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Testimony by The Correctional Association of New York Before the Senate Judiciary Committee's Subcommittee on the Constitution, Civil Rights and Human Rights
Reassessing Solitary Confinement – June 19, 2012

The Correctional Association of New York (CA) would like to thank the Subcommittee for the opportunity to provide written testimony about New York State's use of solitary confinement, referred to in the state as special housing units (SHU), S-block, and keeplock.[1] Our testimony will document the extensive and expanding abuse of isolated confinement in New York prisons and its devastating impact, particularly on those suffering from mental illness. We will also offer New York as a model for beginning to address the isolation of persons with serious mental illness, while documenting the ongoing challenges and limitations of the New York experience.

Recent History of Advocacy on Solitary Confinement in NYS

The CA is an independent, non-profit organization that has legislative authority to investigate prison conditions in New York and report its findings and recommendations to the state legislature. The CA has long reported on the use and conditions of solitary confinement in New York and advocated for more humane alternatives. Over the last decade, the CA, along with many other advocates in New York, focused on some of the worst abuses imposed by solitary confinement – isolation of those suffering from serious mental illness. In reports published in 2003 and 2004,[2] based on visits to numerous disciplinary housing units in New York, the CA documented the terrible consequences for people with mental illness who are sent to the harsh isolation of the SHU. For example, the CA found people who smeared themselves with feces or lit their cells on fire and/or who were actively demonstrating severe psychological harm. The CA also found long SHU sentences of up to more than a decade, extremely high rates of suicide and self-harm, and people with overwhelming feelings of isolation and sensory deprivation resulting in depression and withdrawal even for those individuals who did not suffer from a mental illness prior to entering the SHU. Subsequent to those reports, based on visits to nine Office of Mental Health (OMH) level 1 or 2 maximum security prisons with SHUs between December 2004 and November 2008, the CA again documented the continued overuse and harmful effects of isolation for the seriously mentally ill. Those visited prisons contained 546 SHU cells and housed 515 individuals, nearly 50% of whom were on the OMH caseload. Several of those prisons had very high numbers of people in the SHU requiring psychiatric hospitalization or transfer to a Residential Crisis Treatment Program (RCTP) due to mental deterioration, such as at Auburn and

[1] SHU units are segregated cellblocks in most maximum- and some medium-security prisons, where individuals must spend 23 hours per day in their cell, are offered one hour per day of recreation, and have meals delivered to their cells. Keeplock refers to individuals confined for 23 hours a day either in their cells or in a separate cellblock. S-blocks are segregated freestanding high-tech lockdown units where individuals are double celled; New York State also has two facilities, Southport and Upstate, which constitute entire prisons made up of these high security lockdown units and eight additional S-blocks at other facilities. Because those individuals confined in double cells are held in isolation with a second person, in this testimony we will use the term "isolated confinement" in place of solitary confinement.
[2] Correctional Association, *Mental health in the House of Corrections*, June 2004 and *Lockdown New York*, Oct. 2003.

Elmira, where people in SHU were 20 to 30 times more likely to require psychiatric hospitalization than those in general population. Moreover, the CA documented the repeated cycling of people between the SHU and RCTPs or hospitalization, as well as the disproportionately high prevalence of suicide and self-harm amongst people with mental illness and/or confined in SHU or keeplock units.[3]

As a result of the intense focus on isolation of the seriously mentally ill by numerous advocates, and through a combination of litigation and legislation, New York implemented historic restrictions on solitary confinement for the seriously mentally ill. The SHU Exclusion Law[4] was passed by the New York State Legislature in January 2008 – expanding upon a 2007 litigation settlement in *Disabilities Advocates, Inc. v. NYS Office of Mental Health* – and took full effect in July 2011. The effect of the settlement and the law has begun to produce positive results for people suffering from serious mental illness. However, significant implementation challenges remain to ensure those protected by the law receive treatment and care. Also, the law does not cover large numbers of people with significant mental illnesses, and has not had any impact on stemming the extensive and expanding use of isolated confinement for the majority of people in NYS prisons. Isolation is routinely used, not primarily to address chronically violent behavior or serious security or safety concerns, but often in response to non-violent prison rule violations, or even as retaliation for questioning authority, talking back to an officer, or filing grievances. Moreover, people often accumulate SHU time while in disciplinary confinement, resulting in long-term isolation, sometimes lasting a decade or more.

