal theory was an effective one and should be considered for use where VTC exacerbates a physician's failure to fully inquire into the conditions of an incarcerated plaintiff. The record in *MacDonald*, and the literature on VTC's deficiencies, make clear that courts should evaluate "failure to inquire" claims involving VTC in a fashion more favorable to the plaintiff. Absent a significant change in the law, however, that is unlikely. Furthermore, a plaintiff who pursues a deliberate indifference claim based upon this theory will have to establish, probably through expert testimony, that VTC does in fact hamper communication and discourage physicians from performing thorough examinations. That claim would be weighed against well-established rules affording deference to prison officials in medical and mental health care cases and deference to professional judgment more generally.²⁶¹

257. *Id.* at *4.

258. *Id.*

259. See discussion *supra* Part I.

260. See discussion *supra* Part I.

261. See BOSTON & MANVILLE, *supra* note 220, at 41 nn.274-75.

2. *Defendant Failed to Remedy Known Systemic Deficiencies, such as an Institutional Lack of Access to Qualified Staff or Repeated Failures to Afford Proper Placement*²⁶²

As explained earlier, some corrections departments have used VTC to avoid Eighth Amendment liability for failure to provide access to qualified specialist staff. For some departments, however, expanded use of VTC may not be enough to avoid such liability.²⁶³ And for departments that do not yet use VTC, the need for mental health services has so far outstripped the availability of qualified medical staff that the federal courts have taken notice.²⁶⁴ In a recent and particularly relevant case, *Braggs v. Dunn*,²⁶⁵ the Middle District of Alabama held that the Alabama Department of Corrections' failure to hire and retain qualified psychiatric staff could support a deliberate indifference claim.²⁶⁶ *Braggs*, particularly its remedial process, is instructive for plaintiffs framing a challenge to VTC mental health treatment.²⁶⁷

Prior to *Braggs*, advocates and journalists had written about the geographic sprawl of the Alabama prison system and its impact upon quality of care.²⁶⁸ In fact, legislation had been introduced to open

262. This theory is based upon a theory articulated in *BOSTON & MANVILLE*, *supra* note 220, at 44, 58–64.

263. Though no court has so ruled, it is clear from precedent in cases turning on the availability of specialist care that any claim involving the provision of VTC as a substitute for in-person specialist care will turn largely upon the qualifications, training, and expertise of VTC consultants in the pertinent area of psychiatry. *See id.* at 44, 46–47.

264. *Braggs v. Dunn*, 257 F. Supp. 3d 1171, 1193 (M.D. Ala. 2017) (“Three conditions contribute to all of the deficiencies in [the Alabama Department of Corrections] treatment of mentally ill prisoners: understaffing of mental-health care providers, understaffing of corrections officers, and overcrowding Correctional and mental-health understaffing, both alone and in combination, impose substantial risks of serious harm to mentally ill prisoners, and overcrowding compounds these risks.”).

265. *Id.*

266. *Id.* at 1208 (“Insufficient mental-health and correctional staffing at [the Alabama Department of Corrections] undermines the availability and quality of individual and group counseling sessions. First, as explained earlier, inadequate mental-health staffing combined with the increasing number of prisoners on the mental-health caseload has driven up the number of prisoners on each counselor’s caseload. As a result, both the frequency and quality of counseling sessions have suffered over time, according to both experts and MHM providers.”).

267. *See generally id.*

268. Kristen Connor, *Governor Bentley Introduces Alabama Prison Transformation Initiative Act*, WHNT NEWS19 (Feb. 23, 2016), <http://whnt.com/2016/02/23/governor-bentley-introduces-alabama-prison-transformation-initiative-act/> [<https://perma.cc/2KWN-PFTB>] (“The . . . design of the facilities are causing inefficiencies in the operation of the prison system, including . . . increasing costs of

new prisons to respond both to that sprawl, and to overcrowding.²⁶⁹ Although most advocates argue that prison expansion is the wrong response to these issues,²⁷⁰ such proposals illustrate the extent to which sprawl has been linked to reduced quality of care in state prison systems.²⁷¹ *Braggs* did not squarely challenge the location of Alabama's prisons, but nonetheless challenged the overcrowding and quality of care issues that are clearly caused by the geographic dispersal of prisons systems.²⁷²

Braggs, a case filed by several prisoners with mental health needs and the Alabama Disabilities Advocacy Program,²⁷³ was split by the court into three phases: Phase 1, Phase 2A, and Phase 2B, the last of which has yet to be fully litigated.²⁷⁴ Phase 1 encompassed ADA and Rehabilitation Act claims by incarcerated persons with physical disabilities.²⁷⁵ The claims in that phase were settled.²⁷⁶ Phase 2A includes Eighth Amendment, ADA, Rehabilitation Act, and due process claims by incarcerated persons with mental health care

transporting inmates from prison to medical care facilities, increasing correctional and support staff costs because of the geographic disparity of the system and the antiquated design of prison facilities, and increasing medical costs due to inefficiencies in delivering medical services to inmates.”).

269. *Id.*; see also *Alabama Initiative to Support Construction of Four New Prisons*, CORR. NEWS (Mar. 9, 2016), <http://correctionalnews.com/2016/03/09/alabama-initiative-support-construction-four-new-prisons/> [<https://perma.cc/BS7N-DQWB>] (“Outdated designs combined with age and deterioration is causing numerous operational problems throughout the prison system. This includes increasing regular maintenance and repair costs, and increasing correctional and support staffing costs because of the geographic disparity of the system.”). The bill was framed as a way to provide higher quality and increased rehabilitative programming.

270. Michelle Chen, *How Closing a Jail Could Make New York City Stronger*, THE NATION (May 17, 2017), <https://www.thenation.com/article/how-closing-a-jail-could-make-new-york-city-stronger/> [<https://perma.cc/4TZW-BCWU>] (explaining Rikers Island's lack of proximity to the families of the incarcerated, lawyers, and social services, and quoting Alyxandra Goodwin of the Black Youth Project in support of full-on jail and prison abolition rather than jail and prison relocation).

271. See Robert J. Bentley, Former Governor of Ala., State of the State Address (Feb. 2, 2016), http://www.al.com/news/birmingham/index.ssf/2016/02/state_of_the_state_full_text_o.html [<https://perma.cc/7TV7-Y5ZQ>] (stating that the Alabama Prison Transformation Initiative Act would close fourteen smaller, geographically disbursed prisons and open four “state of the art” regional prisons).

272. See generally *Braggs v. Dunn*, 257 F. Supp. 3d 1171 (M.D. Ala. 2017).

273. *Id.* at 1178–79.

274. *Id.* at 1181–82. Phase 2B will address Eighth Amendment claims related to medical and dental care. *Id.*

275. *Id.* at 1181 (noting the claims and disposition of Phase 1).

