

TESTIMONY OF
PRISONERS' LEGAL SERVICES OF NEW YORK
BEFORE THE
JOINT LEGISLATIVE HEARING
ON
MENTAL HEALTH TREATMENT
IN CORRECTIONAL SETTINGS
CONDUCTED BY THE
ASSEMBLY COMMITTEES ON
CORRECTION AND MENTAL HEALTH

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INTRODUCTION

We would like to thank the members of the Correction and Mental Health Committees for inviting Prisoners' Legal Services (PLS)¹ to testify about the status of incarcerated individuals with mental illness. We hope that our testimony will help your Committees determine the changes that are required to facilitate treatment, recovery and diversion of New Yorkers with mental illness who, in increasing numbers, have become enmeshed in the criminal justice system.

As many of you know, for 38 years, PLS has been responding to the grievances and concerns of incarcerated New Yorkers and many of those concerns have involved issues of mental health care and treatment.² Each year, PLS receives on average, 200 requests for assistance with matters involving general mental health issues and over 1200 requests involving the imposition of solitary confinement on individuals who may or may not already have a history of mental illness. Due to our limited funding, we are not able to investigate all of these claims, but the sheer number of requests

¹ Created in 1976 following the uprising at Attica Prison, PLS provides a voice for incarcerated New Yorkers. Our mission is to provide high quality, effective legal representation and assistance to indigent prisoners, to help prisoners secure their civil and human rights and to advocate for more humane prisons and for a more humane criminal justice system.

² PLS has worked on mental health issues for over thirty years and has been instrumental in improving the treatment of the mentally ill in our prisons. In the 1980's, PLS litigated a number of cases involving the issue of whether a prisoner's mental illness should be considered when imposing punishment for misconduct if that misconduct was a result of the prisoner's mental illness. In Batthany v. Scully, 139 Misc.2d 605 (Sup. Ct. Dutchess Co. 1988), we were successful in obtaining a court order holding that mental illness is evidence of mitigating circumstances and is therefore relevant in a prison disciplinary proceeding. That holding was made applicable to the entire State in 1990, when PLS brought the case Huggins v. Coughlin, 76 N.Y.2d 904 (1990), in which the Court of Appeals held that ". . . in the context of a prison disciplinary proceeding in which the prisoner's mental state is at issue, a Hearing Officer is required to consider evidence regarding the prisoner's mental condition." In Eng v. Goord, 80 CV 385S (W.D.N.Y.), we challenged the lack of adequate mental health treatment for prisoners in solitary confinement. The settlement in this case resulted in New York's first SHU treatment program, the Special Treatment Program ("STP"). In Anderson v. Goord, 87 CV 141 (N.D.N.Y.), PLS and the Prisoners' Rights Project (PRP) of The Legal Aid Society joined in litigating the issue of what relevance an inmate's mental condition should have in a prison disciplinary hearing. As a result, DOCCS agreed to amend its regulations governing when and how a hearing officer must consider a prisoner's mental health at a disciplinary hearing. In 2002, PLS, together with PRP, Disabilities Advocates, Inc. (DAI) and the law firm of DavisPolk, filed Disability Advocates, Inc. v. New York State Office of Mental Health, S.D.N.Y. 02-CV-4002 (Lynch, J.), on behalf of prisoners with mental illness in New York. The lawsuit alleged that such prisoners are denied adequate mental health care, harshly punished for the symptoms of their mental illnesses and frequently confined under conditions amounting to cruel and unusual punishment. As a result, the suit charged, the mental health of mentally ill prisoners routinely deteriorates, sometimes to the point that the prisoners engage in self-mutilation or suicide. A private settlement agreement was reached in this case that included, *inter alia*, using diagnostic criteria to define serious mental illness (SMI), adding hundreds of treatment beds for the diversion of SMI prisoners from isolated confinement, offering the possibility of time cuts to SMI prisoners in long-term SHU or keeplock, and placing limits on the types of misconduct for which SMI prisoners may be punished.

demonstrates that mental health concerns continue to be a critical issue in our prisons.