New York's Extensive and Expansive Use of Isolated Confinement

Despite a substantial decline in the prison population since 2000, DOCCS continues to discipline an extraordinarily high number of individuals in its prisons, and many of these persons are placed in disciplinary confinement for extended periods of time under harsh conditions.

The DOCCS population reached its maximum of 71,538 in December 1999 and has dropped 23% to its January 2012 level of 55,073 individuals. During this time, the number of DOCCS facilities has been reduced from 70 to 60 institutions. Despite this impressive reduction in the prison population, there has not been a concomitant decline in the population in disciplinary confinement. In fact, the percentage of the population in the most severe isolation, the SHU, has increased during the past ten years. **Table 1 – Summary of DOCCS Population and SHU Confinement,** on page 3, illustrates this unfortunate trend. The most recent data represents a 46% increase in the percentage of the prison population in the SHU compared to the 2003-0 period. It should be noted that during the period 2003-05 there was a significant population in keeplock status in the prisons, generally in the range of 1,500 residents; but even with these figures added to the total, the percentage of individuals in disciplinary confinement during that period was still less than the percentage now in SHU. Further, keeplock is still used by DOCCS, and although we believe it is used less frequently than during 2003-05, we have documented a keeplock census that would appear to exceed 1,000 individuals. It should also be emphasized that keeplock can involve significant periods of isolation. During the 2003-06, annually there were more than 800 individuals sentenced to 90 days or more in keeplock.

[3] According to a DOCS' *Inmate Suicide Report, 1998-2007*, from 1998-2004, 34% of the suicides were in a SHU or disciplinary keeplock unit, and even the slightly decreased percentage of 18% for the period 2005-2007 represented a suicide rate more than twice the rate for the general population. Similarly, 57% of DOCS suicide victims were classified as OMH level 1, 2 or 3 patients at the time even though they represented only 15% of the prison population; and in 2007, just prior to the passage of the SHU Exclusion Law, 11% of the total self-harm unusual incident reports in NYS prisons and 39% of the suicide attempts occurred in a special housing unit.

[4] SHU Exclusion Law of 2008, 2008 N.Y. Laws 1 (codified as amended at N.Y. CORRECT. LAW §§ 137 & 401-a (McKinney 2012) and N.Y. MENTAL HYG. LAW § 45 (McKinney 2012)

Table 1 – Summary of DOCCS Population and SHU Confinement

Population	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Prison Pop	66,745	65,197	63,698	62,732	63,304	62,599	60,081	58,378	56,315	55,073
Total SHU Pop	3,450	3,500	3,500	n/a	4,500	4,504	4,329	4,273	4,331	4,308
SHU % of Pop	5.17%	5.37%	5.49%		7.11%	7.20%	7.21%	7.32%	7.69%	7.82%
S-Block Pop *			1,300	1,280	1,300	1,300	1,250	1,270	1,216	1,446

* Residents in S-Block units, each with capacity for 200 disciplinary prisoners, are included in the SHU census total.

The data presented in **Table 1** illustrates the unusually high rates of isolation employed by DOCCS. According to data presented by the Vera Institute, taken from a DOJ Bureau of Justice Statistics report about the prison population in the United States in 2005, 81,622 individuals were in some restrictive housing in federal and state prisons, representing 5.7% of the entire prison population in the country.[5] New York's 2012 figure is 37% higher than the national average and does not include individuals in keeplock, administrative segregation or some other form of restrictive housing.

The census in the SHU at any one time does not measure the full impact of disciplinary confinement on the NY prison population. Our project surveys incarcerated individuals during prison visits and of the 4,440 individuals who have responded to our survey, 21% stated that they had been in the SHU at the prison at which they were currently confined; at several facilities that figure rose to 28% to 38% of all survey respondents. Since most individuals have been at multiple prisons, this figure would be substantially higher if we asked whether they were ever in the SHU. The only conclusion to draw is that the SHU impacts a large portion of the prison population.

New York's disciplinary population is so high because DOCCS issues a large number of disciplinary actions against its population. Each year, approximately 150,000 violations of the prisons rules are prosecuted by DOCCS. Since approximately 95% of individuals charged with a prison violation are generally found guilty, most of these violations result in some form of punishment. SHU confinement is given for the more serious offenses. The vast majority of SHU sentences are 60 days or more, and in practice most SHU residents spend many months in isolation.