276. See *Braggs v. Dunn*, 318 F.R.D. 652, 658 (M.D. Ala. 2016) (granting final approval of the Phase 1 settlement).

needs.²⁷⁷ The ADA and Rehabilitation Act claims in Phase 2A were settled first.²⁷⁸ The due process challenges to involuntary medication policies and procedures were ultimately settled by the parties as well.²⁷⁹

The Phase 2A Eighth Amendment claims, about which this Article is concerned, went to trial and were resolved on the merits.²⁸⁰ In its lengthy disposition, the court addressed a number of deficiencies in mental health care in Alabama State prisons, including screening, treatment, monitoring, and policies on housing and discipline of people with serious mental health needs.²⁸¹ Deficiencies in each of those areas, driven partially by geographic issues, combined to establish an Eighth Amendment violation in Phase 2A of the litigation.²⁸²

Braggs was fundamentally a challenge to major systemic and institutional deficiencies in mental health care in the Alabama State prisons system.²⁸³ Although the Alabama State prison system's mental health case load consisted of 3400 people at the time of the *Braggs* filing,²⁸⁴ the system had only 346 general population mental health beds and 126 crisis beds.²⁸⁵ The Alabama Department of Corrections, the state agency responsible for operating Alabama's state prisons, contracted with a for-profit entity to provide mental health services in its prisons.²⁸⁶ That entity provided meager numbers of mental health staff, though it repeatedly requested and was denied funding from the Alabama Department of Corrections to provide more staff.²⁸⁷

277. *Braggs*, 257 F. Supp. 3d at 1180 (detailing procedural background of “[t]his extremely complex case”).

278. *See* *Braggs v. Dunn*, 321 F.R.D. 653, 659 (M.D. Ala. July 25, 2017) (granting final approval of settlement of ADA and Rehabilitation Act claims for incarcerated persons with only mental disabilities). While the court did not issue an opinion and final order until July, a preliminary approval of the settlement had been issued in February of 2017. *Id.*

279. *See* *Braggs v. Dunn*, No. 2:14cv601-MHT, 2017 WL 5665334, at *1, *9 (M.D. Ala. Nov. 27, 2017) (outlining the court's rationale in approving the settlement on September 6, 2017).

280. *Braggs*, 257 F. Supp. 3d at 1180.

281. *Id.* at 1267–68.

282. *Id.* at 1267 (“Simply put, [the Alabama Department of Corrections’] mental-health care is horrendously inadequate.”).

283. *Id.* at 1180 (“The plaintiffs assert that the State of Alabama provides constitutionally inadequate mental-health care in prison facilities[.]”).

284. *Id.* at 1181.

285. *See id.* at 1182–83.

286. *Id.* at 1183–84.

287. *Id.* at 1194.

The court found that lack of mental health staff and general prison overcrowding caused several instances of harm and substantial risks of harm sufficient to find Eighth Amendment violations on behalf of a class of individuals with mental health needs.²⁸⁸ Those systemic risks included: an inadequate intake process; inadequate referral process; inadequate classification of mental health needs; inadequate utilization of mental health units; inadequate treatment planning; inadequate psychotherapy; improper use of mental health units; inadequate out-of-cell time and programming; inadequate suicide prevention and crisis care; failure to provide crisis treatment to those who need it; placement of people who need crisis cells into an inappropriate environment; unsafe crisis cells; inadequate monitoring of individuals displaying suicidality; inappropriate release from suicide watch; and inadequate follow up.²⁸⁹

The remedial process of Phase 2A of *Braggs* continues as of January 2018.²⁹⁰ Advocates should follow that process closely.²⁹¹ If the Alabama Department of Corrections closes some of its mental health treatment resource gaps by utilizing VTC, it may ultimately fail to provide treatment of the quality it could provide with a sufficient number of on-site mental health professionals.²⁹² *Braggs* will provide a blueprint case theory for addressing deficiencies attendant to

288. *Id.* at 1193. The Commissioner of the Alabama Department of Corrections described his own prison system as “wrestling with a ‘two-headed monster’: overcrowding and understaffing.” *Id.* at 1184. The court noted overcrowding, understaffing, and the compounding risks associated with both conditions throughout its opinion. *See, e.g., id.* at 1194–95 (“The sheer magnitude of overcrowding within [the Alabama Department of Corrections] has meant that some [Alabama Department of Corrections] facilities . . . house more than double the number of prisoners they are designed to hold [The Alabama Department of Corrections] has maintained mental-health staffing levels that are chronically insufficient across disciplines and facilities. Witness after witness identified significant mental-health staffing shortages as one of the major reasons for [the Alabama Department of Corrections] inability to meet the rising mental health care needs of prisoners.”).

289. *See id.* at 1192–93. The court discusses each of these risks in great detail. *See generally id.* at 1191–1250.

290. *See* Phase 2A Order Modifying Order on Hospital-Level Care Remedy, *Braggs v. Dunn*, No. 2:14-cv-601-MHT (M.D. Ala. Jan. 11, 2018) (No. 1542) (scheduling hearings for January 29, 2018 and February 5, 2018 to address part of remedial steps).

291. It remains to be seen whether the remedy will satisfy the court’s call for immediate and long-term solutions. *See Braggs*, 257 F. Supp. 3d at 1268 (“The court emphasizes that given the severity and urgency of the need for mental-health care explained in this opinion, the proposed relief must be both immediate and long term.”).

292. For examples of the deficiencies that may accompany the use of VTC in this remedial process, see *supra* Section I.B.

VTC,²⁹³ as VTC leads to many of the same risks of harm already identified by the court.²⁹⁴ If the remedial process does not make a major systemic impact, *Braggs* will demonstrate what other cases have demonstrated—that courts have limited power to address the underlying geographic sprawl that creates the resource problems they identify.²⁹⁵

In *Coyle v. Cambra*²⁹⁶ and *Rouse v. Caruso*,²⁹⁷ courts addressed similar systemic issues, although those issues were not framed through a geographic lens. In *Coyle*, plaintiff Travis Coyle brought a deliberate indifference claim based upon defendants' failure to provide "adequate, timely, and necessary specialist medical care" for his knee.²⁹⁸ Before he brought the case, Coyle filed a prison grievance and requested a meeting with an orthopedist concerning his knee injury, only to receive a response over two weeks later stating that because the prison's contract with orthopedists had expired and had not been renewed, he would have to be seen through telemedicine.²⁹⁹ Coyle appealed that grievance response five days later, explicitly arguing that telemedicine was inadequate.³⁰⁰ He did not receive a response to that appeal, but was eventually seen a second time by the prison's primary care physician instead, who decided to continue to treat Coyle with medication for his condition and await the telemedicine conference.³⁰¹ The telemedicine conference never took place because the applicable waiting list was full and the prison entered into a new contract with an on-site orthopedist before Coyle advanced on that list.³⁰²

To support his deliberate indifference claim, Coyle alleged that specialists simply were not available during contract renegotiations, implying that telemedicine did not afford true access to specialists.³⁰³

293. See generally *Braggs*, 257 F. Supp. 3d at 1267–68 (detailing the scope of the Eighth Amendment violations).

294. See discussion *supra* Section I.B (highlighting deficiencies in VTC mental health treatment through correspondence between the Justice Center and Disability Rights New York and DOCCS and OMH regarding the use of VTC in New York State prisons).