We have been asked to testify specifically about methods for significantly advancing the stated goals of the SHU Exclusion law and, as such, we have identified the following six areas that we believe would further those goals: 1) independent oversight of the Department of Corrections and Community Supervision's (DOCCS) use of solitary confinement; 2) intensive training by outside experts of DOCCS staff and hearing officers on the effects of solitary confinement on an individual's mental health; 3) the expansion of the diagnostic criteria used to define seriously mentally ill in the SHU Exclusion Law to include a broader spectrum of those suffering from mental illness; 4) a prohibition on long term placement³ in any form of solitary confinement; 5) a requirement that Office of Mental Health (OMH) staff request, review and consider a patient's entire mental health history, including any history of post-traumatic stress disorder and/or organic brain injury, and community medical and mental health records, educational records, etc., in the diagnosis and treatment of incarcerated New Yorkers, and 6) a requirement that OMH provide in-depth and improved training and oversight of its staff with respect to the diagnosis and treatment of incarcerated individuals who are suffering from mental illness.

In sum, our testimony today will focus on how well the SHU Exclusion Law is working and what changes need to be made to more completely effectuate the goals of the law. Before we address the limitations of the SHU Exclusion Law and deficiencies in its implementation, we would like to address the overarching issue of the use of solitary confinement as a prison management tool.

I. PLACING INCARCERATED INDIVIDUALS IN LONG TERM SOLITARY CONFINEMENT CONSTITUTES CRUEL AND UNUSUAL PUNISHMENT: ISOLATED CONFINEMENT CAUSES SIGNIFICANT HARM TO THOSE SUBJECTED TO IT AND ITS USE SHOULD BE BANNED IN NYS PRISONS.

As you all know, the SHU Exclusion Law was passed because there was a consensus among New York State Legislators that prisoners who are seriously mentally ill should not be placed in solitary confinement as punishment for misconduct because solitary confinement, in most cases, exacerbates mental illness. Thus, there was general agreement that, at least with respect to those who

³ We define "long term placement in solitary confinement" as the placement in any form of isolated confinement for over 15 days.

are seriously mentally ill, the State should not impose conditions of confinement that will cause their illnesses to worsen. There are, however, thousands of incarcerated New Yorkers who suffer from mental illness who do not benefit from the SHU Exclusion Law because they do not fall within the statute's definition of "seriously mentally ill," even though they are mentally ill and solitary confinement will exacerbate their illnesses.

We know that solitary confinement will exacerbate the condition of any person who suffers from mental illness because history tells us that solitary confinement has a seriously detrimental effect even on individuals who are mentally healthy when they enter solitary confinement. The origins of solitary confinement in the United States can be traced to the Walnut-Street Penitentiary in Philadelphia, PA, in 1787.⁴ Advocates thought that solitary confinement would be rehabilitative in nature, believing that prisoners, if left alone with only their conscience and a Bible, would reflect on their bad deeds, come to see the nature of their crimes, and voluntarily reform themselves into law-abiding citizens.⁵

In 1829, Quakers and Anglicans expanded on this model by constructing Eastern State Penitentiary, a prison comprised entirely of solitary cells along corridors. Shortly thereafter, in 1831, Gustave de Beaumont, a French prison reformer, and Alexis de Tocqueville, a French political thinker and historian, traveled to America to examine its prison and penitentiary systems and found the following with respect to the use of solitary confinement:

This experiment, of which the favourable results had been anticipated, proved fatal for the majority of prisoners. It devours the victim incessantly and unmercifully; it does not reform, it kills. The unfortunate creatures submitted to this experiment wasted away. . . .⁶

Charles Dickens, in 1842, described conditions of prisoners under solitary confinement in Pennsylvania as follows:

⁴ See *In re Medley*, 134 U.S. 160, 168 (1890) (describing conditions in a Philadelphia Penitentiary circa 1787).

⁵ See SHARON SHALEV, A SOURCEBOOK ON SOLITARY CONFINEMENT 2 (2008); see, e.g., Craig Haney & Mona Lynch, *Regulating Prisoners of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 N.Y.U. REV. L. & SOC. CHANGE 477, 481—82 (1997).

⁶ Haney & Lynch, *supra* note 4, at 483. Another commenter observed that the prison reforms at Auburn, New York were a "hopeless failure that led to a marked prevalence of sickness and insanity on the part of the convicts in solitary confinement." *Id.* at 484.