Our project has analyzed DOCCS data for all disciplinary dispositions for the period 2003 through August 2006. During these three and two-third years, each year12,200 SHU sentences were imposed, affecting a total of 22,525 individuals. Of these, approximately 4,500 individuals each year were given six months or more of SHU time, and annually more than 1,600 individuals were given a year or more in the SHU for a single violation. Although these numbers are disturbing, they do not fully present the true impact on these individuals. The 2003-06 data allowed us to link SHU sentences to specific individuals, revealing that a majority of individuals given lengthy SHU sentences were given multiple SHU sentences during this time period. Nearly 80% of people with a six month or more SHU sentence had at least one additional rules violation resulting in additional SHU time. Similarly, nearly 80% of those with a year or more SHU sentence had multiple SHU dispositions. Due to these multiple SHU sentences, many people spend many months and even years in the SHU.

During our prison visits we survey individuals in the SHU and ask about their total disciplinary sentence. Nearly one-quarter of the more than 500 survey respondents reported a cumulative SHU

[5] Browne, Cambier, & Agha, Prisons Within Prisons: The Use of Segregation in the United States. Federal Sentencing Reporter, Vol. 24, No. 1, Sentencing Within Sentencing (October 2011), pp. 46-49; Stephen, James, J, Census of State and Federal Adult Correctional Facilities, 2005 (Bureau of Justice Statistics, U.S. Department of Justice, October 2008).

sentence of one year or more. At certain maximum security prisons a majority of respondents were serving a year or more, and many indicated they were facing multiple years. This accumulation of additional SHU time is particularly prevalent for people already in disciplinary confinement. Although these individuals have very limited opportunity to leave their cell, we find very high numbers of SHU residents receiving additional disciplinary tickets. The SHU becomes a vicious cycle of: isolation, actual or perceived misconduct in the SHU, and additional discipline; many residents surrender to the proposition that they will never be able to leave the SHU until released from prison. Not surprisingly, the despair and anger that results from this hopeless cycle makes getting out of the SHU even more difficult.

General Impact of Isolation

People in the SHU and other forms of isolated confinement are not able to participate in any meaningful programs, jobs, or group interactions, are generally denied such basic "privileges" as making phone calls or purchases from commissary, are allowed a maximum of five books, letter writing supplies, and religious materials, receive food in their cells, and often receive increasingly harsh deprivation orders for rule violations, including restrictions on such basic amenities as food, showers, recreation, and haircuts.[6] The sensory deprivation, lack of normal interaction, and extreme idleness can cause intense suffering and severe psychological debilitation for any person subjected to it, and can have even more devastating impacts on those suffering from mental illness. Incarcerated women face additional special issues related to solitary confinement and its impact on emotional and physical health.[7] For example, isolation can have particularly damaging affects on survivors of domestic violence and abuse, which represents the overwhelming majority of incarcerated women. Extended isolation may trigger symptoms of Post Traumatic Stress Disorder (PTSD) such as flashbacks, self-destructive acts, emotional dissociation, difficulty sleeping, and irritable and aggressive behavior. In addition, isolation can have a devastating affect on women's sense of self-worth and ability to access needed supports, as women often place particular importance on sustaining relationships and community.[8] Moreover, isolation can compromise women's ability to fulfill their particular needs related to reproductive health care, for instance by impeding pregnant women's access to critical obstetrical services, preventing them from getting the regular exercise and movement vital for a healthy pregnancy. Similarly, women in isolation may be dissuaded from requesting care related to sensitive gynecological issues because they are required to inform correction officers about details of their medical problem, may have serious difficulty accessing appropriate medical staff when they do reach out, may be shackled during gynecological appointments that do occur, and will often interact with medical providers in full view of correction officers and/or receive superficial evaluations through closed cell doors.

