

Mental Health in the House of Corrections
The Correctional Association of New York

mental health

IN THE HOUSE OF CORRECTIONS

A Study of Mental Health Care in New York State Prisons
by the Correctional Association of New York



June 2004

The Correctional Association of New York

“Because the dangers of abuse inherent in the penitentiary are always present, the work of the Correctional Association—an organization of knowledgeable experts unaffected by political forces—is so important.”

—Judge Morris E. Lasker, Former U.S. District Court Judge, Southern District of New York

Founded in 1844, The Correctional Association of New York is a privately funded, nonprofit organization that conducts research, policy analysis and advocacy on pressing criminal justice issues. It is one of only two independent agencies in the country—and the only independent agency in New York—with legislative authority to visit prisons, report on conditions and make recommendations to the Legislature on behalf of prisoners, correctional staff and the society at large.

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ADVISORY BOARD

An advisory board of psychiatrists, university professors, attorneys and criminal justice advocates guided this study from inception to completion. They advised on the research design, presentation of findings and formation of recommendations. They provided important editorial input and review. Several members joined us on site visits and evaluated correctional mental health services based on facility tours, staff interviews, clinical evaluations of inmates and chart reviews. Their write-ups and feedback appear throughout this report.

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7. **Jamie Fellner, Esq.**, Director of U.S. Programs, Human Rights Watch; co-author of *Ill Equipped: U.S. Prisons and Offenders with Mental Illness*.
8. **James Gilligan, M.D.**, Director of the Center for the Study of Violence; former director of mental health services for the Massachusetts Department of Correction; author of *Violence: A National Epidemic*, based on his experience as a prison psychiatrist.

9. **Stuart Grassian, M.D.**, Faculty, Harvard Medical School; has been retained as an expert witness on the psychiatric effects of solitary confinement in a number of class action lawsuits, including several involving New York State prisons.
10. **Michael Perlin, Esq.**, Professor of Law at New York Law School; author of the five-volume treatise *Mental Disability Law: Civil and Criminal*; serves on the Board of Directors of the International Academy of Law and Mental Health; former director of the Division of Mental Health Advocacy in the New Jersey Department of the Public Advocate.
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EXECUTIVE SUMMARY

The Correctional Association's two-year study of mental health care in New York State prisons—which involved 22 visits to 20 correctional facilities, survey interviews with over 400 inmates on the mental health caseload and focus groups with correction officers, mental health staff and prison administrators—reveals both systemic problems and service deficiencies as well as some model programs. Specifically, the prison system's sole psychiatric hospital has not been expanded since it opened in 1980, despite a tripling in the inmate population since that time. System-wide, staff and treatment beds have not kept pace with the increasing volume and severity of mental illness among incoming inmates. Model programs exist within the system, notably the 11 residential Intermediate Care Programs for victim-prone inmates with chronic mental illness and the Central New York Psychiatric Center, a treatment-rich facility with a total capacity of 206 beds: 189 for state inmates and 17 for county inmates with acute mental health needs.

Similar to prison systems in the country at large, the New York State prison system, comprised of approximately 65,000 inmates in 70 correctional facilities, is home to an increasing number of inmates with mental illness. As of December 2003, approximately 7,500 inmates, or 11% of the total prison population, were assigned to the mental health caseload, receiving psychotropic medication, counseling or both. According to Office of Mental Health (OMH) estimates, slightly less than half of the inmates on the mental health caseload (3,200) have a major mental disorder (such as schizophrenia, major depressive disorder or bipolar disorder) and require long-term psychiatric treatment.

Since 1991, the number of inmates with mental illness in New York State prisons has grown by 71%, three times the rate of increase of the overall inmate population. Most of the correctional and mental health administrators we interviewed reported that mental health programs are understaffed and under-resourced, resulting in overburdened clinicians, untreated inmates and a revolving door of admissions to the Central New York Psychiatric Center.

Because of the limited number of residential treatment programs, most inmates with mental illness are housed with general population inmates in maximum-security prisons, where mental health services are woefully insufficient. Correction officers and inmates we interviewed reported that inmates with mental illness are often isolated, stigmatized and easily victimized by other prisoners (extorted, "set up" or assaulted) in general population. Moreover, they receive little treatment beyond psychotropic medication.

Equally disturbing, by the state's own estimate, approximately one-fifth (821 inmates) of the 4,400 inmates in disciplinary lockdown¹ system-wide are on the mental

¹ Disciplinary confinement in New York takes one of three forms: solitary confinement in single-cell Special Housing Units in maximum-security prisons or at Southport Correctional Facility; double-cell

health caseload; OMH reports that 480 of the inmates with mental illness in lockdown have been diagnosed with a major mental disorder—outside experts familiar with New York prison mental health care say this is likely a significantly underestimated figure. The prisoners are locked in a cell 23 hours a day with little natural light, minimal human contact, and few activities to occupy their time. Only on an extremely limited basis are mental health services available to them. Because New York places no limit on the amount of time a person can be sentenced to disciplinary lockdown, inmates with serious mental illness can spend years in social isolation. If their prison sentences expire while they are in lockdown, they are released directly to society.

The study's principal findings are as follows:

- The prison system's sole psychiatric hospital, Central New York Psychiatric Center (CNYPC), has a capacity for only 189 state inmates. Despite a tripling of the general prison population since 1980 when the hospital was opened, no expansion has taken place. Approximately 65% of inmates discharged from CNYPC to the general prison population decompensate and are re-hospitalized within a year.
- Over the past decade, increases in mental health staff positions have not kept pace with the rising number of inmates on the mental health caseload. System-wide, approximately 20% of mental health positions were vacant, including 35% of psychiatrists, 25% of psychologists and 11% of nurses (as of November 2002).
- New York's eleven Intermediate Care Programs (ICPs) are model residential treatment units that provide intensive treatment and programs to inmates with serious mental illness. ICP inmates report high satisfaction with services, high medication compliance and are charged with fewer disciplinary infractions. Correction officers in these units report high job morale and strong collaboration with mental health staff.
- There are only 534 ICP beds system-wide for the 3,200 inmates with major mental disorders.
- Inmates with mental illness housed in general population reported high levels of victimization. Approximately half of the over 400 inmates we interviewed reported having their property stolen or being assaulted by other inmates.
- Inmates with mental illness living in the general prison population receive virtually no treatment aside from psychotropic medication and brief consultations with mental health staff. Many inmates reported not knowing what medications they were on or why they were taking them.

confinement in one of the system's 9 S-Blocks or at Upstate Correctional Facility; or single-cell confinement in long-term keeplock.

- Correction officers uniformly reported that the eight hours of mental health training they receive in the Department of Correctional Services' Academy is insufficient to prepare them to supervise inmates with serious mental illness.
- By state estimate, over 800 of the 4,400 inmates in disciplinary lockdown units are on the mental health caseload, and about half of the inmates with mental illness in lockdown (480 as of December 2003) suffer from a major mental disorder such as schizophrenia.
- According to prisoner surveys, the average disciplinary sentence for inmates with mental illness is six-and-a-half times longer than that of inmates generally: 38 months compared to the Department's figure of 5 months generally.
- The Special Treatment Program (STP), New York's therapeutic program for inmates in disciplinary confinement, offers only two hours of out-of-cell time daily. During group therapy, inmates are shackled and placed in "bird cages" the size and shape of phone booths. Outside psychiatrist James Gilligan described the treatment offered in these units as superficial, akin to "putting band-aids on hemorrhages."
- Between 1998 and April 2004, 34% of the system's 76 suicides occurred in disciplinary lockdown, although inmates in these units comprise 7% of the total prison population. Over half (53%) of the inmates with mental illness we interviewed in disciplinary lockdown reported previous suicide attempts.
- Forty percent of inmates with mental illness in disciplinary lockdown reported acts of self-harm (self-mutilation) during their current incarceration. The Department issues misbehavior reports to inmates who mutilate or attempt to kill themselves. Over half (55%) of the inmates in our sample who reported committing an act of self-harm or attempted suicide also reported receiving a ticket for it.
- Every year, approximately 3,000 inmates with mental illness are discharged from New York State prisons. The Community Orientation and Re-Entry Program (CORP), housed at Sing Sing Correctional Facility—the Department's program to provide intensive discharge planning and aftercare services to inmates with serious mental illness—has only 31 beds.

PRINCIPAL RECOMMENDATIONS

Reducing the number of inmates with mental illness behind bars through diversion to community-based treatment and supervised housing would alleviate many of the problems discussed in this report. However, as long as New York continues to incarcerate thousands of individuals suffering from mental illness, it is critical to provide the resources necessary to treat them. Governor Pataki's proposed 2004-05 budget recognizes the need for increased staff and treatment programs for inmates with mental illness. The Governor has called for the addition of 66 full-time clinicians, 87 more beds in Intermediate Care Programs, 75 more beds in the Special Treatment Program and the creation of two Behavioral Care Units to divert inmates with serious and persistent mental illness from 23-hour disciplinary lockdown. We endorse these proposals and recommend the following additional steps. A more complete list of recommendations can be found on page 77.

- **Expand Central New York Psychiatric Center to a 350-bed capacity.** Staffing and expanding Central New York Psychiatric Center from 206 beds to a 350-bed capacity would allow more inmates to be admitted and to stay longer, thereby maximizing their potential for long-term recovery.
- **Increase the number of clinical staff and fill system-wide vacancies.** The addition of 66 full-time clinicians to staff the new units proposed by the Governor is a necessary and positive step. However, more staff are needed to fill system-wide vacancies.
- **Enact legislation that prohibits confining inmates with mental illness in 23-hour lockdown.** New York policymakers should pursue remedies on their own, before current litigation mandates those remedies and millions of taxpayer dollars are spent on protracted litigation. The Governor and the Legislature should endorse Bill A-8849 introduced by Assemblymember Jeffrion Aubry, Chair of the Corrections Committee, which prohibits housing inmates with serious mental illness in 23-hour lockdown and establishes standards for alternative therapeutic housing.
- **Expand the Intermediate Care Programs (ICPs) and place new units in medium-security prisons.** Currently, the 534 ICP beds system-wide can accommodate a small fraction of the 3,200 inmates with major mental disorders. Moreover, ICPs are currently located only in maximum-security prisons. The 87 new ICP beds proposed by the Governor should be located in medium-security prisons to accommodate inmates with lower security classifications in a less restrictive environment.
- **Provide more beds in therapeutic housing units for inmates with mental illness diverted from 23-hour lockdown.** The Governor's proposal for 102 beds at two new Behavioral Care Units and an additional 75 beds in Special Treatment Programs are steps in the right direction. However, in light of the 480 inmates

with major mental disorders in disciplinary housing, significantly more treatment beds should be added.

- **Correct deficiencies in the Special Treatment Program (STP).** In the new STPs proposed by the Governor, the counter-therapeutic “birdcages” used to confine inmates during group therapy should be eliminated and the 12-week STP curriculum should be expanded to accommodate the many inmates who stay in the program longer. Also, Dialectical Behavioral Therapy, a new form of treatment with demonstrated success in reducing violence, suicide and self-injury among behaviorally disordered individuals, particularly those with Borderline Personality Disorder and Antisocial Personality Disorder, should be considered as a treatment modality given its demonstrated success with incarcerated populations. Finally, inmates should be able to have (or earn) more than two hours a day out of their cells.
- **Increase training for correction officers.** OMH and the Department of Correctional Services (DOCS) should require correction officers to participate in annual, follow-up training on the symptoms and management of mental illness. The two agencies should make sure that officers are given the time to participate in training. In addition, correction officers who work in designated mental health housing areas (Intermediate Care Programs, Residential Crisis Treatment Programs and Special Treatment Programs) should receive annual clinically-based training.
- **Review all inmate death reports published by the New York State Commission of Correction (a government oversight agency) and implement the Commission’s recommendations.** These carefully considered recommendations often go unheeded because no entity monitors or requires their implementation. An independent oversight board and/or the Governor’s Director of Criminal Justice should review the Commission’s reports and hold DOCS and OMH accountable for making reforms.
- **Create a permanent, independent oversight board comprised of psychiatrists, psychologists and correctional experts to monitor conditions in mental health units and disciplinary lockdown.** The oversight board should be authorized by the Governor to conduct regular monitoring visits to all areas of the prisons, make unannounced inspections, investigate complaints, evaluate compliance with standards and directives, and report findings and recommendations annually to the Legislature and the public.
- **Institute a suicide prevention program in every 23-hour lockdown unit, including keeplock.** A properly administered suicide prevention program could mean the difference between life and death.
- **Require nurses to conduct evening rounds in the cellblocks of maximum-security prisons and other areas where inmates with mental illness are**

- concentrated.** Regular rounds by nurses can help identify neglected inmates and ensure better access to care.
- **Offer psychotherapeutic groups and classes on such topics as anger management, medication compliance and self-care to inmates in general population.** Aside from monthly appointments with mental health staff, few if any supports exist for inmates with mental illness in the general population. Groups facilitated by mental health staff should be offered to general population inmates. The Georgia Department of Corrections found that this practice decreased the use of costly psychotropic medication.
 - **Expand the Community Orientation and Re-Entry Program (CORP).** The 31-bed program housed at Sing Sing Correctional Facility should be significantly expanded to serve the thousands of inmates on the mental health caseload who are released to society each year.

