Working to end solitary confinement
for people with psychiatric disabilities

MHASC

Mental Health Alternatives to Solitary Confinement

TESTIMONY FOR NYS MENTAL HYGIENE BUDGET HEARING

Regarding the New York State Executive Budget Proposals
State Fiscal Year 2018-2019
February 13, 2018

Mental Health Alternatives to Solitary Confinement (MHASC), a coalition of more than sixty criminal justice and mental health advocacy organizations and hundreds of concerned citizens, formerly incarcerated people, and their family members, seeks to end the practice of placing people with mental illness in solitary confinement (Special Housing Units (SHU), keeplock, and administrative segregation) in New York State prisons. Offering effective treatment – rather than punishment – should be New York's response to people with mental illness in correctional facilities as well as communities.

We thank the New York State legislature for the opportunity to comment on the need to allocate funding in the FY2019 Mental Hygiene budget to expand prison mental health care and to provide adequate oversight. In addition, we urge the legislature to pass the Humane Alternatives to Long-Term (HALT) Solitary Confinement Act (A. 3080A / S. 4784) which prohibits the placement of people with mental illness in solitary confinement and places significant restrictions on its use generally.

People with Mental Health Needs in NYS Prisons

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, fails to provide adequate mental health treatment in prison, and too often inflicts abusive conditions that create or exacerbate mental health needs. At the end of 2016, 10,484 people in state prison were receiving treatment from the Office of Mental Health (OMH), 20.4% of the total DOCCS population.[1] From 2011 to 2016, the number of people on the OMH caseload in DOCCS prisons *increased* by 26% at the same time that the total prison population *declined* by 8%.[2]

With only 1,200 residential mental health beds in the state prisons, the vast majority of people who receive mental health treatment are in the general prison population, where they receive

[1] The Office of Mental Health reported this information in its Central New York Psychiatric Center (CNYPC) Facility Monitoring Report, 4th Quarter 2016.
[2] This data is based on DOCCS Fact Sheet, January 1, 2018; CNYPC Facility Monitoring Report, 4th Quarter 2016; and the 2011 OMH Annual Corrections-based Operations Statistical Report.

limited, if any, individual or group therapy.[3] While specialized mental health treatment units provide significantly better access to and better quality of mental health services than is available in general population, there is a lack of individually tailored treatment plans and, as a result, many people's needs are not met in the program model provided.

The Torture of Solitary Confinement

Many people with mental health issues have a difficult time while incarcerated, are often not able to control their temper, miss social cues, and too often end up in solitary confinement. 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 (RMHTU), except in exceptional circumstances.

However, the law has not resulted in a significant decrease in the number of people with mental illness placed in SHU. At the end of 2016, 844 people with mental illness were in SHU receiving very limited mental health treatment while confined there.[4] Moreover, the torturous conditions of 23-to-24-hour isolation cause psychological damage to individuals with no history of mental illness. New York continues to hold over 2,800 people in the SHU and hundreds of others in keeplock in their own cells for 23 to 24 hours per day.[5]

The United Nations General Assembly recognized the severe mental pain and suffering caused by solitary confinement and included in the Standard Minimum Rules for the Treatment of Prisoners (known as the Mandela Rules) a prohibition against holding any person in solitary confinement beyond 15 consecutive days. The Mandela Rules follow the standards articulated by the United Nations Special Rapporteur on Torture, which included a recommendation that solitary confinement of vulnerable populations, such as people with mental illness, for *any* time period be abolished. Yet, in New York, it remains regular practice for DOCCS to hold people in solitary confinement, including people with pre-existing mental health needs, for months and years at a time.

[3] According to OMH, mental health treatment for individuals in the general prison population consists of being seen monthly by a primary therapist and at least once every three months by a psychiatrist. Half of all people whom OMH designates as having a serious mental illness are in the general prison population.