Mental Health and Disciplinary Confinement in NYS – the SHU Exclusion Law

As noted above, people suffering mental illness face some of the most severe impacts of isolation, and the CA and other advocates have thus far focused their advocacy related to solitary confinement on improving conditions for that population. In part due to the closing of numerous psychiatric

[6] As a particularly harsh deprivation order, individuals are placed on a restricted diet where all meals consist of what is known as "the loaf," a dense, binding, tasteless, one pound loaf of mixed ingredients with a side of raw cabbage.
[7] Bedford Hills and Albion are the only two women's facilities with a SHU – Bedford's unit has 24 cells and Albion's has 48 – and all facilities except Beacon have a Keeplock area.
[8] Barbara Bloom, Barbara Owen, and Stephanie Covington, *Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders*, the National Institute of Corrections

hospitals across New York, and the limited availability of community based treatment options, the state has seen a significant rise in the number of individuals with a mental illness who are confined in correctional facilities. Over the past decade the number of individuals on the prison mental health caseload has soared, reaching a high of 9,067 patients in 2008, before dropping to 7,958 as of January 1, 2011. Individuals with a mental illness are often subjected to disciplinary sentences because of difficulty complying with strict prison rules, and isolation often exacerbates any mental illness, and leads to more behavioral issues and SHU time. The devastating effect of isolation on people with mental illness is particular pressing for incarcerated women as they suffer from mental illness at substantially higher rates than their male counterparts, with more than 42% of women in NY prisons having been diagnosed with a serious mental illness as of January 2007. The SHU Exclusion Law aims to limit some of the worst forms of abuse of isolated confinement for those with serious mental illness, and has made significant progress in improving conditions for these patients. Data, primarily provided by DOCCS and OMH,[9] indicates both that the law has already achieved substantial results and that serious challenges remain in its implementation.

Provisions of the SHU Exclusion Law

The SHU Exclusion Law requires that any individual who suffers from a serious mental illness and is sentenced to a period of disciplinary confinement that could exceed 30 days must be diverted from a SHU or separate keeplock unit to a Residential Mental Health Treatment Unit (RMHTU), except in "exceptional circumstances."[10] RMHTUs must be therapeutic in nature, jointly operated by DOCCS and OMH, and include all NYS Residential Mental Health Units (RMHU), Behavioral Health Units (BHU), Therapeutic Behavioral Units (TBU), Intermediate Care Programs (ICP), and the Intensive Intermediate Care Program (IICP).[11] The law requires that individuals in RMHTUs be offered at least four hours a day, five days a week, of structured out-of-cell therapeutic programming and/or mental health treatment.[12] The law also requires RMHTU residents to "receive property, services, and privileges" similar general population,[13] and places restrictions on discipline in RMHTUs, including prohibiting: restricted diets, misbehavior reports for refusing medication or treatment, and removal to disciplinary confinement absent a significant and unreasonable safety or security risk; as well as creating a presumption against disciplinary charges for acts or threats of self-harm.[14] In addition to the provisions related to diversion, the law requires all new DOCCS staff who will regularly work in programs providing mental health treatment to receive eight hours of training on such topics as types and symptoms of mental illness, treatment goals, suicide prevention, and effective and safe management of individuals with mental illness.[15] The law empowers the NYS Commission on Quality Care & Advocacy for Persons with Disabilities ("CQC") to monitor the quality of mental health care provided to incarcerated individuals, ensure compliance with the law, make

[9] Some of the data analyzed was provided by the Office of Mental Health's (OMH) Central New York Psychiatric Center (CNYPC), which operates a forensic psychiatric wing for patients in prison who require hospitalization. The data analyzed included annual summaries of the services provided both within DOCCS facilities by OMH staff and data about people in DOCCS prisons transferred to the inpatient unit at CNYPC for psychiatric hospitalization. We also reviewed OMH annual reports for specific mental health programs for the periods 2007 through 2011, where such data was available, and system-wide data provided by DOCCS concerning its prison population.
[10] *See* N.Y. CORRECT. LAW § 137.6(d)(i).
[11] N.Y. CORRECT. LAW § 2.21. If a diverted individual is placed in an RMHU or BHU, the time spent in those units will be credited toward any disciplinary sanction that has been imposed.
[12] N.Y. CORRECT. LAW § 2.21. The law carves out an exception to the four hour requirement for the 38 BHU unit beds currently at Great Meadow Correctional Facility, where only two hours of out of cell time are required.
[13] N.Y. CORRECT. LAW § 401.2(b).
[14] N.Y. CORRECT. LAW § 401.2(b), 3, 5(a)
[15] N.Y. CORRECT. LAW § 401.6.

recommendations related to the diversion and removal of individuals with serious mental illness from disciplinary confinement, and have an advisory committee composed of mental health experts, advocates, and family members of incarcerated individuals with serious mental illness.[16]

