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American Civil Liberties Union of Colorado
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Attention:
Mark Silverstein
Legal Director, ACLU of Colorado

Rebecca Wallace
Staff Attorney, ACLU of Colorado

February 17, 2016

Dear Mr. Silverstein and Ms. Wallace:

This letter is in response to your letter addressed to me dated January 8, 2016, in which you shared the American Civil Liberties Union of Colorado's (ACLU) year-and-a-half long review of the Colorado Department of Corrections' (DOC) reforms and DOC's use of solitary confinement and provisions to mental health services to prisoners. Thank you for your interest in this area as you obviously spent a considerable amount of time critiquing our progress. It should be noted that because we are moving so rapidly in this area of reform, we have already met and surpassed some of the recommendations that you state in your letter.

The responses provided are collaborative responses between the divisions on my executive team. Attached with this letter, you will also find a response from Dr. Darren Lish, MD, the Department's Chief of Psychiatry.

Thank you for acknowledging DOC's efforts to decrease the number of prisoners released directly from maximum security to the community. As a matter of fact, this is one of those initiatives that we have met and surpassed without having released any offender from extended restrictive housing confinement since March 2014.

In your letter, you voice concern about the nature of isolation in maximum security, removal of the level system, purchasing of food items off the canteen, and duration/frequency of phone calls and visitation. At this time the DOC is not interested in and/or considering implementing a level system for offenders housed in extended restrictive housing, i.e. Restrictive Housing - Maximum Security Status. Quite frankly, the level systems that previously existed, which we eliminated, were part of the problem in the long term confinement model. One of the issues that we identified during the reforms were that there were offenders who had been housed in Administrative segregation for long periods of time who were there because they liked the single cell environment, conditions and privileges that were afforded to them. Thereby having no incentives to motivate them to progress to general population environments. The current model, which is unlike any other in the United States, demonstrates a 90 day austere environment where privilege revocation is the result of a dangerous or violent behavior. Our reforms were based upon a progressive and pro-social model of offender management. The opportunity to order food items off of the Canteen is a privilege that is not afforded to offenders in any form of restrictive housing. And, offenders housed within extended restrictive

housing, are currently afforded the opportunity to earn the privilege of having a TV within their cell after 90 days. The DOC may consider allowing these offenders to also earn additional phone time and visitation privileges in the future.

You state "At least some Management Control Units are effective functioning as long-term solitary confinement", and "unlike for maximum security, there are few if any regulations governing why prisoners may be placed in an MCU or the length prisoners will remain there.

The DOC does not agree with or support that statement. Offenders housed within close custody management control units (MCU's) are afforded the opportunities to exit their cells and engage in pro-social activities with other offenders for a minimum of 4-hours per day, 7-days per week. Long term solitary confinement and restrictive housing is defined as daily in cell confinement for 22+ hours per day. Offenders housed within close custody management control units are not confined to the individual cells for 22+ hours each and every day, and therefore do not fall within or under the specific definition of long-term solitary confinement, i.e. extended restrictive housing.

As to your concerns regarding "there are few if any regulations governing why prisoners may be placed in an MCU or the length of time prisoners will remain there", DOC Administrative Regulation 600-09 (Management of Close Custody Offenders) specifically outlines "why" offenders may be placed into a close custody management control unit. This AR has also recently been updated, with specific language added that requires all offenders in close custody management control units to be reviewed for progressive movement every 90-days. Again, demonstrating the department's initiative to meet and surpass recommendations.

You also make the statement that "there is no restriction on placement of prisoners with serious mental illness in MCU's." MCU is not restrictive housing. MCU is not Administrative segregation. MCU is not long term isolation. MCU is not solitary confinement. MCU is a closed custody designation that affords stable offenders with serious mental illness to be housed within small pro-social environments to assist in their transition to general population. Even though we believe in all of the segregation reforms that we have encountered, we also understand that there are some offenders with a level of criminal thinking that require that they be transitioned in a more controlled environment.

