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SENT VIA Email and USPS

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Dear Executive Director Raemisch,

We write to share with you some of the results of the American Civil Liberties Union of Colorado's (ACLU) year-and-a-half long review of the Colorado Department of Corrections' (CDOC) reforms in its use of solitary confinement and its provision of mental health services to prisoners. As you of course are aware, your reform efforts have been lauded nationally, and we here at the ACLU of Colorado are grateful for your efforts. Your administration's reforms share a common goal of creating safer, more humane prisons in the State of Colorado and better public safety outcomes for all people. The goal of the ACLU's review is to support these important outcomes.

We thank you heartily for CDOC's remarkable openness and transparency during the course of our review. Over the last year a half, CDOC has provided records responsive to over one hundred ACLU records requests and responded to dozens of questions by email and phone with what we believe is an unprecedented level of openness. CDOC's increased attention to the importance of collecting consistent data on policy and program implementation, as well as its transparency in providing this data to the public, has made this research possible and, we believe, reflects CDOC's commitment to ensuring that its reforms are real and measurable.

During the course of our investigation, we were pleased to find that many of the reforms you promulgated have resulted in tangible, measurable changes for prisoners. This letter will describe some of the positive, meaningful changes we have documented. At the same time, we are mindful of how difficult it is to alter a deeply-entrenched overly-punitive correctional system that in some respects inadequately resourced. This letter will therefore also describe significant obstacles to reform that we have observed which have resulted in some critical gaps between policies that you have implemented and actual practices that are occurring. That there remain areas for improvement does not diminish the significance of your accomplishments to date. Given the massive sea change you have undertaken, particularly with a staff that has been

accustomed to the wide use of prolonged solitary confinement for nearly twenty years and the punitive culture that goes along with such a regime,[1] it is to be expected that fully realizing the reforms will take time and significant additional resources, and require persistent monitoring and correction.

This letter reviews your efforts and the remaining challenges related to (I) reducing the use of solitary confinement, (II) increasing the quality and quantity of mental health care for prisoners, and (III) CDOC as a national model of reform and transparency. We also make five recommendations to begin addressing the challenges to reform identified in this letter.

We truly hope you will find the results of our research and review helpful as you and your staff strive to ensure that the impressive reforms you and former Executive Director Tom Clements have set into motion are fully realized in practice. After you have reviewed the letter, the ACLU of Colorado along with the American Civil Liberties Union National Prison Project – who has collaborated with us on this review, would welcome the opportunity to meet together and partner with you to further your administration's goals. We ask that you respond to this letter by **February 4, 2016**.

I. CDOC'S EFFORTS TO REDUCE THE USE OF SOLITARY CONFINEMENT

A. Positive changes we documented

1. CDOC has substantially reduced its population of prisoners held in prolonged solitary confinement.

The hallmark of your administration's reforms is the dramatic reduction of the number of prisoners housed in long-term solitary confinement. In August of 2011, there were 1500 prisoners (7% of the prison population) held in long-term isolated confinement (then called "administrative segregation)."[2] Because of a series of CDOC policy changes discussed below, CDOC reported that as of September 2015, it held 177 prisoners (or 1% of the prison population) in "maximum security," the term CDOC now uses to describe prolonged solitary confinement.[3] CDOC used to be known for its remarkably high percentage of prisoners held in administrative segregation. Now, greatly due to the actions of your administration, CDOC ranks below the national average.[4] Additionally, since 2011, CDOC has reduced the number of female prisoners held in administrative segregation/maximum security from thirty-nine (2% of the female custodial population) to zero.[5]

We were pleased to find that many of the prisoners CDOC has released from administrative segregation have successfully transitioned to general population and are living in a much less restrictive environment. Between July 2013 (shortly after you became the executive director of CDOC) and October 2015, CDOC has released 1,162 prisoners from administrative segregation/maximum security, 895 of whom remained housed in CDOC as of November 2015.[6] Of these 895 prisoners, 421 (or 47% of the total) were being held in general population with no restrictive custody status,[7] thus living in conditions that do not pose the psychological dangers of long-term isolated confinement[8]. That your administration has successfully transitioned hundreds of prisoners from isolated confinement to unrestricted general population is a tremendous accomplishment and provides a model for reform in other states.

2. CDOC has instituted forward-thinking, rational policies regarding placement of prisoners in administrative segregation/maximum security.

As you are aware, in mid-2014 CDOC adopted a sentencing matrix for maximum security. This matrix places rational and humane limits on the length of time prisoners can be confined in maximum security, while also narrowing and more clearly defining the types of serious offenses that can warrant placement there.[9] The sentencing matrix does the important work of removing CDOC staffs' discretion to "solve" low-level, but persistent behavior management problems with solitary confinement.[10] Prisoners must now have committed a specific, discrete, violent or highly dangerous act to be sentenced to maximum security. That CDOC's maximum security units now house a total of 150 prisoners evidences meaningful progress toward that goal.

Additionally, the sentencing matrix limits a prisoner's term in maximum security to between six and twelve months depending on the offense. CDOC's adherence to the sentencing matrix has resulted in much shorter stays in maximum security. Before the sentencing matrix, prisoners spent about two years on average in administrative segregation (median of fourteen months),[11] and some prisoners were housed in isolation for upwards of five, ten, and even twenty years.[12] In comparison, data provided by CDOC to the ACLU in September 2015 reflects that, since adoption of the sentencing matrix, prisoners now spend on average less than six months in maximum security, and that only one prisoner has spent in excess of a year there.[13] While the ACLU hopes to see further decreases in prisoners' length of stay in maximum security, CDOC has made remarkable progress on this front.[14]

3. CDOC has dramatically decreased the number of prisoners released directly from maximum security to the community.

Both you and Executive Director Clements focused attention upon the fact that as of 2011, 47% of administrative segregation prisoners were being released directly from administrative segregation to the community, frequently after years in solitary confinement. In contrast, in Fiscal Year ("FY") 2014, only 7% of maximum security prisoners were released directly to the community.[15] We understand you seek to reduce the number of such releases to zero. We applaud this effort and its reflection of your commitment to public safety. We agree with you that prisoners must be given opportunities to engage in pro-social activities and receive re-entry services prior to release from prison. Both the ACLU of Colorado and the National Prison Project would welcome further discussion and tracking of the re-entry/step-down programs delivered to prisoners prior to return to the community. We also wish to be advocates for CDOC in the event that additional resources are required to achieve these goals.

B. Challenges that remain

1. Conditions in maximum security are so harsh as to be counterproductive to rehabilitation.

Conditions of confinement in CDOC's administrative segregation/maximum security units have always been harsh and isolating. Prisoners spend twenty-two or more hours alone in their cell every day, with minimal opportunities for perceptual, social or occupational

stimulation. The ACLU does not question CDOC's need to hold prisoners accountable for acts of violence or that periods of separation can be necessary to ensure the safety of prisoners and staff. However, we have concerns about the extreme nature of the isolation in maximum security, which experts agree is counterproductive to rehabilitation and ultimately decreases safety of prisoners and staff.

In 2014, when CDOC adopted the maximum security sentencing matrix, it simultaneously removed the level system previously in place, and established one set of privileges applicable to all prisoners in maximum security. Under current regulations, privileges for all prisoners in maximum security are now essentially those of the harshest disciplinary level of former administrative segregation – a level of deprivation that administrative segregation prisoners could have only been placed on by being regressed there after a serious behavioral issue.[16]

Currently, prisoners in maximum security are denied television for at least the first three months (sometimes longer) and are allowed to check out from the library only three books at a time.[17] They are permitted to spend at most $10 on canteen items (excluding telephone time) and are never allowed to purchase food off canteen.[18] Prisoners are allowed only one twenty minute phone call per month and are allowed only one one-and-one-half-hour duration visit per month (after thirty days) with only immediate family members and relatives.[19] In contrast, when administrative segregation was in place, the first non-disciplinary level of the program (Privilege Level II) allowed prisoners to purchase up to $25 of canteen items, including food; allowed four phone calls per month not to exceed eighty-eight minutes per month; allowed two non-contact visits per months up to one-and-one-half-hour each in duration (not restricted to immediately family members and relatives); and provided a television shortly after arrival in administrative segregation (usually within seven days).[20]

We recognize that CDOC made policy changes in November 2015 that slightly ameliorated the deprivations in maximum security.[21] However, even with these changes, the harsh conditions of maximum security are extreme when compared to correctional facilities in many other states. While highlighting the many positive changes in Colorado that lie far ahead the norm, the most recent national comparative study of state correctional agencies' use of solitary confinement found that the opportunities for interpersonal contact in maximum security at CDOC lags significantly behind the norm.[22]

Experts agree that extreme isolation and boredom in solitary confinement breed deep resentment and anger among prisoners, and can cause mental decompensation. These feelings predictably can and do lead to outbursts by prisoners that can put the safety of prisoners and staff at risk.[23] Likewise, cutting off contact between prisoners and their family is wholly counterproductive to rehabilitation and generally does nothing to advance prison security.[24] While we recognize CDOC's need to punish violent behavior and, when necessary, segregate prisoners who pose an immediate threat to safety of staff or prisoners, we urge CDOC to rethink its decision to increase the harshness and isolation of its maximum security units.