INTRODUCTION

Letter from an Inmate in Disciplinary Lockdown: August 6, 2002

8/6/02

RE: The Correctional Association of New York

Dear Ms. or Mrs. Alisa Szatrowski

I received your information from _____, you came to see him on July 24th. I am in the last cell and you never came to the rear section to speak to me.

I am the inmate who basically brought Mr. _____ problems to your attention through the folks in Albany N.Y. (Advocates)

I understand that you and your association is conducting research in the Mental Health area within the N.Y. Prison system, so I wish to share mental health issues in which I myself experience while in prison. I hope you will understand because these psychologist, doctors in the system seem not to.

I know I have some type of mental health disorder but im no doctor and I cant diagnose myself. I suffer from some type of anger management disorder, but these folks here just brush it off as if its nothing! One doctor in Attica told me I suffer from "Bipolar disorder" and chose to give me medication for something I know I do not suffer from.

So, I now sit in my cell. I am a walking time bomb! I receive no type of mental health treatment nor did I rehabilitate for society. I started out my time with a non-violent crime of 2 1/2-5. Im going on my 7th year now and I have sick dreams of truly hurting a certain types of peoples! This all stems from the bitterness and

hate that I learned while incarcerated. After all, this is what the DOCS breeds - Am I right? I also, am very well aware that if I commit another felony, esp. violent, "Its almost lights out for me". Naturally, im not stupid enough to waste my next shot of the front door over something petty. Its in the bank, just sitting and waiting!

So, next year when you publish your report of findings and assemble your coalition for the improvements etc. I will be walking out the front door with the mental fuse dangling out of my brain with no supervision, no rehabilitation and without any mental health care. At least there wont be any strip cells, or loaves of hard bread to humiliate and punish me at the same time. The water deprivations are the worst though!

I'll just medicate myself when I am released, and I'll try to figure out exactly what events in my childhood affected my life.

Until then, I'll just wait in my cell, like I have from 1996 till now, in "confinement", for my release. The bitterness and hatred I harbour just might disappear, so the monster that DOCS created might be tamed by then. Lets hope so for society's sake!

Sincerely,

Why Care About Prison Mental Health Care?

- **There are five times as many people with mental illness confined in correctional facilities as in psychiatric hospitals.**

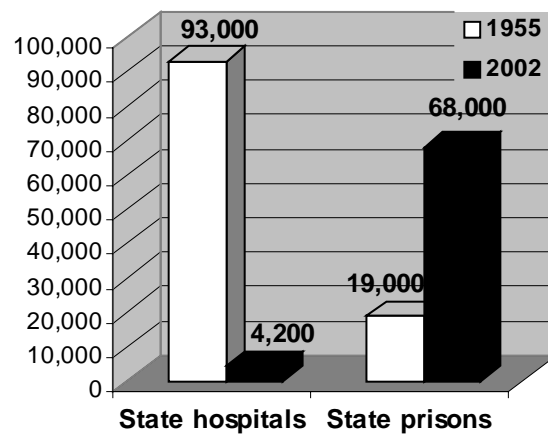
The United States currently confines five times as many individuals with mental illness in jails and prisons than in all state mental hospitals combined. Nationally, public mental hospitals have downsized from approximately 560,000 patients in 1955 to fewer than 60,000 patients today. The shutting of psychiatric hospitals (known as de-institutionalization), the lack of community-based services for individuals with mental illness and the concomitant boom in prison construction over the past several decades have led to the massive confinement of people with mental illness. Of the nation's 2.3 million jail and prison inmates, 16% suffer from mental illness, compared to 5% of the general population.²

Similar to prison systems in the country at large, the New York State prison system, comprised of approximately 65,000 inmates, is home to an increasing number of inmates with mental illness. Currently, about 7,500 inmates (11% of the total prison population) receive mental health services inside New York's 70 state prisons, a 71% increase since 1991 and three times the rate of increase of the general prison population during the same period. According to OMH estimates, slightly less than half of these inmates (3,200) have a major mental disorder (such as schizophrenia, major depressive disorder or bipolar disorder) and require long-term psychiatric treatment. Meanwhile, staff, services and treatment beds have not kept pace with the growing volume and severity of mental illness among new inmates.

- **The prison experience exacerbates mental illness.**

Serving time is, for anyone, a harsh and stressful experience. For individuals suffering from mental illness, the experience can be nightmarish. Not only is the prison environment dangerous, loud and sometimes chaotic, but treatment resources are scarce. Prisons were never intended to be mental hospitals, and fiscally strained Departments of Correction generally lack the funds to provide adequate treatment to the growing number

**Shifting Populations in
New York State**



Reprinted from the *Albany Times Union*³

² Ditton, Paula M., *Mental Health and Treatment of Inmates and Probationers*, Bureau of Justice Statistics: U.S. Department of Justice, July 1999.

³ Grondahl, Paul, "Prisoners in Body and Mind," *Albany Times Union*, October 20, 2002, A6-A7.

of inmates with mental illness. Thus, inmates who enter the system with pre-existing mental disorders sometimes leave more ill than when they entered.

Equally serious, a disproportionate number of prisoners with mental illness are housed in solitary confinement. In New York, nearly one-fifth of the inmates in disciplinary lockdown units suffer from mental illness, according to figures from the Office of Mental Health (OMH). They are locked in a cell 23 hours a day with little natural light, minimal human contact and few, if any, activities to occupy their time. Inmates whose prison sentences expire while they are housed in these units are released directly to society after months or years of isolation.

➤ **Prison mental health care is a public concern.**

An often-overlooked aspect of incarceration is the “backdoor” of prisons, the re-entry of poorly prepared prisoners into the community. Nationally, over 600,000 prisoners are released to society every year. In New York, approximately 28,000 state inmates are released annually, some 3,000 or 11% of whom suffer from mental illness. Prospective neighbors and communities have a stake in prison mental health care, because the treatment inmates receive on the inside will affect their experiences and relationships on the outside.

Background

The Correctional Association’s interest in prison mental health care dates back to the 1980s. In 1987, the Correctional Association published its Prison Mental Health Report, which included an analysis of staffing patterns and resources and provided compelling evidence of the urgent need for expansion of services. The report generated significant media attention and resulted in a two-day working session with state policymakers, including officials from the Division of Budget, to discuss how to enhance programs to better serve the growing number of inmates with mental illness. Two outcomes of the meeting were the construction of three mental health satellite units and the expansion of capacity in special residential treatment units known as Intermediate Care Programs.

The genesis of the current report was the growing evidence of inadequate mental health care observed during monitoring visits conducted by the Correctional Association of New York.⁴ Superintendents and correction officers spoke of the strain that housing a growing number of inmates with serious mental illness placed on staff and resources. Mental health employees told us of overwhelming caseloads and inadequate resources that relegated their role to little more than crisis managers.

While touring solitary confinement cellblocks (officially known as Special Housing Units, or SHUs) in conjunction with a study on conditions in 23-hour lockdown

⁴ See *State of the Prisons: Conditions of Confinement in 25 New York Correctional Facilities*, Correctional Association of New York, June 2002, 16-18.

units, we found that inmates with serious mental illness sometimes comprised the majority of prisoners held in these dungeon-like areas.⁵ We encountered inmates who were dazed and overmedicated, floridly psychotic or delusional. Some inmates expressed paranoid thoughts, e.g. “The correction officers are poisoning my food,” and shouted as we walked through the cellblocks. Others had regressed to the point where they engaged in such behaviors as smearing feces on themselves or the walls of their cells, or cutting, biting or burning themselves. Some men would extend their forearms, laced with scars, through the bars to show us where they had slashed their wrists in suicide attempts or mutilated their own flesh.

Other agencies have documented the problems with mental health care in New York State prisons. In 1997, a task force commissioned by the New York State Office of Mental Health (OMH), the agency that provides mental health care inside state prisons, conducted an internal study that revealed serious deficiencies in staffing, psychiatric services and the number of inpatient treatment beds.⁶ The report, which was never made public, stated that the system had reached “a breakpoint where need currently far exceeds staff resources.” It noted that “New York has lower per capita inpatient beds than all other states of comparable or smaller [inmate] populations with the exception of New Jersey,” and that “the outpatient program is becoming less and less able to provide ongoing monitoring and supportive therapy for an increasingly mentally disabled population.”⁷

Officials with the New York State Commission of Correction (a government oversight agency) have issued numerous warnings to DOCS and OMH officials regarding inadequate mental health care, staffing deficiencies, inmate neglect, and prison conditions that contribute to inmate suicide. The Commission of Correction investigates inmate suicides and has published many sharply critical reports in recent years. For example, in its report on the death of Harry Figueroa at Auburn Correctional Facility in 2001, the Commission found that the 45-year-old inmate died of starvation (officially described as “decreased intake of food and water”) following a hunger strike. The inmate, who had a history of mental illness, somehow died while he was in an observation cell on suicide watch. The Commission reported that security and mental health staff should be disciplined “for service inadequacies,” noting that “no vital signs or weights were ever taken” and that “the entire process clearly violates accepted standards of practice.” Unfortunately, the Commission’s recommendations mainly go unheeded because no outside entity (or the Commission itself) holds DOCS or OMH accountable for implementing them.

⁵ See *Lockdown New York: Disciplinary Confinement in New York State Prisons*, Correctional Association of New York, October 2003.

⁶ Smith, H. E., *NYS OMH Task Force on the Future of Forensic Services: Report of the Subcommittee on Prison Mental Health Services*, New York: January 31, 1997.

⁷ *Ibid.*

A number of lawsuits have successfully challenged the quality of mental health care in New York prisons over the past fifteen years.⁸ In 1988, a federal class action suit, *Eng v. Smith*, was brought on behalf of prisoners in Attica's Special Housing Unit after an inmate with a long history of psychiatric illness committed suicide in the SHU. After ten years of litigation and negotiation between DOCS, OMH and the plaintiffs' attorneys, a settlement was reached that stipulated enhanced treatment and protections for inmates with mental illness in the Attica SHU. Plaintiffs' attorneys have noted, however, the difficulty they have had in enforcing the consent decree ordering DOCS and OMH officials to keep prisoners with serious mental illness out of the Attica SHU.⁹

In the 1999 case *Perri v. Coughlin*, which concerned deficient mental health treatment and the conditions under which an inmate was held at Clinton Correctional Facility, the Court found that "while a smattering of mental health and prison personnel attempted to alleviate plaintiff's torment, the overwhelming majority of those charged with his health care did nothing more than act to exacerbate it." The Court awarded the inmate \$50,000 in compensation for which the defendants—the former commissioners of DOCS and OMH—were held personally liable.

Inadequate mental health care throughout the New York State prison system is the focus of an ongoing lawsuit filed in May 2002 by a consortium of three prisoners' rights organizations (Disability Advocates, the Legal Aid Society's Prisoners' Rights Project and Prisoners' Legal Services) and the Manhattan-based law firm, Davis, Polk & Wardwell. A key issue of the lawsuit is the claim that DOCS and OMH fail to care for or remove prisoners with mental illness confined in harsh, 23-hour disciplinary lockdown units, even when the segregated isolation is exacerbating their illness or causing mental deterioration. According to Sarah Kerr, a senior attorney with the Legal Aid Society, "The stringent conditions of isolated confinement are simply inhumane. They cause mentally ill prisoners to psychiatrically deteriorate and contribute to a significant number of prisoner suicides."

Mental Health Services in New York State Prisons

Until 1977, inpatient psychiatric services for inmates in New York were provided not by OMH but directly by DOCS at Dannemora and Mattewan Hospitals. Poor conditions at the hospitals were successfully challenged in a lawsuit, *Negron v. Ward*, which resulted in their closing. In April 1977, statutory responsibility for prisoners with mental illness was transferred from DOCS to OMH, and an inpatient hospital, Central New York Psychiatric Center, was opened in Marcy, New York.

Similar to the community model of mental health care, outpatient and limited inpatient services are provided to inmates throughout the state. Central New York

⁸ See *Anderson v. Coughlin*, 119 F.R.D. 1 (N.D.N.Y. 1988) (Green Haven and Auburn); *Langley v. Coughlin*, 715 F. Supp. 522 (S.D.N.Y. 1989) (Bedford Hills); *Eng v. Smith*, 849 F.2d 80 (2d Cir 1988) (Attica); and *Perri v. Coughlin*, 90-CV-1160 (N.D.N.Y. 1999) (Clinton).