[T]here is a depth of terrible endurance in it which none but the sufferers themselves can fathom . . . this slow and daily tampering with the mysteries of the brain [is] immeasurably worse than any torture of the body.⁷

In 1890, in the case of *In Re Medley*, the U.S. Supreme Court condemned the use of solitary confinement, setting forth the scientific evidence regarding the use of solitary confinement and noting that:

A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.⁸

The nearly universal consensus of observers that solitary confinement was both inhumane and ineffective as a rehabilitative tool led to its general abandonment in America for over a century. But its use was renewed in the mid 1900's, not as a rehabilitative measure, but as a prison management tool.⁹

Since that time, we have learned even more about the effects of solitary confinement on an individual's mental health. The research available today on the effects of solitary confinement on humans shows that just a few days in solitary confinement can jeopardize the physical and mental health of people so confined. Human rights experts across the world, including Human Rights Watch, the Human Rights Committee and the Committee against Torture, have criticized the use of long term solitary confinement.¹⁰ Thus, although scientific research shows that subjecting any individual, mentally ill or not, to solitary confinement will, in almost all cases, drive them insane, the only law on the books in New York State against placing prisoners in solitary confinement is a law that prohibits the use of solitary confinement only for those prisoners who are already "seriously

⁷ New York City Bar Assoc., Comm. on Int'l Human Rights, *Supermax Confinement in U.S. Prisons* p. 6 (2011).

⁸ *In re Medley*, 134 U.S. 160, 168 (1890).

⁹ H. Daniel Butler et al., *Supermax Prisons: Another Chapter in the Constitutionality of the Incarceration Conundrum*, 9 RUTGERS J.L. & PUB. POL'Y, 1, 25 (2012).

¹⁰ Given the absence of an international standard for its permitted maximum overall duration, the Human Rights Council's Special Rapporteur on Torture, Juan Mendez, has suggested "15 days as the limit between solitary confinement and prolonged solitary confinement, since at that point, according to his research, some harmful psychological effects of isolation could become irreversible." <http://www.un.org/News/Press/docs/2011/gashc4014.doc.htm> See also: <http://www.hrw.org/en/news/2010/03/22/solitary-confinement-and-mental-illness-us-prisons>

mentally ill.” Based upon what we know to be true, based upon history and current science, the SHU Exclusion Law should be expanded to completely prohibit the long-term solitary confinement of any person.

II. THE STATUS OF THE IMPLEMENTATION OF THE SHU EXCLUSION LAW

The percentage of individuals in DOCCS custody who require mental health care has steadily increased over the past 14 years: 10% in 2000;¹¹ 11% in 2003;¹² 13.9% in 2009;¹³ 14.5% in 2011;¹⁴ and 15% in 2013.¹⁵ Acknowledging the need to address some of the issues associated with mental health issues inside New York’s prisons, the SHU Exclusion Law was passed and went into effect in July 2011. The overarching premise of the SHU Exclusion Law was the recognition that subjecting seriously mentally ill individuals to solitary confinement causes further harm. The goal of the SHU Exclusion Law was to provide treatment rather than punishment for seriously mentally ill individuals who engaged in misconduct.

Since its passage, however, there have been problems with reaching that goal. First, the law is only applicable to individuals who are already suffering from a “serious mental illness” as defined by the law. Individuals who are either misdiagnosed or do not meet the exact definition of “serious mental illness” as set forth in the statute, cannot receive the benefit of the law. As a result there are hundreds of incarcerated New Yorkers who suffer from mental illness who are placed in solitary confinement and who suffer further harm. Second, prison culture has a tropism toward punishment; DOCCS staff, and to a lesser extent, OMH staff, tend to view all misconduct – even that which is the product of mental illness – as warranting punishment as opposed to treatment. The law itself cannot change prison culture; it will take leadership, intense training, education and buy-in from everyone involved. Until there is a change in the prison culture, the goal of the SHU Exclusion Law cannot be attained.