295. The *Braggs* court, despite issuing a lengthy opinion, did not address the state of prison mental health in Alabama through a geographic lens.

296. No. C 02-1810 SBA PR, 2005 WL 2397517 (N.D. Cal. Sept. 26, 2005).

297. No. 06-10961, 2009 WL 891728 (E.D. Mich. Mar 31, 2009).

298. *Coyle*, 2005 WL 2397517, at *7.

299. *Id.* at *3–4.

300. *Id.* at *4.

301. *Id.*

302. *Id.*

303. *Id.* at *7.

The Court disagreed with Coyle and granted summary judgment to defendants.³⁰⁴

Coyle's argument was similar to the plaintiff's argument in *MacDonald v. Schriro*,³⁰⁵ discussed above. MacDonald was subjected to the exact type of telemedicine consultation that Coyle sought to avoid³⁰⁶—a perfunctory assessment by a clinician who neither credited the patient's complaints nor fully examined relevant records.³⁰⁷ Like MacDonald, Coyle argued that the VTC medium aided the incompleteness of his consultation.³⁰⁸ Unfortunately, the court did not evaluate Coyle's VTC argument that telemedicine was inadequate and that therefore necessary specialist care was not made available.³⁰⁹ Instead, the court endorsed the defendants' argument that the defendants were not responsible for the delay and that, in consideration of Coyle's multiple appointments with medical staff between 2000 and 2002, he received reasonable care under the circumstances.³¹⁰

The court held that even if the defendants were negligent, negligence is not sufficient to support a deliberate indifference claim.³¹¹ Neither are most “[differences] of medical opinion,” which is how the court described the dispute between Coyle and the defendants.³¹² The court emphasized that a plaintiff can make out a deliberate indifference claim based upon a difference of opinion only where they can show that the course of treatment doctors performed was “medically unacceptable under the circumstances” and chosen in “disregard of an excessive risk to plaintiff's health.”³¹³ In this particular situation, the court pointed to the fact that the physicians had seen the plaintiff and had evaluated his symptoms in response to his complaints, and that plaintiff's allegations therefore did not rise beyond a simple difference of opinion.³¹⁴ The court therefore granted

304. *Id.* at *15.

305. No. CV 04-1001-PHX-SMM (MHB), 2008 WL 2783472, at *3 (D. Ariz. July 17, 2008).

306. *Coyle*, 2005 WL 2397517, at *3.

307. *Compare Coyle*, 2005 WL 2397517, at *9-12, *with MacDonald*, 2008 WL 2783472, at *1.

308. *Coyle*, 2005 WL 2397517, at *9-12.

309. *Id.* at *9-13.

310. *Id.*

311. *Id.* at *8.

312. *Id.*

313. *Id.*

314. *Id.* at *9.

the defendants' motion for summary judgment, holding that Coyle had not made such showing.³¹⁵

A major difference between *MacDonald* and *Coyle* is that MacDonald confined his argument to the quality of the evaluation he personally received, whereas Coyle explicitly tied his argument to his displeasure with VTC as a medium.³¹⁶ The *Coyle* court did not consider that disagreement, but confined its analysis to the quality of care that Coyle received.³¹⁷ This distinction is material in our assessment of whether courts are willing to address systemic issues related to the provision of VTC, or are more likely to address VTC's deficiencies as applied to particular plaintiffs.

In *Rouse v. Caruso*, the Eastern District of Michigan similarly confined its analysis and failed to reach the systemic issue raised by the plaintiff.³¹⁸ The *Rouse* court held that it could not enjoin the Michigan Department of Corrections's telemedicine policy as the plaintiff, Arthur Rouse, had not proven that it was unconstitutional.³¹⁹ Rouse had alleged—and the defendants did not dispute—that the Michigan Department of Correction did not maintain medical staff at the Mid-Michigan/Pine River Correctional Facility³²⁰ after 8:00 p.m. or on the weekends, and that telemedical services were afforded only during “life threatening emergencies” pursuant to the applicable policy.³²¹ The defendants admitted that staff vacancies had caused a reduction in hours and that the inability to fill those vacancies was caused by the absence of viable candidates, but maintained that “just because Mid-Michigan does not have medical staff present in the facility for eight hours a day does not establish that Plaintiff has not received adequate or appropriate

315. *Id.* at *13.

316. Compare *MacDonald*, 2008 WL 2783472, at *3, with *Coyle*, 2005 WL 2387517, at *3.

317. *Coyle*, 2005 WL 2397517, at *8.

318. *Rouse v. Caruso*, No. 06-10961, 2009 WL 891728, at *8 (E.D. Mich. Mar 31, 2009).

319. *Id.*

320. Mid-Michigan Correctional Facility and Pine River Correctional Facility have since been consolidated. The consolidated facility is called Central Michigan Correctional Facility. *Prison Directory*, MICH. DEP'T OF CORR., http://www.michigan.gov/corrections/0,4551,7-119-68854_1381_1385--,00.html [<https://perma.cc/DG28-YSE7>]. It is located in Gratiot County, Michigan, an area noted for its lack of physicians. CITIZENS RESEARCH COUNCIL OF MICH., WHERE ARE THE PRIMARY CARE DOCTORS? A LOOK AT MICHIGAN'S PRIMARY CARE PHYSICIAN SHORTAGE 7-11, app. B (2015).

321. *Rouse*, 2009 WL 891728, at *4.

medical care.”³²² The defendants disputed Rouse’s reading of the applicable telemedicine policy, which was that the policy permitted diagnoses over the phone.³²³ Although it did not resolve the factual dispute regarding the applicable telemedicine policy, the court determined that any decision to enjoin the policy would be premature, albeit acknowledging that the policy could be read to permit phone diagnoses.³²⁴

B. A Grassroots Approach is Necessary to Correct the Systemic Problems Litigation Usually Cannot Address

As illustrated above, the viability of challenging VTC using an Eighth Amendment theory is questionable at best. Most advocates agree that VTC is here to stay and devote attention to either closing the general prison medical care resources gap,³²⁵ or to other initiatives that promise to improve prison medical care generally.³²⁶ One such initiative is the closure of prisons and their relocation to more resource-rich areas, both as a response to medical and mental health resource issues and as a response to other problems caused by prisons’ geographic isolation.³²⁷ Those initiatives, particularly where pursued by grassroots organizations, have at times succeeded.³²⁸ They present greater prospects for successful systemic change than

322. *Id.* at *5.

323. *Id.* at *6.

324. *Id.* at *8.