[4] The SHU Exclusion Law applies only to people who have a serious mental illness, as diagnosed by OMH. We are concerned that OMH does not designate some individuals who have serious impairments, diagnosed as serious mental illness by a community treatment provider, as having a serious mental illness and thus excludes them from the law's protections. From 2008 to 2015, there was a 29% drop in the percentage of people diagnosed with schizophrenia and psychosis (diagnoses that qualify as serious mental illness) and a 50% increase in the percentage of people diagnosed with adjustment disorder, anxiety, and personality disorder (diagnoses which do not).

[5] DOCCS reported that there were 2,805 people in the SHU on January 1, 2018.

Overly Punitive Mental Health Units

The Residential Mental Health Units (RMHUs), Behavioral Health Unit (BHU), and Therapeutic Behavioral Unit (TBU) – created to be therapeutic alternatives to SHU for people with serious mental illness – remain overly punitive and abusive for many people held there. Many people remain in these units for months and years at a time, and people report frequent security staff abuse, excessive force, overuse of disciplinary tickets, and a punitive environment. In September 2017, Disability Rights New York (DRNY), the federal Protection and Advocacy System for individuals with disabilities in NYS, found that DOCCS and OMH neglected and abused participants in Attica Correctional Facility's RMHU.

People on these units are generally offered programming of two hours or four hours per day, five days a week, in addition to one hour for recreation,[6] but are locked down 19 to 21 hours per day during the week in conditions akin to the SHU, and 23 to 24 hours a day on weekends. Moreover, many individuals report to MHASC that they do not even leave their cells for this limited period of time or participate in any programming, either because DOCCS has claimed "exceptional circumstances" to deny them programming[7] or they have refused to participate in recreation or programming often because of the units' punitive nature.

Also disturbing and related, people held in the RMHUs, BHU, TBU, and in the other Residential Mental Health Treatment Units (RMHTUs)[8] receive disciplinary tickets and additional SHU time on the unit – a practice disallowed by the SHU Exclusion Law – at rates higher than any other DOCCS prisons.[9] In 2015 and 2016, the Attica RMHU, Bedford Hills TBU, Five Points RMHU, Great Meadow BHU, and Marcy RMHU had some of the highest rates of disciplinary infractions and hearings of any unit in the DOCCS system. Given an average daily census of approximately 200 people on these five units, it is shocking that each year more than 200 received additional segregation time while on the unit. Even more disturbing is the amount of additional disciplinary time they received. For the two-year period, 433 people received an average of nearly one year of additional segregation time with the average at each unit ranging from 7 months (Marcy) to more than 2.3 years (Great Meadow).

[6] People held in Great Meadow BHU are only afforded two hours per day out of cell for therapeutic programming, while people held in Marcy, Five Points, and Attica RMHUs and Bedford Hills TBU are afforded four hours of out-of-cell programming.

[7] The SHU Exclusion Law allows DOCCS to deny a person the otherwise required out-of-cell programming under "exceptional circumstances" in which DOCCS finds the person to be an "unacceptable risk to the safety of [incarcerated persons] or staff."

[8] The RMHU, BHU, and TBU are not the only RMHTUs in DOCCS. The other RMHTUs include the Intermediate Care Program (ICP), the Intensive ICP, and the Transitional ICP.

[9] Individuals housed in an RMHTU "shall not be sanctioned with segregated confinement for misconduct on the unit, or removed from the unit and placed in segregated confinement, except in exceptional circumstances where such [incarcerated person's] conduct poses a significant and unreasonable risk to the safety of [incarcerated persons] or staff, or to the security of the facility." N.Y. CORRECT. LAW § 401.5(a).

Beyond disciplinary tickets, the extremely punitive and abusive approach to people with mental health needs in the residential units and throughout the prison system also manifests itself in correction staff treating people with mental health needs disrespectfully and even subjecting them to verbal and at times physical abuse. Mental health staff and correction staff should be promoting a safe, therapeutic environment rather than provoking residents who are known to have issues regulating their mood and behavior. As the most horrific outcome of such abusive treatment, Samuel Harrell and Karl Taylor – both individuals with serious mental health needs – were reportedly beaten to death by corrections officers in April 2014. MHASC is unaware of DOCCS or OMH taking any corrective actions in response to their deaths. Much more needs to be done to protect and support people with mental health needs, and to ensure at a minimum their safety from physical abuse and homicide.

