Working to end solitary confinement
for people with psychiatric disabilities

MHASC

Mental Health Alternatives to Solitary Confinement

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Mental Health Alternatives to Solitary Confinement (MHASC) is 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. We advocate for humane criminal justice policies for people with psychiatric disabilities. MHASC has worked for more than ten years to end the practice of placing people with mental illness in solitary confinement (known as "Special Housing Units" or "SHU") in New York State prisons.

The New York State legislature recognized the harm caused by isolating people with mental illness in solitary confinement and responded by passing legislation to limit the practice. The SHU Exclusion Law, which was enacted in 2008 and took effect on July 1, 2011, was an important first step toward ending the torture experienced by people with mental illness confined to a small cell for 23 to 24 hours a day and subjected to social isolation and sensory deprivation. The law requires that people with serious mental illness who could potentially be confined in SHU for more than 30 days be diverted from SHU to a residential mental health treatment unit, except in exceptional circumstances.

The law along with advocacy efforts, litigation, and agency reform have increased and enhanced the prison mental health services provided by the New York State Office of Mental Health (OMH). However, many serious challenges remain:

1) Adequate mental health treatment is not available to most people incarcerated in New York State prisons.
2) Insufficient funding impedes robust oversight of prison mental health care and implementation of the SHU Exclusion Law.
3) People with mental illness still languish in solitary confinement

We submit this testimony to call your attention to these challenges and to make recommendations for change. Both additional funding allocations and legislative action are needed to address these issues.

<u>Prison Mental Health Care</u>

New York State over-criminalizes behavioral manifestations of mental illness, incarcerates large numbers of people with mental illness in Department of Corrections and Community Supervision

(DOCCS) prisons, and fails to provide adequate mental health treatment in prison. Last year the Office of Mental Health (OMH) reported that the number of people receiving mental health services in the state correctional system had grown in absolute numbers.[1] They account for 15.6% of the overall prison population.[2] This increase occurred at a time when the overall prison population declined to its lowest level in more than two decades.

Around 1,200 people, or 14% of those on the OMH caseload, are in an OMH residential treatment unit or receive enhanced services in a transitional intermediate care program.[3] But the vast majority of the more than 8,400 people with mental health needs in New York prisons – about 7,200 people – are in general population or SHU.[4] The treatment that these people receive consists of very limited, short check-in meetings with OMH staff and medication, if needed.

Expanded treatment

DOCCS and OMH should expand treatment opportunities for people in general population and SHU to include cognitive behavioral therapy, trauma treatment, group therapy, and peer support. DOCCS and OMH should also expand Integrated Dual Disorder Treatment (IDDT) for people with both mental health and substance abuse issues, and enhance OMH collaboration in all prison substance abuse programs.

In its February 2013 report, the Commission on Quality of Care and Advocacy for Persons with Disabilities (CQCAPD) found that people with co-occurring mental health and substance abuse disorders were not treated for substance abuse as part of their mental health treatment in general population.[5] CQCAPD documented that when people who have co-occurring disorders are in general population, their substance abuse treatment needs are "deferred to DOCCS," which means that they must wait to be placed in a DOCCS substance abuse program. CQCAPD concluded:

> Treatment outcomes would also be improved by treating, not deferring, substance abuse needs. There is a substantial body of evidence showing that effective prison-based substance abuse treatment which combines substance abuse and mental health interventions to treat disorders is the most effective method to reduce the likelihood of relapse and recidivism for participants. Untreated substance abuse can also lead to disciplinary sanctions while incarcerated and undermine effective mental health treatment.[6]

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[1] According to OMH, 8,478 imprisoned people were on the OMH caseload as of July 31, 2013.

[2] DOCCS reports that 54,235 people were in its custody as of January 1, 2013.

[3] Just fewer than 1,000 of those are in specialized units for people diagnosed with a Serious Mental Illness (SMI) and over 200 are in treatment units for people with SMI sentenced to SHU sanctions but diverted under the SHU Exclusion Law.