325. The American Civil Liberties Union, Perkins Coie, Jones Day, and the Arizona Center for Disability Law, for example, recently settled a case against several Arizona Department of Corrections senior officials. Included in the stipulation of settlement is a provision that requires the Arizona Department of Corrections to provide telemedicine practitioners with their patient’s recent medical records before a telemedicine consultation. Stipulation at 12, *Parsons v. Ryan*, No. CV 12-00601-PHX-DJH (D. Ariz. Oct. 14, 2014); *see also* Ollove, *supra* note 46 (“[David] Fathi, of the [American Civil Liberties Union], said too often, doctors practicing telemedicine on inmates don’t have their full medical histories. That was a federal court’s finding in a recent lawsuit concerning prison health care in Arizona penitentiaries. One provision of the court-approved settlement in the case requires mental health providers practicing telemedicine on prisoners be provided with their recent medical records, including laboratory results. ‘Telemedicine does offer some positives but it is never going to be as good as having an on-site physician who can perform hands-on diagnosis and treatment,’ Fathi said.”).

326. *See, e.g.*, CORR. ASS’N OF N.Y., HEALTH CARE IN NEW YORK STATE PRISONS: A REPORT OF FINDINGS AND RECOMMENDATIONS BY THE PRISON VISITING COMMITTEE OF THE CORRECTIONAL ASSOCIATION OF NEW YORK 69–80 (2000), <https://static.prisonpolicy.org/scans/healthcare.pdf> [<https://perma.cc/VZ5L-VHY4>].

327. *See* discussion *infra* Part III.

328. *See* discussion *infra* Part III.

does litigation alone, as they address the underlying geographic cause of VTC, not merely the problems VTC causes.

III. A GRASSROOTS SOLUTION TO THE GEOGRAPHIC CRISIS CAUSING SUBPAR PRISON MENTAL HEALTH TREATMENT

The litigation landscape cannot singlehandedly improve VTC, reverse its use, or cure the geographic problems causing its use.³²⁹ But even where litigation is the best tool, and even where it succeeds, it often creates only fleeting change.³³⁰ That is because no litigation lasts forever, and lawyers representing defendants in civil rights cases use ample tools—sunset dates, termination motions, and the like—to skirt permanent implementation of private settlement agreements and consent decrees.³³¹ In the prison and jail context, some of those tools were created by the Prison Litigation Reform Act, which limits the scope and duration of consent decrees.³³² Because of litigation’s structural limitations, it is an imperfect tool to achieve widespread systemic change.³³³ When paired with grassroots activism, however, litigation serves as a much more potent tool to create that change.³³⁴

Two New York-based organizations are most instructive in pairing grassroots and litigation models—Mental Health Alternatives to Solitary Confinement (“MHASC”),³³⁵ and #CLOSErikers.³³⁶ Neither

329. See *supra* Section II.A (discussing the Eighth Amendment framework).

330. See generally Beth Van Schaack, *With All Deliberate Speed: Civil Human Rights Litigation as a Tool for Social Change*, 54 VAND. L. REV. 2305 (2004) (“[T]his essay cautions that such litigation should not replace other forms of human rights advocacy. An over-reliance on adversarial litigation, as opposed to other processes to promote durable social change and the ability of the judicial process to address major social and economic problems.”).

331. A sunset date is a date upon which a private settlement agreement or a consent decree will end. Defendants often attempt good faith implementation of a private settlement agreement only until the sunset date. If the parties have not agreed on a sunset date, defendants may file a termination motion and argue that they have substantially complied with the terms of the agreement.

332. See 18 U.S.C.A. § 3626 (West 2017).

333. Ronald Slye, *Community Institution Building: A Response to the Limits of Litigation in Addressing the Problem of Homelessness*, 36 VILL. L. REV. 1035, 1045, 1049–54 (1991) (explaining why litigation is “a poor tool for comprehensively addressing broad and complex social issues that require long-term structural solutions” irrespective of the doctrinal landscape).

334. Sheila R. Foster & Brian Glick, *Integrative Lawyering: Navigating the Political Economy of Urban Redevelopment*, 95 CAL. L. REV. 1999, 2057–61 (2007); Judith E. Kroons, *Fair Housing and Community Empowerment: Where the Roof Meets Redemption*, 4 GEO. J. ON FIGHTING POVERTY 75, 87–93 (1996).

335. *Hearing on Mental Illness in Correctional Settings Before the New York State Assembly Standing Committees on Correction and Mental Health*, 2014 Leg. (2014) (statement of Mental Health Alternatives to Solitary Confinement, describing the

organization has litigated in its own name, but both count among its members people who have litigated to combat the issues the respective groups were formed to combat and both organizations have utilized litigation in their multi-pronged advocacy efforts.³³⁷ Although MHASC and #CLOSErikers do not focus solely on prison siting issues, each has included those issues in their analyses.³³⁸ They have secured major positive changes in the allocation of prison and jail resources, and can serve as models for the multi-pronged strategies advocates should use to reduce the sprawl of the New York State prison system and force DOCCS and OMH to utilize the mental health resources that exist only near urban centers.³³⁹

MHASC provides the best example of a grassroots organization channeling a major litigation victory into permanent change. Prior MHASC's creation, lawyers had worked since the 1980s to improve the treatment of people with mental health needs in solitary confinement in New York State, predominantly through litigation.³⁴⁰ For example, the State settled *Langley v. Coughlin*,³⁴¹ *Eng v. Goord*,³⁴² and *Anderson v. Goord*³⁴³ in the 1980s and 1990s, all of which challenged subpar mental health treatment in New York's

organization as "a coalition of more than sixty organizations and hundreds of concerned citizens, advocates, mental health and criminal justice professionals, formerly incarcerated people, and their family members [that advocates] for humane criminal justice policies for people with psychiatric disabilities").

336. #CLOSERIKERS, <http://www.closerikers.org/> [<https://perma.cc/E9Z8-Y4FB>]. Other organizations, such as the Committee to End the Marion Lockdown, the New York City Jails Action Coalition, and Critical Resistance have combatted prison siting issues and problems attendant to the geography of America's mass incarceration epidemic. Those organizations have further illustrated the power of multi-pronged, grassroots approaches, though their work is not addressed in this Article.

337. See discussion *infra* Part III.

338. Tanya Christian, *#CLOSErikers: Here's Why the Entire Country Should Be Paying Attention*, ESSENCE (May 8, 2017), <https://www.essence.com/news/glenn-martin-close-rikers-campaign> [<http://perma.cc/5SCM-7UFA>] (quoting Glenn Martin, founder of #CLOSErikers, concerning the unique issue of Rikers Island's location); see also 2017 Meeting Minutes, *supra* note 190.

339. See discussion *infra* Part III.

340. See discussion *infra* Part III.

341. Stipulation and Order, *Langley v. Coughlin*, 84 Civ. 5431 (S.D.N.Y. Dec. 27, 1989).

342. Settlement Agreement, *Eng v. Goord*, 80 Civ. 385S (W.D.N.Y. Mar. 8, 1998). For the report required by *Eng*, see STUART GRASSIAN, *ENG SITE VISIT ONE* (1999), https://www.hrw.org/reports/2003/usa1003/Grassian_Report_Eng_Site_Visit_One.pdf [<https://perma.cc/F7A9-25V2>].

