



Out of Sight, Out of Mind

Colorado's continued warehousing of mentally ill
prisoners in solitary confinement



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Executive Summary

This report examines past and continued use of solitary confinement by the Colorado Department of Corrections (CDOC) to manage mentally ill prisoners; considers the moral, fiscal, safety and legal implications of CDOC's continued warehousing of mentally ill prisoners in solitary confinement; and makes recommendations to bring Colorado's prisons in line with modern psychiatric, correctional and legal standards. The report draws on 18 months of research by the American Civil Liberties Union (ACLU) of Colorado, which included correspondence with mentally ill prisoners housed in solitary confinement by CDOC; analysis of data provided by the CDOC in response to over a dozen public records requests by the ACLU, as well as other publicly available CDOC records; in-depth review of several prisoner mental health files; extensive written and in-person dialogue with CDOC's executive team; on site visits to CDOC; and multiple consultations with correctional and psychiatric experts.

Key Facts and Findings

- While the Residential Treatment Program was initiated in early 2013 as a means of providing intensive mental health care to prisoners with the most significant mental health needs, CDOC continues to resort to solitary confinement to manage many mentally ill prisoners.
- As of March 2013, CDOC housed at least 87 seriously mentally ill prisoners in solitary confinement, 54 of whom have been living in isolation for over a year and 14 of whom have been in solitary confinement for more than 4 years.
- Prisoners with moderate to severe psychiatric needs now constitute a majority of those in solitary confinement in Colorado.
- Mentally ill prisoners are disproportionately likely to be held in solitary confinement because mental illness often makes it impossible to comply with the strict behavioral expectations of prison.
- In 2012, the average length of stay for mentally ill prisoners in solitary confinement was 16 months.
- Housing prisoners in solitary confinement can cost taxpayers nearly twice as much as holding them in general population.
- Once in solitary confinement, the mental health of seriously mentally ill prisoners often deteriorates further, making them a greater threat to their own safety, as well as the safety of other prisoners, prison staff, and – ultimately – the public at large, to whom almost all Colorado prisoners will one day be released.
- Courts and the U.S. Department of Justice have agreed that the Constitution forbids subjecting prisoners with serious mental illnesses to prolonged solitary confinement.

Policy Recommendations

The ACLU of Colorado strongly encourages the Colorado Department of Corrections (CDOC) to promptly implement the following recommendations:

- CDOC should bar seriously mentally ill prisoners from placement in prolonged solitary confinement, or administrative segregation.
- CDOC should adopt policies requiring mental health involvement in disciplinary and criminal charging decisions related to seriously mentally ill prisoners.
- All seriously mentally ill prisoners, including those at the lowest levels of the Residential Treatment Program (RTP), should be provided a minimum of 20 hours of out-of-cell time per week, including 10 hours of dedicated therapeutic time.
- RTP should be fully staffed to provide adequate out-of-cell therapeutic and non-therapeutic time. To accomplish this goal, CDOC must have the funding and the will to fill all mental health staff positions, particularly those of psychiatrists and psychiatric nurses.

Introduction

Every day, hundreds of mentally ill prisoners across Colorado are forced to live in extreme isolation, confined to small barren cells where they spend 23 hours per day. These prisoners are deprived of human interaction, mental stimulation and meaningful mental health care. Disembodied hands deliver meals to the prisoner through a slot in the cell door. Human touch is limited to those instances when the prisoner is being transported or disciplined. Most of these mentally ill prisoners “exercise” in a small concrete room with a single pull-up bar and are intentionally denied the opportunity to feel sun on their face, rain on their body or wind in their hair. No activities, programs, or classes break up the day. Few, if any, phone calls are allowed. Few personal possessions are permitted. Prisoners languish in these isolating conditions (called “administrative segregation” by CDOC) for months and often years on end. For many of these prisoners, their mental illness will worsen in solitary confinement. For some, the isolating conditions will drive them to a psychotic state and lead them to attempt suicide, attack others, eat their own feces, or bang their heads against the wall in an effort to drown out the voices in their heads.

It is time for the state of Colorado to stop warehousing seriously mentally ill prisoners in long-term solitary confinement and to begin providing these prisoners with the intensive mental health treatment they need to allow them to be productive members of society upon release.

Background

During each day of fiscal year 2012 (FY 2012),¹ CDOC housed between 537 and 686 mentally ill prisoners in the solitary conditions of administrative segregation.² This data derives from a CDOC report released in January 2013 pursuant to Senate Bill 11-176 (“2013 Report”).³ The 2013 report reflects that CDOC, to its credit, significantly decreased its administrative segregation population during this time. Of serious concern, however, is that even as administrative segregation numbers have decreased, the proportion of prisoners in administrative segregation who are mentally ill has increased. From June 2011 to June 2012, the percentage of mentally ill prisoners in administrative segregation jumped from 46.4 percent to 57.7 percent, an increase of over 11 percent.⁴ Prisoners with moderate to severe psychiatric needs now constitute a majority of those in administrative segregation.⁵ Yet a substantially smaller portion of the Colorado prison population as a whole – 32 percent – have such psychiatric needs.⁶ Given this comparative data, it is clear that one of CDOC’s methods of managing the scores of mentally ill prisoners under its charge is to confine them in administrative segregation.