¹¹ <http://www.prisonpolicy.org/articles/massdissent040100.html>

¹² http://www.correctionalassociation.org/publications/download/pvp/issue_reports/Mental-Health_summary.pdf

¹³ http://www.urbanjustice.org/pdf/publications//MHASC_testimony_public_protection_budget_hearing.pdf

¹⁴ Currently over 8000 prisoners are on the caseload of the Office of Mental Health and, “of that number, over 2,500 are considered seriously mentally ill.”

http://www.docs.state.ny.us/Commissioner/Speeches/2011_Attica_Riot_40th_Anniversary_Conference.html

¹⁵ <http://www.timesunion.com/local/article/21-year-old-state-prisoner-from-Selkirk-hangs-5870531.php#page-1>

At PLS, we have seen numerous instances of prisoners whom OMH initially concluded were suffering from a “serious mental illness” being found to no longer be seriously mentally ill, thus depriving them of the protections of the SHU Exclusion law. Equally disturbing are the hundreds of cases we see every year where our clients are not diagnosed as “seriously mentally ill” but do suffer from some form of mental illness which is exacerbated by solitary confinement. Because they are not covered by the SHU Exclusion law, however, they are still subjected to such confinement regardless of the harm it is causing.

Even if the law were expanded to cover a broader category of those suffering from mental illness, to fully implement the SHU Exclusion Law requires a change in the prison culture – a culture that, when it comes to the issue of mental illness, has historically been unable to accept the premise that individuals should not be punished for conduct that is a result of their mental illness. This culture favors punishment over treatment and is much more inclined to label a person a manipulator than a person suffering from mental illness. For many on the corrections staff and some on the mental health staff, responding to bad behavior with treatment rather than punishment is tantamount to giving in to manipulation. In our 2011 testimony before these committees, we urged rigorous training by outside experts of those who are responsible for the diagnosis, treatment and supervision of prisoners including corrections officers, OMH staff, hearing officers and others – and today, we urge such training again, because such training is critical to changing this cultural mindset.

In addition, clear, decisive and strong administrative policies, that mandate immediate therapeutic responses to mental health problems, are critical to sending the message to DOCCS and OMH employees that New York State is serious about addressing, not hiding or exacerbating, the mental health problems within its prisons.

III. HOW TO ADVANCE THE GOALS OF THE SHU EXCLUSION LAW

A. Provide Independent Oversight of DOCCS Use of Solitary Confinement & Intensive Training by Outside Experts for DOCCS Staff, Including DOCCS Hearing Officers, on the Effects of Solitary Confinement on a Person’s Mental Health

At the heart of the SHU Exclusion Law is the acknowledgement that mentally ill prisoners should not be punished if their misconduct is a product of their mental illness or if isolated

confinement will be counter-therapeutic. To this end, the SHU Exclusion Law prohibits punishment of people who engage in self-harm. However, we have seen numerous cases where individuals, who engage in self-harm, are disciplined for based on charges relating to the self-harm, thus thwarting the purpose of the law.

It is unclear why this is happening. Perhaps it is because of inadequate training on the purpose of the law; perhaps it is due to the current prison culture that favors punishment over treatment; perhaps it is a combination of both. Regardless of the reasons, the purpose of the SHU Exclusion Law is often frustrated by correction staff who either purposefully or ignorantly circumvent the statute. Two examples of such are set forth below:

J.D.¹⁶

JD set a fire in his cell in the Marcy Regional Mental Health Unit. He was then taken to an outside hospital where a psychiatrist determined that setting the fire was a suicide attempt. When he returned to the prison, OMH staff concurred with the view that the fire was a suicide attempt. Because the SHU Exclusion Law creates a presumption against discipline and punishment for acts of self-harm and related conduct, JD was not charged with arson or setting a fire. However, he was charged with violating several disciplinary rules relating to the fire: assault on staff, violent conduct, possession of flammable materials and property damage. At the conclusion of his hearing, JD was found guilty of all charges, and given a penalty of five (5) months solitary confinement, loss of all privileges and monetary restitution. Upon appeal, DOCCS dismissed all of the charges except the charge of property damage, but did not modify the penalty. As a result, JD was found guilty of the single charge of property damage but still given a penalty of five (5) months in solitary confinement.

D.B.

DB swallowed a razor in a suicide attempt. He was taken to the hospital to have it surgically removed. When he returned to prison, DB was charged with possessing a weapon, found guilty and given nine (9) months of solitary confinement. PLS submitted an administrative appeal arguing that sustaining a guilty finding of possession of a weapon, when it was obvious that DB's conduct was one of self-harm, would allow DOCCS to circumvent the entire purpose of the SHU Exclusion Law. As a result, DOCCS did reverse the hearing, but only after our client spent 3½ months in solitary confinement.