343. Settlement Agreement, *Anderson v. Goord*, 87 Civ. 141 (N.D.N.Y. Dec. 16, 2003) (on file with author).

prisons, particularly for people in solitary confinement. *Langley*,³⁴⁴ in particular, was brought on behalf of a class of individuals incarcerated at Bedford Hills Correctional Facility. Those cases brought temporary change to individual facilities, but did not have the type of lasting systemic impact plaintiffs had hoped for.³⁴⁵ In fact, over fifteen years after the *Langley* Stipulation³⁴⁶ was implemented, incarcerated individuals with serious mental health needs continued to be placed in solitary confinement not only at Bedford Hills Correctional Facility, but statewide.³⁴⁷

Community activists, advocates, and lawyers determined that they could address systemic problems only by developing a new grassroots strategy guided by people directly affected by those problems. They envisioned a movement that used three tools—litigation, legislation, and public education—rather than a movement that fought battles only in the courtroom.³⁴⁸ MHASC was created shortly before *Disability Advocates, Inc. v. New York State Office of Mental Health* was filed, in pursuit of that type of movement.³⁴⁹ Both before and during the litigation, members of MHASC engaged in a public education campaign concerning the issues raised in the litigation.³⁵⁰ They attended community meetings with the National Alliance on Mental Illness³⁵¹ and New York Association of Psychiatric Rehabilitation Services,³⁵² testified at public hearings on mental

344. *Langley*, 84 Civ. 5431.

345. *Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences, Hearing Before the Sen. Judiciary Subcomm. on the Constitution, Civil Rights, and Human Rights*, 112th Cong. 2–3 (2012) (statement of Sarah Kerr, Staff Attorney, Legal Aid Society, Prisoners' Rights Project).

346. *Langley*, 84 Civ. 5431.

347. Sarah Kerr, *Litigation and Legislation Efforts to Improve Mental Health Treatment for Prisoners in New York*, in PRACTICING LAW INSTITUTE PRISON LAW 2010, at 15 (2010) (on file with author).

348. *See Implementation of Special Housing Unit (SHU) Exclusion Law Providing Effective Mental Health Treatment in Prison Suicides, Hearing Before the Assemb. Comms. on Corr. & Mental Health*, 2011 Leg. 2 (2011) (statement of Sarah Kerr, Staff Attorney, Legal Aid Society, Prisoners' Rights Project).

349. *See id.*; Press Release, N.Y. Ass'n of Psychiatric Rehabilitation Servs., GNS, TU: Sponsors Pledge SHU Bill Passage to Assure Permanent Policy Change in NYS (Apr. 18, 2007); *see also History*, MENTAL HEALTH ALTERNATIVES TO SOLITARY CONFINEMENT, <https://boottheshu.wordpress.com/history/> [<https://perma.cc/2YG4-UJ9W>]; discussion *supra* Introduction.

350. *See* sources cited *supra* notes 348–49.

351. For more information on this institution, see NAT'L ALL. ON MENTAL ILLNESS, <https://www.nami.org/> [<https://perma.cc/3E88-C5HK>].

352. For more information on this institution, see N.Y. ASS'N OF PSYCHIATRIC REHABILITATION SERVS., INC., <http://www.nyaprs.org/> [<https://perma.cc/5E93-FZAZ>].

health care in state prisons,³⁵³ and prepared reports about the mistreatment of people with mental health needs in solitary confinement.³⁵⁴ MHASC's public education campaign created the groundswell for the first iteration of the SHU Exclusion Bill, introduced in 2003.³⁵⁵ By the time *Disability Advocates, Inc.* had settled,³⁵⁶ the second iteration of the SHU Exclusion Bill had already passed the New York State Legislature and been vetoed by then Governor George Pataki.³⁵⁷

Because of the sustained public pressure created by MHASC, that veto did not kill the bill. The bill also did not die in its third iteration, which passed the New York State Legislature but was amended after further negotiation with the governor's office.³⁵⁸ In 2008, less than a year after the state settled *Disability Advocates, Inc.*, a then-amended SHU Exclusion Bill was passed and signed into law by Governor Spitzer.³⁵⁹ Governor Paterson later proposed amendments to the SHU Exclusion Law that would have undercut many of the law's specific requirements.³⁶⁰ Thanks in part to the impact of MHASC's public education campaign, the legislature rejected those changes after a lengthy hearing.³⁶¹ The SHU Exclusion Law has helped to mitigate the impact of the end of the *Disability Advocates, Inc.* settlement in late 2011.³⁶²

353. See Press Release, Mental Health Alternatives to Solitary Confinement, As Bill Ending State's Practice of Solitary Confinement of Prisoners Moves Ahead in NYS Legislature, Advocates Call for Prompt Passage and Approval by Governor in the Twelve Remaining Days of Session (2007), https://mhp.urbanjustice.org/sites/default/files/MHASC_Press_Release_2007.pdf [<https://perma.cc/64MJ-RC4M>].

354. See *id.*; see also *Historical Documents*, MENTAL HEALTH ALTERNATIVES TO SOLITARY CONFINEMENT, <https://boottheshu.wordpress.com/history/historical-documents/> [<https://perma.cc/W84H-SG25>].

355. A.B. A08849A, Reg. Sess. 2003–2004 (N.Y. 2003).

356. See Private Settlement Agreement, *supra* note 25, at 31.

357. See A.B. A3926A, Reg. Sess. 2005–2006 (N.Y. 2006); S.B. S2207C, Reg. Sess. 2005–2006 (N.Y. 2006); see also Sol Wachtler, Opinion, *A Cell of One's Own*, N.Y. TIMES (Sept. 24, 2006), <http://www.nytimes.com/2006/09/24/opinion/nyregionopinions/24CIwachtler.html> [<https://nyti.ms/2FnsOfW>].

358. See A.B. A4870, Reg. Sess. 2007–2008 (N.Y. 2007); S.B. S00333B, Reg. Sess. 2007–2008 (N.Y. 2007); “*Boot the SHU*” *Bill Becomes Law in New York*, 18 PRO SE MAG., Winter 2008, at 2 (“Governor Spitzer’s office worked with Assembly and Senate leaders to modify the bill in accordance with information from DOCS and OMH leadership.”).

359. See A.B. A09342, Reg. Sess. 2007–2008 (N.Y. 2008); S.B. S06422, Reg. Sess. 2007–2008 (N.Y. 2008); see also 2008 N.Y. Sess. Laws 1 (McKinney).

360. See sources cited *supra* notes 348–49.

361. See sources cited *supra* notes 348–49.

362. Private Settlement Agreement, *supra* note 25, at 27.

Although the SHU Exclusion Law did not codify all of the protections of the *Disability Advocates, Inc.* private settlement agreement, it codified many of the most crucial ones.³⁶³ Most notably, the SHU Exclusion Law greatly restricted the placement of individuals with serious mental health needs in solitary confinement.³⁶⁴ As opposed to the litigation-only strategies pursued during the 1980s and 1990s, the three-prong strategy utilized during the 2000s through MHASC achieved a more sustained systemic impact.³⁶⁵ Although problems remain, quality of care has improved and the census of people with mental health needs in solitary confinement has dropped.³⁶⁶ MHASC achieved ever-elusive systemic change.