⁹ *Eng v. Smith*, 849 F.2d 80 (2d Cir 1988).

Psychiatric Center serves as the hub for the network of mental health services in state prisons. Each of New York's 70 prisons has a mental health service classification level depending on the resources available. Levels range from 1 to 6 (there is no level 5). Level 1 facilities¹⁰ offer the most intensive services, including inpatient and outpatient care and full-time clinical staff. Level 2 facilities¹¹ provide outpatient care only and have full-time OMH staff. Level 3 facilities¹² and Level 4 facilities¹³ provide outpatient care through part-time OMH staff. Level 6 facilities¹⁴ have no mental health services on site.

Key components of the prison mental health care system are as follows:

1. Reception and Classification Centers

Male inmates entering the prison system are processed and classified at reception centers located at Downstate, Elmira and Ulster Correctional Facilities. Female inmates are processed and classified at Bedford Hills Correctional Facility. After various assessments and record reviews, DOCS assigns inmates to a correctional facility according to their security status and medical and mental health needs. OMH clinicians at reception centers evaluate the mental health needs of inmates referred to them by DOCS staff.

2. Mental Health Satellite Units

Mental Health Satellite Units provide short-term inpatient and ongoing outpatient care to inmates with the highest mental health needs. There are twelve Mental Health Satellite Units in the system located on the grounds of maximum-security correctional facilities with an OMH Level 1 designation.¹⁵

¹⁰ Level 1 Correctional Facilities: Attica, Auburn, Bedford Hills, Clinton, Downstate, Elmira, Five Points, Great Meadow, Green Haven, Sing Sing, Sullivan and Wende.

¹¹ Level 2 Correctional Facilities: Albion, Arthur Kill, Coxsackie, Eastern, Fishkill, Groveland, Mid-State, Southport, Shawangunk, Taconic and Woodbourne.

¹² Level 3 Correctional Facilities: Adirondack, Barehill, Bayview, Clinton Annex, Collins, Franklin, Greene, Marcy, Merle Cooper, MidOrange, Mt. McGregor, Ogdensburg, Oneida, Otisville, Ulster, Upstate, Walkill and Washington.

¹³ Level 4 Correctional Facilities: Beacon, Butler ASACTC, Butler, Cape Vincent, Cayuga, Chateaugay ASACTC, Edgecombe, Fulton, Gouverneur, Gowanda, Hale Creek, Hudson, Lakeview Shock Incarceration, Lincoln, Livingston, Mohawk, Monterey Shock Incarceration, Moriah Shock Incarceration, Orleans, Riverview, Summit Shock Incarceration, Watertown and Wyoming.

¹⁴ Level 6 Correctional Facilities: Altona, Buffalo, Camp Gabriels, Camp Georgetown, Camp Pharsalia, Lyon Mountain, Queensboro, Rochester and Willard Drug Treatment Center.

¹⁵ Recently, DOCS and OMH have taken steps to offer the highest level of mental health care in less-restrictive settings by opening a mental health satellite unit at Fishkill, a medium-security correctional facility.

3. Mental Health Units

Located in 6 medium- and 5 maximum-security prisons, Mental Health Units offer outpatient services (medication and counseling) to inmates assigned to OMH Levels 2, 3 or 4.

4. Residential Crisis Treatment Programs

Located in the twelve Mental Health Satellite Units, Residential Crisis Treatment Programs (RCTPs) provide short-term inpatient care in dormitory beds and observation cells for inmates who are actively suicidal or in psychiatric crisis. There are a total of 151 “crisis beds” in the system.

5. Intermediate Care Programs

Jointly administered by DOCS and OMH, Intermediate Care Programs (ICPs) are treatment-rich, self-contained housing units separated from the general prison population for victim-prone inmates with chronic mental illness. While the goal of ICPs is to provide inmates with the treatment necessary to return to the general prison population, inmates with chronic mental illness typically spend the duration of their prison sentence in ICPs. There are a total of 11 ICPs located in maximum-security prisons¹⁶ with a capacity for 534 inmates.

6. Central New York Psychiatric Center

Located in Marcy, New York, near Utica, Central New York Psychiatric Center (CNYPC) is a maximum-security psychiatric hospital staffed and operated by OMH with 189 beds for state inmates and 17 beds for county inmates. CNYPC receives inmates from state prisons who become acutely psychotic and a small number of inmates from local jails. Inmates transferred to CNYPC are civilly committed under Section 402 of Correction Law. The median length of stay is 40 days; the average is 75 days.

¹⁶ Attica, Auburn, Bedford Hills, Clinton, Elmira, Five Points, Great Meadow, Green Haven, Sing Sing, Sullivan and Wende Correctional Facilities.

Central New York Psychiatric Center

Satellites and Mental Health Units

Unit	Crisis Beds	ICP Beds
Auburn	8	50
Attica	11	78
Bedford Hills	15	30
Clinton	10	60
Downstate	12	
Elmira	8	56
Five Points	14	38
Great Meadow	14	38
Green Haven	11	51
Sing Sing*	22	62
Sullivan	12	64
Wende	14	38
Totals	151	565

* In Spring 2003 Sing Sing's ICP was reduced to 31 beds to make room for CORP, a pilot discharge planning program for inmates with mental illness



Chart Provided by OMH 10/1/01

Methodology

We initiated our study of the quality of mental health services in New York State prisons in 2001. Using the Correctional Association's legislative authority to visit New York State prisons,¹⁷ we conducted 22 visits to 20 correctional facilities. To identify weaknesses and strengths in service delivery, we employed the following research methods:

Site Visits and Inmate Surveys

Between November 2001 and January 2003, we conducted site visits to a total of 20 correctional facilities: 11 maximum-security prisons with Mental Health Satellite Units, 3 medium-security prisons with Mental Health Units, 4 S-Blocks (freestanding Special Housing Units where inmates are held in 23-hour lockdown), the state's largest reception and classification center (Downstate Correctional Facility), and the inpatient psychiatric hospital, CNYPC.

During site visits, project staff and accompanying outside psychiatrists took notes, reviewed inmate records, observed facility operations, inspected mental health units, conducted survey interviews with inmates on the mental health caseload and conducted focus groups with: prison administrative staff; key mental health staff (the unit chief, clinicians and discharge planner); members of the Inmate Liaison Committee (an inmate-elected leadership group); and correction officers.

To gather quantitative data, we administered a survey to inmates on the mental health caseload in Intermediate Care Programs and Special Housing Units. Designed with input from clinical and correctional experts, the surveys captured a broad range of data pertaining to access to services, quality of care, medication compliance, victimization, psychiatric history, suicide attempts, acts of self harm, and treatment by correctional and mental health staff. Surveys for inmates in Special Housing Units also collected information on the charges that led to disciplinary confinement, the psychological effects of living in 23-hour lockdown, and problems experienced in lockdown. Existing research on SHUs and supermax prisons is generally descriptive in nature and focuses primarily on conditions. We know of no other study that involved a systematic in-person survey of a large sample of inmates in lockdown.

A total of 402 survey interviews were conducted by research staff: 213 of inmates in Intermediate Care Programs, 27 of inmates in Special Treatment Programs and 162 of inmates on the mental health caseload in Special Housing Units.

Site visits were conducted at the following facilities:

¹⁷ In 1846, the New York State Legislature granted the Correctional Association the authority to visit prisons throughout the state and to report its findings to policymakers and the public.

1. **Arthur Kill Correctional Facility**, a medium-security prison with 800 male inmates and a Mental Health Unit.
2. **Attica Correctional Facility**, a maximum-security prison with 2,100 male inmates, a Mental Health Satellite Unit, a 78-bed Intermediate Care Program, and an 18-bed Special Treatment Program for inmates with serious mental illness in the 23-hour lockdown Special Housing Unit.
3. **Auburn Correctional Facility**, a maximum-security prison with 1,760 male inmates, a Mental Health Satellite Unit and a 50-bed Intermediate Care Program.
4. **Central New York Psychiatric Center**, the maximum-security inpatient psychiatric hospital operated by OMH with a total capacity of 206 beds: 189 beds for state inmates and 17 beds for county inmates.
5. **Clinton Correctional Facility**, a maximum-security prison with 2,300 male inmates¹⁸, a Mental Health Satellite Unit and a 60-bed Intermediate Care Program.
6. **Downstate Correctional Facility**, a maximum-security prison and the state's largest reception and classification center.
7. **Eastern Correctional Facility**, a maximum-security prison with 1,050 male inmates and a Mental Health Unit.
8. **Elmira Correctional Facility**, a maximum-security prison with 1,800 male inmates, a Mental Health Satellite Unit and a 56-bed Intermediate Care Program.
9. **Five Points Correctional Facility**, a maximum-security prison with 1,350 male inmates, a 25-bed Special Treatment Program for inmates with serious mental illness sentenced to disciplinary confinement, and a 38-bed Intermediate Care Program.
10. **Great Meadow Correctional Facility**, a maximum-security prison with 1,600 male inmates, a Mental Health Satellite Unit and a 38-bed Intermediate Care Program.
11. **Green Haven Correctional Facility**, a maximum-security prison with 2,000 male inmates and a 51-bed Intermediate Care Program.
12. **Greene Correctional Facility**, a medium-security prison with 1,050 male inmates, the majority of whom are 16 to 22 years old.

¹⁸ Clinton Correctional Facility also has a medium-security annex with 600 male inmates on the grounds of the prison.

13. **Greene S-Block**, a freestanding, double-celled, total lockdown “disciplinary” prison with 200 male inmates on the grounds of Greene Correctional Facility.
14. **Mid-State Correctional Facility**, a medium-security facility with 1,400 inmates and a Mental Health Unit.
15. **Mid-State S-Block**, a freestanding, double-celled, total lockdown “disciplinary” prison for 200 male inmates on the grounds of Mid-State Correctional Facility.
16. **Sing Sing Correctional Facility**, a maximum-security prison with 2,230 male inmates, a Mental Health Satellite Unit, a 31-bed Intermediate Care Program and the state’s first residential pre-release unit for inmates with serious mental illness (capacity 31).
17. **Southport Correctional Facility**, a total lockdown “disciplinary” facility with 780 male inmates and a Mental Health Unit.
18. **Sullivan Correctional Facility**, a maximum-security prison with 600 male inmates, a Mental Health Satellite Unit and a 64-bed Intermediate Care Program.
19. **Upstate Correctional Facility**, a double-celled, total lockdown “disciplinary” prison with 1,200 male inmates and a Mental Health Unit.
20. **Wende Correctional Facility**, a maximum-security prison with 960 male inmates, a Mental Health Satellite Unit and a 38-bed Intermediate Care Program.

In-depth Interviews with Experts

To gain a deeper understanding of the issues, we conducted in-depth interviews with numerous individuals in New York and throughout the country, including: current and former officials with the New York State Office of Mental Health; the court-appointed monitor of conditions in Pelican Bay prison in California and Attica in New York; officials with the New York State correction officers union (NYSCOPBA); the criminal justice director of the National Alliance for the Mentally Ill (NAMI); the directors of mental health services in the Florida and Colorado Departments of Correction and the former director of mental health services in the Massachusetts state prison system; staff at Human Rights Watch and the New York State Commission of Correction (a government oversight agency); retired OMH and DOCS employees, and various correctional and psychiatric experts throughout the country.

Secondary Data and Policy Analysis

We collected and reviewed pertinent data and reports, including inmate death reports produced by the State Commission of Correction, policies and protocols of OMH and DOCS, internal agency reports and relevant case law.

Out-of-State Models

To identify out-of-state treatment models, we reviewed quantitative outcome studies on innovative correctional programs published in journals and relevant correctional materials over the last five years. We conducted telephone interviews with the correctional and psychiatric administrators of the Federal Bureau of Prisons' Dialectical Behavioral Therapy program and the Louisiana Department of Corrections' Phoenix Project. We conducted a site visit to San Carlos Correctional Facility in Pueblo, Colorado and spoke with inmates, correction officers and mental health staff. Shortly after we contacted the Louisiana DOC to arrange a visit to its Phoenix Project, the program was ended due to state budget cuts.

Limitations of the Research

As with all research projects, particularly those conducted in highly restrictive environments such as prison, there were certain limitations with the research. Interviews with inmates, while conducted out of earshot but within eyesight of correctional staff, were not entirely private, a factor that may have influenced inmates' responses. In addition, survey data was self-reported. The possibility exists that inmates over-reported or under-reported information, believing that in our capacity as outsiders we might have influence over their custodial status. We took steps to mitigate these factors by informing inmates of the nature and scope of the research, explaining that we had no influence over their status within the correctional system, and assuring them that the information they provided was confidential. The vast majority of inmates were eager to participate and spoke with apparent candor, even when discussing highly sensitive or incriminating information such as their criminal activity in prison, psychiatric history, and victimization by other inmates.