Positive Outcomes of the SHU Exclusion Law

Although implementation of the SHU Exclusion Law remains in its early stages and thus it is difficult to assess the law's effectiveness, positive outcomes have resulted from the preparation for and implementation of the law. Evidence suggests that a significant number of individuals with serious mental illness have been diverted from the SHU to RMHTUs. New York has expanded the number of treatment beds available for individuals with a serious mental illness sentenced to disciplinary housing, meaning more people receive increased mental health services, the opportunity for disciplinary time-cuts, and the use of non-punitive information reports in response to problematic behavior, instead of discipline that results in additional SHU time. As seen in **Table 2**, in the years leading up to full implementation of the law, and presumably in anticipation of its required implementation, the number of patients with serious mental illness housed in the SHU dropped significantly from 174 in 2007 to 47 in June of 2011, just prior to the law taking full effect. While the total number of people with serious mental illness in disciplinary units has remained fairly constant with a slight decline from 260 patients in 2007 to 241 in 2011,[17] the vast majority of these patients were in a disciplinary mental health treatment program as of June 2011, whereas in 2007, only 35% were receiving intense mental health services. Similarly, the percentage of the SHU population on the OMH caseload has dropped from under 19% to under 14%, indicating that although the total number of OMH patients in some form of disciplinary mental health housing has remained at nearly 800 patients or 18% of those units, a greater number are receiving more intense mental health services.

Table 2 – Disciplinary Confinement for DOCCS Patients with Mental Illness

Disciplinary Units	2003	2004	2005	2006	2007	2008	2009	2010	6/2011
Total SHU Pop	3,450	3,500	3,500	n/a	4,500	4,504	4,329	4,273	4,254
S-Block Pop *			1,300	1,280	1,300	1,300	1,250	1,270	1,216
SHU Patients on OMH caseload	849	798	753	711	660	644	606	561	579
"S" Designated SHU Patients**	n/a	n/a	n/a	n/a	174	166	125	104	47
BHU Patients †	n/a	n/a	76	83	96	90	62	60	78
RMHU Patients††	-	-	-	-	-	-	-	67	88
Total SHU, BHU, RMHU on OMH			829	794	756	734	668	688	792

* S-Block unit residents, each with capacity for to hold 200 people, are included in the SHU census total.
** The number of "S" designated patients in SHU includes patients in the STP and GTP but not the BHU or RMHU.
† BHU census data was obtained from DOCS population data from 7/2005, 9/2006, 6/2007, 9/2008, 6/2009 and 9/2010.
†† RMHU census figures were obtained from DOCCS 9/2010 population data.

[16] N.Y. CORRECT. LAW § 401-a(1), (2), (3).
[17] Prisoners with serious mental illness (SMI), or an "S" designation according to OMH, meet the criteria specified in the SHU Exclusion Law. We have computed this census by adding the patients in the BHU and RMHU to the SHU residents listed as "S" designated. In 2011, it appears STP patients were not included in the listing of "S" designated patients in the SHU, so we added that population of 28 prisoners to the group of SHU, BHU and RMHU patients.

In addition, all individuals with serious mental illness who were previously confined in Special Treatment Program (STP) units – where patients remained in the SHU and participated in two hour group sessions five days a week in caged therapeutic cubicles in which participants were physically separated from each other – were transferred to RMTHUs or non-punitive housing areas and therefore are receiving more treatment in a more therapeutic environment. As an indication of the positive impact, the percentage of patients discharged from the STP to the ICP rose significantly[18] at the same time that, because of the DAI litigation, the number of ICP beds and patients in the ICP both rose more than 35% from 2007 to 2010.[19] To the extent that more individuals have been transferred to the ICP as a result of the DAI litigation and the SHU Exclusion Law, patients receive much more intensive mental health services in a more therapeutic environment, as the vast majority of ICP patients receive 20 hours of therapy per week. Moreover, the feasibility of transitioning disciplinary patients with serious mental illness to non-punitive treatment programs is amply demonstrated by data from 2008 to 2010 whereby discharges from STPs to all non-punitive mental health programs were routine, remained stable at approximately 40%, and constituted the largest single disposition of patients leaving STPs. This increased number of such transfers is a marked change from a decade ago when few disciplinary prisoners left the SHU.