“ Prisoners with psychiatric needs now constitute a majority of those in administrative segregation. ”

Recently, CDOC has taken steps to move some mentally ill prisoners out of administrative segregation and into treatment, but this report finds that CDOC’s provision of mental health treatment for many of its mentally ill prisoners remains seriously deficient. At the end of 2012, CDOC made the prudent decision to abandon the Offenders with Mental Illness (OMI) Program, which purported to provide treatment to mentally ill prisoners in an administrative segregation setting. According to CDOC’s own statistics, the program had only a 27 percent success rate.⁷ In conversations with the ACLU of Colorado, CDOC executives frankly acknowledged that the

¹ FY 2012 closed June 30, 2012.

² SB 11-176 2012 Annual Report, p. 10, Figure 10.

³ In 2011, the Colorado legislature enacted SB 11-176 to address growing concern over CDOC’s overuse of administrative segregation. The statute requires CDOC to provide an annual written report to the senate and house judiciary committees “concerning the status of administrative segregation; reclassification efforts for prisoners with mental illnesses or developmental disabilities, including duration of stay, reason for placement, and number and percentage discharged; and any internal reform efforts since July 1, 2011.” Colo.Rev.Stat. § 17-113.9(1).

⁴ 2013 Report, p.10, Figure 10. CDOC uses a code system to identify and track offenders with mental health treatment needs. “The psychiatric needs level codes (P codes) ranges from 1-5, with 3-5 indicating moderate to severe needs.” 2013 Report, p. 10. “Mentally ill offenders” are defined by CDOC as offenders with a psychiatric needs level code (P code) of 3-5. 2013 Report, p. 10.

⁵ Ibid.

⁶ CDOC Statistical Report Fiscal Year 2011, p. 54, Table 40.

⁷ Offenders with Mental Illness Report, submitted to House and Senate Judiciary Committees January 31, 2013, p. 5.

OMI program had largely refrained from enrolling seriously mentally ill prisoners, and that CDOC had instead cherry-picked prisoners who were likely to succeed in the program. CDOC's statements to the ACLU are supported by the recommendations of CDOC's consulting clinical psychologist Dr. Joel Dvoskin, who played an integral role in the design and execution of the OMI program. In December 2010, Dr. Dvoskin "recommended that historically when starting

“CDOC’s provision of mental health treatment for many of its mentally ill prisoners remains seriously deficient.”

programs, you want to cheat and pick people you know will succeed so that you build a safety net for both the offenders and staff and get people to trust the program. Rig it to succeed in the first year before you take chances on the cases that make you nervous.”⁸ Especially given this careful selection of prisoners, the OMI program's 27 percent success rate sends a strong message that mentally ill prisoners cannot get better in the solitary conditions of administrative segregation.

In place of the OMI program, CDOC opened a 240-bed Residential Treatment Program (RTP) at Centennial Correctional Facility in early 2013. The RTP purports to provide intensive mental health care to those prisoners with the most significant mental health needs in a setting that avoids the isolating conditions of administrative segregation.⁹ Unfortunately, as discussed in greater detail below, early reports on the RTP strongly suggest that some residents are still being held in solitary confinement. Further, even with the opening of RTP, CDOC acknowledges that as of March 2013, it still housed at least 87 seriously mentally ill prisoners in administrative segregation who were not part of the RTP program, the majority of whom had been living in isolation for a year or more.¹⁰ CDOC persists in this practice despite agreement by psychiatrists and courts that administrative segregation is no place for the seriously mentally ill, because prolonged isolation poses a substantial risk of causing and/or exacerbating mental illness. **CDOC must stop relying on prolonged isolation as the means of managing seriously mentally ill prisoners.**

⁸ "OMI Meeting," CDOC Meeting Notes, December 8, 2010, p. 4

⁹ See *Generally*, Offenders with Mental Illness Report, submitted to House and Senate Judiciary Committees January 31, 2013, pp. 13-14.

¹⁰ CDOC Response to March 4, 2013 Colorado Open Records Act Request by ACLU of Colorado. "Seriously mentally ill prisoners" are those identified by CDOC as having a "major mental illness," which CDOC defines as:

those chronic mental disorders that cause longstanding problems with emotional regulation and/or reality testing, which leads to poor functioning in multiple domains, including social, occupational, and relational. [Major mental illnesses] include psychotic disorders such as schizophrenia, schizoaffective disorder, and psychoses not otherwise specified. Bipolar disorder and major depression are also considered [major mental illnesses].

Offenders with Mental Illness Report, submitted to House and Senate Judiciary Committees January 31, 2013, p. 15.