You state that you have "found evidence that prisoners in some MCU's are getting less that four hours out-of-cell time per day" and "that many MCU prisoners complained repeatedly" to you about this and that you are "concerned that the current policy and practice in the MCU's create risk that the units will devolve into "administrative segregation" by another name". The intent is to ensure offenders housed within close custody management control units are afforded the opportunities to exit their cells and engage in pro-social activities with other offenders for a minimum of 4-hours per day, 7-days per week. As with all facilities, there are times when the facility, a unit and/or a specific pod is locked down, for a variety of reasons. The DOC will continue to monitor the frequency and duration of facility lock downs in an attempt to minimize disruptions to scheduled out of cell time. Close custody management control units are not and will not devolve into any form of extended restrictive housing. At a minimum, during normal operations, offenders will always be afforded the opportunities to exit their cells and engage in pro-social activities with other offenders for a minimum of 4-hours per day, 7-days per week, exigent facility lock downs and emergency situations.

In your report, you state a substantial number of prisoners in the Residential Treatment Programs (RTP) have received little out-of-cell time due to unacceptably high rates of refusal of mental health treatment and that Dr. Jeffrey Metzner advised refusal rates in well-run programs can expect a 25% refusal rate. He warned that refusal rates climbing in excess of 30% indicated systemic problems. In our attempt to model the type of program Dr. Metzner alluded to, we in our research, could not find any empirical data validating these statistics. Further, in reaching out to other states, we found Colorado is the only state that is tracking refusal rates. The department has experienced high refusal rates in the residential treatment programs and has actively pursued identifying causes resulting in the implementation of innovative interventions to reduce refusal rates. For instance, we have surveyed

offenders, implemented customized curricula to meet the needs of the offenders, increased staffings with offenders and staff, created and implemented de-escalation cells, audited groups and facilitators, increased process and recreation groups and provided additional staff training. Despite these inventions, high refusal rates continue to exist. We are currently looking at the possibility of implementing a token economy and creating a peer specialist program as a means of encouraging participation.

Regarding the statement that mental health groups are so poorly run and are of so little utility that many prisoners avoid them is simply opinions of some offenders who are choosing not to engage in treatment. The root cause is not incompetent mental health therapists, the problem lies with offender's right to refuse treatment as well as safety concerns. When the department determined offenders were not comfortable engaging in round robin groups, we went to a closed group schedule. Although group participation increased, the lack of staff and physical plant resources limited all offenders from receiving their 10 hours out of cell time. Therefore, the round robin group structure was re-implemented and closed groups were suspended.

In your letter you stated, "In contrast to the very high refusal of mental health treatment generally, prisoners refused to participate in individual mental health sessions less than 15% of the time. This finding that suggests that most prisoners are willing to leave their cells for mental health treatment they perceive to be helpful" is an opinion that is not founded in fact. The population of offenders at the San Carlos Correctional Facility (SCCF) has changed over the years. In fact, the acuity of SCCF's population has significantly increased in response to a centralized referral system that effectively and efficiently identifies those who are in need of this higher level of care. With higher acuity at SCCF, offenders are cautious, suspicious and paranoid with regard to interacting with their environment. As such, individual sessions provide the opportunity to engage in treatment with the sole attention of the therapist in a perceived safe environment. Individual therapy sessions provide a safe haven where shared information remains confidential and the risk is controlled resulting in lower refusals. In contrast, our clients are offenders housed in a prison and there is risk involved when they share information with other group members which contributes to higher refusal rates.

You also state that prisoners at SCCF are receiving very few individual mental health contacts. Yes, in comparison to group therapy, offenders in the SCCF RTP have been offered and have received fewer individual therapeutic sessions. The focus has been on delivering group therapy to promote community cohesion, increase social interaction and trust. Although offenders receive individual therapy and regular psychiatric appointments, the emphasis has not been on the quantity. In response to the increasing group refusal rates, an action plan was created to ensure offenders who are not engaging in consistent therapeutic activities are offered more frequent individual therapy sessions based on stability and need. That plan was implemented and on-going.

The Department has identified significant raw data outcomes over the course of the last fiscal year as it relates to the management of the Residential Treatment Programs:

San Carlos Correctional Facility:

- Special Controls reduced by 93%
- Forced cell entries declined by 77%
- Offender on staff assaults declined by 46%

Centennial Correctional Facility:

- Special controls reduced by 85%
- Forced cell entries declined by 81%
- Offender on staff assaults declined by 50%

There has been no other agency developing a plan to ambitiously intervene in long term isolation. These reforms have been implemented over the course of 2 years at various stages and the data is raw and without adequate time to define best practice. But nonetheless, it established progress in our initiatives.