Without MHASC's work, the *Disability Advocates, Inc.* private settlement agreement³⁶⁷ may have suffered the dismal fate of similar agreements in prison cases—defendants may have been tempted to dismantle any gains won by litigators after the end of monitoring and the conclusion of the settlement's term.³⁶⁸ Today, MHASC continues to build upon the SHU Exclusion Law in its biannual meetings with the Justice Center and its close collaboration with other advocacy groups to expand mental health treatment options in the state

363. See discussion *supra* Section II.A (detailing the private settlement agreement and the SHU Exclusion Law).

364. N.Y. CORRECT. LAW § 137.6(d)(i) (McKinney 2017).

365. Kerr, *supra* note 347, at 15–22.

366. *Mental Health Services in NY Prisons, Hearing Before the Assemb. Comms. on Corr. & Mental Health 1* (2014) (statement of Jack Beck, Dir., Prison Visiting Project, Corr. Ass'n of N.Y.) (“As a result of intense scrutiny and demand for enhanced services by prison mental health patients, their families, the legislature, courts, and prison and mental health advocates, DOCCS and OMH have increased and in some cases improved mental health services over the last decade. Most significantly, in large part because of a 2007 litigation settlement in *Disability Advocates, Inc. v. New York State Office of Mental Health*, and the Special Housing Unit (SHU) Exclusion Law—passed by the NYS legislature in 2008 and gone into full effect in July 2011—there has been a diversion of people with the most serious mental illness (SMI or S-designated) from solitary confinement, and a substantial increase in the number of both disciplinary and non-disciplinary Residential Mental Health Treatment Units (RMHTUs).”).

367. See generally Private Settlement Agreement, *supra* note 25.

368. See, e.g., *Health Care in New York State Prisons, Hearing Before the Assemb. Comms. on Corr. & Health*, at 5–7 (Oct. 30, 2017) (statement of Stefan R. Short, Staff Attorney, Prisoners' Rights Project of the Legal Aid Society of N.Y.C.) (concerning the dismantling of the reforms mandated by the consent decree in *Milburn v. Coughlin*, 79 Civ. 5077 (S.D.N.Y. 1991) (modified final judgment)); see also Letter from author to Cathy Sheehan, Deputy Counsel, N.Y. Dep't of Corr. & Cmty. Supervision, 1–2 (Aug. 29, 2017) (concerning DOCCS's rollback of a major reform mandated by the private settlement agreement in *Medina v. Fischer*, 11-cv-176 (S.D.N.Y. 2014) which had expired in May 2017).

prisons.³⁶⁹ MHASC's work achieved the re-allocation of state resources to provide improved and more widespread treatment options for incarcerated individuals with mental health needs.³⁷⁰ Although geographic problems remain, the resource re-allocation that drove the implementation of the SHU Exclusion Law is proof of what is possible.

#CLOSErikers is another example of a movement that has built off of the success of decades of litigation and public advocacy by not only lawyers, but advocates, activists, and, most notably, people who are directly impacted by the scourge of Rikers. Rikers Island is a 400-acre island in the East River that serves as New York City's main jail complex.³⁷¹ The island is notorious for its culture of violence and staff brutality, inhumane conditions of confinement, and woeful medical and mental health treatment.³⁷² Family members, friends, and advocates must make an arduous journey to reach the island, because of its remote geographic location and poor public transportation options.³⁷³ Each of these problems has been documented extensively over several decades in multiple forums—newspapers have written about them,³⁷⁴ federal courts have documented them in their opinions,³⁷⁵ and advocates have testified to

369. See, e.g., 2017 Meeting Minutes, *supra* note 190.

370. See discussion *supra* Part III.

371. Michael Schwartz, *What Is Rikers Island?*, N.Y. TIMES (Apr. 5, 2017), <https://www.nytimes.com/2017/04/05/nyregion/rikers-island-prison-new-york.html> [<https://nyti.ms/2oJAH6O>].

372. See, e.g., U.S. ATTORNEY FOR THE S. DIST. OF N.Y., U.S. DEP'T OF JUSTICE, CRIPA INVESTIGATION OF THE NEW YORK CITY DEPARTMENT OF CORRECTION JAILS ON RIKERS ISLAND 4–51 (2014), <https://www.justice.gov/sites/default/files/usao-sdny/legacy/2015/03/25/SDNY%20Rikers%20Report.pdf> [<https://perma.cc/4QPB-2V DK>] (regarding a Civil Rights of Institutionalized Persons Act investigation of the New York City Department of Correction jails on Rikers Island); see also Dana Goldstein et al., *Inside Rikers Island, by the People Who Live It*, N.Y. MAG. (Jun. 28, 2015, 9:00 PM), <http://nymag.com/daily/intelligencer/2015/06/inside-rikers-island-interviews.html> [<https://perma.cc/YV3R-LDRW>].

373. See Edgar Sandoval & Sarah Ryley, *Activists Slam de Blasio's Plan to Renovate Rikers Island 'Hell,'* N.Y. DAILY NEWS (Mar. 18, 2017, 11:41 AM), <http://www.nydailynews.com/new-york/activists-slam-de-blasio-plan-renovate-rikers-island-hell-article-1.3002003> [<https://perma.cc/G6NB-CEJ5>] (discussing Rikers Island's remote location).

374. See, e.g., The Editorial Board, Opinion, *A Culture of Violence on Rikers Island*, N.Y. TIMES (Aug. 5, 2014), <https://www.nytimes.com/2014/08/06/opinion/a-culture-of-violence-at-rikers-island.html> [<https://nyti.ms/2Fkmd5Z>].

375. See, e.g., *Fisher v. Koehler*, 692 F. Supp. 1519, 1521 (S.D.N.Y. 1988) (“Systematic deficiencies in the operation of [the Correctional Institution for Men on Rikers Island], most significantly, overcrowding, overreliance on open dormitory housing, lack of adequate classification, inadequate staffing and supervision, and inadequate systems for controlling, investigating and disciplining misuse of force have

them in front of New York City Council³⁷⁶ and the New York City Board of Correction.³⁷⁷

#CLOSErikers is a movement led by formerly incarcerated individuals who are affiliated with the nonprofit JustLeadershipUSA.³⁷⁸ #CLOSErikers kicked off its work in 2016 and within one year, it achieved its core demand: in 2017, New York City Mayor Bill de Blasio committed to closing Rikers.³⁷⁹ The success of #CLOSErikers is tied in large part to a multi-pronged effort spanning many decades.

For decades, horrendous conditions at Rikers have been the subject of litigation and advocacy. By many accounts, New York City's modern jail reform saga began in 1970 with the death of Young Lord Julio Roldán at Manhattan Detention Center, often referred to as "the Tombs."³⁸⁰ Roldán's death mobilized the community against the decrepit conditions in the New York City jails, and mobilized the

led to a world where inmates suffer physical abuse, both by other inmates and by staff, in a chillingly routine and random fashion.”).

