



**Working to end solitary confinement  
for people with psychiatric disabilities**

# **MHASC**

**Mental Health Alternatives to Solitary Confinement**

**New York State Assembly Standing Committee on Correction  
& Assembly Standing Committee on Mental Health**

**Mental Illness in Correctional Settings Hearing  
November 13, 2014**

The Mental Health Alternatives to Solitary Confinement (MHASC) would like to thank Assembly Member Daniel J. O'Donnell and Assembly Member Aileen M. Gunther for the opportunity to present written testimony on the subject of mental illness in New York State's prisons and jails.

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 passage of the SHU Exclusion Law in 2008 demonstrated that the New York State legislature recognized the damaging consequences of solitary confinement on individuals with mental illness. Enacted in 2011, the law served as a powerful first step towards ending the suffering of this form of extreme isolation and was a tremendous victory in protecting the rights of people with mental illness in NYS prisons. However, many grave problems remain:

- The SHU Exclusion Law does not go nearly far enough to protect people living with psychiatric disabilities from being exposed to torture in New York's prisons and, in some cases, is not appropriately implemented.
- People living with mental health challenges are not receiving adequate mental health care in correctional settings, from general population to the units designed specifically for people in mental health crisis.

It is time for the New York State legislature to take a lead in ensuring that people receive the mental health care they need and to take the next step in protecting people from the traumatic

effects of solitary confinement by passing the Humane Alternatives to Long Term (HALT) Solitary Confinement Act (A08588A/S06466A).

### Solitary Confinement

Since the implementation of the SHU Exclusion Law, many people with severe symptoms of mental illness as well as deeply concerning suicidality remain in solitary confinement. In New York State today, there are still approximately 650-700 people in solitary confinement who are living with mental illness. These people, who may have histories of mental illness or may have developed symptoms while in the damaging conditions of extreme isolation,<sup>1</sup> may still not be assessed to fall under the narrow definition of “serious” mental illness under the law and therefore be subjected to unrestricted torture.

Furthermore, hundreds of people with serious and milder mental illnesses are suffering for months and even years in solitary confinement in county jails across New York State, where the SHU Exclusion Law has no jurisdiction.

OMH and DOCCS staff habitually do not respond properly to mental health crises in SHU or elsewhere in the prison system. Individuals in need often are not transported to Residential Crisis Treatment Program (RCTP) and when they are, this environment remains a punitive one rather than a therapeutic one. We are concerned about family members’ reports of loved ones spending extended periods of time in RCTP, being beaten up or facing harassment on the way to the RCTP, or being shuttled back and forth between RCTP and SHU rather than assessing the underlying issue and utilizing more intensive mental health interventions, like Central New York Psychiatric Center.

These punitive environments, particularly the SHU, put individuals with mental illness at a higher risk of self-harm or attempted suicide. And while the suicide rate in New York prisons is higher than the national average for state prisons, individuals attempting to take their life are often, unfairly, seen as malingerers, trying to outsmart the system rather than as people in genuine and terrifying distress. Instead of penalizing such behavior, staff should be required to properly address these crises through counseling, treatment, and/or transfer to an RMHTU or CNYPC. Staff should also be required to address the traumatic impact of self-harm on others through individual and/or group discussions.

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<sup>1</sup> Extensive research documents the harmful, at times irreversible, impact of solitary confinement on a person’s mental, physical, and emotional well-being. Individuals who have not experienced symptoms of mental illness in the past may develop symptoms of anxiety, depression, even psychosis and suicidality in even a short time in solitary.

The HALT Solitary Confinement Act provides a comprehensive approach to ending the torture of solitary confinement while creating alternatives and rehabilitation for people displaying unsafe behavior. This bill would limit solitary confinement for people with mental illness and other particularly vulnerable groups for any amount of time and limit the amount of time that any person can spend in solitary confinement to 15 consecutive days. If any person needs to still be separated from the general prison population for longer periods of time, the bill would require those individuals to be housed in alternative units with substantial out-of-cell time and rehabilitative and therapeutic program opportunities. The bill is guided by the UN Special Rapporteur on Torture's conclusions that more than 15 days constitutes torture, and any amount of time for certain populations including people with mental illness, could result in permanent damage. We strongly urge the Assembly leadership to support this legislation and take a stand against this ongoing form of torture in our state which, as our experience with the SHU Exclusion Law tells us, urgently requires sweeping form.

### Mental Health Care

As reported by the Office of Mental Health (OMH) in 2013, the number of individuals receiving mental health services in jails and prisons has grown<sup>2</sup>, accounting for 15.6% of the overall prison population. Paradoxically the figures increased at a time when there was an overall decline in the prison population.