2. At least some Management Control Units are effectively functioning as long-term solitary confinement.

A substantial number of prisoners who have completed their term in or been diverted from administrative segregation/maximum security have been transferred to Management

Control Units (MCU).[25] According to CDOC policy, these units are "primarily used as a progressive management assignment for offenders who are progressing from Restrictive Housing Maximum Security status," but may also be used for "those general population offenders who have demonstrated, through their behavior, that they pose a significant risk to the safe and orderly operation of a correctional facility."[26] Unlike for maximum security, there are few if any regulations governing why prisoners may be placed in an MCU or the length of time prisoners will remain there. Further, there is no restriction on placement of prisoners with serious mental illness in MCUs. Indeed, CDOC recently reported that MCUs house at least 18 prisoners with serious mental illness.[27] Notably, prisoners with mental illness are disproportionately likely to be placed in an MCU by a ratio of 2:1.[28]

By policy, MCU prisoners are limited to four hours of out-of-cell time with other prisoners per day,[29] with minimal opportunities for work or education.[30] When CDOC first began transferring prisoners to MCUs, the ACLU was in close communication with CDOC's executive team. Given the stringencies of this confinement, we expressed our hope that the MCU would be used only as a *temporary* step-down or diversion unit from maximum security. Such a use of the MCU was, in our view, sensible and fair. After all, the MCU, unlike maximum security, provides prisoners some opportunities for out-of-cell time and pro-social interaction with other inmates, which is a meaningful step down from the near total isolation of administrative segregation.

However, after nearly a year and half of monitoring, it seems that for a substantial number of prisoners, an MCU will be their long-term home.[31] While on average prisoners stay in an MCU for less than a year, as of September 21, 2015, over eighty prisoners had spent more than a year in an MCU,[32] and fifty additional prisoners had spent in excess of a year in consecutive terms in an MCU and maximum security.[33] As of October 31, 2015, thirty-one prisoners had been in an MCU for 522 days.[34] Especially for those prisoners who are to remain in MCUs in excess of a year, promising just four hours of out-of-cell time per day, with limited access to educational and work opportunities, raises concerns.

Moreover, we have found evidence that, on average, prisoners in at least some MCUs are getting much less than four hours of out-of-cell time per day. Many MCU prisoners complained repeatedly to us that their out-of-cell time is cancelled as often as it occurs. We investigated these complaints and, based upon the limited information CDOC has been able to provide, determined the complaints were founded. Data from CDOC suggests that, in at least some MCUs, day hall is cancelled so frequently that prisoners are spending more than twenty-hours per day in their cell.[35]

Based on the foregoing, we are concerned that the current policy and practice in the MCUs create a risk that the units will devolve into "administrative segregation" by another name, including for some prisoners with serious mental illness. We know this is not the intended result, but believe that implementation of stricter limits on the use of MCUs and greater oversight and accountability for the out-of-cell time on these units will be necessary to prevent such an unwanted outcome.

II. YOUR ADMINISTRATION'S EFFORTS TO INCREASE THE QUALITY AND QUANTITY OF MENTAL HEALTH CARE TO PRISONERS

A. Positive changes we documented

1. CDOC has prioritized moving many prisoners with serious mental illness out of long-term solitary confinement and into mental health treatment programs.

Since the beginning of your reform work, you have understood that many of the prisoners housed in solitary confinement need intensive mental health treatment, and that prolonged isolation would only make such prisoners more ill and more likely to engage in disorderly behavior.[36] Early in you tenure, you took the momentous step of directing your staff to stop placing prisoners with serious mental illness in administrative segregation.[37] Together with the ACLU, you then supported the passage of Senate Bill 64 (now codified at C.R.S. § 17-1-113.8), which prohibits CDOC from placing prisoners with serious mental illness in long-term isolation absent exigent circumstances. Over a period of only a few months, you succeeded in removing all prisoners CDOC identified as having a serious mental illness from administrative segregation.[38] When you began your tenure, there were at least 87 prisoners with serious mental illness in administrative segregation.[39] According to recent CDOC records, there was only one prisoner designated as having a serious mental illness in maximum security.[40] This dramatic change in CDOC's policy and practice makes it a national leader in protecting individuals with serious mental illness from the harms of prolonged isolation.

2. CDOC established a 240 bed residential treatment program dedicated to improving prisoner mental health through long-term care.

In January 2013, CDOC moved its Offenders with Mental Illness (OMI) program from the Colorado State Penitentiary (CSP) – where treatment took place only within the confines of administrative segregation – to the Centennial Correctional Facility (CCF) – where prisoners could receive mental health treatment without having to be held in near complete isolation. As CDOC has repeatedly acknowledged, "administrative segregation . . . is not conducive to mental health treatment."[41] Indeed, the OMI program located at CSP had only a 27% successful completion rate in FY 2012.[42] Improvements are readily apparent. In FY 2014, the Residential Treatment Program (RTP) at CCF had a successful completion rate of 48%.[43] Similarly, the rate of unsuccessful terminations from the program has dramatically decreased. In FY 2012, CDOC reported a failure rate for the OMI program of 61%. [44] In FY 2014, that number dropped to only 9%.[45] CDOC has explained this decrease as "demonstrat[ing] a change in the program's philosophy to work with offenders despite their noncompliance or resistance to therapy." [46] This commendable philosophy[47] is reflected in other data as well. The average length of stay in the RTP has increased over the last several years,[48] reflecting CDOC's commitment to work with prisoners over long periods of time to make progress on mental health issues, rather than terminating them from the program at early signs of non-compliance or disruptive behavior.[49]

3. CDOC's policy now requires that prisoners in mental health treatment units receive substantial out-of-cell time.

During your tenure, CDOC adopted a new policy requiring that all prisoners in RTP programs be afforded twenty hours of out-of-cell time each week, including ten hours of

therapeutic out-of-cell time.[50] Moreover, this CDOC policy mandates that prisoners in an RTP receive one-on-one mental health contacts with varying levels of frequency depending on the prisoner's level in the program. These one-on-one contacts are the primary way that prisoners establish a trusting therapeutic relationship, which is essential to program success.[51] We especially applaud these policies since, as you know, many prisoners now in the RTP were either transferred or diverted from administrative segregation/maximum security, where they would have had at most two hours out of their cell per day.

Since the summer of 2014, CDOC has provided to the ACLU a substantial amount of data reflecting therapeutic out-of-cell time for prisoners living in the CCF and SCCF RTPs.[52] We are pleased to report that, based on our review of early 2015 data, it appears that prisoners in both SCCF and CCF RTPs were generally offered the ten hours of out-of-cell therapeutic time required by your mandate.[53] Earlier data from 2013 and parts of 2014 showed problems with achieving this level of therapeutic time in the RTPs,[54] so this marked improvement demonstrates CDOC's continuing efforts to achieve program success.

4. CDOC adopted an expanded definition of "serious mental illness".

In Spring 2014, CDOC expanded its definition of "serious mental illness" to include not only prisoners diagnosed with specific Axis I disorders, but also those prisoners, "regardless of diagnosis, indicating a high level of mental health needs" who "demonstrate significant functional impairment within the correctional environment."[55] According to the definition, significant functional impairment can be evidenced by "engaging in deliberate self-harming behaviors," "difficulty maintaining activities of daily living," and pervasive patterns of bizarre, dysfunctional, or disruptive conduct.[56] This was a welcome change in definition given that prisoners with significant functional impairment – including those who engaged in extensive self-harm, but who mental health staff classified as suffering from solely an Axis II personality disorder – were often found by CDOC staff not to be seriously mentally ill. As a result, these prisoners could be (and often were) denied the highest level of mental health care and could be subjected to long-term solitary confinement.