Seriously Mentally Ill Prisoners Living in Isolation

Why are so many mentally ill prisoners housed in the isolating conditions of administrative segregation? It is likely that mental illness is a root cause of this placement. This is particularly true for those prisoners who suffer from a serious mental illness, such as schizophrenia or depressive disorder with psychotic features. According to the American Psychiatric Association (APA), several studies have shown that prisoners with serious mental illness have more difficulty conforming their actions to the strict behavioral expectations of prison life than do prisoners without mental illness.¹¹ One study concluded that “seriously mentally ill prisoners were less able to successfully negotiate the complexity of the prison environment, resulting in an increased number of rule infractions leading to more time in segregation and in prison.”¹² Other studies found that “inmates with serious mental illnesses committed infractions at three times the rate of non-seriously mentally ill counterparts.”¹³

Once in administrative segregation, prisoners must conform their behavior to extraordinarily strict conduct guidelines in order to work their way through a four-level system and gain release back to the general prison population. Given that mental illness makes it extremely difficult for some prisoners to control their behavior and that the conditions of administrative segregation have been proven to exacerbate mental illness, many seriously mentally ill prisoners suffer for years in the solitary conditions of administrative segregation, and they appear to have no road out of these extremely restrictive conditions of confinement. These prisoners, due to their mental illnesses, are unable achieve even simple, short-term behavioral goals, much less the more difficult and sustained behavioral goals necessary to progress out of administrative segregation.

“ Due to their mental illnesses, these prisoners are unable to achieve the simple behavioral goals necessary to progress out of administrative segregation. ”

¹¹ Background to the Position Statement on Segregation of Prisoners with Mental Illness, APA Official Actions, Dec. 2012 (hereinafter “APA Background to Position Statement”).

¹² APA Background to Position Statement (citing for this proposition Morgan, D.W., A.C. Edwards, and L.R. Faulkner. *The Adaptation to Prison by Individuals with Schizophrenia*. Bulletin of the American Academy of Psychiatry and the Law, 1993).

¹³ APA Background to Position Statement (citing for this proposition Lovell, D. and R. Jemelka. *When Inmates Misbehave: The Costs of Discipline*. The Prison Journal, 1996; Lovell, D. and R. Jemelka. *Coping With Mental Illness in Prison*. Family & Community Health, 1998, as cited in Background to the Position Statement on Segregation of Prisoners with Mental Illness). Notably, CDOC’s own statistics support the notion that mentally ill prisoners face significant hurdles in conforming their behavior to prison expectations. The top two reasons for CDOC’s placement of mentally ill prisoners in administrative segregation relate to repeated prison rule violations. 2013 Report, p. 11, Figure 12.

In 2012, the ACLU of Colorado learned of several prisoners in long-term administrative segregation who, according to the ACLU of Colorado's review of confidential CDOC records related to each prisoner, have repeatedly attempted suicide, suffered from psychotic episodes,

“ For many, if not all, of these prisoners, the isolating conditions of administrative segregation are making them sicker. ”

and/or persistently heard voices in their heads telling them to harm themselves or others. As their mental health deteriorated in isolation, several of these prisoners were charged with violations of the Code of Penal Discipline (COPD) and/or the criminal law. These charges were based on behavior, such as suicide attempts or throwing feces or urine, that forensic psychiatrists have opined stemmed from mental illness in each case. COPD and criminal convictions related to this behavior have resulted in prisoners' failure to progress out of administrative segregation, or worse, have turned shorter

sentences into virtual life sentences. These prisoners likely are too mentally ill to meet the behavioral expectations that would allow them to progress out of administrative segregation. For many, if not all, of these prisoners, the isolating conditions of administrative segregation are making them sicker.

The following is a case study of John Quinn, a seriously mentally ill prisoner confined in long-term isolation who the ACLU has been following for more than a year. This case study underscores the cruelty and fundamental unfairness of confining prisoners in the most restrictive prison setting as a consequence of their mental illness.

CASE STUDY – Descent into Madness

John Quinn* has been incarcerated since he was a 14-year-old boy. When he was 19 years old, CDOC placed him in administrative segregation for participating in a three-way phone call and tampering with a bathroom lock. John spent the next 15 years in the near-complete isolation of administrative segregation until he was moved to the RTP in December 2012. Prior to this long period in administrative segregation, John had been noted to be a young man who was funny, warm and reasonably articulate. All of this is gone.

John had not shown signs of serious mental illness until he had spent about a decade in isolation at the Colorado State Penitentiary (CSP), a supermax prison designed to deny prisoners human contact. During that time, John did not cause serious harm to himself or others, but he could not

manage to work his way out of administrative segregation. By 2006, he was in a deep depression. Under the pressure and stress of long-term isolation with no apparent way out, John's mental health began to deteriorate rapidly. By 2009, he reported hearing a woman's voice in his head that verbally abused him and demanded that he hurt himself. John began to exhibit bizarre and often self-harming behavior that worsened over time. He experienced frequent psychotic breaks, including three suicide attempts and an episode in which he smeared excrement on his food tray because he believed staff members were putting rat feces in his food. At one point, John lost nearly 20 percent of his body weight.