376. See generally, e.g., *Examining Violence in New York City Jails and the City's Response, Oversight Hearing Before the New York City Council* (May 6, 2015) (statement of the N.Y. Civil Liberties Union), <https://www.nyclu.org/en/publications/testimony-regarding-city-councils-examination-violence-nycs-jails> [<https://perma.cc/5S6R-WFGX>].

377. *Hearing on Proposed Rule Regarding Enhanced Supervision Housing, Before the N.Y.C. Bd. of Corr.*, at 8–9 (Dec. 19, 2014) (statement of Gabrielle Horowitz-Prisco, Dir., Juvenile Justice Project, Corr. Ass'n of N.Y.), [http://www1.nyc.gov/assets/boc/downloads/pdf/Correctional%20Association%20\(Revised%20and%20Original\).pdf](http://www1.nyc.gov/assets/boc/downloads/pdf/Correctional%20Association%20(Revised%20and%20Original).pdf) [<https://perma.cc/FWQ8-2Q65>] (“In discussing the sheer brutality children and adults on Rikers Island face day in and out, we want to acknowledge that these problems long preceded the current Department of Correction (DOC) and city administration The Department of Justice Report is shocking not for its revelations—the violence on Rikers, including that against children, was made public long ago. What is shocking is how little has been done to protect the children and adults on Rikers, despite this knowledge. The tentacles of brutality on Rikers are historic and deep.”).

378. See *JustLeadershipUSA—Campaign to Close Rikers*, OPEN PHILANTHROPY PROJECT (Feb. 2016), <https://www.openphilanthropy.org/focus/us-policy/criminal-justice-reform/justleadershipusa-close-rikers-campaign> [<https://perma.cc/DSU2-M5PC>].

379. See Bill de Blasio, Mayor of the City of New York, Statement from Mayor Bill de Blasio on Closure of Rikers Island (Mar. 31, 2017), <http://www1.nyc.gov/office-of-the-mayor/news/193-17/statement-mayor-bill-de-blasio-closure-rikers-island#/0> [<https://perma.cc/F6ZS-TFDR>]; see also *How Do We Close Rikers?*, #CLOSERIKERS (Oct. 3, 2017), <http://www.closerikers.org/wp-content/uploads/2017/10/closerikers-10years-demands.pdf> [<https://perma.cc/5D83-DKCR>].

380. See Jason B. Nicholas, *A History of Hell: How Rikers Island Became a Modern Municipal Abomination*, VILLAGE VOICE (Apr. 11, 2017), <https://www.villagevoice.com/2017/04/11/a-history-of-hell-how-rikers-island-became-a-modern-municipal-abomination/> [<https://perma.cc/LH5V-E453>].

New York City Board of Correction and the Legal Aid Society to take action.³⁸¹ The Legal Aid Society subsequently filed several major cases about conditions in the New York City jails, including Rikers Island.³⁸²

One outcome of this litigation was that it forced city officials, at least briefly, to confront the problems stemming from the geographic isolation of Rikers Island. In 1978, with numerous class actions still pending and with conditions in city jails at a nadir, Mayor Ed Koch appointed Herb Sturz Deputy Mayor for Criminal Justice.³⁸³ Deputy Mayor Sturz was keenly aware of the conditions in the city jails and endeavored to fix them.³⁸⁴ As a first step, he agreed to consolidate and settle pending class action cases concerning conditions on Rikers Island and he proposed to sell the island to New York State and move detainees to new, modern facilities in each borough.³⁸⁵ He was later quoted as stating that the idea was to “put[] accused persons right near the courthouse and closer to their families.”³⁸⁶ Unfortunately, that plan fell through due to pushback from unions and uncertain legislative prospects.³⁸⁷ In the 1980s and 1990s, before Rikers could be “fixed,” “tough on crime” policies and the city’s response to the crack epidemic combined to balloon the population on Rikers Island and in other city jails.³⁸⁸ As discussed earlier, the criminalization of mental health needs also played a role in this development.³⁸⁹

381. *See id.*

382. *See, e.g.,* Arroyo v. Schaefer, 548 F.2d 47, 48 (2d Cir. 1977); Detainees of Brooklyn House of Det. v. Malcolm, 520 F.2d 392, 394 (2d Cir. 1975); Rhem v. Malcolm, 527 F.2d 1041, 1042 (2d Cir. 1975); Rhem v. Malcolm, 507 F.3d 333, 335 (2d Cir. 1974); Valvano v. McGrath, 325 F. Supp. 408, 412–13 (E.D.N.Y. 1970).

383. Mark Schmitt, *The Persuasion Broker*, AM. PROSPECT (Mar. 19, 2009), <http://prospect.org/article/persuasion-broker> [<https://perma.cc/3LUE-JLX4>] (“Sturz entered government in 1978, serving as deputy major and later as planning commissioner in the early years of Mayor Ed Koch, an underappreciated period of innovation and change in New York City.”).

384. *See* Nicholas, *supra* note 380.

385. *Id.*

386. *Id.*

387. Clyde Haberman, *Rikers Sale Proposal ‘Dead,’ Commissioner Asserts*, N.Y. TIMES (June 3, 1981), <http://www.nytimes.com/1981/06/03/nyregion/rikers-sale-proposal-dead-commissioner-asserts.html> [<https://perma.cc/KSZ9-C637>].

388. *See* Timothy Egan, *Crack’s Legacy: A Special Report; A Drug Ran Its Course, Then Hid with Its Users*, N.Y. TIMES (Sept. 19, 1999), <http://www.nytimes.com/1999/09/19/us/crack-s-legacy-a-special-report-a-drug-ran-its-course-then-hid-with-its-users.html> [<https://nyti.ms/2kFpvsN>] (“Over the last 10 years, the New York police made nearly 900,000 drug arrests—more than any other city in the world. Almost a third were for using and selling crack. But a broader look at the arc of the crack years suggests that it was not the incarceration of a generation, or the sixfold increase in the number of police officers assigned to narcotics, that

The Legal Aid Society's consolidated class action—now known as *Benjamin v. Brann*³⁹⁰—is still pending before the Southern District of New York with major systemic issues still unaddressed.³⁹¹ The Prisoners' Rights Project of the Legal Aid Society continues to litigate that case, which is now over forty-two years old, underscoring the intractable nature of the problems at Rikers.³⁹² The Prisoners' Rights Project has also litigated an essentially uninterrupted series of use of force cases out of the city jails.³⁹³

turned the tide in New York, which the police called the crack capital of the world In Washington, however, the drug arrest rates actually declined in some of the peak crack years—and the city still recorded a steeper drop than New York in the percentage of its young residents using cocaine from 1990 to the present In Bushwick, the police cordoned off the Well in the early 90's and special teams of officers made thousands of arrests. So many people were sent to jail that Rikers Island became known as a Bushwick block party.”)