According to national mental health experts, this tendency against finding prisoners with a personality disorder to have a serious mental illness has been a problem in corrections departments around the country, resulting in many severely impaired individuals being subject to the harmful effects of extreme isolation. The changes in Colorado and some other jurisdictions reflect a far better understanding of mental illness, disruptive prisoners, and the impacts of isolation on human beings. CDOC's current definition of serious mental illness appears intended to prohibit a broader spectrum of prisoners with mental illness from placement in long-term solitary confinement and to ensure provision of the highest level of mental health care to prisoners who need it.

B. Challenges that remain

1. A substantial number of prisoners in the RTPs have received little out-of-cell time due to unacceptably high rates of refusal of mental health treatment.

As discussed above, it appears that, at least in the SCCF and CCF, staff are complying with policy by ensuring that prisoners are <u>offered</u> ten hours of therapeutic out-of-cell time each week in the RTPs. However, many RTP prisoners have complained to the ACLU that they rarely leave their cells. They report that almost all of the therapeutic out-of-cell time they are

offered is for mental health groups which are so poorly run and of so little utility that many prisoners avoid them. These prisoners state that they spend their days alone in a cell, much like they once did in administrative segregation. A disproportionate number of the most serious allegations of isolation from RTP prisoners came to the ACLU from San Carlos Correctional Facility – the CDOC hospital that houses prisoners in acute mental health crisis.

Our data analysis reflects that RTP prisoners are indeed in their cells far more than the data regarding offered therapeutic out-of-cell time would suggest. This is because of an alarmingly high rate at which RTP prisoners refuse to participate in mental health groups. Data reflect that between August 2014 and August 2015, prisoners in CCF's RTP refused group therapy on average about 45% of the time.[57] Refusal rates are even higher at SCCF. From August 2014 through April 2015,[58] RTP prisoners refused therapeutic out of cell time more than 50% of the time.[59] This trend appears to be worsening over time: between February and April 2015, average refusal rates have consistently exceeded 75%.[60]

These refusal rates translate into days, weeks and months in their cell for many prisoners in acute mental health crisis at SCCF. Between February and April 2015, prisoners at SCCF averaged less than two-and-one-half hours of therapeutic out-of-cell time every week; the median was even worse – just over one hour.[61] On any given week, about eighty prisoners (out of about 230) went without any therapeutic out-of-cell time at all.[62]

The ACLU first discussed with CDOC concerns about the extremely high refusal rates within the RTPs during the September 12, 2014 meeting of the "serious mental illness in long-term isolated confinement work group."[63] CDOC's explanation at the time was that many prisoners were resistant to treatment. Dr. Jeffrey Metzner, a forensic psychiatrist and member of the group, advised that a well-run prison mental health program can expect a refusal rate of up to 25%. However, he warned that refusal rates climbing in excess of 30% are red flags indicating that there are systemic problems with the provision of mental health care, such as timing, relevance and quality of treatment being offered. Clearly, when refusal rates climb in excess of 70%, there is reason for great concern regarding the quality of the mental health programming being provided.

In contrast to the very high rate of refusal of mental health treatment generally (mostly comprising group therapy programs), prisoners refused to participate in <u>individual</u> mental health sessions less than 15% of the time.[64] This finding that suggests that most prisoners ***<u>are</u>*** willing to leave their cells for mental health treatment they perceive to be helpful.

2. Prisoners at SCCF are receiving very few individual mental health contacts.

One-on-one contact with a trusted mental health professional is the hallmark of a successful therapeutic treatment program.[65] Without such a meaningful connection, prisoner mental health is very unlikely to improve, resulting in poor outcomes for both the prisoner and the Department.[66] Unfortunately, the data indicate that many prisoners in the RTPs, particularly at SCCF, continue to be afforded very few opportunities for meaningful individual mental health contacts, despite requirements for some such contact in administrative regulations. For instance, between February and April 2015, prisoners in SCCF were offered a mean of less than fifteen minutes of individual therapy per week; the median actually being none at all.[67] On average, about two-thirds of prisoners in the RTP at SCCF were offered <u>no</u> individual contact with a mental health professional during a given week.[68]

In order to get a sense of the individual experience of prisoners, we reviewed data reflecting individual therapy offered to two prisoners who had lengthy stays at SCCF.[69] During an almost 27 week period ending October 1, 2015, one of these prisoners was offered zero hours of individual contact; the other was offered a total of two hours, with a mean of less than five minutes a week. This is especially troubling since prisoners housed at SCCF are likely to be in an acute mental health crisis, and in high need of individualized attention.

3. The RTPs have insufficient mental health staff.

The quality and quantity of mental health care in the RTPs is compromised by persistent understaffing.[70] As of November 2015, CDOC's RTPs experienced a nearly 30% vacancy rate in mental health staffing.[71] In San Carlos Correctional Facility, the vacancy rate was 46%. Those vacancies include two of four psychologists for the between 425 and 500 prisoners typically housed in CDOC's RTPs. SCCF also has no clinical therapist and only half of its twelve slated on-call social worker/counselors.[72]

Additionally, although all of CDOC's funded psychiatric positions are fully staffed,[73] the psychiatrist-to-patient ratio is entirely inadequate. With only 2.6 full-time psychiatrists, CDOC's psychiatrist-to-patient ratio is approximately 1:170.[74] American Psychiatric Association (APA) guidelines for an RTP require a ratio of 1:50 (one full-time psychiatrist position for every 50 patients).[75] Since CDOC's RTP census can reach nearly 500,[76] APA guidelines mandate 10 full-time psychiatrist positions for these RTP's – far more than the 2.6 positions currently funded.

Perhaps most important, a comparison of the funded mental health positions for the Colorado Mental Health Institute at Pueblo, which like CDOC's RTPs serves between 400 and 450 mental health patients, underscores just how under-resourced CDOC's RTPs are. Last month, CMHIP reported it had 18.83 full-time equivalent psychiatrists, 39.5 full-time equivalent psychologists, 6 full-time equivalent psychologist candidates for between 400 and 450 mental health patients.[77] Compare this to CDOC's RTPs' 2.6 psychiatrists, 4 psychologists, and 8 psychologist candidates for about 430 current mental health patients.[78] Given CDOC's shortage of psychiatric coverage, its low mental health staffing numbers and high vacancy rates, it seems virtually impossible for CDOC to be able to meet the needs of its RTP population.[79]

4. CDOC staff's assessment of some prisoners' mental health raises concerns.

a. <u>Since the Spring of 2013, there has been an alarming decrease in diagnoses of serious mental illness among CDOC prisoners.</u>

In Spring 2013, before you became executive director, CDOC informed the ACLU that mental health staff were undertaking a significant number of mental health reassessments. We were pleased, believing that these reassessments were intended to identify the high number of CDOC prisoners with serious mental illness, particularly those prisoners held in or being considered for placement in administrative segregation. However, we very quickly became concerned that this reassessment process was doing precisely the opposite. We began hearing reports from prisoners and other advocates that many prisoners whom CDOC mental health staff had long-diagnosed as having serious mental illness were now being reassessed as not having a serious mental illness.

The ACLU reviewed a handful of prisoner records reflecting such a re-classification, but until recently was unable to assess whether there was a larger trend of downgrading prisoners'

mental health diagnoses. We now have data that suggests there was such a widespread practice. In February 2013, CDOC mental health staff viewed 3,480 prisoners, or about 17% of the prison population, as having a serious mental illness.[80] This percentage had been relatively steady within CDOC for at least the eighteen months prior; in both August 2011 and August 2012, CDOC reported that approximately 16% of its prisoners had a serious mental illness.[81] However, within a six month period between February 2013 and August 2013, the number and percent of prisoners CDOC mental health staff deemed to have a serious mental illness dropped precipitously. As of August 2013, CDOC reported that only 10% of the prison population (2,117 prisoners), had serious mental illness.[82] And this "new," lower rate has remained steady at least through October 2015.[83]

Thus, there was a major decrease in the number and percent of prisoners perceived as having serious mental illness at the precise moment when CDOC was considering expanding services to these prisoners and excluding them from solitary confinement. We consulted with experts in this area. They expressed skepticism that such a large number of mental health reassessments could be competently completed in such a short period of time. Their skepticism was stoked by the apparent outcome of the reassessments – a substantial decrease in the number of prisoners found to have serious mental illness. We believe you may not be aware of this very rapid and widespread downgrading of clinical diagnoses, and that these findings will raise concerns for you as well.

b. <u>Some CDOC mental health staff tend to under-diagnose serious mental illness and over-diagnosis malingering.</u>

Since the ACLU began reviewing administrative segregation prisoners' mental health files in 2011, we have observed many instances of CDOC clinician's apparent hesitance to diagnose disruptive prisoners as having a serious mental illness. These clinicians appear, instead, to inappropriately attempt to find disruptive prisoners are either suffering exclusively from personality disorders or are malingering.[84] They do so even in the face of strong evidence that the prisoner suffers from a severe Axis I disorder such as schizophrenia.