[4] At any given time, more than 6,500 people in general population, in addition to approximately 700 people in the SHU who have not been diverted, are receiving mental health treatment

[5] *A Review of Mental Health Screening, Access to Mental Health Services, and Mental Health Status of People in Segregated Confinement in New York State Correctional Facilities*, February 2013, p. 10, available at http://www.justicecenter.ny.gov/sites/default/files/archivereports/Publications/MH%20DOCCS%20Report.pdf.

[6] Mental Health Screening Review, p. 14.

People in residential mental health treatment units (RMHTUs) also need improved quality of mental health care. While RMHTUs provide significantly better access to and better quality of mental health services than is available in the general population, there is a lack of individually tailored programs and many individuals' needs are not met because they do not respond to the one-size-fits-all model provided.

Medication

OMH needs to develop a medication review protocol. In its February 2013 report, CQCAPD documented concerns regarding psychiatric medication reported by incarcerated people, staff, and family members.[7] Over 25% of the people receiving treatment reported that they had problems getting medication. CQCAPD found that "psychiatric medication was changed frequently and sometimes without any apparent clinical reason."[8]

Comprehensive Assessment

OMH needs to ensure that individuals in both general population and RMHTUs are properly assessed, diagnosed, and given appropriate treatment. OMH should enhance assessments for all people with mental health needs; increase reliance on individuals' mental health history, past treatment, and family input to determine accurate diagnoses; and develop more appropriately individualized treatment plans. OMH should utilize its own information about past difficulty experienced by people while in the SHU, and evaluate patients' concerns about misdiagnosis and changes in diagnosis, to ensure patients are appropriately diagnosed and diverted from the SHU when required.

CQCAPD found that despite procedures that require clinicians to obtain information about prior mental health treatment, only slightly more than a third of those with a treatment history had records from other providers in their case files.[9]

Family Member Involvement in the Mental Health Care Team

OMH should work more collaboratively with family members and loved ones. Family members and loved ones provide invaluable support to incarcerated people and useful information to OMH and DOCCS staff. Yet, some staff exhibit callous attitudes toward family members, and some fail to provide or receive information from them. DOCCS and OMH should clarify protocols for what information can be shared, widely distribute those protocols, and provide staff training on them. The agencies should also expand training to ensure staff respectfully listen to, consider, and offer feedback on information from family members. Staff should also facilitate communication by proactively obtaining consent to release information.

In its February 2013 report, CQCAPD found that none of the treatment plans reviewed contained input from family members.[10] CQCAPD's survey of family members revealed that more than half did not know how to contact OMH staff and that many who did speak with mental health staff reported that staff did not listen, were defensive, or were unfriendly.[11]

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[7] Mental Health Screening Review, p. 11.

[8] Mental Health Screening Review, p. 11.

[9] Mental Health Screening Review, pp. 9-10.

[10] Mental Health Screening Review, p. 9.

[11] Mental Health Screening Review, p. 9.

OMH has been receptive to MHASC's concerns about the need to involve family members and provided two opportunities in 2013 for family members to provide training to OMH staff in different parts of the state. However, OMH has not provided any funding for this training. For this effort to be sustainable and for all OMH prison-based staff to have the opportunity to attend such training, travel stipends and honoraria for family members who conduct these presentations must be provided.

OMH needs dedicated staff to receive information from family members, community treatment providers, and advocates; to request input from families where authorized by the person receiving treatment; and to obtain prior treatment records.

Need for More Humane, Therapeutic, and Effective Interventions for People in Crisis
DOCCS and OMH staff often fail to respond appropriately to individuals in mental health crisis. Individuals in crisis are not moved promptly to the Residential Crisis Treatment Program (RCTP), a housing area where people in psychiatric crisis can be observed and treated, and security staff often subject people to verbal and sometimes physical abuse before, during, and/or after transfer.

CQCAPD's initial review of the RCTPs found that more should be done to maximize the therapeutic nature of the programs.[12] CQCAPD's follow-up review more than two years later revealed problems with the clinical care and assessments individuals received during their stay in the RCTPs.[13]

The RCTP remains a punitive environment rather than a therapeutic place of support to help people stabilize. It should be a short-term placement, where amenities are quickly restored to people who are stabilizing or where transfer to the psychiatric hospital is facilitated promptly. Yet, RCTP stays are far too lengthy, and OMH is not promptly sending people in need of a hospital level of care to Central New York Psychiatric Center (CNYPC).