It is clear that in the 15 years John lived in isolation, he became seriously mentally ill. At least eight different psychiatrists since 2010 have diagnosed John as suffering from a serious mental illness with psychotic features, including chronic paranoid schizophrenia. Recently, an independent psychiatrist recommended psychiatric hospitalization for John. **In 2012, an evaluating psychiatrist determined that John's placement in long-term solitary confinement was a source of his mental deterioration. This doctor also concluded that improvement of John's mental health was likely impossible in isolation.**

John's psychotic breaks have often led to his placement in the administrative segregation ward of CDOC's mental health prison, San Carlos Correctional Facility (SCCF). During fiscal year 2011, John spent 183 days in SCCF recovering from various psychotic episodes. John was repeatedly placed in four-point restraints for days at a time – once for a full two weeks. Once stabilized, John was sent directly back to administrative segregation at CSP and the same isolating conditions that were exacerbating – if not causing – his mental illness.

Although John was moved to the RTP in late 2012, a February 22, 2013 report from CDOC shows that John had not been able to progress from the lowest levels of the program. As a result, he was still spending the vast majority of his time in isolation.

John currently has state-appointed lawyers who are asking the court to shorten his sentence because of a change in the law. According to John's lawyer, he is too mentally ill to assist in his own advocacy. **His lawyers have found that John is often drugged into incoherence and resembles a zombie more than the fully functional young man he once was.**

**name changed to protect privacy*



***Restraint chair for transportation within
Colorado State Penitentiary***

John’s story lends credence to the wide and growing consensus among psychiatrists that isolation is predictably damaging to seriously mentally ill prisoners. In December 2012, the APA adopted a position statement against segregation of prisoners with serious mental illness.¹⁴ Specifically, the APA espoused that “[p]rolonged segregation of adult inmates with serious mental illness, with rare exception, should be avoided due to the potential for harm to such inmates.” The APA clarified that “prolonged segregation means duration of greater than 3-4 weeks” and explained that “placement of inmates with a serious mental illness in these settings can be contraindicated because of the potential for the psychiatric conditions to clinically deteriorate or not improve.”¹⁵

Further, as CDOC well understands, it is nearly impossible to provide intensive mental health treatment to prisoners who are locked down 23 hours per day, denied all social interactions, and can only leave their cells to meet privately with a therapist or to participate in group therapy when fully restrained and escorted by two or more prison guards (which deters many prisoners from engaging in private therapy at all). As CDOC frankly acknowledged in a 2013 report to the Colorado legislature:

It is difficult to operate a mental health treatment program in an administrative segregation environment. Designed with security in mind, the atmosphere is not necessarily conducive to behavior change. In addition, due to the highly restricted movement and facility design with segregation at the forefront, it has been challenging at best to conduct group treatment sessions.¹⁶

¹⁴ Position Statement on Segregation of Prisoners with Mental Illness, APA Official Actions, Dec. 2012.

¹⁵ Background to the Position Statement on Segregation of Prisoners with Mental Illness, APA Official Actions, Dec. 2012.

¹⁶ Offenders with Mental Illness Report, submitted to House and Senate Judiciary Committees January 31, 2013, p. 14.

Yet CDOC routinely places seriously mentally ill prisoners in segregated housing for months and sometimes years. **By CDOC’s own count, as of March 2013, 87 seriously mentally ill prisoners were confined in administrative segregation, 54 of whom had been living in isolation for over a year and 14 of whom had been in administrative segregation for over 4 years.**¹⁷ According to CDOC’s 2013 Report, for FY 2012, the median length of stay in administrative segregation for mentally ill prisoners was 485 days, or 16 months.¹⁸

“ Their untreated and often worsened mental illness will lead to criminal actions after release, leaving the public to suffer the consequences of misguided CDOC policies. ”

Placing seriously mentally ill prisoners in prolonged isolation is not only cruel, it is also financially costly and poses a significant risk to public safety. Housing prisoners in administrative segregation can cost nearly twice as much as holding them in general population.¹⁹ More importantly, 97 percent of Colorado prisoners will one day be released to the community. Mentally troubled individuals who enter the prison system and find themselves housed in administrative segregation are likely to emerge with even more serious mental health issues. For some of those prisoners, their untreated and often worsened mental illness will lead to criminal or antisocial actions after release, leaving the public to suffer the consequences of misguided correctional policies.

Also of concern is that CDOC, by allowing seriously mentally ill prisoners to languish in long-term administrative segregation, exposes itself to a very real and significant risk of civil liability. Courts are *unanimous* in their conclusion that the Constitution forbids subjecting prisoners with serious mental illnesses to prolonged segregated confinement.²⁰ Specifically, because isolation is so predictably damaging to the seriously mentally ill, courts have

¹⁷ CDOC Response to March 4, 2013 Colorado Open Records Act Request by ACLU of Colorado.

¹⁸ 2013 Report, p. 12.

¹⁹ CDOC Statistical Report, FY 2011, p. 14.