This is a common problem for mental health professionals in corrections settings, where experts agree the pressures encourage under-diagnosis of serious mental illness and over-diagnosis of malingering.[85] Faced with too few resources and pressured to conform to a security-centric culture, mental health professionals can begin to distance themselves from patients, become especially skeptical of prisoners exhibiting disruptive behavior, and minimize complaints that later reveal themselves to be true signals of severe psychological distress. Prisoners crying out for help are routinely ignored as "troublemakers" and are pegged as "manipulators" faking distress for attention.[86] Clinicians and staff may find themselves resentful or even afraid of dangerous and disruptive prisoners and judgmental of their violent and disruptive acts. Such bias may cloud clinical judgment and make it difficult to view these challenging prisoners as "patients," which a diagnosis of "serious mental illness" undoubtedly requires.[87] Bona fide psychiatric problems then may worsen, especially when an individual faces segregation.[88]

One prisoner's story provides a compelling example of this problem at work. The ACLU has reviewed the entire mental health file for a prisoner who spent almost a decade in

administrative segregation until he was moved to SCCF in 2014. In administrative segregation, this prisoner came to believe – and still believes – that correctional officers were conspiring to poison him, often by putting feces or urine in his food. In one incident reflected in his clinical notes, he ate his own feces to show guards that he did not care that his food was being poisoned. He also swallowed over a dozen foreign bodies, requiring surgery to remove them. For years, this prisoner moved back and forth between administrative segregation and the SCCF, often receiving psychotropic medications for acute psychotic episodes. Still, through all the years, CDOC doctors have refused – except during a one month period in 2014 – to recognize that the prisoner has serious mental illness. Instead, several doctors have diagnosed him as having solely a personality disorder or as "malingering."

In order to test our lay observation that this prisoner (like many others) was recurrently under-diagnosed and unreasonably disbelieved, we sent this prisoner's entire mental health record to Dr. Stuart Grassian, a nationally-known psychiatric expert in this area. Based on his review of the file, Dr. Grassian opined that despite the fact that this prisoner was recurrently diagnosed as either "malingering" or with some "personality disorder," the evidence was inescapable that he had a serious chronic psychotic disorder, likely chronic paranoid schizophrenia. Dr. Grassian noted that mental health staff appeared "very eager to diagnose [this prisoner] with a personality disorder."[89] Despite their willingness to administer antipsychotic medication over objection to this prisoner, they asserted that his symptoms were faked. Dr. Grassian opined that this assertion was unsupportable, and concluded that the massive inconsistency and illogicality in this prisoner's mental health record could only be explained as the product of a callous indifference towards this prisoner's suffering.[90]

While this prisoner is not currently in maximum security, CDOC doctors' refusal to assess him as having a serious mental illness leaves him vulnerable to future placements in maximum security.[91] Additionally, CDOC doctors' recurrent findings that this prisoner is malingering causes mutual distrust between the prisoner and mental health staff, dramatically limiting the efficacy of any possible treatment plan.

III. CDOC AS A NATIONAL MODEL OF REFORM AND TRANSPARENCY

A. Positive changes we have documented

1. As the leader of the Colorado Department of Corrections, you have become the national spokesperson and a catalyst for national change in the correctional use of solitary confinement and provision of mental health care to prisoners.

During your tenure, you have become the national spokesperson from within the correctional community on the terrible toll that prolonged solitary confinement takes on prisoners, correctional staff, and public safety.[92] You have set course to show correctional leaders across the country that sensible reform of solitary confinement and the provision of meaningful mental health care can and should take place in any modern, evidence-based prison system.[93] You are helping focus correctional leaders on their important role in rehabilitating prisoners, who in almost all cases will return to society and be our neighbors. We are grateful for your leadership.

2. CDOC has taken meaningful steps toward transparency and accountability with respect to its reforms of solitary confinement and provision of mental health care.

Throughout CDOC's reforms, it has collected extensive data related to its reform efforts. By way of example, CDOC collects data regarding therapeutic out-of-cell time for prisoners in CCF's RTP, progress of prisoners' transitions out of administrative segregation/maximum security, success rates of RTPs, and incidents of violence. Additionally, we recognize that CDOC has made information about its reforms available to the public on a level nearly unprecedented in this country. Not only does CDOC's website provide extensive information regarding the reforms, but CDOC has readily provided the ACLU a broad array of data and information about the reforms in response to a multitude of records requests. We believe that CDOC's efforts to collect data on its reforms and make that data available to the public reflects a commitment to ensuring that the reforms are real and measurable.

B. Challenges that remain -- *Improvements in tracking, analyzing, and/or accuracy of essential data are needed.*

Despite CDOC's significant efforts at data collection, there are essential pieces of data that CDOC currently does not collect, analyze, and/or audit for accuracy. This missing data would help CDOC identify and overcome challenges to implementing its reforms. For examples, CDOC does not consistently track and analyze therapeutic out-of-cell time for prisoners in its SCCF RTP.[94] (Notably, what data CDOC did provide to the ACLU contained concerning inaccuracies.[95]) Additionally, CDOC does not track non-therapeutic out-of-cell time for prisoners in RTPs or MCUs.[96] As you know, RTPs and MCUs are the landing spot for many prisoners released or diverted from administrative segregation/maximum security. Further, the majority of prisoners in MCUs and all prisoners in RTP have significant mental health needs. Thus, data regarding the actual out-of-cell time for these prisoners gets at the heart of your administration's efforts to reform CDOC's use of solitary confinement and the provision of mental health care.

We recognize CDOC cannot be expected to collect data on every movement of every prisoner. Nonetheless, without stronger data collection and analysis, as well as quality control protections, we are concerned CDOC will not be able to ensure that its reforms are being fully implemented.

IV. CONCLUSIONS AND RECOMMENDATIONS

Executive Director Raemisch, you have set into motion reforms that elevate public safety while improving the humanity of Colorado's prisons. We recognize that because of policy changes under your administration, hundreds of men and women have been freed from long-term isolation and no doubt hundreds more will never endure it. Your work and public advocacy are not just affecting prisoners in Colorado, but are having positive ripple effects across the country and abroad.

We want to support you in making all of your reforms real and lasting, so that Colorado can be the true model for reform around the country. We hope, after reviewing this letter, you will invite the ACLU of Colorado along with the ACLU National Prison Project, to collaborate with you to implement the following recommendations. We recognize that undertaking some of these recommendations would require significant funding. To the extent CDOC believes it

would be helpful, the ACLU is ready and willing to come out in strong support of any budgetary request by CDOC aimed at implementing these reforms.

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.[97]

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

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 recommendations for policy and practice changes, and (c) monitor implementation of those changes.[98] This team – which should ideally be headed by a forensic psychiatrist with expertise in prison mental health treatment programs, psychiatric diagnosis and the effects of solitary confinement – would help CDOC identify the cause of and solutions for, among other things: (a) difficulties recruiting and maintaining mental health staff; (b) high mental health treatment refusal rates; (c) minimal offerings of individual therapy; and (d) under-diagnoses of serious mental illness and over-diagnosis of malingering. This team would also identify specific mental health staffing deficiencies. Finally, this team would audit mental health assessments, including those which resulted in a finding that a prisoner who was once diagnosed with a serious mental illness was no longer seriously mentally ill, and would review quality control practices and procedures that should deter or catch unsupportable mental health assessments.

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

5. Institute a policy of tracking, analyzing, auditing, and reporting *all* out-of-cell time offered, cancelled, and refused in all of CDOC'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.[99]

We appreciate you taking the time to read through our findings and recommendations. We look forward to hearing back from you.