From CY2007 to CY2012, the number of people treated in the RCTP increased by 48%, while those discharged from the RCTP to CNYPC dropped by 50%. Total CNYPC admissions dropped from 773 admissions in 2008 to 385 in 2012, a decline of 51%.

DOCCS and OMH must enhance RCTP services, ensure it is a therapeutic environment free of staff abuse, house people in crisis in the least restrictive setting given their mental health needs, and hasten their transfer to CNYPC.

Better Prevention of and Response to Self-harm
Significant numbers of people with mental health needs, and particularly those in the SHU, attempt suicide or self-harm. Comparing DOCCS data from 2005 through 2013 with the latest

[12] *Review of Residential Crisis Treatment Programs (RCTPs)*, July 2010, available at http://www.justicecenter.ny.gov/sites/default/files/archivereports/Publications/RCTP%20Review%20Rpt%20Appendices%207-10.pdf.

[13] *Residential Crisis Treatment Program (RCTP) Follow-up Review*, June 14, 2013, available at http://www.justicecenter.ny.gov/sites/default/files/documents/FOR003-Final-RCTP-Review-Report-6-24-13.pdf.

available data from the Bureau of Justice Statistics, the suicide rate in New York prisons is 40% higher than the national average for state prisons. The number of suicide attempts by individuals in DOCCS custody increased by almost 150% between 2007 and 2012. Despite repeated tragic outcomes, DOCCS and OMH staff continue to view inappropriately those who self-harm or threaten self-harm as malingerers trying to game the system. Staff must recognize these acts as indications of crisis, not penalize them, and respond appropriately through counseling, treatment, and/or transfer to an RMHTU or CNYPC. Staff must also address the traumatic impact of self-harm on others through individual and/or group discussions.

More Effective Discharge Planning Services
Most people with mental illness released from state prison do not receive adequate assistance preparing for their release. The Community Orientation and Reentry Program (CORP) aims to provide comprehensive mental health discharge planning for people returning to New York City, but the program only has a capacity of 31. DOCCS and OMH should expand CORP, and other OMH discharge planning services, throughout the system. Staff should adequately document individuals' mental health needs, past courses of treatment, and the level of services needed; help them locate and enroll in community mental health treatment, apply for public benefits, and obtain housing; and prepare people mentally and emotionally for return to their communities.

Many of the challenges described above may be addressed by OMH and DOCCS without additional funding. However, to provide adequate treatment to the more than 8,400 people who require mental health care in New York prisons, the legislature must provide funding for additional OMH and DOCCS staff.

Oversight

Prisons are closed environments. For the legislature and the public to understand what takes place inside those wall, outside oversight and reporting are essential. The SHU Exclusion Law requires that the Commission on Quality of Care and Advocacy for Persons with Disabilities (CQCAPD) monitor prison mental health care and ensure compliance with the SHU Exclusion Law. The Justice Center for the Protection of People with Special Needs (Justice Center) assumed the oversight functions previously assigned to CQCAPD when it became operational on June 30, 2013.

CQCAPD embraced its obligation to monitor prison mental health care when it assumed this responsibility in July 2008. CQCAPD conducted systemic reviews of the Residential Crisis Treatment Programs, the mental health screening process, and OMH's complaint procedures; worked with DOCCS and OMH to develop mental health training for correction officers; and met with advocacy groups concerned about the quality of prison mental health care. After the SHU Exclusion Law took effect in 2011, CQCAPD began its work monitoring implementation of the law. This monitoring is essential because people with serious mental illness who should be diverted from SHU can languish there if they are not properly assessed or if the "exceptional circumstances" provisions of the law are not correctly applied.

The additional responsibilities imposed by the SHU Exclusion Law were expected to require CQCAPD to dedicate at least 14 full-time employees to the task. However, due to the budget

crisis, only four staff members were assigned to these monitoring duties. We are pleased that the Executive Budget provides for the hiring of two additional staff members. However, the Justice Center will still have less than half of the staffing needed to carry out its responsibilities.