In addition, after the *Disability Advocates, Inc. v. Office of Mental Health* lawsuit was filed in May 2002, the state's mental health employees were not permitted to speak with us. However, through discussions prior to that date, we were able to obtain the perspectives of many OMH employees and retired OMH staff. Finally, due to time and resource constraints, we did not investigate issues specific to female inmates with mental illness.

I. LIVING IN PRISON WITH MENTAL ILLNESS

The vast majority of the approximately 7,500 inmates on the mental health caseload are not housed in residential treatment programs but in the general population of maximum-security facilities.¹⁹ Regardless of their security status, inmates with serious mental illness are sent to the system's most restrictive (and, arguably, dangerous) prisons because mental health satellite units are located at those facilities. For individuals with mental illness, living in the general prison population can be a terrifying experience. Our research found that inmates with mental illness living in the general prison population are often stigmatized, isolated and sometimes victimized.

A psychologist who screens incoming inmates at Downstate Correctional Facility explained that some individuals minimize their need for services for fear of being sent to a maximum-security prison. "A problem with the system is that a person who comes in with a nonviolent history but who is also mentally ill will be sent to a maximum-security prison even though his security status doesn't warrant this level of restriction," the psychologist said. "So he gets mad at us and maybe even refuses his meds. The inmate starts to hate mental health staff from the beginning."

Reception

New York has two main intake facilities for male prisoners: Ulster County Correctional Facility for medium- and minimum-security prisoners and Downstate Correctional Facility for maximum-security prisoners. Each facility processes approximately 10,000 men a year. Downstate processes all inmates entering the system with a documented history of mental illness.²⁰

While at Downstate, inmates are classified according to their security status and medical and mental health needs. All inmates receive a Mental Health Level of 1 through 6, with Level 1 indicating a high need of mental health services and Level 6 indicating no current mental health needs. Based on these classifications, prisoners are assigned to one of the 70 correctional facilities throughout the state with a corresponding mental health classification.

Initial mental health screening at Downstate is conducted by an entry-level counselor's aide. An OMH study of inmates who entered the system in 2000 showed that 70% were determined to be "at-risk" of needing mental health services in these initial

¹⁹ Profile of inmates on the mental health caseload receiving outpatient services: 86% of the outpatients are male; the mean age is 37; 44% have a Mood Disorder and 22% have Schizophrenia/other psychotic disorder. Way and Nash, *CNYPC Patient Demographic and Diagnostic Profile: Year 2003*, Marcy, New York: Central New York Psychiatric Center, 2003.

²⁰ See Appendix 1 for excerpts of a letter from an inmate entering the NYS prison system at Downstate.

screenings.²¹ Fewer than half, however, then received the in-depth interview by a psychologist that is a prerequisite to being placed on the mental health caseload. In explaining how someone might get missed in the screening process, a deputy superintendent at Downstate said: “If there’s no paperwork, if no one phones, and if he doesn’t self-refer, he falls through the cracks.”

Barriers to Treatment in General Population

➤ Inmates on the mental health caseload face isolation and stigma.

The stigma of mental illness in prison is ubiquitous; individuals with mental illness are perceived as disruptive, unpredictable and sometimes dangerous. “The mentally ill are on a lower level [of the prison hierarchy],” a member of the Inmate Liaison Committee at Elmira explained to us.²² “They have poor hygiene so no one wants to be celled next to them or forced to sit at their table in the mess hall. They scream all night or bang on the walls and most of the general population just refuses to deal with them. They’re constantly being moved between the blocks until no one can stand them anymore.” At Sing Sing, a member of the ILC said: “I’ve been here seven years and I try to have no dealings with the mentally ill. We have nothing in common.” Prisoners with mental illness “live as a sub-population,” said an inmate at Great Meadow. “In the yard they hang out by themselves, standing in a little cloud of smoke, picking up cigarette butts.” These comments, echoed throughout our research, revealed the outcast status of individuals on the mental health caseload.

➤ Inmates prescribed psychotropic medication have little confidentiality.

Exacerbating the stigma of mental illness is the lack of confidentiality for individuals on mental health medication. In most correctional facilities, medication delivery is a loud, public affair, with prisoners either lining up at the pharmacy window to be served their medication, or marching off to the nurse’s station. At two facilities we visited, correction officers announce medication call-outs by shouting “Psych meds!” over the loud speaker. “You can tell who’s on the mental health caseload just by seeing who’s on the med run,” said an inmate in Sing Sing. At Clinton, the pharmacist brings medication to the officer’s station, where inmates line up in full view of others in the cellblock. At Elmira, prisoners must wait outside the mental health clinic, sometimes for 20 minutes or more, regardless of the weather, while other inmates pass by on their way to programs and make jokes at their expense.

²¹ Hill, Michael J., Tessie Abastillas, Joseph Steinfeld, James Barrett, Lynda Irish, *Forensic Mental Health Triage and Admission Services: The Operations of the NYS-OMH Forensic Diagnostic Unit within a Maximum-Security Environment*, New York: Downstate Correctional Facility.

²² On each site visit, we met first with the prison’s Inmate Liaison Committee (the inmate-elected body that represents prisoner issues) to learn its perspective on how inmates with mental illness are treated by inmates and staff and if there were areas we should visit where inmates with mental illness were neglected and/or in need of treatment.

➤ **Inmates with mental illness are often pressured by other inmates to stop taking medication.**

Prison is a paranoid environment to begin with, and prisoners are especially suspicious of psychotropic medication and the staff who prescribe it. Some inmates view mental health staff as extensions of security, believing that they use medication “to drug inmates up.” Many inmates described experiences of being overmedicated to the point where they could not participate in programs, or of witnessing the extreme side effects of medication in other prisoners. “Guys become addicted to the meds,” said an ILC member at Attica. “They go to mental health and one month later, their bodies have blown up, their hair is falling out.” While inmates’ level of suspicion struck us as extreme, it was not altogether irrational. Psychotropic medications typically require repeated adjustment before the right combination of drugs and dosage are achieved. However, the shortage of psychiatric staff in prisons makes frequent monitoring and adjustment virtually impossible. The result is that inmates exhibit the very side effects that foster prisoners’ suspicion of mental health staff.

“They called me bug, psycho and butthead,” an inmate at Sullivan told us. “They said I was taking the white man’s medication.” The inmate had transitioned out of the Intermediate Care Program and into general population, where he succumbed to peer pressure and went off his medication. Several months later, he said, he became so ill that he was transferred to Central New York Psychiatric Center. When we met him, he was back in the Intermediate Care Program and taking his medication.

Staff and inmates reported that prisoners with mental illness are more likely to take their medication when housed in residential treatment units rather than in general population because medication is served directly on the unit and inmates live separately from the general prison population. Some inmates with psychiatric disorders fear being “slowed down” by medication in the predatory environment of general population and will go off their medication to avoid being victimized or stigmatized. In general population, inmates with mental illness have no support groups, no refuge, and no peer group to help them withstand stigma, stay on their medication and handle conflict. “I’d try to tough it out and do without my meds, and that’s why I ended up [in the hospital] four times,” said an inmate at CNYPC. “Here, I’ve had self-awareness, self-management and stress reduction training. I’m much more in touch with myself now. Now I know I need my meds, and I’m going to keep taking them.”

➤ **The shortage of Spanish-speaking clinicians hinders Spanish-dominant inmates from accessing services.**

Foreign-born inmates are one of the fastest growing segments of the New York State prison population. Between 1985 and 2002, the number of New York State inmates born in the United States increased 87% while the number of foreign-born prisoners increased by 216%.²³ The majority of foreign-born prisoners are Spanish-dominant and

²³ *The Impact of Foreign-Born Inmates on the New York State Department of Correctional Services*, State of New York Department of Correctional Services, February 2003.

have a limited ability to speak, read or write in English. Moreover, they are predominantly housed in the prison “hubs” or regions with the fewest number of Spanish-speaking mental health staff.

In its report on the impact of foreign-born inmates, DOCS expressed concern about “communication problems arising from the diversity of languages represented in the foreign-born population.”²⁶ The lack of Spanish-speaking counselors and clinicians forces many inmates to use correction officers or other prisoners as interpreters. Not surprisingly, most inmates are reluctant to share sensitive personal information that could make them look weak or subject them to harassment from officers or other inmates. We encountered a particularly egregious practice at Southport, a disciplinary confinement facility where inmates are locked in their cells 23-hours a day. There, a nurse reported an incident where she had to use an inmate housed four cells away from the inmate whom she was screening to shout the translation of his medical problems down the block. A Spanish-speaking member of our research team who interviewed monolingual inmates during site visits concluded that the lack of bilingual staff prevents the majority of Spanish-dominant inmates from seeking help.

HUB	Spanish Dominant Inmates ²⁴	Spanish Speaking OMH Staff ²⁵
Clinton	764	2
Elmira	456	4
Great Meadow	495	2
Green Haven	552	4
NYC	488	3
Oneida	664	2
Sullivan	588	7
Watertown	566	0
Wende	1019	2

High Rates of Victimization

Interviews with 375 inmates on the mental health caseload in Intermediate Care Programs and Special Housing Units revealed high levels of victimization. Approximately half of the individuals we interviewed reported having their property stolen or being assaulted by other inmates while in prison.

Correction officers expressed serious concerns over the vulnerability of inmates with mental illness. At Auburn Correctional Facility, a captain with 25 years on the job reported: “Mentally ill inmates are easily exploited, extorted for their money, sodomized, you name it.” A sergeant at Sing Sing noted that inmates with mental illness who receive packages and food from family members are particularly vulnerable to extortion by other inmates, although most lead fairly deprived existences. Cellblock officers reported that inmates with mental illness were especially vulnerable if they had poor hygiene or problems controlling their behavior. A deputy superintendent at Attica reported that an inmate recently told him: “We don’t want him [a prisoner with mental illness] here

²⁴ *Hub System: Profile of Inmate Population Undercustody on January 1, 2003*, State of New York Department of Correctional Services.

²⁵ Office of Mental Health, “CNYPC Language Bank (Outpatient),” January 9, 2003.

²⁶ *The Impact of Foreign-Born Inmates on the New York State Department of Correctional Services*, State of New York Department of Correctional Services, February 2003, p. 4.

stinking up the block. Either you take care of him or we will.” The deputy superintendent recalled situations where prisoners would “set up” inmates with mental illness by putting a razor blade under their pillow so that they would be moved to disciplinary confinement. An officer at Auburn reported that inmates with mental illness are sometimes pressed into delivering drugs: “They get set up by the drug dealers. They think the dealer is their friend. And the drug dealers think it’s no big deal if these guys get caught because to them, they’re just ‘bugs.’”

Prisoners also told us that individuals with mental illness were highly vulnerable in maximum-security prisons. An inmate on Attica’s ILC reported: “Mentally ill inmates can live in general population, but they are victimized by both sides—by us because some inmates are predators, and by officers because mentally ill guys are like playthings to them.” ILC members stated that inmates with mental illness needed protection and help from other inmates to survive in general population.

Minimal Treatment Other Than Medication

Medication supplemented by brief consultations with clinical staff is the primary and often only form of mental health care for general population inmates. In 2003, DOCS spent \$14.8 million on mental health programs and psychotropic drugs, up from \$5.6 million in 1995.²⁷ A substantial portion of this budget purchases “atypical” medications, the newest drugs available, which typically have the least number of side effects. While the availability of first-generation medication is noteworthy, psychiatric treatment standards and legal precedent show that medication alone is not sufficient to facilitate recovery and is therefore inadequate as the sole treatment option in correctional systems.

The American Psychiatric Association’s (APA) guidelines for mental health services in prisons and jails state: “The fundamental policy goal for correctional mental health treatment is to provide the same level of mental health services to each patient in the criminal justice process that should be available in the community.” Among those services, the APA includes: “supportive and informative verbal interventions in an individual or group context.”²⁸ The court in *Estelle v. Ruiz*, the landmark case in Texas that established prison health care standards, criticized mental health care consisting of medication alone as “rudimentary at best.”²⁹ If prison mental health care is to meet community standards, additional therapeutic options must be offered.

²⁷ *Joint Statements of Glenn S. Goord, Commissioner, New York State Department of Correctional Services, and Sharon E. Carpinello, Acting Commissioner, New York State Office of Mental Health, to the Assembly Committees on Correction and Mental Health, Mental Retardation and Developmental Disabilities, on The Disciplinary Confinement and Treatment of Inmates with Serious Mental Illness*, January 13, 2004.