389. See discussion *supra* Part I (highlighting the criminalization of manifestations of mental health needs).

390. No. 75-cv-03073-LAP (S.D.N.Y. filed June 24, 1975).

391. See *id.* (demonstrating that issues left unaddressed include lighting, fire safety, sanitation, ventilation, and cooling of extended confinement units).

392. There have been eleven reported decisions in the case, many of which underscore the intractable conditions and problems in the city jails. See, e.g., *Benjamin v. Schriro*, 370 F. App'x 168, 169–71 (2d Cir. 2010) (affirming order requiring city to carry out its proposed plan to renovate jail ventilation); *Benjamin v. Horn*, 353 F. App'x 473, 473–74 (2d Cir. 2009) (vacating and remanding decision terminating sanitation provisions of order); *Benjamin v. Fraser*, 343 F.3d 35, 41, 44, 57 (2d Cir. 2003) (affirming most findings regarding unconstitutional environmental conditions in certain jails); *Benjamin v. Fraser*, 264 F.3d 175, 184, 190–91 (2d Cir. 2001) (affirming findings of unconstitutional counsel visiting and restraint practices); *Benjamin v. Malcolm*, 803 F.2d 46, 51, 53 (2d Cir. 1986) (affirming order requiring state to remove from the city jails people convicted of felonies and sentenced to a prison term); *Benjamin v. Horn*, No. 75 Civ. 3073(HB), 2006 WL 1370970, at *1, *3 (S.D.N.Y. May 18, 2006) (extending and supplementing an order concerning incarcerated individuals with conditions causing heat sensitivity); *Benjamin v. Fraser*, No. 75 Civ. 3073(HB), 2002 WL 31845111, at *1 (S.D.N.Y. Dec. 6, 2002) (holding city in contempt for its failure to comply with a 2001 order concerning restraints); *Benjamin v. Kerik*, No. 75 CIV. 3073(HB), 1998 WL 799161, at *1 (S.D.N.Y. Nov. 13, 1998) (finding unconstitutional fire safety conditions in several jails); *Benjamin v. Malcolm*, 156 F.R.D. 561, 566–68 (S.D.N.Y. 1994) (holding city in contempt for its failure to comply with an order concerning food); *Benjamin v. Sielaff*, 752 F. Supp. 140, 143 (S.D.N.Y. 1990) (holding city in contempt for its failure to comply with an order concerning housing); *Benjamin v. Malcolm*, 564 F. Supp. 668, 688 (S.D.N.Y. 1983) (holding jail crowding unconstitutional and ordering compliance with a population cap).

393. See, e.g., *Nunez & United States v. City of New York*, No. 1:11-cv-5845 (LTS-THK) (S.D.N.Y. 2011); *Ingles v. Toro*, 438 F. Supp. 2d 203, 205–06 (S.D.N.Y. 2006); *Sheppard v. Phoenix*, 210 F. Supp. 2d 450, 460 (S.D.N.Y. 2002). The case profile for the ongoing *Nunez* case is available at *Case Profile*, CIVIL RIGHTS LITIG. CLEARINGHOUSE, UNIV. OF MICH. L. SCH., <https://www.clearinghouse.net/detail.php?id=12072> [<https://perma.cc/9ZR2-C68H>].

Now, #CLOSErikers has bridged a gap between the dogged efforts of litigators and advocates to challenge horrific conditions at Rikers and the community's demands for much broader systemic change. The Legal Aid Society and virtually every other group that has played a role in the Rikers reform and Rikers closure movements has an official seat at the #CLOSErikers table.³⁹⁴ Organizational decisions are made in a truly collaborative way. Lawyers do not monopolize conversation and do not discern strategy in a vacuum. For the first time, a multi-pronged approach has been developed that provides advocates of all stripes and all backgrounds with a space to talk, theorize, and strategize on the best way to solve the Rikers problem—the foremost among them being the culture and Rikers' geographical location.

Recently, the Independent Commission on New York City Criminal Justice and Incarceration Reform, or the Lippman Commission,³⁹⁵ issued detailed findings about the atrocious conditions of confinement on Rikers Island, stemming from a culture of brutality and dehumanization.³⁹⁶ The Commission recommended Rikers Island's closure.³⁹⁷ The Lippman Commission report's findings concerning Rikers Island's culture of brutality and dehumanization, and poor conditions of confinement largely mirror what #CLOSErikers and advocates have been saying for decades—Rikers Island's lack of proximity to courts and family members isolates people detained there from critical support systems.³⁹⁸ #CLOSErikers put geographic considerations at the center of its argument to close the Island.³⁹⁹ Those considerations were partially responsible for #CLOSErikers' success.⁴⁰⁰ But only through a multi-

394. See *Partners*, #CLOSERIKERS, <http://www.closerikers.org/partners/> [<https://perma.cc/K6TT-4KZT>].

395. INDEP. COMM'N ON N.Y.C. CRIMINAL JUSTICE & INCARCERATION REFORM, A MORE JUST NEW YORK CITY 13 (2017) [hereinafter A MORE JUST NEW YORK CITY], <http://www.morejustnyc.org/#home-1> [<https://perma.cc/ZDV9-AD2M>].

396. *Id.* at 13–14.

397. *Id.* at 14.

398. These findings are not new. Entities such as the New York City Board of Correction have found that detainees miss a bulk of their off-island medical and mental health appointments, due in part to distance and resources issues. *Health Care in New York State Prisons, Hearing Before the Assemb. Comms. on Corr. & Health* (Oct. 30, 2017) (statement of Bobby Cohen); see also A MORE JUST NEW YORK CITY, *supra* note 395, at 13–16.

399. See *Fact Sheets*, #CLOSERIKERS, <http://www.closerikers.org/reimagining-criminal-justice/> [<https://perma.cc/W4AU-6KAD>] (fact sheet information available by scrolling down page).

400. See, e.g., *id.*

pronged grassroots strategy were those considerations given full voice. Even Deputy Mayor Sturz could not achieve what the advocates achieved where truly working in tandem.

CONCLUSION

Law is all too often billed as a neutral arbiter of social problems, and litigation is all too often billed as the vehicle for achieving neutral, socially just outcomes. For that reason, lawyers are trained to develop their litigation skills before most other skills, and are convinced that almost anything is achievable through litigation. In most cases, however, law and litigation cannot fit their bill. As it relates to New York State prisons, law and litigation have proven insufficient to create sustained systemic change on their own.⁴⁰¹ The same will prove true as advocates work to address the geographic sprawl of the prison system and its impact on mental health treatment, particularly the use of VTC and other technologies.⁴⁰² People who are passionate about solving those problems should borrow significantly from MHASC, #CLOSErikers, and other organizations that have paired the law and litigation with more robust grassroots strategies that center the narratives of people who are directly impacted.⁴⁰³ Those organizations provide a blueprint for working toward the larger goal of closing upstate prisons and taking advantage of mental health resources available only in more well populated urban centers.⁴⁰⁴ Only by building these nontraditional movements can we achieve sustainable systemic and institutional change.

401. *See supra* Section II.B.

402. *See supra* Part II, III.

403. *See supra* Part III.

404. *See supra* Part III.