Around 1,200 people, or only approximately 14% of those on the OMH caseload, reside in an OMH residential treatment unit or receive enhanced services in a transitional intermediate care program.<sup>3</sup> While such units provide enhanced treatment, it is often not tailored to the needs of the individual patients. More emphasis should be put on reinforcing individual needs assessments and treatment plans, individual and group therapy, cognitive behavioral therapy, trauma treatment, IDDT, and peer support.

In addition to the lack of individualized programming, units that are intended as therapeutic settings continue to reflect the punishment model of the prisons overall. People in the residential treatment units, particularly in the disciplinary Residential Mental Health Units (RMHUs) and Behavioral Health Unit (BHU), have reported mistreatment including verbal, physical and psychological abuse, use of excessive force and overuse of disciplinary tickets from staff. Such behaviors contradict the intended therapeutic environment of promoting psychological and emotional well-being.

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<sup>2</sup> According to OMH, 8,478 imprisoned people were on the OMH caseload as of July 31, 2013.

<sup>3</sup> According to OMH, just fewer than 1,000 of those are in specialized non-disciplinary units for people diagnosed with a Serious Mental Illness (SMI) and around 200 are in treatment units for people with SMI sentenced to SHU sanctions but diverted under the SHU Exclusion Law.

Also of concern, the remaining 7,200 or more people suffering from mental illness are located in general population or SHU<sup>4</sup> with limited access to mental health care. There are very few opportunities for people in the general population or SHU to receive any group or individual therapy. Access to treatment must be expanded for individuals both in general population and in SHU. Additionally both DOCCS and OMH should strengthen substance abuse programs for people with mental illness by expanding the Integrated Dual Disorder Treatment (IDDT).

Equally important to treatment is the involvement of family members and loved ones, as they provide valuable support to incarcerated individuals. Family members can also be of assistance to the OMH staff, providing important information regarding medical and mental health history. Developing a substantial relationship with families could serve as an important step in ensuring proper assessment of individuals taking into account their mental health history, past treatment, and family input to determine correct diagnoses. Proper diagnosis will allow individuals to receive the proper treatment or be diverted from the SHU when needed. Yet, some family members experience dismissive and even disrespectful communication from the mental health staff working with their loved ones. As a way to foster this communication, we recommend that there be a full-time family liaison position created and that OMH and DOCCS staff be required to participate in a training led by family members to better understand their needs. In a recent meeting with Commissioner Ann Sullivan of the Office of Mental Health, we were encouraged by her appreciation of family-member involvement, when possible, with the care of their loved ones who are incarcerated, and we hope that the legislature will support efforts to make sure that OMH has meaningful engagement with family members.

Also of great importance, the voices of family members and people who have been incarcerated should be included in trainings for both DOCCS and OMH staff. In 2013, MHASC family members led two interactive workshops with OMH staff about their experiences with and requests of mental health staff. We received positive feedback from participants and OMH leadership and hope to expand on this and similar workshops. Similarly, the 2013 training by DOCCS and OMH for staff who work in mental health and punitive settings featured testimonies of people's experience with mental health services and recovery. While people who experienced mental health services and recovery were not part of the 2014 training, we encourage such participation to be reinstated, and expanded on, with a focus on people's experiences of mental illness within correctional settings. We also encourage the legislature to support, through funding or otherwise, increased and enhanced training for DOCCS and OMH staff on how to work effectively with people with mental health needs.

Lastly, individuals who received care from OMH often leave prisons with no adequate discharge planning. Although the Community Orientation & Re-entry Program (CORP) aims to provide

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<sup>4</sup> At any given time, more than 6,500 people in general population, in addition to approximately 650-700 people in the SHU who have not been diverted, are receiving mental health treatment

comprehensive mental health discharge planning for people returning to New York City, the limitation in staff does not allow them to serve large number of people, with a total program capacity of only 31 people. DOCCS and OMH should be required to expand CORP, and other OMH discharge planning services to document patients' mental health needs, past courses of treatment, and the level of services needed. Also, these agencies should help patients locate and enroll in community mental health treatment, apply for necessary public benefits, obtain housing, and prepare people mentally and emotionally for return to their communities.

### Conclusion

Too many individuals with significant mental health needs continue to suffer in our jails and prisons. The SHU Exclusion Law was the first, significant step in reversing the terrible trend of torture rather than treatment. Yet, after three years, it is clear that it is not enough. We hope that New York will continue to be a leader in the national movement to reform the use of solitary confinement by passing the HALT Solitary Confinement Act. We furthermore urge the New York State Legislature to take immediate steps to ensure that the State's prisons and local county jails provide appropriate mental health care and critical reentry services to all who need them. Lastly, we fundamentally believe that investments need to be made in community-based mental health care, bail reform, diversion and prevention to keep people and resources in their communities.