In addition, DOCCS has adopted regulations that require a hearing officer who is presiding

¹⁶ Names have been changed to protect and honor attorney – client confidentiality.

over a Tier III hearing to consider whether the prisoner's mental condition was at issue at the time of the misconduct and/or is at issue during the hearing.¹⁷ When certain factors pertaining to a prisoner's mental state are found to exist, his mental condition becomes an issue at his Tier III hearing.¹⁸

The regulations promote the purpose of the SHU Exclusion law by mandating that hearing officers consider a prisoner's mental illness in assessing culpability and determining the appropriate penalty. However, we have reviewed a number of disciplinary hearings where it is apparent that DOCCS hearing officers have not been adequately trained regarding the effects of solitary confinement on a person's mental health.

DOCCS' handling of Benjamin Van Zandt, as was reported in the Albany Times Union on November 5, 2014, is instructive on this issue. Mr. Van Zandt came to prison at the age of 19. "He entered the prison as a baby-faced teen who played violin in his school orchestra and excelled at math and science before he was placed among hardened criminals twice his age."¹⁹ Benjamin was a fragile individual who suffered from mental illness and, at one point while in DOCCS custody was given an "S" diagnosis, meaning that he was seriously mentally ill. He was apparently constantly harassed and physically abused by other prisoners. Recently, Benjamin was apparently taken off his anti-depressant medication and then, on October 28, 2014, was placed in solitary confinement for fighting with another prisoner. Two days later, on October 30, 2014, he hung himself in his cell.

Cases like Benjamin's are not uncommon. Benjamin's suicide was the 11th suicide in DOCCS this year. The fact that a young, vulnerable boy like Benjamin, was, at some point, diagnosed as seriously mentally ill, but subsequently placed in solitary confinement where he took his own life, screams of inadequate training, supervision and oversight on all levels at both OMH and DOCCS.

There are many other cases that tell the same story. Below are four examples of PLS cases that demonstrate the need for meaningful training, supervision and oversight of DOCCS and OMH staff.

D.S.

DS entered DOCCS in April 2013 and was sent directly to the infirmary. Together

¹⁷ Title 7 New York Code, Rules, Regulations (NYCRR) §254.6[f].

¹⁸ Title 7 NYCRR §254.6[b][1] lists seven trigger factors that relate to psychiatric history and one catch-all factor.

¹⁹ <http://www.timesunion.com/local/article/21-year-old-state-prisoner-from-Selkirk-hangs-5870531.php#page-1>

with a plethora of medical diagnoses at the time, DS was also diagnosed with **schizophrenia**, a diagnosis that is clearly set forth in the SHU Exclusion Law as constituting a “serious mental illness.” For the following seven months, he stayed in the infirmary where nurses had to remind him to tend to simple things like washing himself and brushing his teeth. He often acted bizarre, laughed inappropriately, had an unsteady gait, garbled speech, and needed frequent redirection.

In November 2013, he was issued a misbehavior report for allegedly choking a nurse, although there were no injuries. That incident, together with a refusal to submit to a urine test resulted in him being sentenced to 18 months in solitary confinement. PLS became aware of DS’s presence in solitary six months later when a person in a neighboring solitary cell wrote to us about him. The neighbor stated that DS moaned and talked nonsensically to himself all day. A review of his medical records showed that, on more than one occasion, DS was found lying on the floor in his cell, covered in his own feces.

A PLS staff attorney visited DS. DS could barely walk, but was carried to the visiting room in waist/wrist shackles. We later learned he had fractured his ribs from a recent fall in his cell. He had difficulty speaking. We requested that staff take him immediately to the infirmary after our visit. After being brought to the infirmary, he was sent to the emergency room and diagnosed with lung cancer the next day. On August 22, 2014, DS passed away at the Walsh Regional Medical Unit at Mohawk CF from Stage 4 non-small cell cancer of the lung, extensive hemorrhagic brain metastasis and extensive adrenal metastasis. His other diagnoses at that time were incompetence, atrial fibrillation (abnormal heartbeat), diabetes, TBI, hypothyroidism, **schizophrenia**, questionable seizure disorder, and Tourette’s Syndrome.