Sincerely,

Mark Silverstein
Legal Director, ACLU of Colorado

Rebecca Wallace
Staff Attorney, ACLU of Colorado

[1] Testimony by T.A.Kupers, 2014-02-25 Hearing before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights: Reassessing Solitary Confinement – The Human Rights, Fiscal, and Public Safety Consequences (discussing the "irrational culture of punishment" that is a cause and symptom of overuse of solitary confinement), *available at* http://solitarywatch.com/wp-content/uploads/2014/02/U.S.-Senate-Subcomm-2014-Kupers.pdf.

[2] CDOC Dashboard Measures, Prison Behavior, *available at* https://www.colorado.gov/pacific/cdoc/departmental-reports-and-statistics.

[3] CDOC Dashboard Measures, Prison Behavior, *available at* https://www.colorado.gov/pacific/cdoc/departmental-reports-and-statistics.

[4] Shames, A., *et al.*, VERA Institute of Justice, SOLITARY CONFINEMENT: COMMON MISCONCEPTIONS AND EMERGING SAFE ALTERNATIVES (May 2015) p. 6, *available at* http://www.vera.org/sites/default/files/resources/downloads/solitary-confinement-misconceptions-safe-alternatives-report_1.pdf; The Liman Program of Yale Law School, Association of Correctional Administrators, TIME-IN-CELL: THE ASCA NATIONAL SURVEY OF ADMINISTRATIVE SEGREGATION IN PRISON (Aug. 2015), p. 15 (hereinafter "Liman Report"), *available at* http://www.asca.net/system/assets/attachments/9195/*asca-liman_administrative_segregation_report_sep_2_2015.pdf?1450213204.

[5] Liman Report (*see* n.4, *supra*), pp. 25-26; *see also* R. Raemisch, K. Wasko, OPEN THE DOOR – SEGREGATION REFORMS IN COLORADO, *available at* https://drive.google.com/file/d/0B30yLl0I1yBRY2h2UDBCZ0Q5WlE/view?pref=2&pli=1.

[6] 2015-11-20 CDOC response to 2015-11-17 ACLU records request (Ad Seg Releases); French-Marcelin Analysis (Table I – Inmates released from administrative segregation currently incarcerated as of November 2015). Megan French-Marcelin is the Policy Research Manager at the National ACLU. She holds a PhD in American history with a focus on policy studies from Columbia University.

[7] *See* French-Marcelin Analysis (Table I – Inmates released from administrative segregation currently incarcerated as of November 2015); *see also* CDOC, SB11-176 ANNUAL REPORT: ADMINISTRATIVE SEGREGATION FOR COLORADO INMATES (Jan. 2014), pp. 2-3, *available at* https://drive.google.com/file/d/0B8WLSXAb0Mg8VXpNSnRGb3R4T28/view.

[8] *See, e.g.*, C. Haney, MENTAL HEALTH ISSUES IN LONG-TERM SOLITARY AND 'SUPERMAX' CONFINEMENT, Crime & Delinquency, Vol. 49 No. 1, Jan. 2003, pp. 124-156 (describing "the prevalence of pain and suffering in supermax"), *available at* http://www.academia.edu/2001164/Mental_health_issues_in_long-term_solitary_and_supermax_confinement.

[9] CDOC Administrative Regulation 650-03I(V)(B)(2).

[10] Prior to adopting the sentencing matrix, CDOC staff had broad discretion in determining whether a prisoners' behavior warranted placement in administrative segregation. Austin, J., Sparkman, E., COLORADO DEPARTMENT OF CORRECTIONS ADMINISTRATIVE SEGREGATION AND CLASSIFICATION REVIEW (Oct. 2011), p. 11, *available at* http://www.doc.state.co.us/sites/default/files/Final%20Ad%20Seg.pdf. Several categories of offenses that warranted placement in administrative segregation were quite broad and open to interpretation of staff, including for instance being "a serious management problem," "advocating a facility disruption," or "engaging in Security Threat Group conduct [gang activity]." CDOC, SB11-176 ANNUAL REPORT: ADMINISTRATIVE SEGREGATION FOR COLORADO INMATES (Jan. 2012), p. 6, table 2; CDOC Administrative Regulation 650-03, Administrative Segregation (May 15, 2012), Section (IV)(B)(4). These flexible categories of offenses allowed prisoners to be sent to long-term solitary confinement for relatively minor repeat infractions, and sometimes only because the prisoner angered or showed disrespect to staff. Indeed, the number one reason for administrative segregation placements in FY 2011 and 2012 was that the prisoner was a "serious management problem." CDOC, SB11-176 ANNUAL REPORT: ADMINISTRATIVE SEGREGATION FOR COLORADO INMATES (Jan. 2013), page 11, figure 12.

Many prisoners who engaged in conduct which staff considered a "serious management problem" had mental illness at the root of their misconduct. ACLU of Colorado, OUT OF SIGHT, OUT OF MIND – COLORADO'S CONTINUED WAREHOUSING OF MENTALLY ILL PRISONERS IN SOLITARY CONFINEMENT (July 2013), pp. 6-14, *available at* http://aclu-co.org/wp-content/uploads/files/imce/Solitary%20Report.pdf. Rather than receiving treatment, these prisoners were sent to long-term, indefinite isolation. Indeed, at the time the ACLU issued our 2013 report,

CDOC's large administrative segregation population included many prisoners who committed multiple minor infractions – often due to mental illness – but who did not pose a serious threat to the safety of staff or other inmates.

[11] *See, e.g.*, Austin, J., Sparkman, E., COLORADO DEPARTMENT OF CORRECTIONS ADMINISTRATIVE SEGREGATION AND CLASSIFICATION REVIEW (Oct. 2011), p. 18.

[12] *See, e.g.*, 2013-04-12 CDOC response to 2013-03-04 ACLU records requests (length of stay for MMI in Ad Seg).

[13] *See* 2015-09-21 CDOC resp. to ACLU 2015-08-11 records request (Max data); French-Marcelin Analysis (Table II – Max DATA as of 2015-09-21).

[14] The ACLU hopes to see average length of stays in maximum security decreased to three months and maximum sentences decreased to six months except in the case of murder. *See, e.g.*, Liman Report (*see* n.4, *supra*), pp. 20-29 (noting three state departments of corrections that report the majority of prisoner stays in segregation are fewer than 90 days).

[15] CDOC, SB11-176 ANNUAL REPORT: ADMINISTRATIVE SEGREGATION FOR COLORADO INMATES (Jan. 2014), p. 7, Figure 4.

[16] We have received many prisoner complaints about the extremely harsh conditions of confinement in maximum security, which serve to almost completely isolate prisoners and leave them with little to occupy their brains for days, weeks, and months on end. The complaints make clear that life in maximum security is particularly harsh during the first three months (sometimes longer) when prisoners are locked alone in a cell often for the entire day without a television. Some prisoners who transfer into maximum security have already gone a month or more without television in punitive segregation or while waiting for transfer. Additionally, many prisoners have also reported that, for at least the first three weeks, they have no books because correctional officers refuse to give maximum security prisoners books until they are cleared to use the library, which often takes up to three weeks. With no visitors for thirty days and only one phone call a month, maximum security serves to weaken ties between prisoners and their support system outside of prison. *See* D. Fathi, SEPARATION NOT ISOLATION, Correctional Law Reporter (June/July 2014), p. 5 (discussing examples of "[d]raconian restrictions" on "contact with the outside world" that "serve little or no valid security purpose" and noting that "[d]enial of telephone contact and visitants surely exacerbates [] social isolation and loneliness, which pose a serious risk to the physical and mental health"), *available at* http://www.civicresearchinstitute.com/CLR26_1/Separation%20Not%20Isolation.html.

[17] CDOC Administrative Regulation 650-03(IV)(C)(15), (IV)(C)(13), Restrictive Housing (Nov. 1, 2015) (hereinafter "AR 650-03"), *available at* https://drive.google.com/file/d/0B4vYiI52TzO6a1J6R3o5THdBZW8/view.

[18] AR 650-03(IV)(C)(14).

[19] AR 650-03 (IV)(C)(5), (IV)(C)(8).

[20] CDOC Administrative Regulation 650-03(IV)(H(2), Administrative Segregation (May 15, 2012).