²⁰ See, e.g., *Ruiz v. Estelle*, 37 F. Supp. 2d 855, 915 (S.D. Tex. 1999) (“conditions in [the] administrative segregation units clearly violate constitutional standards when imposed on the subgroup of the plaintiffs’ class made up of mentally-ill prisoners”); *rev’d and remanded on other grounds*, 243 F.3d 941 (5th Cir. 2001), *adhered to on remand*, 154 F. Supp. 2d 975, 984–86 (S.D. Tex. 2001); *Coleman v. Wilson*, 912 F. Supp. 1282, 1320–21 (E.D. Cal. 1995) (inappropriate disciplinary treatment and placement in segregation units of prisoners with mental illness was unconstitutional); *Casey v. Lewis*, 834 F. Supp. 1447, 1548–49 (D. Ariz. 1993) (condemning placement and retention of mentally ill prisoners in lockdown status); *Inmates of Occoquan v. Barry*, 717 F. Supp. 854, 868 (D.D.C. 1989) (holding that prisoners with mental health problems must be placed in a separate area or a hospital and not in administrative/punitive segregation area); *Langley v. Coughlin*, 715 F. Supp. 522, 540 (S.D.N.Y. 1988) (holding that evidence that prison officials fail to screen out from SHU “those individuals who, by virtue of their mental condition, are likely to be severely and adversely affected by placement there” states an Eighth Amendment claim).

repeatedly found segregated confinement of such prisoners violates the Eighth Amendment’s ban on cruel and unusual punishment. As a district court explained when it banned segregation of seriously mentally ill prisoners at California’s Pelican Bay State Prison:

For these inmates, placing them in the [segregated housing unit] is the mental equivalent of putting an asthmatic in a place with little air to breathe. The risk [of suffering serious injury to their mental health] is high enough, and the consequences serious enough, that we have no hesitancy in finding that the risk is plainly unreasonable.²¹

Similarly, in 2001, the federal court considering conditions at Wisconsin’s Supermax Correctional Institution noted “[m]ost inmates have a difficult time handling these conditions of extreme social isolation and sensory deprivation, but for seriously mentally ill inmates,



***Colorado State Penitentiary
Administrative Segregation unit***

the conditions can be devastating.”²² After protracted litigation, the court ordered that all prisoners with serious mental illness must be removed from Wisconsin’s supermax facility. At the end of 2012, yet another federal court found “extensive evidence” that “segregation harms

²¹ *Madrid v. Gomez*, 889 F. Supp. 1146, 1265 (N.D. Cal. 1995) (quotation marks omitted).

²² *Jones’El v. Berge*, 164 F. Supp. 2d 1096, 1098 (W.D. Wis. 2001).

mentally ill prisoners,” and ruled that segregation of certain mentally ill prisoners by the Indiana Department of Corrections violated the Eighth Amendment.²³

Quite simply, courts and psychiatrists agree that seriously mentally ill prisoners do not belong in administrative segregation, because prolonged isolation poses a substantial risk of exacerbating mental illness.

“ CDOC is aware that confining seriously mentally ill prisoners in administrative segregation is unconstitutional. ”

In May 2013, the United States Department of Justice (“DOJ”) issued damning findings regarding solitary confinement practices of the Pennsylvania State Correctional Institution at Cresson (“Cresson”). These findings are instructive in considering the legitimacy of CDOC’s continued confinement of seriously mentally ill prisoners in prolonged administrative segregation. After an initial investigation, the DOJ determined

that Cresson’s placement of prisoners with serious mental illness in prolonged isolation degrades the prisoners’ physical and mental health, leads to an increased risk of suicide, and violates the Eighth Amendment. As the DOJ cogently explained:

Neither the interests of the Pennsylvania Department of Corrections nor those of the Commonwealth of Pennsylvania are served when one of its prisons subjects prisoners to conditions that deny prisoners with psychiatric disabilities the benefit of mental health treatment and exacerbate their mental illness. When the mental health of prisoners deteriorates, when their episodes of paranoia and psychosis intensify, and when they engage in behaviors more dangerous to themselves and others, taking care of them becomes more difficult and more dangerous for correctional officers and more expensive for the Commonwealth. Moreover, those living outside the prison’s walls feel the negative impact of the prison’s mistreatment of prisoners with serious mental illness when these prisoners return to the community.²⁴

It is worth noting that the DOJ’s findings rested on Cresson’s placement of seriously mentally

²³ *Indiana Protection and Advocacy Services Commission v. Commissioner, Indiana Department of Correction*, Case No. 1:08-cv-01317-TWP-MJD, 2012 WL 6738517 (S.D. Ind. Dec. 31, 2012).

²⁴ Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation, undated 2013 Letter signed by Assistant Attorney General Thomas E. Perez and United States Attorney, David J. Hickton (hereinafter “Cresson Findings”), p. 2.

ill prisoners in solitary confinement for relatively short periods of time when compared with CDOC placements. Most seriously mentally ill prisoners placed in isolation at Cresson were there for a matter of months, and according to the Cresson Findings, only two dozen prisoners spent more than a year in isolation.²⁵ These numbers pale in comparison to CDOC's self-reported 87 seriously mentally ill prisoners in administrative segregation, 54 of whom, as of March 2013, had been housed in isolation for more than a year.