Again, how D.S. ended up in solitary confinement when he entered and exited DOCCS with a diagnosis of schizophrenia, and when his medical condition was such that he was almost completely incapacitated, is a question that needs to be asked and answered. Independent oversight would do just that.

J.B.

JB was experiencing a mental health crisis between mid-October and mid-December 2013 and during that time he received seven (7) tickets as a result of which DOCCS imposed a total of 15 months of solitary confinement time. PLS advocated on his behalf, noting that the imposed sanctions were counter-therapeutic. DOCCS ultimately reversed three (3) of the seven (7) hearings and reduced the SHU sanction by six (6) months.

The problem with the above example is that 6 months is far too long for any individual to be held in

solitary, especially when his punishment is the result of conduct he engaged in when he was experiencing a mental health crisis. Thus, the need for in-depth intensive training by outside, independent experts on the effects of solitary confinement on one's mental health.

Alberto Rodriguez:²⁰

Alberto Rodriguez was in the Residential Mental Health Unit at Marcy Correctional Facility when he received a misbehavior report charging him with lewd exposure in the presence of an Office of Mental Health psychologist. He did not attend his hearing, writing on a refusal form the following: "I am feeling suicidal and hearing voices[.] At this time I cannot attend the hearing." The hearing officer held the hearing in Mr. Rodriguez's absence simply noting that he refused to come to the hearing. The hearing officer found Mr. Rodriguez guilty and sentenced him to 90 days in solitary confinement which was later reduced to 45 days. PLS filed litigation on this case and the court issued a decision in favor of Mr. Rodriguez, reversing and expunging the hearing decision.

The hearing officer in the above-reference case failed to recognize that Mr. Rodriguez was in need of psychiatric care and failed to adjourn the hearing until such treatment could be provided. Worse, the hearing officer imposed 90 days solitary confinement time on a person who had admitted to feeling suicidal and hearing voices. Such conduct evidences a total lack of understanding of the harmful effects of solitary confinement and/or a total disregard for the need for psychiatric treatment for a person in crisis. Again, whether this is due to lack of training or the failure to change the prison culture regarding the relationship between mental illness and solitary confinement, it is clear from this example, as well as numerous others, that further training is critical to achieving the goals of the SHU Exclusion Law.

C.S.

CS wrote PLS requesting assistance with two disciplinary hearings conducted at Attica C.F. as a result of which CS received a total of 12 months solitary confinement and 19 months loss of good time. CS explained that he had received two misbehavior reports, the first for becoming disruptive in SHU by flooding his cell, and the second for hiding under his bed while on suicide watch and refusing to make himself visible for staff. CS explained that the second incident was the result of a panic attack. PLS reviewed CS's extensive OMH history and argued in an appeal that the Hearing Officer did not adequately consider CS's mental status at the time of the incidents.

²⁰ *Rodriguez v. Fischer*, (Alb. Co. Sup. Ct.) (Platkin, J.) (July 19, 2012).

DOCCS reduced the recommended loss of good time to 3 months but CS's solitary confinement penalties remained unchanged.

Here we have a case where an individual *who was on a suicide watch* has now been sentenced to a year in solitary confinement. We know that such punishment will not deter him from similar misconduct, as the "misconduct" was the product of mental illness. We know that he is likely to waste away and that he will come out of solitary confinement worse off than he was when he went in. We know that subjecting him to 12 months in solitary may kill him and is likely to make him more, not less dangerous. And yet, he remains in solitary.

PLS sees people treated like this on a regular basis. Because of this, it is imperative that DOCCS and OMH staff are given intensive in-depth training on the effect solitary confinement has on mental health, including but not limited to, all aspects of the SHU Exclusion Law and the types of misbehaviors that should be a red flag when hearing officers assess consider a person's mental health in assessing culpability and imposing punishment.

In addition, we recommend independent oversight of hearing officers' decisions that impose a period of isolated confinement greater than 15 days on any prisoner who has a mental health history or an issue regarding his/her intellectual capacity.²¹ This oversight should be done by a team of independent psychiatric experts who are knowledgeable about effect of solitary confinement on mental health and who, immediately following the imposition of solitary confinement, review the disciplinary charge, mental health record and punishment imposed.