²⁸ American Psychiatric Association, *Psychiatric Services in Jails and Prisons*, 2nd Edition, Washington D.C.: American Psychiatric Association, 2000.

²⁹ *Ruiz v. Estelle*, 503 F. Supp.1265, 1336 (S.D. Tex., 1980), *aff’d in part*, 679 F.2d 115 (5th Cir., 1982), *cert. denied*, 460 U.S. 1042 (1983).

Researchers have described the same effects of insufficient mental health services that we observed in the course of this research. Correctional mental health care expert Thomas Fagan states:

When too few services are offered, the psychotic and/or suicidal behaviors of offenders with mental disorders can easily disrupt the smooth and orderly running of a correctional facility. Untreated offenders with mental illness frighten some criminal offenders and may also be victimized by other offenders. Their idiosyncratic behavior often alienates them from other offenders (thereby leaving them isolated), creates housing dilemmas and management difficulties for correctional staff, and may lead to liability issues for correctional administrators.³⁰

Unfortunately, resource constraints limit the availability of individual and group therapy for most general population inmates in New York. “We need more space, more staff to run groups, more treatment options and more resources for patients,” a psychologist at Mid-State reported. A mental health unit chief commented: “Few resources are invested in individuals whose treatment needs are not urgent or acute.”

Inmates are aware of the limitations of mental health services and critical of the over reliance on medication to address mental health needs. “I stopped going [to the mental health unit] because I felt like I tried to talk to the psychologist and didn’t get a response,” said an inmate at Attica. “They’ll only see you for 15 to 20 minutes because they have other people to see.” Another prisoner reported: “You get to the clinic and mental health says, ‘What do you want us to do?’ And then it’s just medication, medication, medication. They offer medication real fast for anything, even before they know what the problem is.”

When the Georgia Department of Corrections faced cuts to its mental health budget, administrators initiated a pilot program that provided group therapy to general population inmates. Researchers found that medication usage decreased when inmates were also provided group therapy. Only 17% of the inmates who participated in a twelve-week group therapy program needed medication, compared to 87% of inmates in a control group who were not offered therapy. In a cost-benefit analysis of 3,500 inmates, the Georgia DOC projected that the group therapy program would save \$235,970 a *month* in drug costs.³¹ These findings suggest that providing comprehensive mental health care in prison may actually save money for correctional systems.

Neglect of Inmates’ Mental Health Needs

The human costs of insufficient mental health care were observable to us in the number of neglected and seriously impaired inmates living in general population

³⁰ Fagan, Thomas J., “Mental Health in Corrections: A Model for Service Delivery,” in *Correctional Mental Health Handbook*, ed. Thomas J. Fagan and Robert K. Ax, California: Sage Publications, 2003: 7.

³¹ DeGroot, James, *Strategies to Maintain a Constitutional Level of Mental Care in Correctional Settings Amid Budget Cuts*, A Presentation at the National Commission on Correctional Health Care Conference in Texas: Georgia Department of Corrections, October 2003.

cellblocks. In nearly every site visit to a maximum-security prison, members of the Inmate Liaison Committee (ILC) spoke of prisoners living in their cellblock who were visibly ill but not receiving treatment. A member of Elmira's ILC reported: "As long as an individual is taking his medication, or staff thinks he is, they don't intervene. Some of these guys cut themselves or never leave their cells, but staff does very little about it." "You'll find a lot of guys with bad physical hygiene," said a member of Clinton's ILC. "Their cells are in complete disarray, they don't shower, and staff just lets them stay there so the whole tier smells." At Green Haven, inmates reported: "If someone is calm and they're not a problem, then most staff aren't even aware of what's going on. There was a guy two cells down from me who stayed in his cell for 15 days straight and wouldn't come out: not for showers, not for chow, nothing until they finally called medical to check on him."

Frequently, our observations during tours of general population cellblocks confirmed these reports. At Great Meadow we encountered several inmates in serious psychiatric distress languishing in their cells. A staff researcher documented the following:

The Inmate Liaison Committee reported that there were a number of mentally ill and neglected inmates in the 6 company of B-Block. Before we even walked onto the tier—which sometimes incites a fair degree of noise—we could hear the raucous din of dozens of men, calling out to each other, yelling for a correction officer, cursing and cat-calling. The cellblock had the feeling of an asylum. One man was imitating a rooster, repeatedly making the "cock-a-doodle-doo" sound, which prompted similar barnyard noises in response. The inmates' voices echoed off the walls and up and down the tier. Although the temperature outside was below freezing, the heat in the cellblock was stifling. A psychiatrist who was accompanying us reported being astonished by the number of untreated and seriously impaired inmates she encountered.³² One man she interviewed was highly agitated and delusional, speaking at a rapid-fire pace about devils and killing people. Other men said that because of their mental illness, they had not been assigned to programs. They complained bitterly about being locked in their cells most of the day.

At Clinton Correctional Facility, a maximum-security prison for 2,300 men near the Canadian border,³³ a staff researcher encountered the following individuals in a particular general population cellblock:

- Inmate RB was huddled on the floor of his cell with a blanket draped over his head. His cell was sparse; his mattress was folded on the bed. According to a correction officer, the inmate had arrived on the block two weeks before from Central New York Psychiatric Center and had not left the floor of his cell for showers, meals or recreation since then. Inmates in neighboring cells said that they gave him food. A deputy superintendent accompanying us on the tour stated that mental health staff believed the inmate was trying to "manipulate" his way back to the hospital. He refused to take his medication, the deputy superintendent said, but since he had not yet become a disciplinary problem, neither DOCS nor OMH staff knew what to do with him.

³² See Appendix 2 for an evaluation of mental health services for general population inmates at Great Meadow and suggestions for reform by Gail Allen, M.D.

³³ Clinton Correctional Facility also has a medium-security annex with 600 male inmates on the grounds of the prison.

- Inmate SP was lying in his bed, stock-still and staring into space. He appeared dazed and catatonic. He either would not or could not speak. A correction officer on the block reported that the inmate had not spoken to anyone *in almost a year*. We were told that he does not leave his cell for showers but bathes in his cell. Again, because the inmate was not a disciplinary problem, he was simply left in his cell.
- Similarly, inmate AP had not left his cell for showers or recreation “for several months,” according to the correction officer. He sat in his cell picking incessantly at his scalp. He seemed disoriented and paranoid. When we asked if he wanted to speak with a mental health counselor, he refused.

Given the limited mental health resources in general population, inmates often do not come to the attention of staff until they become so mentally impaired that they require hospitalization or end up in solitary confinement for violating prison rules. When asked about the lack of intervention in these kind of cases, some superintendents expressed frustration at having to manage so many inmates who, in their opinion, belong in mental hospitals rather than prison. “A lot of these guys are people that society can’t deal with. They get sent to us and it’s not always clear what we can really do either,” reported one superintendent.

Other superintendents emphasized that the care and custody of inmates with severe mental illness have become extremely problematic in recent years due to the increase in illness severity and in the overall number of newly admitted inmates with mental illness. Many expressed concern over the seemingly endless and rapid growth of the mental health caseload. One superintendent said: “In the last ten years we’ve seen more individuals in need of mental health services than ever before, and the numbers are increasing all the time.”

II. STAFFING AND TRAINING DEFICIENCIES

The majority of correctional and mental health administrators we interviewed reported that mental health units throughout the state prison system are understaffed and under-resourced, resulting in overburdened clinicians, untreated inmates and a revolving door of admissions to Central New York Psychiatric Center (CNYPC). Many mental health employees reported feeling overwhelmed by burgeoning caseloads and inadequate time to treat individuals with serious psychiatric disorders. “I’m supposed to say that current staffing levels allow us to meet the needs of our patients, but the truth is, they don’t,” a mental health unit chief told us.

Staff Shortages and Vacancies

Over the past decade, increases in mental health staff positions have not kept pace with the rising number of inmates on the mental health caseload. Since 1991, the number of inmates on the mental health caseload increased by 71% while mental health staffing positions increased by only 53%.³⁴ This problem is compounded by high staff vacancies. In 2002, 19% of mental health positions in the prisons were unfilled.³⁵ (Author’s note: these figures are the most current numbers available to us.) “We need a lot more staff, but it’s very difficult to recruit qualified psychiatrists, particularly in rural areas where most of the prisons are located,” a mental health unit chief reported. “This is an ongoing challenge and a serious problem. There are some facilities, particularly Mental Health Level 2 facilities, where clinicians are carrying caseloads of 75 to 100 patients. That’s unacceptable practice. Across the board, we need more psychiatrists, more psychologists, more social workers, and more nurses.”

In most of the OMH Level 1 prisons we visited, staff reported that the number of inmates on the mental health caseload far exceeded available mental health resources. At Auburn, three psychologists share a caseload of 200 inmates. There, as in other OMH Level 1 facilities, they also oversee about a dozen prisoners in the Residential Crisis Treatment Program (RCTP) who are in serious and immediate psychological distress or on suicide watch; the three psychologists must also address any emergencies that arise in the facility. As a result, mental health staff at Auburn explained that their primary function is to provide “maintenance, not treatment.”

Psychiatrist James Gilligan, former Director of Mental Health Services at the Massachusetts Department of Correction, accompanied us on a visit to Attica and

³⁴ Pfeiffer, M., “State Prisons Falter in Psychiatric Care: Officials Fail to Heed Recommendations,” *Poughkeepsie Journal*, March 10, 2002. (Based on Figures provided by the State Department of Correctional Services.)

³⁵ OMH memo to Correctional Association: “OMH Outpatient Staffing 11/1/02.”

interviewed mental health staff and inmates. Commenting on the under-resourced New York State system, he said: “Within their limited hours, OMH can only deal with acute mental health needs. Each day the counselor comes in and gets a run-down of the incidents that occurred overnight. He’s so busy putting out fires, he can’t see how the fires get started.”

➤ **Mental Health Satellite Units need more psychiatrists and psychologists.**

System-wide, 35% of psychiatrist positions and 25% of psychologist positions were vacant in 2002.³⁶ At some prisons, multiple part-time or per diem employees are used in lieu of full-time staff. At Midstate Correctional Facility, where three part-time psychiatrists provide services, a staff psychologist explained the difficulties of having no full-time psychiatrist dedicated exclusively to the facility: “Patchwork psychiatric care is problematic. It disrupts continuity of care, particularly in relaying and receiving critical information from staff, getting to know the patients and monitoring and adjusting medication.”

The insufficient number of psychiatrists and psychologists affects medication compliance. Some individuals we interviewed did not know what medications they were taking or why (54% of inmates in disciplinary confinement, for example, said the psychiatrist did not explain to them what medications they were taking), and some inmates complained of serious side effects that had not been addressed despite repeated requests for lower dosages or different medication. The shortage of psychiatrists results in reduced medication compliance, mental deterioration and, ultimately, costly hospitalization.

➤ **Mental Health Level 2 facilities need more mental health nurses.**

System-wide, 11% of mental health nurse positions were vacant in 2002.³⁷ Mental health staff reported that OMH Level 2 facilities have too few mental health nurses to deliver medication, facilitate compliance and conduct rounds in the cellblocks. A number of facilities with mental health caseloads of more than a hundred inmates had no mental health nurses.³⁸ “It’s a problem in Level 2 facilities, which is where there are more and more patients with serious mental illness,” a mental health unit chief told us. “There are a phenomenal number of patients in Level 2 facilities on psychotropic medication. For example, in Fishkill, there are over 250 patients on medication, some men on three different types. And because these facilities aren’t Level 1s with mental health satellite units, they don’t have sufficient staff, so DOCS nurses have to administer all of these

³⁶ Ibid.

³⁷ Ibid.

³⁸ For example, Office of Mental Health figures indicate that as of November 1, 2002, Arthur Kill had no mental health nurses for a caseload of 340 inmates; Coxsackie had no mental health nurses for a caseload of 343 inmates; Fishkill had 1 mental health nurse for a caseload of 381 inmates; and Groveland had no mental health nurses for a caseload of 144 inmates.

medications on a directly observed, one-to-one basis. DOCS nurses are doing OMH nurses' jobs, despite being over-extended with their own work."

The lack of nursing staff also compromises oversight of mental health care for inmates in the general prison population. "If we had more psychiatric nurses," one psychologist explained, "they could walk the cellblocks during the evening rounds, assess individual inmates to see if anyone is in bad shape, speak with the officers and get their feedback on how the inmates are doing."