CDOC is aware that confining seriously mentally ill prisoners in administrative segregation worsens the prisoners' mental health and is unconstitutional. In 2010, CDOC took the positive step of retaining Dr. Joel Dvoskin, an independent clinical psychologist with expertise in the treatment of persons with serious mental illness. On several occasions between 2010 and early 2013, Dr. Dvoskin advised CDOC officials that the courts have made clear that seriously mentally ill prisoners are not to be placed in administrative segregation because of the substantial risk of exacerbating their mental illness.²⁶ Unfortunately, despite Dr. Dvoskin's advice, the unanimous rulings of several federal courts, the opinion of the APA, the DOJ's Cresson Findings, and the repeated requests of the ACLU of Colorado, CDOC continues to place seriously mentally ill prisoners in the solitary conditions of administrative segregation for prolonged periods.



Administrative Segregation Cell

²⁵ Ibid.

²⁶ See, e.g., "OMI Meeting," CDOC Meeting Notes, December 8, 2010, p. 2.

Discipline of Mentally Ill Prisoners in Solitary Confinement

As discussed above, mentally ill prisoners often have difficulty conforming their behavior to prison rules, particularly in the highly structured environment of administrative segregation. As a result, some mentally ill prisoners languish for years in administrative segregation at CDOC, repeatedly violating prison rules and racking up COPD disciplinary charges, or even new criminal charges that may lengthen their sentences.

“ Prisoners in ad seg who break a rule as a result of a serious mental illness are punished rather than given treatment. ”

CDOC lacks any formal policy requiring the input of mental health staff into disciplinary decisions regarding prisoners with serious mental illness, including decisions of whether to refer the case to the district attorney’s office for possible criminal prosecution, bring COPD charges, or handle the disciplinary issue therapeutically. This means that many prisoners in administrative segregation who break a prison rule as a result of a serious mental illness – often while in the context of psychiatric deterioration due to prolonged isolation – are punished rather than given treatment. **Punishing mentally ill prisoners for behaviors that result from their mental illness serves no legitimate purpose and raises serious constitutional concerns.** In fact, in the Cresson Findings, the DOJ determined Cresson violated the Constitution by failing to make appropriate considerations for mental health in the course of disciplinary hearings.²⁷

Punishing prisoners for infractions that suggest mental illness, including self-harming or smearing feces, is counterproductive to therapeutic success. Dr. Dvoskin advised CDOC that for mentally ill prisoners, “the lines are blurred between the symptoms of mental illness and an intentional behavioral choice,” so that misbehavior by mentally ill prisoners should be handled clinically, rather than through the disciplinary process, whenever possible.²⁸ Dr. Dvoskin recognized that “there will be instances when . . . the situation must be handled disciplinarily.”²⁹ He warned, however, that “this should occur in a small number of cases and only after a determination has been made that the behavior is not a symptom of mental illness.”³⁰ Recognizing these constitutional and therapeutic concerns, many state prison systems, including California, Connecticut, New Jersey, New York, Ohio and Wisconsin, provide for mental health staff to participate in the process of disciplining prisoners with mental illness.

²⁷ Cresson findings, pp. 20-22.

²⁸ “OMI Meeting with Joel Dvoskin, Ph.D.,” CDOC Meeting Notes, February 15, 2011, pp. 2-3.

²⁹ Ibid.

³⁰ Ibid.

It is for all of these reasons that during the course of 2012 the Colorado Public Defender's Office, the ACLU of Colorado, and CDOC's own expert, Dr. Dvoskin, all urged CDOC to adopt a policy mandating the involvement of mental health staff in all disciplinary decisions related to seriously mentally ill prisoners and especially those housed in administrative segregation. In a March 1, 2013 letter to the ACLU of Colorado, CDOC reported that it was in the process of drafting a regulation that would require consultation with mental health workers at the beginning and end of the COPD disciplinary process.³¹ We await a draft of this welcome new rule. Of continuing concern, however, is that, according to CDOC, the rule apparently will neither require nor even encourage mental health staff to provide input in the decision of whether to urge the district attorney to initiate a criminal prosecution against a seriously mentally ill prisoner – a prosecution that could result in lengthening of the prisoner's sentence.³²

The following is a case study of a seriously mentally ill prisoner who has been confined by CDOC in administrative segregation for over eight years.

CASE STUDY – The Tower of Power

Marcus Aguilar* has been housed in administrative segregation since 2004, when he was initially diagnosed with bipolar disorder. Marcus's mental health has deteriorated in long-term isolation and he suffers from ongoing auditory and command hallucinations. He believes that CDOC is trying to control him using radio waves from the "Tower of Power," a radio tower he can see from his cell and the voices he hears tell him to harm himself.

Multiple forensic psychiatrists have evaluated Marcus extensively and agree that he suffers from serious psychiatric disorders including psychosis. At least two have stated that the conditions of administrative segregation have caused Marcus's sensory deprivation and intensified his psychosis.

Between 2007 and 2010, while in administrative segregation, Marcus was charged with several counts of assault with his bodily fluids – incidents which appear closely related to periods of mental deterioration. Rather than receiving specialized mental health treatment, Marcus was charged with and convicted of three assault charges. Prior to these convictions, Marcus was set to be released from CDOC in 2012. The convictions have extended his sentence substantially and his mandatory release date is now 2049.

Marcus is currently facing another assault charge. All of his examining psychiatrists agree that he is mentally incompetent to stand trial on this charge and that his condition is unlikely to change unless he is removed from isolation and administered psychotropic medications. Marcus remains in administrative segregation indefinitely.