You also voice concern that the DOC mental health staff "tend to under-diagnose serious mental illness and over-diagnose malingering". Deception is a common human behavior that occurs in everyday life. This is especially true in complex situations such as surviving the dynamics in a prison environment. Additionally, personal gain, such as improved living conditions (single cell) adds motivation to deceive others which has the potential to occur during mental health assessments. We also know malingering may coexist with genuine psychosocial problems. Therefore, it becomes challenging to unravel the characteristics that refute or support malingering. It has been documented in many research studies the difficulty for professionals in all settings to evaluate those who are apt at feigning psychological issues. In prison settings, this is particularly magnified due to the concentration of the criminogenic component of the offender population. Regardless of the setting, mental health staff will encounter clients who exaggerate symptoms. On the flip side, some offenders keep silent regarding their mental illness symptoms for safety purposes, denial of symptoms, stigma of being labeled mentally ill and/or are not interested in engaging in treatment. To offset malingering diagnoses concerns as well as identifying treatment needs, offenders are re-assessed throughout their incarceration or as their needs change. At any time, any offender may be referred to the diagnostic unit for an evaluation. This assessment unit has provided a clearer treatment picture for offenders who have conflicting mental health histories. Further, the department has a process which requires an assessment by a health care professional prior to offender placement to a restrictive housing environment. Assessments are completed on an as-needed basis to determine appropriate diagnoses.

Conclusions and Recommendations

1. Lessen the isolation, boredom, and length of stay in maximum security. We recommend that CDOC, at minimum, return prisoner privileges to former Level II administrative segregation privileges. The ACLU also urges CDOC to limit maximum security sentences to six months except in the case of murder and to work toward an average length of stay of three months.

The DOC has reduced the numbers of offender's held within long-term segregation from 1505 in February of 2011 to an average of 160 today. Furthermore, the average length of time has been reduced from 28 months to 6 months. Colorado is also the only State that has set maximum length of stays in extended restrictive housing, which do not exceed 12-months.

The DOC has eliminated the use of Administrative Segregation and has adopted nationally recognized and supported guiding principles of restrictive housing. We have no interest in going backwards and re-implementing any previous form of "Administrative Segregation".

2. Limit MCU terms to six months until DOC can ensure sufficient out-of-cell time for prisoners in MCUs.

MCU's are not a form of long-term segregation and the DOC will not set a term or maximum period of time for offenders housed in close custody management control units (MCU's). Administrative Regulation 600-09 (Management of Close Custody Offenders) has recently been updated, with specific language added that requires all offenders in close custody management control units to be reviewed for progressive movement every 90-days.

3. Hire an outside expert team for at least a two-year contract to: (a) assess current policies and practices related to treatment and housing of prisoners with serious mental illness, (b) make

Thank you for this recommendation, however the DOC will not be hiring an outside expert team as we already have an internal expert team that is viewed as developing a national model in this area.

4. Seek funding for psychiatric positions for the RTPs so that DOC can meet the American Psychiatric Association's recommendation of one psychiatrist for every fifty RTP patients.

See attached letter from Dr. Lish.

5. Institute a policy of tracking, analyzing, auditing, and reporting all out-of-cell time offered, cancelled, and refused in all of DOC's residential treatment programs and management control units for a minimum of two years, so that CDOC can accurately assess actual out-of-cell time for prisoners held in these conditions.

Even though this level of tracking is not an industry standard, the department has already taken proactive steps to track and analyze this information to the best of our abilities with current technology and resources. We are unable to locate any other system that tracks the level and amount of data that this recommendation suggests.

Once again, thank you for sharing this information. We appreciate your concern and interest in our reforms and continued conversations regarding these successes. The initial results of the Colorado Department of Corrections reforms for Administrative Segregation are worth celebrating. There were no suicides in Restrictive Housing last year. The rate on staff assaults, across the state, are half of what they were in 2006. Less than 1% of the DOC population are spending an average of 6 months in extended Restrictive housing right now. We are proud of these accomplishments and we look forward to sharing more validated data as our reforms grow.