Insufficient Training for Correction Officers

Throughout our site visits, correction officers' leading criticism concerning mental health services was the lack of training provided to front-line officers. "We don't believe there is adequate training among our officers to deal with mentally ill prisoners," said Dennis Fitzpatrick, spokesman for the New York State Correctional Officers & Police Benevolent Association (NYSCOPBA), the union that represents the state's 20,000 correction officers. "Our officers need to learn the latest thinking and best techniques in how to calm down or subdue a person who is not in his right mind, so neither the officer nor the inmate gets hurt."³⁹

A sergeant we interviewed at Sing Sing's B-Block emphasized the pressing need for increased training. "Dealing with mentally ill inmates is a major, ongoing challenge that's gotten worse over the years as the numbers have grown. Just last week, we had a guy who burned up his cell." He asserted that more training was necessary to prepare officers for this challenge. "COs who work in the cellblocks should be trained on how to deal with mentally ill inmates, the kinds of ways they're victimized, how to recognize if they've gone off their meds and what can happen if they do." An officer at Mid-State who had not received any on-the-job mental health training echoed this sentiment: "We want to know how to recognize the symptoms and how to talk to these inmates."

Although OMH provides mental health care in prisons, it is correction officers who spend the most time with inmates and play a vital role in the delivery of care. Correction officers are responsible for making rounds, referring inmates to treatment, managing inmates with chronic mental illness in Intermediate Care Programs, supervising inmates in crisis in Residential Crisis Treatment Programs and overseeing inmates on suicide watch in observation cells. Correction officers also escort and motivate stable individuals to attend programs, go to recreation and stay on their medication. They are the ones who must respond first if these attempts fail.

At the training academy, new recruits receive eight hours of training on mental health issues and four hours on suicide prevention.⁴⁰ Officers who work in housing areas where inmates with serious mental illness are concentrated (the ICPs and RCTPs) may receive additional training but neither DOCS nor OMH requires it. In 2002, DOCS

³⁹Grondahl, Paul, "A Special Risk to Prison Staff," *Albany Times Union*, October 20, 2002, A7.

⁴⁰ Ibid.

introduced a 3½-hour in-service training session entitled “Understanding and Dealing with Inmates with Mental Illness” for officers system-wide, but most officers told us they were unable to participate due to staffing shortages. In fact, the majority of officers we spoke with said that they had never received the new training.

While many officers knew basic suicide prevention techniques, they struggled with other issues related to supervising inmates with mental illness. An officer at Southport stated: “There’s been no mental health training here except for one 8-hour class in suicide prevention. We’re a mental health Level 2 facility and supposed to have 4 hours of mental health training sessions every year, but it doesn’t happen.”

Correction officers who had participated in the new mental health training reported that it was insufficient. A Woodbourne officer explained: “The training focused mainly on what to do if you see abnormal behavior but not on how to evaluate inmate behavior or deal with inmates who go off medication.” When Woodbourne was reclassified as a mental health Level 2 facility, this CO found himself unprepared to respond to the needs of the increasingly ill population.

Correction officers throughout the prison system described situations where inmates with mental illness created disturbances that they were untrained to manage. At Southport, four officers told us of being stabbed, spat at, assaulted, or having feces thrown at them. They reported that “the biggest problem” at Southport is that “a quarter of the inmates are mentally ill and shouldn’t be here.” Two Southport psychologists share a caseload of 130 inmates, all of whom are in 23-hour disciplinary lockdown. One officer recounted a situation where mental health staff ignored two inmate referrals made by security staff, and the dire consequences that resulted.

When T. came from Attica, he was paranoid as hell. Early on we tried to move him to another cell because we were painting the tier, but he wouldn’t come out, saying “You’re gonna jump me, I know it. You’re gonna mess with my legal papers.” I agreed to use a video camera for everyone’s protection and then things went smoothly. After that, I put in a mental health referral but had to give the inmate a ticket for disobeying a direct order—refusing to move from his cell. At the disciplinary hearing, the lieutenant put in another psych referral because he could tell that T. was nuts. Unfortunately, both referrals were ignored.

About a week later, a group of officers had to move him again to a different cell for logistical reasons. He agreed to come out, with cuffs and waist chains, and stand on the gallery, facing the window as directed. But then T. started panicking, getting riled and yelling paranoid thoughts about the COs destroying his papers. The officers got nervous and decided to just put him in his cell and get the hell out of there. When they removed the waist chain, he flipped. He bit two of the officers and spit blood in one guy’s face. It was a bloody mess. In total, six officers were injured and three of them went out on sick leave. I took T. to the hospital for a full CT scan and 14 x-rays. He was basically fine, no broken bones, but his knee was a little messed up.

Author’s note: Because T. had never been tested for HIV, the officers were put on prophylactic medication for six months. Side effects of this medical regimen generally include extreme nausea, vomiting and headaches. Sexual intercourse is highly discouraged.

So now there are three COs on the cocktail, they can't have sex with their wives, and one is still out on sick leave. You've got an inmate with a new court case, maybe years added to his sentence, plus hospital costs, and maybe weeks of workers' comp. Meanwhile, the whole reason is that T.'s a bug. But according to OMH, he's not mentally ill at all.

Dual-Agency Conflict

Correctional mental health care in New York involves the efforts of two different agencies: the Department of Correctional Services (DOCS), which runs the prisons, and the Office of Mental Health (OMH), which provides mental health care. This system, known as “dual-agency,” presents certain challenges. In general, providing mental health care in prison has never been an easy fit. There are wide philosophical and practical differences between the goals of clinical and correctional personnel. “Our patients are their inmates,” explained an OMH clinician.⁴¹

However, a growing body of literature attests to the importance of collaboration between security and mental health staff in effectively administering mental health services. In his study of suicide prevention measures in the Pennsylvania prison system, Lance Couturier found that formal mechanisms that encourage collaboration between custodial and clinical staff are essential to any meaningful suicide prevention strategy.⁴² John Dignam, Psychology Services Administrator in the Federal Bureau of Prisons, expands on this idea, asserting that integration of mental health and security staff is necessary for the delivery of all mental health services, not just suicide prevention. Dignam coined the term “collaborative rehabilitation” to describe how all staff, not just mental health staff, can play an important role in promoting positive therapeutic goals. “To conduct truly comprehensive assessments or realize treatment or programmatic success, there should be genuine collaboration between mental health and other staff in correctional settings,” he noted. Under his model of collaborative rehabilitation, everyone who works in a correctional facility has a role and a stake in providing effective treatment.⁴³

In New York, there is little formal collaboration between front-line correction officers and mental health staff. Throughout our research, correction officers expressed frustration over having to manage inmates with mental illness with little support from prison clinicians. Officers described mental health employees as responsive when called, but as primarily isolated from the prison community and taking a reactive rather than proactive approach. Some officers described the role of mental health as “guests in the prison system” rather than as an integrated part of operations. Officers felt that this

⁴¹ See Appendix 3 for a case study by Psychologist Nancy Duggan, Ph.D. of an inmate at Southport Correctional Facility illustrating the mismanagement that results from dual-agency conflict and insufficient oversight.

⁴² Couturier, Lance, “Suicide Prevention in a Large State Department of Corrections,” *Corrections Today* 63, 5, August 2001, 90-97.

⁴³ Dignam, John T., “Correctional Mental Health Ethics Revisited,” in *Correctional Mental Health Handbook*, ed. Thomas J. Fagan and Robert K. Ax, California: Sage Publications, 2003, 46-47.

dynamic encouraged inmates to play correction officers and mental health staff against each other.

Mental health staff also reported frustration. In some facilities, they told us that their “step-child” status leaves them disempowered. “Everything we do—whether it’s a resource issue, a clinical issue, or a policy issue—depends on our ability to negotiate with the superintendent and his deputies,” explained a mental health unit chief.

A particularly difficult issue is the coordination of DOCS and OMH in monitoring medication compliance. Officers felt that they lacked sufficient information and support from mental health staff to manage inmates who stop taking or refuse medication. An officer at Woodbourne explained: “We call OMH when these inmates act out, but usually they blame us if the inmate hasn’t taken his medication. I have 30 inmates on my unit, no access to their records and no list of who should be taking medication. OMH should check medication compliance and contact the officers if they want our assistance.” Correction officers reported that mental health staff rarely solicit input from the line officers who spend the most time with inmates.⁴⁴ One Sing Sing officer explained: “We’re the last ones to be consulted, but the first ones to blame.” He reported that when there are meetings in the Psychiatric Services Unit about the status of inmates on suicide watch, no correction officers—i.e., the people who spend the most time with the inmates observing them and monitoring their behavior—are invited.

Perhaps the most damaging effects of dual-agency conflict are manifested in the disciplinary process, when inmates on the mental health caseload violate prison rules and are sentenced to 23-hour disciplinary lockdown. While DOCS regulations require that mental health staff present information to a DOCS hearing officer when a prisoner’s mental state is an issue, prisoners’ attorneys say that DOCS and OMH have not enforced these regulations in a manner that protects prisoners with mental illness from being punished for being ill.⁴⁵ One problem is that it is a DOCS hearing officer who determines whether an inmate’s mental illness played a role in the incident being investigated. Hearing officers are typically security specialists, however, not clinicians with the specialized training to make such assessments. Moreover, even when a hearing officer

⁴⁴ In November 2003, OMH revised their policies to require mental health staff that provide services to SHU inmates to meet with SHU correction officers at least once a week. In December 2003, DOCS proposed new regulations that would establish a SHU Case Management Committee in each Level 1 correctional facility to monitor the status of inmates on the mental health caseload in SHU. These committees would be comprised of mental health and security staff including line correction officers who work in the SHU.

⁴⁵ In December 2003, DOCS implemented more comprehensive regulations that would require hearing officers to solicit input from mental health staff as to whether or not an inmate’s mental illness was an issue during the commission of an offense if: the inmate is classified as an OMH Level 1; the inmate is charged with engaging in an act of self-harm; the incident occurred while an inmate was in transit to or from CNYPC; the inmate was a patient at CNYPC within 9 months of the incident; the incident occurred while the inmate was assigned to an OMH satellite unit or ICP; the incident occurred while the inmate was being escorted to or from an OMH satellite unit or ICP; the hearing was delayed because an inmate became an inpatient at CNYPC or was assigned to an OMH satellite unit; or it appears to the hearing officer that the inmate may have been mentally impaired at the time of the incident.

does receive input from OMH staff, he or she is not bound to follow their recommendations.

“There’s constant tension between DOCS and OMH on this issue,” a mental health unit chief said. “It’s rare that an individual won’t be given SHU time if he violates a prison rule, regardless of whether he has a serious mental illness. DOCS always rules.”

III. RESIDENTIAL CARE

Inmates deemed victim-prone or unable to function in the general prison population because of mental illness may be placed in special residential treatment units called Intermediate Care Programs (ICPs). Located in eleven maximum-security prisons throughout the state, ICPs have a combined capacity of 534 inmates. Each unit has its own cellblock with offices for mental health staff and separate areas for programming and recreation. All participants reside in unit cellblocks and receive intensive treatment services. Overall, ICPs are islands of compassionate care in the stressful and sometimes violent world of maximum-security prisons.

ICP Location	Number of Beds
Auburn	50
Attica	78
Bedford Hills	30
Clinton	60
Elmira	56
Five Points	38
Green Haven	51
Great Meadow	38
Sing Sing	31
Sullivan	64
Wende	38
TOTAL	534

During the course of our research, we visited all ICPs (except the ICP at Bedford Hills, a women’s correctional facility) and spoke with mental health staff and correction officers. In addition, we conducted structured survey interviews with 213 ICP inmate-residents. Findings were as follows:

Intermediate Care Programs

Intermediate Care Programs perform an essential function for inmates with serious mental illness. They offer a therapeutic, safe environment and access to a range of mental health services, including one-on-one counseling, group therapy and mental health medication. Daily group therapy sessions focus on topics such as anger management, life skills, personal hygiene, medication compliance and substance abuse. Individual counseling on an as-needed basis is the cornerstone of ICPs. Inmates reported that regular contact with mental health staff is among the most important benefits of the program. Fully 60% of inmates said that they received individual therapy more than once a month.

Not only do ICP residents receive intensive treatment, they also participate in a variety of vocational, recreational and educational activities. Most ICPs have gardens where inmates grow flowers and vegetables, kitchens for preparing meals and learning cooking skills, shops where inmates learn leatherwork, ceramics and/or woodworking and indoor and outdoor recreation such as ping-pong and basketball. Among the more innovative programs we observed were:

- Music therapy and gardening at Clinton
- Summer picnics and athletic tournaments at Wende
- Poetry and “self-discovery” workshops at Sing Sing

High Medication Compliance

The vast majority of inmates in ICPs are prescribed psychotropic medication as part of their treatment, and 95% of ICP inmates reported that they take their medication regularly. Patient education, symptom management, and frequent psychiatric consultations to adjust dosages and reduce side effects facilitate this high rate of medication compliance. Over 80% of inmates we surveyed knew what medications they were taking and why, and reported that their psychiatrist had explained to them the importance of medication compliance and what side effects they might experience.