**name changed to protect privacy*

³¹ Letter from CDOC Executive Director Tom Clements to ACLU of Colorado Staff Attorney Rebecca Wallace, dated March 1, 2013.

³² Ibid.

Out of Cell Time for Mentally Ill Prisoners

Psychiatrists agree that mentally ill prisoners need significant out-of-cell time every week, including opportunities for therapy, recreation and socializing.³³ As Dr. Dvoskin explained to CDOC representatives, there is common consensus on “the simple philosophical position... that 23 hours per day lockdown is not a mental health treatment.”³⁴ Dr. Dvoskin posited that seriously mentally ill prisoners should presumptively be provided a minimum of 20 hours out-of-cell time every week, including 10 hours of therapeutic activity.³⁵ The OMI program was originally envisioned by Dr. Dvoskin to provide these 20 hours of out-of-cell time.³⁶ Yet August 2012 data provided by CDOC shows that,



Exercise room at Colorado State Penitentiary for ad seg prisoners

on average, prisoners in the now-abandoned OMI program spent an average of only about two hours per week engaged in out-of-cell therapeutic activities.³⁷ Of particular concern, prisoners at the lowest levels of the OMI program were out of their cells for therapeutic activity only an average of 25 minutes per week.³⁸

“Prisoners at the lowest levels of the OMI program were out of their cells for therapeutic activity only an average of 25 minutes per week.”

In conversations with the ACLU of Colorado, CDOC stated the new RTP was also designed with the goal of providing prisoners the recommended 20 hours of out-of-cell therapeutic activity each week. However, CDOC reports from early 2013 suggest that, for most participants, the RTP program is no better than the defunct OMI program in its provision of therapeutic out-of-cell time. According to data provided by CDOC to the ACLU of Colorado, RTP residents spent an average of two hours of out-of-cell time engaged in

³³ Position Statement on Segregation of Prisoners with Mental Illness, APA Official Actions, Dec. 2012.

³⁴ “OMI Meeting,” CDOC Meeting Notes, December 8, 2010, p. 3.

³⁵ Ibid.

³⁶ Ibid.; “OMI Meeting with Joel Dvoskin, Ph.D.,” CDOC Meeting Notes, February 15, 2011, p. 4.

³⁷ CDOC Response to Request for Information from Representative Claire Levy, Dec. 7, 2012, pp. 10-11.

³⁸ Ibid.

therapeutic activity (which includes the gym) each week during April 2013.³⁹ Notably, prisoners like John Quinn who are in the lowest and most restrictive levels of the RTP spent negligible time out of their cell. Prisoners at level 1 of the program spent an average of 14 minutes out of cell each week engaged in therapeutic activity, and prisoners at level 2 spent an average of 55 minutes out of cell each week engaged in therapeutic activity.⁴⁰ For reasons detailed above, seriously mentally ill prisoners are likely to face significant challenges in meeting the behavioral expectations required to move up from the lowest levels of the RTP program. It is these prisoners – those who are seriously mentally ill and stuck at the lowest and most restrictive levels of an incentive program – with whom the federal district court was concerned in the Wisconsin Supermax case. The court found:

Not surprisingly, the mentally ill inmates identified by plaintiffs rarely progress out of Level One of the incentive program or, if they do, their upward movement is only temporary. . . . These inmates are stuck in the lowest levels, a circumstance that by itself suggests the inappropriateness of subjecting such persons to an incentive program that is so all encompassing and harsh.⁴¹

Prolonged isolation will inevitably exacerbate some RTP prisoners' mental illness and further decrease their ability to meet the behavioral goals necessary to graduate to less restrictive levels of the RTP program. While CDOC claims that RTP prisoners are not held in "administrative segregation," many RTP residents are still held in conditions that are as isolating as administrative segregation, making their transfer from administrative segregation to RTP nearly meaningless.

³⁹ CDOC Response to May 23, 2013 Colorado Open Records Act Request by ACLU of Colorado.

⁴⁰ *Ibid.*

⁴¹ See *Jones'El v. Berge*, 164 F. Supp. 2d 1096, 1117 (W.D. Wis. 2001).

Mental Health Staffing Levels

The ACLU of Colorado is deeply concerned that, as of early 2013, the RTP was woefully understaffed. Dr. Dvoskin affirmed in 2011 and again in a conversation with the ACLU of Colorado in 2013 that one of the most significant threats to CDOC's success in managing its mentally ill population is its severe shortage of psychiatrists and psychiatric nurses.⁴² In February 2011, Dr. Dvoskin noted that "[OMI] remains severely understaffed," and that with such understaffing "there is no remote possibility of achieving the goal of 10 and 10 [out-of-cell hours]."⁴³ Understaffing problems extend far beyond the RTP program. In 2011, Dr. Dvoskin noted that CDOC had only 8 psychiatric providers for 6000 mentally ill offenders, falling 32 providers short of the APA guideline of one provider for every 150 mentally ill inmates.⁴⁴ As a result, Dr. Dvoskin told CDOC representatives that "if the Department was sued today and he was hired as an expert witness, he is not sure what he could say in the Department's defense."⁴⁵ As of May 23, 2013, more than two years after Dr. Dvoskin's comments, CDOC had added less than two full-time psychiatric providers, with 1.5 positions still unfilled.⁴⁶ According to CDOC, as of July 1, it will have funding for an additional 13.4 full-time psychiatric providers.⁴⁷ This is welcome news, despite the fact that – even if CDOC were to fill all of the vacant positions – it would still be 8 providers, or 25 percent, short of APA recommendations. Of greater concern, however, is that CDOC has not completely filled its vacant psychiatric positions since 2010 when the OMI program was created. The ACLU of Colorado is doubtful that CDOC has the either plan or the will to promptly fill the new positions. CDOC will need to consider new hiring strategies, including increased salaries and/or a location change for the RTP program, to ensure all open psychiatric provider positions are filled quickly. Until those positions, and likely others, are filled, the RTP will continue to have a low chance of success.