Inadequate Crisis Response, Self-harm, and Suicide

The combination of the incarceration of large numbers of people with mental illness, the lack of mental health programs and services for most people on the OMH caseload, the use of solitary confinement, and abusive conditions in the RMHTUs lead to pain, suffering, and most disturbingly mental health crisis, self-harm, and suicide. The Residential Crisis Treatment Program (RCTP), where individuals in crisis are placed, is a punitive environment rather than a therapeutic place of support to help people stabilize. In the RCTP, security staff often subject people to verbal and sometimes physical abuse before, during, and/or after transfer. Lengths of stays in the RCTP are frequently substantially longer than the four-day goal that was included in the *Disability Advocates, Inc. v. New York State Office of Mental Health*, Private Settlement Agreement.[10] In fact, fewer and fewer people are being transferred from the RCTP to the Central New York Psychiatric Center to receive needed psychiatric care. Instead, people are often returned to the very same conditions, including solitary confinement, that led to the crisis in the first place, leading to repeated cycles between solitary confinement and the RCTP.

DOCCS suicide rate from 2010 to 2016 was 56% higher than the national average for all U.S. prisons. From 2014 through 2016, DOCCS suicides primarily occurred only at a few prisons; five prisons (Auburn, Clinton, Coxsackie, Elmira and Wende) accounted for over half of the 38 suicides during this three-year period, at rates that were three to nine times the national prison suicide rate. Moreover, 30% of the suicides during this period occurred in solitary confinement,

[10] The Private Settlement Agreement (PSA) in *Disability Advocates, Inc. v. New York State Office of Mental Health*, 02 Civ. 4002 (GEL) (April 27, 2007) was the basis for the SHU Exclusion Law. The PSA stated at Par. 7:

> a. Length of Stay. The use of observation cells [RCTP] should be no longer in duration than necessary to deal with the mental health crisis which caused the inmate-patient to be placed in observation. Defendants' goal shall be to keep inmates in observation cells for no more than four (4) days and there shall be a presumption in favor of releasing inmates from observation cells within four (4) days. However, any decision to release an inmate from an observation cell after more or less than any particular number of days is a clinical judgment. All cases in which an inmate is held over seven days in observation shall be referred to the CNYPC Clinical Director of designee for consultation.

even though those units only account for 8% of the DOCCS population, a rate that was almost six times higher than in DOCCS' general population.

Insufficient Discharge Planning Services

During 2015, 3,920 individuals receiving mental health treatment were released from state prison to the community. Most people with mental illness released from state prison do not receive adequate assistance preparing for their release. For instance, according to OMH's 2015 Pre-release Service Report, only about 65% of individuals with serious mental illness had an SSI application completed before release and 37% were referred to a shelter upon release. The Community Orientation and Reentry Program (CORP) provides comprehensive mental health discharge planning for people returning to New York City, but the program only has a capacity of 31. Eligible individuals spend approximately 90 days in the program preparing for their release. In 2015, only 70 people were released from CORP.

The Need for Enhancing OMH Budget Allocations

The Executive Budget does not provide the funding required to address the deficiencies in the mental health care provided during incarceration. Improving treatment is essential not only to meet the needs of individuals while they are in prison but also to prepare them to make the transition to the community upon release. People with mental illness who participate successfully in mental health treatment in prison will be more likely to engage in treatment in the community upon release.