With inadequate staffing, the Justice Center cannot provide necessary oversight to ensure that people with mental illness are diverted from SHU[14] and adequately monitor prison mental health care. We encourage you to increase funding to the Justice Center so that these monitoring responsibilities can be competently carried out.

Continued Use of Solitary Confinement

The SHU Exclusion Law did not result in a significant decrease in the number of people with mental illness placed in SHU as it should have. As of June 2013, 700 people with mental illness remain in SHU, where they receive very limited mental health treatment and where they deteriorate often uninterrupted by the OMH clinical staff until the need for psychiatric hospitalization or emergency observation arises. The torturous conditions of 23-to-24-hour isolation which cause psychological damage to individuals with and without mental illness continue in contradiction to the goals of the SHU Exclusion Law to end this cycle of torment.

The severe mental pain and suffering caused by solitary confinement led the U.N. Special Rapporteur on Torture to conclude that isolating any person in such conditions beyond 15 days constitutes torture.[15] The Special Rapporteur recommended that solitary confinement of vulnerable populations, such as people with mental illness, for *any* time period be abolished.

DOCCS is not unaware of the enormity of the problem in New York prisons. Judge Gerard Lynch of the Second Circuit Court of Appeals, when he was a Judge in the Federal Court of the Southern District of New York presiding over the litigation *Disability Advocates, Inc. v. New York State Office of Mental Health*, stated to DOCCS:

> However justified the conditions in SHUs might be as a matter of discipline and security, they almost were guaranteed to worsen the mental condition of just about anyone but certainly those with vulnerable psyches. My one policy aside, and I hope it's something that will get attention at the department of correctional services, is that greater attention should probably be paid to the problem of extremely lengthy SHU confinement even to those who are not mentally ill.

April 27, 2007, transcript at 9 (*DAI v. OMH* Settlement Approval Hearing).

The inclusion of $3.8 million in the Executive Budget for "updated policies and programs regarding supervision of inmates in Special Housing Units" and the related staff increase of 66 FTEs suggest that DOCCS is prepared to pay *some* attention and take *some* action toward reforming its use of isolated confinement. We are gratified that the administration is attempting

[14] There are approximately 5,000 SHU beds in 39 prisons across the state.

[15] *Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, A/66/268, August 5, 2011, pp. 20-21 available at http://solitaryconfinement.org/uploads/SpecRapTortureAug2011.pdf.

to address the problem. However, increased DOCCS staffing and programming in SHU will not prevent the damage that this toxic environment causes. People with mental health issues and other vulnerable populations must be *entirely* excluded from placement in SHU. SHU (and other forms of isolation such as administrative segregation) for anyone in DOCCS custody should not be of the excessive duration that is the current practice.

The Humane Alternatives to Long-Term (HALT) Solitary Confinement Act (A08588/S06466) is a comprehensive approach to eradicating harmful long-term isolated confinement. The bill requires the creation of rehabilitative and therapeutic units for individuals whose serious misconduct requires that they be separated from the general prison population. In stark contrast to SHU, Keeplock and Administrative Segregation, these secure residential rehabilitation units will offer the programs, therapy, and support needed to address underlying causes of the problematic behavior. The bill completely bans the placement of people with mental disabilities in isolated confinement and limits the maximum amount of time that any imprisoned person can spend in isolated confinement to 15 consecutive days or 20 days total in a 60-day period.

MHASC encourages the legislature to pass the HALT Solitary Confinement Act without delay. Imprisoned people must not be subjected to the torture of solitary confinement any longer.

Conclusion

Too many people with significant mental health needs are in our jails and prisons – and the numbers appear to be growing – in large part because of an underfunded and under-resourced community mental health system. Stronger community mental health services and preventive services which keep people with mental illness from ever penetrating the criminal justice system are needed. But for as long as we continue to lock away in the state correctional system people with mental illness, we must be concerned for the plight of those among us who can easily be forgotten and ensure that their illnesses are treated and that they are not left to suffer their delusions, hallucinations, mania, and depression in solitary confinement.