“ One of the most significant threats to CDOC's success in managing its mentally ill population is its severe shortage of mental health staff. ”

⁴² "OMI Meeting with Joel Dvoskin, Ph.D.," CDOC Meeting Notes, February 15, 2011, p. 4.

⁴³ "OMI Meeting with Joel Dvoskin, Ph.D.," CDOC Meeting Notes, February 16, 2011, p. 1.

⁴⁴ Ibid.

⁴⁵ Ibid.

⁴⁶ CDOC Response to May 23, 2013 Colorado Open Records Act Request by ACLU of Colorado.

⁴⁷ Ibid.

Conclusion and Final Recommendations

While recent steps taken by CDOC are positive, including the dismantling of the OMI program and the institution of the new RTP, there is still much work to be done. Below are recommendations that the ACLU of Colorado strongly encourages CDOC to implement promptly:

- **CDOC should bar seriously mentally ill prisoners from placement in prolonged administrative segregation.⁴⁸**
- **CDOC should adopt policies requiring mental health involvement in disciplinary and criminal charging decisions related to seriously mentally ill prisoners.**
- **All seriously mentally ill prisoners, including those at the lowest levels of RTP, should be provided a minimum of 20 hours of out-of-cell time per week, including 10 hours of dedicated therapeutic time.**
- **RTP must be fully staffed to provide adequate out-of-cell therapeutic and non-therapeutic time. To accomplish this goal, CDOC must have the funding and the will to fill all mental health staff positions, particularly those of psychiatrists and psychiatric nurses.**

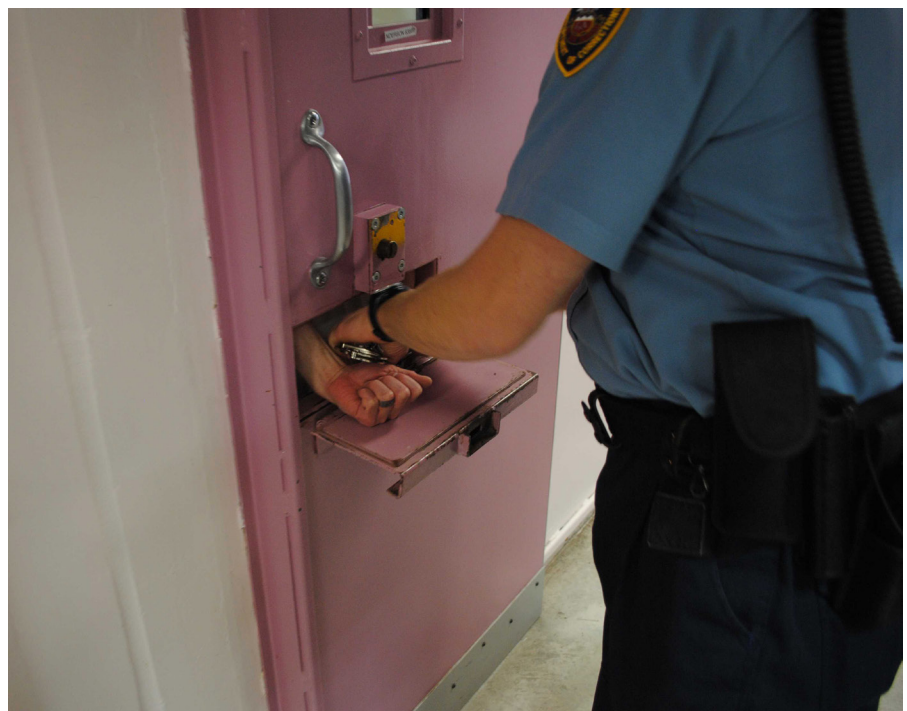
⁴⁸ APA guidelines posit that “prolonged segregation means duration of greater than 3-4 weeks.” APA Background to Position Statement, APA Official Actions, Dec. 2012.

Administrative Segregation at CSP



An administrative segregation cell for mentally ill prisoners at Colorado State Penitentiary

For most prisoners in administrative segregation, being handcuffed through their cell doors is the only physical human contact they receive.





Group therapy cages for mentally ill inmates fortunate enough to be granted therapeutic out-of-cell time

A closer look into the group therapy cages



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