B. Expand The Definitions In The SHU Exclusion Law To Include A Broader Spectrum Of Those Suffering From Mental Illness and To Prohibit Long-term Placement in Any Form of Solitary Confinement

Presently the SHU Exclusion Law only applies to prisoners who are so impaired by illness that at the time of the alleged misconduct and/or hearing, they fall within the SHU Exclusion Law's definition of suffering from a "serious mental illness" and to prisoners who are actively suicidal or who have significant functional impairment as a result of organic brain syndrome, personality

²¹ New York State Bar Association Committee on Civil Rights Report to the House of Delegates, *Solitary Confinement in New York State*, Presented to and Approved by the NYS Bar Association House of Delegates, January 25, 2013, available at: <http://www.nysba.org/WorkArea/DownloadAsset.aspx?id=26699>.

disorder and/or self-harming behavior. Because of the limitations of this definition, there are hundreds of prisoners who suffer from mental illness but who do not receive the benefits of the SHU Exclusion Law. In addition, if OMH staff fails to accurately diagnose a person as “seriously mentally ill” or, as happens in many cases, remove the “S” from a prisoner’s OMH service level, he/she will not be covered by the SHU Exclusion Law. Below is just one example of a case where our client, although apparently seriously mentally ill, cannot receive the benefit of the SHU Exclusion Law:

In 2010, VS arrived at Upstate Correctional Facility to serve four months in solitary confinement. Since being at Upstate, VS has accumulated over 5½ years of solitary confinement and keeplock time and has received the “loaf” diet for over 48 days. He is now scheduled to max out of solitary confinement.

For the past seven months, VS has been refusing medication and meals and is complaining of brain tumors, smelling his intestines rotting, his brain "leaking" into his body, respiratory problems, constipation and bleeding from orifices. He also complains of DOCCS’ staff tampering with his medical documentation and other life-threatening diseases and illness which have not yet developed. VS is so concerned that his meals and mail are being tampered with, that he refuses meals, believing he is being poisoned, and often wonders if his family is dead when he does not hear from them.

VS’s OMH records note that he claims he has delusions and that his brain is eroding. There are notations that referrals were made from medical staff due to VS’s numerous medical complaints and erratic behavior. VS’s records indicate that he has poor compliance with medication, which he states is because the nurses are trying to poison him. Ironically, his medications have been discontinued several times because he was not compliant and did not present as acutely psychotic. In some of VS’s most recent mental health records, he stated he was "trying to stay alive" and voices were telling him to "get out of here." He refuses any medical tests that are offered to him because of a firm belief that DOCCS will try to kill him during the procedure or in the infirmary where there are no cameras.

In May 2014, VS swallowed a razor. He denied a suicide attempt stating that he simply wanted to get to an outside hospital so that they could figure out how DOCCS was trying to poison and kill him. OMH’s response to PLS’ advocacy was that VS’s current diagnosis is Adjustment Disorder with Anxiety and he does not meet the criteria for referral to a Special Program [the alternative to solitary confinement for prisoners who suffer from serious mental illness].

The SHU Exclusion Law should be expanded to include individuals such as V.S. No reasonable person would argue that someone with V.S.’s mental state should be subjected to

solitary confinement, and yet, due to the current limitations of the SHU Exclusion Law, OMH has concluded that VS does not fall within its embrace.

In addition, the SHU Exclusion Law only applies to those individuals who suffer from a “serious mental illness” who are sent to solitary for disciplinary reasons. Every year, there are hundreds of prisoners in New York State who are housed under the identical conditions, but under a different label such as administrative segregation or protective custody. PLS has clients who have been held in administrative segregation or protective custody for decades. These individuals should also have the benefits and protections of the SHU Exclusion Law.