[21] CDOC now allows prisoners to have in their cells five personal books and five personal magazines, allows an initial phone call within 24 hours of placement in maximum security, and leaves open the possibility of a monthly contact visit (while fully restrained) with a family member. AR 650-03(IV)(C)(15), (IV)(C)(13).

[22] *See* Liman Report (*see* n.4, *supra*), p. 45 - Table 13, p. 46 - Table 14.

[23] Frank Wood, former Minnesota Commissioner of Corrections has commented: "When you take away televisions, when you take away weights, when you take away all forms of recreation, inmates react as normal people would. They become irritable. They become hostile. Hostility breeds violence, and violence breeds fear. And fear is the enemy of rehabilitation." T.A. Kupers, HOW TO CREATE MADNESS IN PRISON, p. 8 (source: D. Jones, Ed., Humane Prisons (Oxford: Radcliffe Publishing, 2006)), *available at* http://www.fmhac.net/Assets/Documents/2009/Presentations/Kupers%20Humane%20Prisons.pdf.

[24] According to Dr. Terry Kupers, a nationally renowned forensic psychiatrist and expert on the effects of prolonged isolated confinement: "[R]esearch clearly demonstrates that prisoners who are able to sustain quality contact with loved ones over the length of a prison term are much more likely than others to succeed at 'going straight' after they are released." T.A. Kupers, HOW TO CREATE MADNESS IN PRISON, p. 10 (internal citations excluded) (source: D. Jones, Ed., Humane Prisons (Oxford: Radcliffe Publishing, 2006. Conversely, "obstacles [] to quality contact with friends and family tend to increase the general level of madness within the prisons." *Id.*

[25] As of October 31, 2015, there were 306 prisoners housed in an MCU. 2015-11-23 CDOC response to 2015-11-17 ACLU records request (MCU population); French-Marcelin Analysis (Table IV – Inmates remaining in MCU as of October 31, 2015). Of those 306 prisoners, approximately 235 are individuals who CDOC released from

administrative segregation/maximum security after July 1, 2013. French-Marcelin Analysis, Table VIII (Inmates released from administrative segregation currently incarcerated as of 2015-10-31; *see also* 2015-11-20 CDOC response to 2015-11-17 ACLU records request (Ad Seg Releases).

[26] CDOC Administrative Regulation 600-09(III)(C), Management of Close Custody Offenders (hereinafter "AR 600-09"); *see also id.*, (III)(D).

[27] 2015-11-18 CDOC response to 2015-10-21 ACLU records request (P&Q codes by status).

[28] As of November 2015, approximately 60% of all prisoners in MCUs had significant mental health needs, compared with approximately 30% of CDOC's overall (male) population. *Compare* 2015-11-18 CDOC response to 2015-10-21 ACLU records request (P&Q codes by status); *with* CDOC, Statistical Report (FY 2013), pp. 30-31, figures 39-40; *see also* French-Marcelin Analysis (Table VI - P&Q data by status).

[29] AR 600-09(IV)(G)(1)(b), (IV)(G)(2)(b).

[30] We are heartened by your recently stated commitment to "increase[] programming the programming opportunities in the Close custody management control units." R. Raemisch, K. Wasko, OPEN THE DOOR – SEGREGATION REFORMS IN COLORADO (*see* n.5, *supra*), p. 9.

[31] MCU as a form of isolated housing is relatively new. Demonstrating patterns over time is hampered by the fact that nearly half of the prisoners ever assigned to MCU remain in an MCU as of the date of the most recent data production. When processing the data, we were mindful that including in our data pool lengths of stay of those prisoners still in the MCU will skew the data in one way (relying on numbers that are not controlled given the lack of an out date); while excluding from the data pool those prisoners who remain in MCU—many of whom are those who have been in MCU the longest—would skew the data in another way (namely not record those who have been in for lengthier stays and who remain in an MCU indefinitely). Thus, the data remains an imperfect depiction of what is occurring in MCUs. Nonetheless, data provided to by CDOC does allow us to point to several disconcerting patterns, particularly with respect to stays in MCU of over 365 days.

[32] French-Marcelin Analysis (Table III – Time in MCU as of 2015-09-21).

[33] French-Marcelin Analysis (Combined MCU & Max DATA as of 2015-09-21). Note that for this analysis, MCU and maximum security data were combined as of September 21, 2015. Data was used to chart prisoners as they moved between MCU and Max. Where inmates were still in either Max or MCU, total number of days in is calculated using September 21, 2015 as the out date. Data thus depicts incomplete, but significant, trends in the concurrent use of MCU and maximum security.

[34] French-Marcelin Analysis (Table IV – Inmates remaining in MCU as of 2015-10-31).

[35] To test complaints regarding prolonged isolation of prisoners held in MCUs, we requested CDOC provide data reflecting all cancellations of day halls in CSP's MCU Unit A (which we randomly selected as a sample unit) due to lockdowns during March 2015. CDOC provided this data, which reflected that pod time was cancelled over 40% of the time that month. 2015-04-14 CDOC response to 2015-04-01 ACLU request (CSP – Reason for lock down ACLU request 4-10-15); 2015-04-16 Spears Analysis (A-Unit CSP Lockdown Chart). If that data were accurate, these MCU prisoners would have averaged only 2.3 hours of day hall per day in the month of March. However, according to a CDOC representative, the data in all likelihood *underestimates* the number of cancelled day halls, since lock downs sometimes go undocumented, and because day halls can be cancelled for reasons other than a lockdown. 2015-06-01 Email from Adrienne Jacobson to Rebecca Wallace (Re: A Unit Lockdown). Thus, it seems probable that, on average, prisoners spent *more than 22 hours per day in their cell* that month.

We tried to gather more comprehensive data, but have been unable to do so. When we sought broad data on lockdowns across MCUs, CDOC indicated that, by policy, staff are under no obligation to and often do not track lock downs, and that there is no systematic tracking of MCU out-of-cell time. *See, e.g.*, 2015-05-08 Email from Adrienne Jacobson to Sarah Spears (re A Unit Lockdown); 2015-06-01 Email from Adrienne Jacobson to Rebecca Wallace (re A Unit Lockdown). We are confused by CDOC's inability to provide information regarding out-of-cell time for MCU prisoners given the requirements of AR 600-09 (IV)(C)(11) that "All pod/day hall, and recreation times for offenders housed in Close Custody Management and Transition Units status shall be documented.".

[36] *See, e.g.*, R. Raemisch, MY NIGHT IN SOLITARY, The New York Times (Feb. 20, 2014), *available at* http://www.nytimes.com/2014/02/21/opinion/my-night-in-solitary.html?_r=0; R. Raemisch, "Opening the Steel Door: Solitary Confinement Reform, ACSblog (Nov. 17, 2015), *available at* http://www.acslaw.org/acsblog/opening-the-steel-door-solitary-confinement-reform.