Significant Areas of Concern

1. <u>Individuals Not Protected by the Law and Under-Diagnosis</u>

Although the SHU Exclusion Law has resulted in substantially improved treatment and programs for people with serious mental illness, significant challenges remain. The law has not had an impact on the extensive and expanding use of disciplinary confinement for people in prison without serious mental illness. In addition, people in keeplock, where isolation can be just as devastating, are not afforded the law's protections unless placed in a SHU or separate keeplock unit. Even for those in SHU with some form of mental illness, including diagnoses many would consider serious, the law creates a hard line set by its definition of "serious mental illness," with those who fall above the line receiving intensive mental health treatment and those who fall below receiving little to none. Under the law an individual has a serious mental illness if: a) diagnosed with listed Axis I disorders;[20] b) actively suicidal or engaged in a serious suicide attempt; c) diagnosed with a mental condition, organic brain syndrome, or severe personality disorder with particular characteristics that leads to a significant functional impairment involving acts of self-harm or their equivalent; or d) determined to have substantially deteriorated in isolation to the point of experiencing impairments indicating serious mental illness and involving acts of self-harm or their equivalent. Those not assessed to be in these categories do not receive diversion, treatment, programs, or other protections of the law.

Moreover, the creation of a hard line inherently creates an incentive for OMH and DOCCS to classify people below the line. Diagnoses data over the last few years raises concerns about potential under-diagnosis. For instance, as noted above, the number of patients on the OMH caseload precipitously

[18] The percentage discharged from STPs to ICPs rose from 17.5% in 2008 to 31.5% in 2010; those discharged from STPs to CNYPC dropped from 20.6% in 2008 to 14.3% in 2009 to 8.5% in 2010.
[19] The number of ICP beds increased from 551 in 2007 to 743 in 2010, and the number of patients in the ICP increased from 527 in 2007 to 715 in 2010.
[20] The Axis I diagnoses include: schizophrenia, delusional disorder, schizophreniform disorder, schizoaffective disorder, brief psychotic disorder, substance induced psychotic disorder other than intoxication or withdrawal, psychotic disorder NOS, major depressive disorders, and bipolar disorder I and II.

dropped between 2008 and 2011. While the overall number of individuals incarcerated in New York has also decreased by 6.3% from 2008 to 2011, the number of patients on the OMH caseload has dropped by 12.2%, almost double the decline in the total prison population. More directly related to the SHU Exclusion Law, between 2007 and 2011 the percentage of patients with a primary diagnosis of schizophrenia or another psychotic disorder has significantly decreased while those diagnosed with an anxiety, personality or adjustment disorder has increased.[21] Given that, as discussed above, patients diagnosed with a psychotic disorder automatically qualify for the most intensive mental health services, while those with non-psychotic disorders will only qualify if significant additional criteria are met, and therefore may not receive any protections under the law, this substantial change in diagnoses raises serious concerns about the possibility of under-diagnosis.

2. Punitive Rather than Therapeutic Environment

Serious concerns also remain about the degree to which RMHTUs provide a therapeutic, rather than punitive, environment. Although people with serious mental illness in these units are required under the law to receive two or four hours per day in a therapeutic environment, patients spend the rest of their time in the harsh punitive environment of a disciplinary confinement unit. Prolonged isolation, even in units that provide some mental health services, can have devastating effects, which, for instance, often manifest in incidents of self-harm. Moreover, many individuals with serious mental illness in these units continue to receive large numbers of disciplinary tickets. Recent visits by the CA to the Great Meadow and Attica Correctional Facilities[22] provide examples of the difficult challenges that remain for people in disciplinary units with a mental illness. Attica and Great Meadow are both maximum-security facilities that confine a total of over 3,700 individuals, have SHU and keeplock cells, and subject 350 individuals to some form of isolation. Both facilities have a significant portion of their population on the OMH caseload,[23] are OMH Level-1 facilities,[24] and operate special disciplinary housing units for people suffering from mental illness with a long-term disciplinary sentence.

Great Meadow's BHU[25] exemplifies the tension between RMHTUs as treatment programs and disciplinary units. A distressingly high number of BHU patients reported that it was common for security staff to physically assault patients. One individual shared that before a particular group therapy session began, he was expressing his concerns about security staff to his fellow patients, when a mental health staff person walked in, heard him and immediately reported it to security staff, who promptly removed him from therapy and physically assaulted him on the way back to this cell.