Sincerely,

Rick Raemisch
Executive Director, Colorado Department of Corrections

attached:/ Letter from Dr. Darren Lish

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February 4, 2016

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Attention:
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RE: ACLU Responses - Psychiatry

INSUFFICIENT MENTAL HEALTH STAFF (PSYCHIATRY)

Regarding the statement that the CDOC's psychiatrist-to-patient ratio is "entirely inadequate," (based upon recommendations from the 2016 APA publication of *Psychiatric Services in Correctional Facilities*), I believe it is important to note that in the preface of the publication, the author specifically notes that **"These guidelines are just that: guidelines. This document is not a set of standards, policies, or procedures."** In the section devoted to staffing, the authors state that "Staffing must be adequate to ensure that every inmate with SMI or in a psychiatric or emotional crisis has timely access to evaluation by a competent mental health professional." We agree and believe that the steps the CDOC has taken to increase psychiatric staffing in recent years is reflective of our attempt to continue improving access to psychiatric professionals across all of our state facilities. In 2012, the CDOC had approximately 10 FTE (full-time equivalent) psychiatric providers on staff. In 2013, the CDOC received funding from the state legislature for an additional 13.4 psychiatric positions. Over the past 2 ½ years we have hired close to an additional 13 FTE psychiatric providers. However, during that same period we lost approximately 6.25 FTE due to turnover (it goes without saying that it is very difficult to recruit and retain psychiatric providers to work within the prison environment). As of today, our current psychiatric FTE stands at 17.375 (with an additional 1.0 FTE planning to join us in August), which is an increase of over 7 FTE from the 10 FTE we had in 2012. There are currently 5806 offenders within the DOC who receive mental health treatment with p-codes of 3-5 (this number excludes those held at private facilities). Of those 5806 offenders, approximately 70% are followed in psychiatry clinic due to the prescription of psychotropic medication. That means there are approximately 4064 offenders being treated by 17.375 psychiatric FTE, which represents a

staff:patient ratio of about 1:230, which is quite adequate, in our opinion, since the majority of those offenders being followed do not have SMI.

In your letter you state that the APA guidelines "require" a ratio of 1 FTE psychiatrist for every 50 RTP patients. Once again, these guidelines are *recommendations*, not requirements. Your letter states that as a result of its staffing ratios it seems virtually impossible for CDOC to be able to meet the needs of its RTP population. As of January of 2016, there were 433 offenders with a P3 or above designation being treated at our RTPs (202 at SCCF, 183 at CCF, and 48 at DWCF). Our current RTP staffing of 2.625 FTE psychiatrists for 433 RTP offenders reflects a staffing ratio of 1:165. Our psychiatric providers, who generally see approximately 10 patients a day, are therefore able to see their entire caseload approximately every 16 working days, or about once a month. Since our psychiatric providers are primarily employed for diagnostic assessment and medication management, we feel that this staffing ratio allows for sufficient frequency of psychiatric contact in the RTPs.

We currently have funding for an additional 8 FTE psychiatric positions and will continue working toward filling those positions with an emphasis toward increasing psychiatric coverage within the RTPs, in particular. As our psychiatric staffing increases within the RTPS, the role of the psychiatrists will likely expand to include more administrative and leadership roles within the facility. In the years ahead, I foresee our staff:patient ratios continuing to improve. However, at this time I disagree with the assertion that our current psychiatric staffing makes it "virtually impossible" to meet the needs of the RTP patients.

THE ALARMING DECREASE IN DIAGNOSES OF SERIOUS MENTAL ILLNESS

In 2013, the DOC created a new definition of serious mental illness (SMI) in order to more accurately track the number of offenders with SMI in the system and to more accurately address the changes made with regard to the limited use of solitary confinement for those identified as having serious mental illness. The definition of SMI included all offenders with psychiatric diagnoses of a major mood disorder (Bipolar Disorder or Major Depressive Disorder) or any type of psychotic disorder (Schizophrenia, Schizoaffective Disorder, Delusional Disorder, or Psychotic Disorder NOS). Those diagnoses are reflected by the "M" qualifier in the p-code system. In addition to offenders characterized with the "M" qualifier reflecting a diagnosis of a "major mental disorder," we include in our number of SMI offenders those offenders who require a higher level of care due to functional impairment or identification of a need for higher frequency of contact due to a high degree of resource consumption (reflected by their RCS score) and/or a high level of symptomatic complaints (reflected by their BPRS score). Those offenders are represented in our numerical needs-based P-code system as P4s and P5s. Therefore, any offender identified as a P4 or 5, regardless of their diagnosis would be considered seriously mentally ill by our definition.