[37] 2013-12-10 Memo from Lou Archuleta to K. Wasko, S. Hager (re: Mental Health Qualifiers (M-Code)), *available at* http://aclu-co.org/wp-content/uploads/files/Memo%20Mental%20Health%20Qualifiers%20Ad%20Seg%20MEMO%20%282%29.pdf..
[38] CDOC's response to ACLU's 2014-07-29 request reflected no prisoners with serious mental illness housed in maximum security as of July 31, 2014.
[39] ACLU of Colorado, OUT OF SIGHT, OUT OF MIND – COLORADO'S CONTINUED WAREHOUSING OF MENTALLY ILL PRISONERS IN SOLITARY CONFINEMENT (July 2013), p. 5.
[40] 2015-11-18 CDOC response to 2015-10-21ACLU request (P&Q codes by status). We presume CDOC justifies placement of this prisoner in maximum security by the "exigent circumstances" exception to C.R.S. § 17-1-113.8, the law which prohibits CDOC from placing prisoners with serious mental illness in long-term solitary confinement. We continue to believe there should be no such exception to the prohibition, but are nonetheless heartened that CDOC has – thus far – severely limited its reliance on the exception. *See* R. Raemisch, K. Wasko, OPEN THE DOOR – SEGREGATION REFORMS IN COLORADO (*see* n.5, *supra*), p. 5.
[41] *See, e.g.*, CDOC, OFFENDERS WITH MENTAL ILLNESS IN CENTENNIAL CORRECTIONAL FACILITY RESIDENTIAL TREATMENT PROGRAM (Jan. 2015), page 1 (hereinafter "2015 CDOC OMI Report"), *available at* https://drive.google.com/file/d/0B8WLSXAb0Mg8R0kzU0tFUEUyNWM/view.
[42] *Id.*, at p. 5, Figure 6.
[43] *Id.*
[44] *Id.*; CDOC, Response to Request for Information, p. 1, answer to question 1 (responding to Representative Claire Levy's 2012-11-05 Request for Information from DOC Regarding Mentally Ill in Solitary Confinement).
[45] 2015 CDOC OMI Report (*see* n.41, *supra*), page 5, Figure 6.
[46] *Id.*, at p. 5.
[47] *See* T. A. Kupers, TREATING THOSE EXCLUDED FROM THE SHU, 12 Correctional Mental Health Reporter (2010), pp. 11-12 ("[P]risoners with mental illness who are consigned to step-down mental health programs and subsequently break rules and assault staff need to be retained within the mental health program, where the consequences for their disruptive or assaultive behaviors can be handled in the context of the mental health treatment plan . . . ."), *available at* www.probono.net/prisoners/stopsol-reports/attachment.212215.
[48] *See* CDOC CCF RTP Discharges November 2010-October 2015.
[49] 2015 CDOC OMI Report (*see* n.41, *supra*), page 5.
[50]CDOC Administrative Regulation 650-04, Residential Treatment Program for Offenders with Mental Illness and Intellectual and Developmental Disabilities (July 1, 2015) (hereinafter "AR 650-04"), *available at* https://drive.google.com/file/d/0B4vYiI52TzO6RnRON1Z3VmZtZEE/view.
[51] *See, e.g.*, T. A. Kupers, TREATING THOSE EXCLUDED FROM THE SHU, 12 Correctional Mental Health Reporter (2010), p. 4 ("After all, a quality therapeutic relationship is the key to success in mental health treatment and for successful rehabilitation in corrections.").
[52] The ACLU's analysis of CCF RTP out-of-cell data benefited greatly from CDOC's improved data collection system for this location. CDOC provided charts to the ACLU which reflected average therapeutic out-of-cell time offered, taken, and refused for prisoners in CCF RTP, and showed average trends over time. SCCF data was more of a challenge to process. CDOC executive staff informed the ACLU that, while CDOC collects some out-of-cell data for SCCF, CDOC does not process or analyze the data. The ACLU gathered the raw therapeutic out-of-cell time data from SCCF through open records request and then had Natalie Pifer, a doctoral student in the Department of Criminology, Law and Society at the University of California at Irvine, analyze the data for trends.
[53] *See* CDOC CCF RTP Therapeutic Time Out-of-cell – By Month (Total Hours January-October 2015); Pifer SCCF Tables (February - April 2015, Weekly Time Verified).
[54] *See* CDOC CCF RTP Therapeutic Time Out-of-cell – By Month (Total Hours February 2013-October 2014); Pifer SCCF Tables (August - December 2014 – Weekly Actual Doc Hours).
[55] *Compare* CDOC Clinical Standards and Procedures, Code Classifications – Psychological (P-Code) and Developmental Disabilities (DD-Code) (adopted March 2011), definition of "major mental illness"; *with* AR 650-04III(U), definition of "serious mental illness."
[56] AR 650-04(III)(V), definition of "significant functional impairment."

[57] French-Marcelin Analysis (Table VII – CCF RTP average refusal rates); CDOC CCF RTP Therapeutic Time Out-of-cell By Month (Date Range 2013-02-01 through 2015-08-31).
[58] We would like to provide more up-to-date data but are not able to do so. It took several months to receive the requested data from CDOC and several more months for one of our experts to process and analyze the data.
[59] Pifer SCCF Tables (Aug. 2014-Jan 2015 and Feb-April 2015, Weekly % Refusal Rates).
[60] *Id.*
[61] Pifer SCCF Tables (Feb-April 2015, Weekly Out-of-cell Time).
[62] Pifer SCCF Tables (Feb-April 2015, Weekly # of Inds w 0 Hours).
[63] C.R.S. § 17-1-113.8(2) established a "serious mental illness in long-term isolated confinement work group" to "advise the department on policies and procedures related to the proper treatment and care of offenders with serious mental illness in long-term isolated confinement, with a focus on persons with serious mental illness in long-term isolated confinement."
[64] Pifer SCCF Tables (Aug. 2014-Jan 2015 and Feb-April 2015, Weekly Refusal % Ind Contacts); CDOC CCF RTP Therapeutic Time Out-of-cell – By Month, September 2014-March 2015 (Individual Therapy).
[65] *See, e.g.*, T.A. Kupers, TREATING THOSE EXCLUDED FROM THE SHU, 12 Correctional Mental Health Reporter (2010), p. 4 ("After all, a quality therapeutic relationship is the key to success in mental health treatment and for successful rehabilitation in corrections."); *id.*, at p. 5 ("Individual Psychotherapy is important, wherein a trusting therapeutic relationship is fostered.").
[66] T.A. Kupers, A COMMUNITY MENTAL HEALTH MODEL IN CORRECTIONS, Stanford Law and Policy Review, Vol. 26:119, p. 129 (2015) ("Research shows that the more trusting and caring the therapeutic relationship, and the more continuous over time, the more likely the patient is to comply fully with treatment and function the best he or she can, given the level of psychiatric disorder.), *available at* *http://journals.law.stanford.edu/sites/default/files/stanford-law-policy-review/print/2015/04/kupers_26_stan_l._poly_rev_119.pdf*.
[67] Pifer SCCF Tables (Feb-April 2015, Weekly Ind. Contacts).
[68] Pifer SCCF Tables (Feb-April 2015, Weekly # of Inds w 0 Hours).
[69] 2015-11-20 Curry Analysis (SCCF Individual OCT).
[70] In the ACLU of Colorado's 2013 report, we highlighted the problem of inadequate mental health staffing levels, noted that CDOC had not completely filled its vacant psychiatric positions since 2010 when the OMI program was created, and opined that without filling these positions and others, the RTPs "will continue to have a low chance of success." ACLU of Colorado, OUT OF SIGHT, OUT OF MIND – COLORADO'S CONTINUED WAREHOUSING OF MENTALLY ILL PRISONERS IN SOLITARY CONFINEMENT (July 2013), p. 17. We applaud CDOC for raising salaries in 2014 for some mental health positions in order to attract more candidates. Unfortunately, this effort alone has not solved the problem of insufficient mental health staff in the Department, and more is needed.
[71] 2015-11-03 CDOC response to 2015-10-26 ACLU records request (RTP FTE vacancies).
[72] *Id.*
[73] 2015-11-24 Email from Jacobson to Wallace (re Psychiatric RTP FTE).
[74] *Id.*
[75] American Psychiatric Association, Psychiatric Services in Correctional Facilities, Third Edition, p. 9.
[76] *See* 2014-08-14 CDOC response to 2014-07-29 ACLU records request (RTP breakdown of P&Q codes) (reflecting 499 prisoners in RTP).
[77] *See* 2015-12-01 and 2015-12-04 CMHIP response to ACLU records request (CMHIP employment numbers); 2015-12-17 CMHIP response to 2015-12-14 ACLU records request (Re: IAA UCD Physicians Attachment; tblDailyCensus 12-15-15).
[78]CDOC 2015-11-03 response to ACLU 2015-10-26 records request (Re: RTP FTE vacancies).
[79] We understand that there are significant challenges to staffing any prison mental health program, and particularly ones located outside of urban centers – as are SCCF and CCF. Moving CDOC's mental health facilities closer to an urban center would certainly aid in filling vacancies. However, it appears that location alone should not categorically prohibit CDOC from significantly improving its mental health staffing levels. The Colorado Mental Health Institute at Pueblo (CMHIP) is located very near to SCCF and only about 40 minutes from CCF. Yet, in

December 2015, CMHIP reported a reasonably low vacancy rate of about 10%. *See* 2015-12-01 and 2015-12-04 CMHIP response to ACLU records request (CMHIP employment numbers).

[80] *See* French-Marcelin Analysis (Table V – Inmates by Qualifier and Code Across Time); 2015-12-16 CDOC responses to 2015-11-18 records request (P + Q Codes); 2015-11-18 CDOC response to 2015-10-21 records request (P + Q Codes October 2015).

[81] *Id.*

[82] *Id.*

[83] *Id.*

[84] Malingering is the fabrication or exaggeration of psychiatric symptoms for secondary gain.