Unlike in the general prison population, where medication call-outs are typically public affairs affording little confidentiality, most ICPs offer individual medication either directly on the unit or at “cell-side.” Inmates reported that the ICP environment was more conducive to taking medication because of the greater privacy and reduced stigma. Only 1% of inmates reported being more medically compliant in general population, while 75% said that it is easier to take medication in the ICP.

<u>Medication Compliance</u>		
➤ Do you take your medication regularly in the ICP?	Yes = 95%	No = 5%
➤ Do you know what mental health medications you take?	Yes = 82%	No = 18%
➤ My psychiatrist explained to me how my medications work and what side effects I might experience.	Agree = 81%	Neutral = 3% Disagree = 16%
➤ Is it easier to take mental health medication in the ICP or in general population?	ICP = 75%	General Population = 1% Same in Both = 24%

Community Care in a Correctional Setting

In addition to providing mental health treatment, ICPs allow participating inmates the opportunity to interact with the larger prison community depending on their level of functioning. Residents can work their way up to jobs in the general population, going to recreation in the main prison yard or participating in regular vocational or academic classes. ICPs encourage participation in the larger prison “community” in order to prepare residents for release to society. “We try to mainstream the ICP guys as much as possible,” said the superintendent at Clinton Correctional Facility. “They might eat lunch in the mess hall or work in the tailor shop but we try to get them out and about as much as possible so they begin living and working with the general population.”

At facilities that accommodate other special needs populations (such as sensorily disabled inmates), interactions between ICP and general population residents were described as especially positive. At Sullivan, for example, which has units for blind and

deaf inmates, participation by ICP prisoners in limited general population activities was described as particularly successful because staff are accustomed to working with vulnerable populations. Prisoners on Sullivan's Inmate Liaison Committee (ILC), a body of elected inmates who meet monthly with the facility's executive team to discuss inmate concerns, said they buy the ICP men supplies from the inmate benefits fund and make a point of attending ICP events. Elmira Correctional Facility allows the ICP to elect a representative from the unit to serve on the ILC. This practice increases communication and understanding between the general population and ICP inmates and allows ICP inmates a serious forum to express their concerns to the prison's executive staff.

One of the most rewarding relationships between ICP and general population inmates occurs in the ICP itself. There, general population inmates can work as Inmate Program Assistants (IPAs) assisting staff and inmate-patients. An IPA at Sullivan described his role as follows:

As an IPA, my duties include interacting with those on the unit, helping them with their problems, motivating them to participate in physical activities, writing letters for them, assisting with administrative requests and grievances, encouraging them to keep themselves and their cells clean, talking to guards on their behalf to solve or avoid problems, and running or assisting in the running of groups or programs.

This IPA runs a substance abuse group for ICP residents, and a creative writing class for Sullivan's inmates. "I attempt to project to every ICP resident that I am a caring friend. I view the ICP community as a family, my family—in which the role I play is similar to an older brother." Many ICP inmates praised the IPAs, describing them as protectors, coaches and advocates. In addition, the relationship with a general population inmate enhances ICP inmates' self-esteem, staff reported, and imparts appropriate social skills.

Vulnerable Inmate Population

ICP participants are among the system's most vulnerable and seriously ill prisoners. The majority suffer from a serious psychiatric disorder; for example, 53% reported schizophrenia; two-thirds reported a prior psychiatric admission; and more than half (54%) reported committing acts of self-harm or attempting suicide while in prison. Nearly 50% reported being victimized by other inmates, i.e. having their property or commissary purchases stolen or being physically assaulted. The majority reported that the ICP affords them necessary protection from the aggressive inmates in general population; in fact, 57% said that they do not feel safe in the general population. Not surprisingly, the vast majority (89%) said that they wanted to remain in the ICP for the duration of their prison sentence.

While DOCS officials state that the purpose of ICPs is to transition residents back to the general prison population, our research revealed that a significant population of ICP inmates are unable or unwilling to return to the general population. A counselor at Clinton's ICP explained: "Many of our guys are never going back [to general population]. They are so fragile, they'd be eaten alive by the sharks." Superintendents at

ICP Inmate Victimization Questions:	Yes	No
Have you ever had your property stolen, been physically assaulted, and/or sexually assaulted by another inmate in general population?	49%	51%
Have you ever committed an act of self-harm (i.e. self-mutilation and/or attempted suicide) while in prison?	54%	46%
Did you feel safe living in general population?	43%	57%

several facilities stated that although the ICP is designed to provide “temporary” treatment, returning to the general prison population is unsafe for many ICP residents not only because they are more likely to be victimized, but because they would be less likely to stay on their medication outside of the residential program. A deputy superintendent at Auburn commented that Department officials are coming to understand the downsides of forcing ICP inmates into general population. “The reality is that we do have long-termers in ICP. Staff encourage inmates to go out to population, but if it is not reachable, the treatment team will let them stay in the ICP.”

A study of New York’s Intermediate Care Programs discussed the adverse consequences of transferring inmates back to general population prematurely:

A study of New York’s Intermediate Care Programs discussed the adverse consequences of transferring inmates back to general population prematurely:

Many of the inmates who were discharged to the general prison population were unable to function adequately in that setting, continued committing disruptive and harmful behaviors, and ended up being disciplined and/or hospitalized again. Thus, Intermediate Care Programs have evolved to the point where, for many inmates, the program essentially serves as their permanent residence until their prison sentences have been completed.⁴⁶

During site visits, we encountered many inmates who would likely never leave the ICP. A Correctional Association staff researcher documented in his field notes:

Mental health staff described AV, an inmate in the Sullivan ICP, as “the most persistent self-cutter” they had ever seen. His face and body were a mass of scar tissue from self-inflicted wounds. He had spent 17 of his 24 years in prison at Central New York Psychiatric Center. Today he lives in the Sullivan ICP, where he has been for over two years, the longest amount of time he’s been out of the psychiatric hospital. AV even participates, tentatively, in some of the treatment groups. This year, he says, his goal is to get out of the ICP and back to general population because he thinks that’s the only way he’ll have a chance at parole. Sadly, his goal of living in general population is still a distant one. There are days that he is too anxious to even leave his cell.

Reductions in Disciplinary Infractions

Our research found that inmate behavior improves in ICPs. Before admission, 67% of inmates reported receiving disciplinary tickets in general population, while only 51% received tickets while on the unit and usually at a less serious level. Significantly, while 38% of ICP inmates reported receiving tickets for violent charges in general

⁴⁶ Condelli, Ward S., Bruce Bradigan and Howard Holanchock, “Intermediate Care Program to Reduce Risk and Better Manage Inmates with Psychiatric Disorders,” *Behavioral Sciences and the Law* 15, 1997, 459-467. This study re-analyzed data from a 1994 study of the mental health and corrections records of 209 inmates who were admitted to New York’s Intermediate Care Programs.

population, only 16% received tickets for violent charges in the ICP. These numbers reflect a significant reduction in violent behavior.

Charges	In General Population	In ICP
Received disciplinary tickets	67%	51%
Tickets for violent offense	38%	16%
Tickets for non-violent offense	29%	35%

High Staff and Inmate Satisfaction

- **ICP employees reported high job morale and strong collaboration between mental health and corrections staff.**

The staff in ICP units tend to be among the most compassionate, creative and enthusiastic employees we have encountered in the state prison system. ICPs exemplify what is possible when security and treatment staff work together to create a therapeutic environment. Many of the correction officers said that they bid on posts in the ICP because they wanted to be part of a rehabilitative environment where they felt they could make a difference. In general, we were struck by the extraordinary level of care and commitment they showed toward inmate-residents.

For example, a correction officer in Sullivan said that the officers stagger their vacations to ensure that at least one “steady” officer who knows the inmates will always be on the unit. A correction officer in Elmira, who was praised by numerous inmates, said that he spends time getting to know each of the men on his unit. “There’s no particular technique,” he said. “It’s more that you have to know the inmates on the unit, what’ll work with each one.”

In most ICPs, correction officers participate in case management meetings with mental health staff to discuss inmates’ progress and evaluate them for reintegration into general population. Some correction officers take an interest in helping inmates re-adjust to general population. “Some of our COs become such great advocates for the guys,” said Sing Sing’s clinical director. “They go out of their way to help them re-integrate in general population. They identify appropriate jobs for them and speak with other officers about how to best work with them.”

- **ICP residents reported high levels of satisfaction with the program.**

It is unusual to speak with inmates in a maximum-security facility who are satisfied with conditions of confinement. Interviews with ICP residents revealed high satisfaction with life on the unit as well as with their access to treatment. The vast majority (84%) of inmates reported that their therapist is responsive to their needs; 90% said they could see a therapist if they had an urgent need. In addition, ICP inmates value the group therapy model: 84% said that the groups were a useful part of their treatment. Prisoners’ views of inmate-officer relations were among the most positive we have seen:

two-thirds of inmates reported that correction officers are respectful of their needs and rights.

ICP Inmate Satisfaction Survey:	Agree	Neutral	Disagree
COs are respectful of my needs and rights as a patient on this unit.	66%	10%	24%
My primary therapist is responsive to my needs as a patient at this facility.	84%	6%	10%
I feel I receive enough therapy as a patient at this facility.	73%	4%	23%
I was an equal participant with my therapist in developing my treatment plan.	83%	6%	11%
I feel I could see a therapist if I had an urgent need.	90%	3%	7%
The groups are a useful part of my therapy.	84%	6%	10%

Capacity Needs Expansion

Throughout our research, superintendents, correction officers, mental health staff and inmates emphasized the need for more ICP beds. The 534 beds system-wide can accommodate a small percentage of the 3,200 inmates with major mental disorders. Most ICPs operate at capacity and have waiting lists for admission. Over half (53%) of the inmates we surveyed said that they were on a waiting list before being admitted to the ICP. When we visited Sing Sing in January 2003, ten inmates were on the waitlist. Nevertheless, the state has cut 31 beds from the 62-bed unit to make room for a transitional services program for inmates with mental illness.⁴⁷

⁴⁷ In his 2004-05 Budget, New York State Governor George E. Pataki proposed an 87-bed expansion of the ICPs.

IV. CRISIS CARE

Crisis care provides short-term stabilization and intervention for individuals in acute psychiatric need. Crisis care for state inmates is offered in two settings: at Central New York Psychiatric Center, a hospital in Marcy, New York with 189 beds for state inmates, and in Residential Crisis Treatment Programs located in Mental Health Satellite Units in 12 maximum-security prisons.

Staffed and operated by the Office of Mental Health (OMH), Central New York Psychiatric Center (CNYPC) is a JCAHO-accredited,⁴⁸ maximum-security hospital that receives inmates from prisons across the state who are civilly committed under Section 402 of Correction Law. CNYPC averages approximately 850 admissions annually. Ninety-three percent of inpatient admissions are male, the mean age is 34, and 71% have a diagnosis of schizophrenia or other psychotic disorder. The median length of stay is about 40 days and the mean is 75 days.⁴⁹ Approximately 65% of inmates sent to CNYPC return to the facility at least once within a year.⁵⁰

Residential Crisis Treatment Programs (RCTPs) provide temporary stabilization and intervention and assessment for transfer to CNYPC. Inmates are held in observation cells (if they are on suicide watch or were previously housed in disciplinary confinement) or in dormitory beds if they present less of a security risk. System-wide there are 151 RCTP beds.

Central New York Psychiatric Center: A Treatment-Rich Facility

Prior to visiting CNYPC, we had heard consistently positive feedback from inmates, advocates and attorneys about the quality of care offered in the facility. After a day at CNYPC, we shared these favorable impressions. From the outside, CNYPC appears as stark and forbidding as the medium-security prison, Mid-State Correctional Facility, across the road. Once inside, however, all similarities to prison drop away. CNYPC is spacious, bright and immaculately clean; a sense of order and calm prevails. Colorful posters with uplifting messages adorn the walls. A patient bill of rights (in English and Spanish) and the hospital mission statement are posted conspicuously throughout the facility.

⁴⁸ JCAHO (Joint Commission on Accreditation of Healthcare Organizations) sets standards for medical organizations and is the leading healthcare accreditation agency in the country. It has accredited 16,000 organizations in the United States.

⁴⁹ Way and Nash, *CNYPC Patient Demographic and Diagnostic Profile: Year 2003*, Marcy, New York: Central New York Psychiatric Center, 2003.

⁵⁰ "N.Y. Rotates Access to Mental Health Care," *Corrections Digest*, November 22, 2002.