Prior to 2013, we had a different qualifier system in place that used the "C" qualifier to identify offenders with "chronic" mental health issues. The C qualifier captured a much larger number of offenders than the M qualifier does. Specifically, individuals diagnosed with Depressive Disorder NOS (not otherwise specified), Mood Disorder NOS (not otherwise specified), or PTSD were identified with the "C" qualifier. A significant percentage of offenders at that time were diagnosed with the more vague and broad diagnoses of Depression NOS or Mood Disorder NOS which describe an individual with depressive complaints not rising to the level of Major Depression, or mood swings/lability not rising to level of a Bipolar Disorder diagnosis. When we changed our definition of SMI and changed the "C" qualifier to an "M" qualifier, diagnoses like Depression NOS, Mood Disorder NOS, and PTSD were no longer included.

In your letter to the DOC, you state that "since the spring of 2013, there has been an alarming decrease in diagnoses of serious mental illness among CDOC prisoners." I believe that the change in numbers is reflected by the change in the use of the M qualifier as described above and reflected by the numbers below:

Date	#SMI ("C" or "M" qualifier plus any additional P4 or 5s)	Facility Total	%SMI
January 2012	3307	18752	17.6%
July 2012	3210	17985	17.8%
January 2013	3208	17696	18.1%
----------Change to use of "M" qualifier for definition of SMI----------			
July 2013	2036	17499	11.6%
January 2014	1937	17825	10.9%
July 2014	1948	17865	10.9%
January 2015	1954	18010	10.8%
July 2015	1883	18203	10.3%
January 2016	1759	17860	9.8%

There is no doubt in my mind that the reduction of the "SMI" percentage seen when we changed from the broad "C" qualifier to the "M" qualifier in 2013 is reflected by the loss of approximately 1200 offenders who likely had diagnoses of Depression NOS, Mood Disorder NOS, or PTSD, which are not included in our definition of serious mental illness. Any suggestion that the psychiatric providers or mental health clinicians in the DOC are intentionally embarking upon a conspiracy to reduce the number of SMI in our system by intentionally "underdiagnosing" serious mental illness is absurd and inflammatory. Our doctors want nothing more than to correctly identify those individuals suffering with more severe diagnoses and symptomatic complaints, and treat them appropriately, because they have taken an oath to do so. It should go without saying that the majority of the population of offenders within the Department of Corrections who seek mental health care have a variety of vague, poorly-defined complaints that are likely reflective of their underlying personality disorders (up to 75% of offenders in a prison setting likely meet criteria for a personality disorder,

most often antisocial personality disorder), substance use disorders (up to 75% of offenders in a prison setting also likely meet criteria for a substance use disorder), or adjustment reactions to being confined in prison (adjustment disorders or disorders characterized by the NOS qualifier).

As our psychiatric staffing has increased in recent years, we have been able to see offenders more frequently and perform more complete diagnostic assessments through interviews and psychological testing, and this increase in time devoted to offenders with mental health needs has likely improved diagnostic accuracy (fewer knee-jerk bipolar or major depressive diagnoses) and reduced the number of high-needs P4/5 offenders which is reflected by the steadily decreasing number of P4/5 offenders since 2012 (which is a good thing, reflecting fewer individuals in crisis). In January of 2012, the total number of P4/5 offenders was **348**, in January of 2014 it was **280**, and in January of 2016 it is **208**.

The number of offenders in the Colorado DOC who currently meet our definition of SMI (psychotic disorder or major mood disorder diagnosis with "M" qualifier and all other offenders identified with a high needs level of P4 or P5) has been consistently maintained at 10 - 11% of the total offender population since 2013. This figure clearly falls within the expected range of 8-19% documented within the background to the APA position statement on segregation of prisoners with mental illness contained within the most recent 2016 APA publication of *Psychiatric Services in Correctional Facilities*: "Studies have consistently indicated that 8% to 19% of prison inmates have psychiatric disorders that result in significant functional disabilities and another 15% to 20% require some form of psychiatric intervention during their incarceration (Metzner 1993; Morrissey et al. 1993).

Respectfully,

Darren Lish, MD, DFAPA
Chief of Psychiatry
Colorado Department of Corrections