[85]Dr. Terry Kupers concludes that the issue of under diagnosis of serious mental illness (often in favor of a diagnosis of malingering) is "an unfortunate combination of stigma, mental health staff trying too hard to fit in with the culture of security, relatively insufficient mental health resources, and burnout." T.A. Kupers, MALINGERING IN CORRECTIONAL SETTINGS, Correctional Mental Health Report, 5, 6, March/April 2004.

[86] *See, e.g.*, T.A. Kupers, TREATING THOSE EXCLUDED FROM THE SHU, 12 Correctional Mental Health Reporter (2010), pp. 8-10 (discussing causes and solutions to correctional facilities "[e]xcessive concern about malingering").

[87] *Id.*, at pp. 3-5 ("Credibility vs. Malingering").

[88] *Id.*, pp. 8-10.

[89] Dr. Metzner made similar findings regarding CDOC's assessments of Samuel Mandez's mental health. He opined:

> It appears that some of the mental health clinicians at the Colorado DOC tend to focus on annoying and disruptive behaviors exhibited by Mandez, which are likely to be more related to his personality disorder, in contrast to his symptoms of his psychotic disorder. This is based on my review of records, which document certain barriers that Mr. Mandez has experienced when asking to be referred to a psychiatrist as well as various assessments raising the question of whether Mr. Mandez was malingering and/or manipulating the system.

Metzner 2013-05-19 Psychiatric Evaluation of Samuel Mandez.

[90] Dr. Grassian further found that the mental health staffs' dismissive diagnoses in fact bore no relationship to what they did – the prisoner had a chronic delusional psychosis with acute flare-ups, and was actually prescribed antipsychotic medication, at times over his objection. Antipsychotic medications are potentially dangerous medications, and can result in permanent neurological harm. More significantly, he opined, it is patently unethical to prescribe medication over objection unless the patient is so psychotic and deranged that he is incapable of making his own treatment decisions. When the mental health staff chose to administer medication over objection, they were acknowledging how severely ill this prisoner was. In short, according to Dr. Grassian, mental health staff's decision to administer antipsychotic medication over objection is utterly inconsistent with their claim that he was not seriously mentally ill. *See Jones 'El v. Berge*, 164 F. Supp. 2d 1096, 1118 (W.D. WI 2001) (finding "if these inmates were only malingering and not seriously mentally ill, there would be no reason for Supermax's psychiatric and psychological staff to prescribe them strong antipsychotic, antidepressant or mood-regulating medications".)

[91] The ACLU has followed another highly disruptive prisoner who provides an additional example of recurrent under-diagnosis by CDOC mental health staff. This prisoner's records reflect a long history of serious mental illnesses, but CDOC doctors on a semi-recurrent basis find he is, instead, malingering mental illness. A sample of the evidence in his CDOC medical records reflecting serious mental illness includes: (1) he was placed in a psychiatric hospital at the age of 8; (2) he was in and out of treatment facilities throughout his teens; (3) in his late teens, he began reporting auditory hallucinations; (4) during the last decade at CDOC, his diagnosis has been recorded as including schizophrenia, delusional disorder, and bipolar disorder; (5) CDOC doctors have prescribed him numerous psychotropic medications; (6) he has been on numerous hunger strikes causing severe weight loss, and CDOC force fed him through a tube; (7) he has had dozens of mental health crisis contacts, including for instance 38 crises coded as self-harming incidents in 2005; and (8) he was held at SCCF for acute care for 2 years until earlier this year. Yet, in 2013, a current CDOC doctor who has been with the department for many years, assessed this man as follows: "continue not to see offender as mentally ill, but as very manipulative." In February 2015, the doctor acknowledged that the prisoner believed his food was being poisoned by the prison, but that "doesn't necessarily mean he is mentally ill."

[92] *See, e.g.*, R. Raemisch, K. Wasko, OPEN THE DOOR – SEGREGATION REFORMS IN COLORADO (*see* n.5, *supra*); Testimony by R. Raemisch, ADMINISTRATIVE SEGREGATION: A STORY WITHOUT AN END, 2014-02-25 Hearing before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights: Reassessing Solitary Confinement – The Human Rights, Fiscal, and Public Safety Consequences, *available at* *http://www.judiciary.senate.gov/imo/media/doc/02-25-14RaemischTestimony.pdf*; R. Raemisch, MY NIGHT IN SOLITARY, The New York Times (Feb. 20, 2014).

[93] *See, e.g.*, R. Raemisch, K. Wasko, OPEN THE DOOR – SEGREGATION REFORMS IN COLORADO (*see* n.5, *supra*).

[94] In response to repeated requests from the ACLU to provide information on out-of-cell time at SCCF, CDOC eventually provided excel spreadsheets that reflected raw out-of-cell time data. A CDOC representative informed us this data was not systematically analyzed or reported.

[95] To test the reliability of the data, we performed a simple, comparison of one month of data. We reviewed one month of out-of-cell therapeutic time data for one SCCF RTP prisoner and compared this to the prisoners' complete set of mental health contact notes from the month. Mental health contact notes should and, we believe, do accurately reflect all of a prisoner's mental health contacts and refusals. We found meaningful disparities between the data and the contact notes, with the data skewing toward reflecting more offered out-of-cell time than the mental health contact notes show actually occurred. Only two of the four weeks of out-of-cell data were accurate. One week reflected that the prisoner had been offered eight hours of out-of-cell therapeutic time, when in fact he had been offered five. Another week reflected that he had been offered twelve hours of out-of-cell time when in fact he had been offered nine. All told, the data reflected the prisoner was offered 26 hours of out-of-cell time over a 4 week period (still far short of the 40 hours he should have received pursuant to policy), when in fact he was only offered 20 hours of out-of-cell time during that period.

We performed a similar comparative analysis with CCF data, which fared better. Overall weekly out-of-cell time was not over-reported, and in a few instances was slightly under-reported. However, for two of the weeks, the length, time and nature of the contacts simply did not match up. Of greatest concern, in those two weeks, CCF data reported individual contacts (one for 45 minutes and one for an hour) that – according to the mental health notes – never occurred.

[96] 2015-11-24 Email from Adrienne Jacobson to Rebecca Wallace (Re: New Requests). Prisoners and other advocates have complained that many prisoners, particularly those in the lower levels of RTP, are not released for ten hours of non-therapeutic time each week. The ACLU has been unable to assess the accuracy of these claims because CDOC does not track the data.

[97] Liman Report (*see* n.4, *supra*), pp. 20-29 (noting three state department of corrections report that the majority of prisoner stays in segregation were fewer than 90 days).

[98] We recognize that in 2012 and 2013, CDOC consulted with forensic psychologist Joel Dvoskin to help aid in setting up the OMI program at CSP and the RTP program at CCF. Shortly before he died, Mr. Clements invited the ACLU to hear Dr. Dvoskin's recommendations for CCF RTP programming, which were quite sound. Although we do not doubt that CDOC fully intended to implement Dr. Dvoskin's suggestions, as this letter demonstrates, there have been significant challenges to complete reform. To implement such a massive change understandably requires constant monitoring and would likely benefit from *long-term* consultation with an outside expert who is not burdened with any institutional history.

[99] After reviewing significant amounts of data provided by CDOC, our analyst offers the following suggestions to improve the accuracy of data collection, reporting and analysis:

(a) Data uniformity: The data we have received from CDOC was not standardized. By this we mean that similar data sets were not always coded in the same way. We recommend that dates, DOC numbers, and totals should be listed in a standard form across all data. Information on a singular data point should be kept uniform across time to allow for comparison and longitudinal evaluation as well as to eliminate the possibility of error.

(b) Length of Stay: Data that CDOC provided shows prisoners moving out and then back into an MCU placement in a single day. It appears CDOC views such a prisoners as having two different stays in an MCU, one ending the same day another begins. For a more accurate reflection of lengths of stay, we recommend that where an inmate is released from and returned to MCU the same day, it should be counted as a singular stay. Only where there is more than 24 hours in between stays (i.e. out September 23, back in September 24) should stays be separated.

(c) In analyzing the collective time inmates have spent in MCU and MAX, we noticed some discrepancies in the data that highlight the necessity to standardize how data is collected, managed, and stored. According to the data,

there seemed to be 5 inmates who were in MAX and MCU at the very same time. As we know, this is an impossibility. These discrepancies points to the need to be more precise in the way data is stored and updated to ensure that systematic error remains minimal.