C. Require OMH Staff To Request The Complete Mental Health History, Including All Community Mental Health and Education Records of Any DOCCS Patient it Treats and Mandate that OMH Staff Review And Consider Any History Of Post-Traumatic Stress Disorder And/or Organic Brain Injury In Diagnosing And Treating Incarcerated New Yorkers

When incarcerated individuals write to PLS for assistance regarding their mental health issues, we typically request all of their mental health records from OMH, in an effort to review their diagnosis and treatment plan. Although many of our clients have had numerous encounters with mental health treatment facilities prior to their incarceration and many have medical, educational, vocational or other records that indicate a history of mental health issues, it is unusual to see references to such treatments and contacts in a patient’s OMH records. Having such information can be critical to being able to accurately diagnose and treat a mental illness and yet, it appears that it is not OMH’s practice to obtain such records which might include documentation of hospitalizations, suicide attempts, traumatic brain injury, diagnoses of PTSD diagnoses and more. Below is one example that demonstrates the usefulness of such information in the diagnoses and treatment of patients:

KM had recently returned to custody following a parole violation. KM contacted PLS complaining that that he was in dire need of mental health services and that he had sought such services but that his requests were being ignored. KM indicated that he had received various mental health services in the county jail, had a number of mental health diagnoses, and had been prescribed numerous psychotropic

medications, none of which he was being afforded since his return to DOCCS custody. PLS contacted OMH officials on his behalf and relayed his concerns, his alleged past diagnoses, and the various medications he had previously been prescribed. OMH personnel acted upon these concerns and subsequently advised PLS that KM was being afforded the necessary care.

OMH should be required to request, review and consider all prior mental health records, including community mental health records and educational records, to have a complete picture of the patient they are treating. OMH should also be required to consider any history of traumatic brain injury or post-traumatic stress disorder in diagnosing and treating incarcerated New Yorkers and to explain how such histories factored into the diagnosis and treatment plan.

D. Require In-Depth And Improved Training And Oversight Of OMH With Respect To The Diagnosis And Treatment Of Those Suffering From Mental Illness

The SHU Exclusion Law can only be effective if those who are responsible for implementing the law understand its purpose and share in the belief that treatment, as opposed to punishment, is often the most effective rehabilitative tool. The case of *Archie v. Fischer*, 119 A.D. 3d 1299 (3rd Dep't 2014), demonstrates the need for a culture change within OMH with respect to how its staff relate to and treat patients who are incarcerated. In *Archie*, it was undisputed that Mr. Archie suffered from a mental health disorder. During a therapy session, when he was encouraged to express his feelings, he discussed his fantasies of harming certain OMH and corrections staff. As a result, Mr. Archie was charged with making threats and engaging in threatening conduct. The author of the misbehavior report was Mr. Archie's psychologist, the therapist who encouraged him to express his feelings during the counseling session. The psychologist testified that she did not know whether her patient was expressing frustration or actually meant to harm the individuals. Because of the psychologist's uncertainty, the court found the determination of guilt was not supported by substantial evidence.

The problem with the *Archie* case, in addition to the fact that the charges were not substantiated, is that fact that the psychologist, with little to no support for her actions and, apparently with little thought, moved from a therapeutic treatment model to a punishment model and did so in her capacity as a psychologist; thus, the need for training, supervision and oversight.

CONCLUSION

The SHU Exclusion Law addresses some of the problems faced by individuals in prison who suffer from “serious mental illness,” but much more is required to protect the mental health of incarcerated New Yorkers.

First, although DOCCS and OMH may be providing some treatment for prisoners once they are diagnosed with a “serious mental illness,” in many cases DOCCS is also responsible for causing or, at the very least, exacerbating an individual’s mental illness problems by imposing prolonged solitary confinement. Because of this, long term solitary confinement should be banned.

Second, to promote the goals of the SHU Exclusion Law, we must provide DOCCS staff with independent oversight and intensive training by outside experts. These individuals should be mental health experts with a keen understanding and sincere appreciation of the effects of solitary confinement on a person’s mental health.

Third, we should expand the “seriously mentally ill” definitions in the SHU Exclusion Law to include a broader spectrum of those suffering from mental illness and we should make the SHU Exclusion Law applicable to anyone being held in any form of solitary confinement including voluntary or involuntary protective custody and administrative segregation.

Fourth, we should require OMH to request the complete mental health history, including all community mental health and education records of any DOCCS patient it treats and mandate that OMH review and consider any history of post-traumatic stress disorder and/or organic brain injury in diagnosing and treating incarcerated New Yorkers.

Finally, we should require in-depth and improved training and oversight of OMH staff with respect to the diagnosis and treatment of those suffering from mental illness to ensure that they are focused on providing treatment, not punishment, through a therapeutic treatment model.

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