To address the above concerns, OMH and DOCCS should expand treatment opportunities for people with mental illness in general population, protective custody, the RMHTUs and SHU (including keeplock and administrative segregation) to include cognitive behavioral therapy, trauma treatment, group therapy, and peer support. OMH needs dedicated staff to receive information from family members and to work more collaboratively with family members. The same ability to cooperate must be established with community treatment providers and advocates. All OMH staff should receive training from family members. 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 turn, DOCCS along with OMH must create a more rehabilitative and therapeutic environment throughout RMHTUs and prisons generally, end staff abuse, decrease the use of disciplinary tickets and punitive sentences, and utilize non-punitive individualized therapeutic interventions in response to difficult behavior. Similarly, OMH along with DOCCS must recognize acts of self-harm as indications of crisis, not penalize them, enhance RCTP services, ensure a therapeutic environment free of staff abuse, house people in crisis in the least restrictive setting given their mental health needs, and hasten people's transfer to CNYPC whenever appropriate.

The Need for Oversight

For the legislature and the public to understand what takes place behind prison walls, outside oversight and reporting are essential. The Justice Center for the Protection of People with Special Needs (Justice Center) is responsible for monitoring prison mental health care and ensuring compliance with the SHU Exclusion Law. However, the Justice Center has not allocated the staff needed to provide effective oversight. Rather than assigning 14 full-time employees, which were projected to be required to carry out these monitoring duties, only four staff members are currently assigned. Without adequate staffing, the Justice Center cannot adequately monitor and report on prison mental health care or provide the oversight necessary to ensure that people with mental illness are diverted from SHU.

The Justice Center conducts SHU Compliance and Quality of Mental Health Care reviews and has begun reporting publicly on its findings. Unfortunately the Justice Center's current method for determining compliance with the SHU Exclusion Law is insufficient; key requirements of the law are not monitored, and the bifurcated review of "compliance" and quality of mental health care provided in SHU does not lead to an accurate and comprehensive assessment of compliance. Effective monitoring of the SHU Exclusion Law requires assessing compliance with provisions regarding solitary confinement and RMHTUs and assessing whether the RMHTUs provide a therapeutic alternative to solitary confinement.

The Justice Center's public reporting is also inadequate. The annual report includes no assessment of the quality of prison mental health care and no recommendations for furthering the goal of diverting individuals with serious mental illness from SHU to RMHTUs.

The Executive Budget provides additional resources for the Justice Center, but it is unclear whether these resources will enhance the monitoring required by the SHU Exclusion Law. We encourage you to inquire into how the increased funding for the Justice Center will be allocated and require that the portion designated for these monitoring responsibilities be significantly increased.

The Need for Legislation to End the Torture of Solitary Confinement

In addition to increasing Mental Hygiene budget allocations to expand and improve mental health treatment, the legislature must act to end the torture of solitary confinement for people with pre-existing mental illness and for all people. The Humane Alternatives to Long-Term (HALT) Solitary Confinement Act (A. 3080A / S. 4784) is a comprehensive approach to ending the torture of isolated confinement for all people. The bill requires the creation of rehabilitative and therapeutic units for individuals whose serious misconduct requires they be separated from the general prison population. In stark contrast to SHU, these secure residential rehabilitation units will offer programs, therapy, and support to address underlying treatment needs and causes of problematic behavior. The bill completely bans the placement of people with mental disabilities in isolated confinement and limits the maximum amount of time any person can

spend in isolated confinement to 15 consecutive days or 20 days total in a 60-day period. New York must no longer subject any person, including those with pre-existing mental illness, to the torture of solitary confinement. MHASC encourages the legislature to pass the HALT Solitary Confinement Act without delay.

Conclusion

Too many, and increasing numbers of, people with significant mental health needs are in our jails and prisons in large part because of an underfunded and under-resourced community mental health system, an overly punitive response to behavioral health issues, and a lack of alternatives to incarceration. 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 and as long as prison conditions themselves lead people to develop mental health needs, we must be concerned for the plight of those in our prisons who can easily be forgotten. We must ensure that their illnesses are treated and that they are not left to suffer delusions, hallucinations, mania, anxiety, post-traumatic stress, and depression in solitary confinement and other abusive prison environments.