[21] Between 2007 and 2011, the percentage of patients diagnosed with schizophrenia or psychosis dropped from 21.4% to 17.8%, representing a decline of 16.8%. In contrast, there was an increase in the diagnosis of personality disorders, from 7.2% to 10.1% from 2007 to 2011, a 40% increase. Similarly, there has been a significant increase in the diagnosis of adjustment disorder, rising from 6.6% in 2007 to 11.6% in 2011, representing a 76% increase. Patients diagnosed with anxiety disorders also rose from 9.8% to 10.5% during this four-year period.

[22] PVP visited Attica Correctional Facility in April of 2011 and visited Great Meadow Correctional Facility in 2009 and, due to serious concerns, returned to Great Meadow again in 2010 and 2011.

[23] At Attica, staff estimated that 21% of the entire population was on the OMH caseload; at Great Meadow 24% of the entire population was on the OMH caseload. The number of patients requiring mental health treatment at these facilities is significantly higher than the estimated 14% of prisoners system-wide who require mental health treatment.

[24] OMH designates facilities from Level 1 to Level 6 according to the availability of mental health staff and the treatment provided. Level 6 facilities have no mental health staff and Level 1 have full-time staff and provided the most intensive services.

[25] The BHU operates in three phases, Phase I, which operates at Great Meadow, is the most restrictive, but provides two hours of out-of-cell therapy and incentives to increase positive behavior; Phase II and III, which operate at Sullivan Correctional Facility provide more freedoms, with additional out-of-cell time and decreased physical constrictions.

Similarly, individuals reported that when they expressed concerns regarding self-harm or suicide, they were met with hostility and physical threats. One person reported that when he told security staff he was feeling suicidal and wanted to see mental health staff, the security staff person responded "Just hang up if you want. It would make it easier for us." Moreover, at both the Great Meadow and Sullivan Correctional Facility BHUs, the vast majority of residents continue to receive disciplinary sanctions, and the practice not only persists, but has increased according to the last two years of available data.[26] This frequent use of discipline seriously undermines the therapeutic nature of the units and the ability of patients to progress to less restrictive mental health housing. Similarly, many patients in BHUs are being transferred to another program with significant SHU or keeplock time remaining, which they will be required to serve. According to data from 2010, the average amount of SHU time and keeplock time remaining for individuals released from the BHU were both over one year. In a related manner, the time-cuts individuals should be receiving are insignificant in terms of their disciplinary sentence. The average amount of time cut for people in the BHU was 78 days, which is relatively small for individuals who may be serving years.

Attica's STP, initially established as a disciplinary unit for people with serious mental illness but now no longer recognized as an RMHTU under the SHU Exclusion Law,[27] similarly demonstrates the difficult challenges facing individuals with serious mental illness confined in disciplinary units. Attica STP patients reported long SHU sentences with a median of three years and some reported sentences of up to 10 years. In addition, many of the individuals had been in other residential treatment programs across the state and had received additional SHU time while on those units. Further, although individuals were offered two hours of out-of-cell therapy everyday, a significant percentage of those in the STP refused to participate. As a further indication of the negative psychological impact of prolonged confinement in the harsh environment of the STP, the number of individuals in all STP units across the state requiring psychiatric hospitalization represents a disproportionately large portion of the total admissions to CNYPC,[28] with a rate roughly three times higher than for non-punitive mental health treatment program patients. Also, as in the BHUs, the majority of STP patients continued to receive disciplinary tickets, and were discharged with significant SHU or keeplock time, with less than half of those on the unit receiving a time-cut while in the STP. In 2010, CNYPC reported that 98% of patients discharged from the STP had received a serious disciplinary sanction while on the unit, only 45.5% had received a time-cut, and the average amount of SHU time remaining was just under one year. This data illustrates the continued use of discipline on the unit, the failure of the time cut process to significantly reduce SHU sentences, and a pattern of STP patients leaving the program with substantial time to serve in restricted housing.

[26] Sixty-one percent of BHU patients with serious mental illness released in 2009 received a serious disciplinary ticket (Tier 3 misbehavior reports), and that figure increased to 71% in 2010.

[27] The Special Treatment Program for disciplinary prisoners with serious mental illnesses was opened at Attica C.F. in 2000 as a treatment program for disciplined people confined to SHU. STP units were subsequently created in the SHUs at Five Points C.F. and Green Haven C.F. The SHU Exclusion Law does not recognize these units as RMHTUs and, therefore, as of July 1, 2011, disciplined persons with serious mental illness could no longer be housed there. Although these units are no longer operational, data analyzing the census and treatment of STP patients is relevant to understand the challenges faced by individuals with serious mental illness in disciplinary units with mental health services, particularly since the STPs at Attica and Five Points were converted into RMHUs. Moreover, although in preparation for full implementation of the SHU Exclusion Law DOCCS began to phase out use of the STP, in 2008 through 2010 there was a substantial increase in STP admissions mostly from the SHU and other disciplinary residential mental health treatment units, demonstrating the continuing need for residential mental health treatment for disciplinary patients.

[28] In CY 2010, STP patients accounted for nearly 5% of all CNYPC admissions even though the STP population is only 1.25% of the patients on the OMH caseload.

Although the SHU Exclusion Law strives to reduce the number of individuals with a mental illness placed in disciplinary confinement, lessen the time served, and limit the use punishment, as demonstrated by data on the BHU and the STP, the practice of continuing to punish and isolate those individuals with a mental illness persists in units across New York State.

3. Suicide and Self-Harm

Self-harm and suicides are perhaps the most devastating manifestation of continued challenges for people with mental illness in isolated confinement. NYS prisons have a comparatively large number of suicides, with a disproportionate number occurring in isolation. The most recent national data for 2001-2004 demonstrates that New York's average annual suicide rate over the past 12 years of 19.7 incidents per 100,000 people in prison is 30% higher than the national average of 15 suicides per 100,000.[29] In 2010, New York's suicide rate of 35 per 100,000 was more than double the national average, and was the highest rate for the past 28 years.[30] Equally disturbing, far too many of the individuals committing suicide are confined in the SHU or keeplock and/or suffer from mental illness. Between 1998 and April 2004, 34% of prison suicides occurred in disciplinary confinement, although prisoners in these units comprised less than 7% of the total prison population.[31] That rate only slightly declined, to 29%, for the period 1998 to 2009.[32] In 2010, although the percentage of suicides in disciplinary confinement dropped to 10%, there is still a concern that many of the individuals who committed suicide had been recently transferred from disciplinary housing.

Suicides can not be viewed in isolation, as they are the devastating final product of often multiple attempts of suicide or acts of self-harm. By analyzing Unusual Incident Reports (UIR) data for 2007-2010,[33] we found a disturbing pattern of destructive behavior indicating that suicides often occurred at facilities that have the highest rates of self-harm. The data also revealed that facilities with the highest incidence of self-harm are facilities with a high percentage of mentally ill patients and large disciplinary housing units, including the two facilities that only confine individuals with long-term disciplinary sentences. Moreover, the rates of self-harm and suicide attempts at the most problematic facilities are five to 10 times higher than the department-wide average.

Conclusion

New York State has begun to make significant progress in addressing the devastating impacts of isolation on people with serious mental illness, and the SHU Exclusion Law can serve as a model for other states still subjecting such patients to solitary confinement. At the same time, any reliance on the New York system must take into account the limitations of the law, the challenges faced in implementation, and the gaps in coverage even for significant numbers of people with debilitating mental illnesses. Moreover, the New York experience demonstrates that providing protections for a particularly vulnerable population is only an initial step in addressing the abhorrent infliction of isolation, with the state remaining one of the worst examples in terms of the frequency and duration of the imposition of disciplinary confinement.

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[29] BJS,US DOJ, *Medical Causes of Death in State Prisons*, at Appendix Table 1, p. 5 (2007).
[30] Pfeiffer, M., *Prison Suicides Rise; Officials Deny Trend*, Poughkeepsie Journal, 12/26/2010 (available at http://www.nyaprs.org/e-news-bulletins/2011/2011-01-04-PJ-Prison-Suicides-Rise-Officials-Deny-Trend.cfm). Mary Beth Pfeiffer is an independent reporter who has been investigating suicides in DOCCS for several years.
[31] Correction Association, *Mental Health in the House of Corrections* at 57 (2004).
[32] Pfeiffer, *supra* note 29.
[33] In New York State, UIRs must be completed after every incident of suicide and self-harm.