CNYPC has outdoor and indoor recreation areas, including a gym, a basketball court, a weight-lifting room, and a racquetball court. Vocational training is offered in woodworking and horticulture. Sun-filled dayrooms with large windows, couches, TVs and board games are adjoined by “music therapy” rooms, where inmates learn stress reduction techniques through music. Sleeping areas include single, double and three- and four-man rooms. There are no cells or bars in the hospital. The prisoners are referred to as “patients” rather than inmates. “This is a hospital,” said Hal Smith, CNYPC’s longstanding executive director. “Our mission is to treat people with serious and persistent mental illness. Our role is to provide one part of treatment in a continuum of care.”

Within 20 minutes of arrival, all inmates are seen by a nurse administrator. Two physicians perform medical screening and a psychiatric assessment. Pictures of the inmates are taken to document any injuries or bruises that may have occurred in transport or back at the prison and sent to CNYPC’s executive director and the State Commission of Correction (a government oversight agency). After processing, the inmate is assigned to a treatment team consisting of a psychiatrist, psychologist, social worker, occupational therapist and treatment assistant, and an individual treatment plan is devised.

A “menu” of therapeutic activities is offered every day in the “Treatment Mall.” All patients spend ten hours a week in the treatment mall participating in groups focusing on conflict resolution, substance abuse, yoga, stress management and medication compliance. About one-third of the patients participate in vocational training. “We have demonstrated that you can safely program people with mental illness,” said Hal Smith. “People with mental illness don’t just need therapy; they need to feel useful and engaged in normal, everyday activities, maybe even have a job.”

Recently, CNYPC designed a new initiative to accomplish just that purpose. Through the Patient Peer Assistant program, patients receive a small stipend to facilitate support groups, conduct orientation and co-develop training modules. Plans are in place for Patient Peer Assistants (PPAs) to work with inmates in Intermediate Care Programs when they return to prison. On the day of our visit, we observed a PPA training session and spoke with participants about their experiences at the hospital and in prison.

The patients we interviewed commented favorably on the quality of care at CNYPC and in Intermediate Care Programs (ICPs) in the prisons. “The problem is, there’s not enough space in ICPs,” said Dan, incarcerated for 24 years. Michael, an inmate suffering from paranoid schizophrenia, also spoke favorably of his time in ICPs: “I’ve been in ICPs at Elmira, Attica and Wende. You get a lot of support there. I got my GED in the ICP.” Michael said he is looking forward to working with ICP inmates when he leaves the hospital. “I like being a PPA. My accomplishments here make me feel like I’m someone.”

Although inmates arrive at CNYPC mentally decompensated, delusional or suicidal, the majority return to the prison system stable and medically compliant. Even the most violence-prone, treatment-resistant inmates tend to do well at CNYPC, an OMH

official told us. “This happens because the inmate builds up trust with staff at CNYPC,” reported Dr. Stuart Grassian⁵¹ in an interview with the Correctional Association. “There is a culture of compliance there because it’s a hospital setting. The inmate takes his medication voluntarily at CNYPC, but then he’s shipped back to general population, or worse yet the SHU, which is a paranoid environment because it’s a scary place, and he goes off them. The failure of medication compliance is not a failure of the inmate. It’s a failure of the system.”

➤ **65% of inmates are re-admitted to CNYPC.**

Despite the tripling of NY’s inmate population since CNYPC opened in 1980, its capacity has never been expanded. The lack of space at CNYPC combined with the lack of treatment in general population results in an endless shuttling back and forth between prison and CNYPC. “Buff ‘em up and send ‘em back,” said a correction officer in the mental health unit at Wende. An article in *Corrections Digest*, a national newsletter on current criminal justice programs and policies, described CNYPC’s policy of rotating admissions in order to provide care to the most needy as a response to having too few treatment beds to allow for longer inpatient stays. “Two years ago, the facility operated at 105 percent of capacity. Since introducing the method of allocating services for shorter periods of confinement, the center has been able to deliver mental health care to more prisoners than under the previous system.” Unfortunately, mental health staff report that shortening inpatient stays has impacted patients’ longterm recovery. A CNYPC psychologist said: “At least two-thirds of our patients return because they go back to prison and deteriorate.”

A mental health unit chief explained: “It’s not surprising that the re-admission rate to CNYPC is about 70%. The issue is, we have hundreds of patients in the system, many of whom are in SHU and need hospitalization and treatment. They aren’t going to get better in the SHU or in an observation cell or by spending a month at CNYPC. Some need longer-term care, but that’s not available in this system.”

These remarks underscore the overarching problem with the provision of mental health care in New York State prisons: the attempt of OMH to superimpose the community mental health model on the correctional system. The philosophy that dominates the mental health field emphasizes short-term hospitalization followed by outpatient care in the community. In the correctional system, however, not only is outpatient care sorely lacking in “the community” of the general prison population, the violence and chaos of prison life itself can destabilize even mentally balanced individuals.

⁵¹ Dr. Grassian is a Harvard based psychiatrist who has been retained as an expert witness on the psychiatric effects of solitary confinement in a number of class action lawsuits, including several involving New York State prisons.

➤ **CNYPC should be expanded to its 350-bed capacity.**

“For several years I have been assured that the inpatient bed capacity would increase...,” wrote DOCS Commissioner Glenn S. Goord to then Commissioner of OMH, James Stone, in a letter in 2000.⁵² “[W]ithout that expansion it may not be possible to meet the psychiatric care needs of the inmates in DOCS.” Almost universally, superintendents and mental health staff we interviewed recommended expanding CNYPC. One superintendent commented on the ethical imperative to expand CNYPC because state correctional facilities are currently unable to serve the most seriously mentally ill individuals. “CNYPC is always full,” he stated. “With de-institutionalization, DOCS is absorbing patients as inmates, but DOCS hasn’t taken the upper hand and built the facilities to deal with this population. It is not quite right to have the seriously mentally ill dispersed throughout general population. There needs to be some place, even within the walls here, a building for these individuals. They need to be looked after the way they should be looked after.”

Mental health staff reported that expanding CNYPC would allow longer hospitalization stays for inmates. A psychiatrist at Auburn noted: “Some of these guys should be hospitalized at CNYPC longer, maybe not be in prison at all. It would be better if CNYPC could take longer with the more clinically complex cases,” he said. Most mental health clinicians felt that the limited space in CNYPC forced inmates out prematurely.

In 1997, OMH officials expressed serious concerns about CNYPC’s ability “to keep pace with the increase in DOCS growth and the increase in the number of inmates within the corrections system with serious mental health problems.”⁵³ In an internal report documenting a range of service gaps, an OMH task force “unanimously supported” the expansion of CNYPC to 350 beds, noting that “since 1981, there has been no inpatient [capacity] growth at CNYPC, yet DOCS has grown from 28,000 inmates to the current 70,000.” The authors stated: “New York has lower per capita inpatient beds than all other states of a comparable or smaller DOC population.”

This internal document reported that the state had already begun the expansion of CNYPC from 200 to 350 beds:

During Fiscal Year (FY) 96-97, it is recommended that OMH plan to continue its eight-year plan, initiated in FY 92-93, to expand Central New York Psychiatric Center from the current 200 beds, incrementally to 350 beds. Beginning in FY 92-93, the facility kitchen expansion was funded and designed for 350 patients. This project was completed in October 1996. In the same year, additional activity space to accommodate the expansion of up to 150 beds was funded and is also near completion. In FY 96-97, OMH was funded to construct a new perimeter fence around the vacant portion of CNYPC’s Building 39 to secure it for expansion. This would enable the expansion of beds at Central New York to occur beginning with the operation of the fifty (50) new forensic beds at CNYPC in FY 98-

⁵² Quoted in “Suicides soar; psychiatric resources lag,” *Poughkeepsie Journal*, Nov. 16, 2001.

⁵³ Smith, H. E., *NYS OMH Task Force on the Future of Forensic Services: Report of the Subcommittee on Prison Mental Health Services*, New York: January 31, 1997, 19.

99 and incrementally expand the facility by 50 beds each year for the following two years, bringing the total capacity from the existing (approximately 200) to a 350-bed capacity.⁵⁴

Even with this expansion, the report noted, “New York will continue to have one of the lowest inpatient bed-to-inmate ratios in the United States.” Ultimately, the report was never published, and the expansion never happened.

Residential Crisis Treatment Programs (RCTPs)

Instead of expanding CNYPC, the state put resources into outpatient services in the prisons’ Residential Crisis Treatment Programs. However, RCTPs are a world apart from CNYPC and its treatment-rich program, top-flight clinicians and sun-filled dayrooms. “These are horrendous places,” said Dr. Grassian in an interview with the Correctional Association. “RCTPs function mainly as holding units for inmates in acute psychiatric distress. They provide virtually no therapeutic treatment beyond stabilization and assessment.”

➤ **RCTPs are compromised by a punitive environment and lack of actual treatment.**

In many RCTPs, particularly those in the old, maximum-security prisons, the observation cells where inmates are held on suicide watch are grim and isolating places. At Auburn, inmates are confined in dimly lit cells behind thick metal doors. At Wende and Great Meadow, the cells lack windows and therefore provide no natural light. At Sing Sing, however, the cells are far less isolating and dreary. A mesh-like screen covers the cells, which have bars instead of doors, thereby allowing for complete visibility.

Before being placed in an observation cell, prisoners are stripped of their clothing and given a hospital gown (or underwear and a T-shirt) and two “mattress pads”—thin, rough blanket pads that barely cover an adult body. To prevent suicides by hanging, correctional administrators usually deny inmates blankets. Not surprisingly, most inmates resist being placed in RCTPs. We encountered inmates in the SHU who were highly distraught but implored us not to contact mental health staff for fear of being put in an observation cell. “They strip you naked and throw you in a cell!” one inmate said. An inmate we interviewed in the observation cell at Elmira said: “I told my psych I was stressed and they kidnapped me and put me in a strip cell.” Almost universally, inmates described the observation cells as punishing places.

Another problem is that most suicidal inmates are placed in observation cells even when dorm beds are available. Although no policy prohibits placing inmates in dorm beds rather than cells, “If the correction officers don’t like it, it’s not happening,” explained a mental health counselor. In visits to ten RCTPs, we rarely saw an occupied dorm bed.

⁵⁴ Ibid.

More problematic is that when the observation cells are full, DOCS uses cells in the SHU to confine inmates on suicide watch. OMH officials acknowledge the problems with this practice: “These cells are not located on the RCTP and are not staffed by OMH personnel,” the CNYPC Policy and Procedures Manual states. However, according to the manual, “DOCS retains the right to place inmates in these beds.”⁵⁵ Thus, suicidal inmates in general population can be placed in stark observation cells in the punitive environment of disciplinary confinement where they are watched over by correction officers rather than clinicians. “The entire mental health system is designed to discourage usage,” observed Dr. James Gilligan, M.D., former director of mental health services in the Massachusetts Department of Correction, who accompanied us on a site visit to Attica.

Physical conditions aside, the overarching problem with RCTPs is how the units are run. OMH employees “have very little say” in their operations, reported a mental health unit chief. Even though RCTPs house inmates in acute psychiatric distress, it is correction officers who oversee the units and dictate the rules, even if those rules could cause further psychological distress. “I’ve known of officers who will give tickets to patients on suicide watch for behavior that is obviously related to their mental illness,” said a former unit chief. “Even if mental health staff know that what the officer is doing is counterproductive or even harmful from a clinical perspective, there is little they can do about it.”

At one facility, we encountered a suicidal inmate in an observation cell who had been placed on a “restricted diet” of bread and raw cabbage for violating prison rules. Once again, inside a correctional setting, the punitive paradigm trumped the therapeutic, and the inmate with mental illness suffered needlessly.

⁵⁵ *Central New York Psychiatric Center: Outpatient Operations Policy and Procedure Manual*, Section 3: Patient Management -B: Patient Housing -3: OMH Responsibilities to Inmates Placed in Non-RCTP Observation Rooms, November 24, 2003.

V. DISCIPLINARY LOCKDOWN⁵⁶

Inmates who are convicted of violating prison rules are sent to Special Housing Units, also known as Close Management Units, Control Units or supermaxes depending on the jurisdiction. Regardless of the terminology, conditions inside these prisons within prisons are basically the same: 23-hour lockdown, sensory deprivation, social isolation and enforced idleness—conditions harmful to anyone’s mental health and devastating to people with psychiatric disabilities.⁵⁷ In *Madrid v. Gomez* (1995), a landmark case involving conditions in California’s Pelican Bay supermax prison, Federal District Court Judge Thelton Henderson observed that 23-hour isolation “may press the outer borders of what most humans can psychologically tolerate.” Placing mentally ill or psychologically vulnerable people in such conditions “is the equivalent of putting an asthmatic in a place with little air to breathe,” he stated.⁵⁸

Inmates in New York’s Special Housing Units (SHUs) generally live in cells an average size of 56 square feet, behind bars, Plexiglas or thick metal doors. They are “cell-fed” through “feed-up” slots in the doors. Whenever they leave their cells, they are mechanically restrained with handcuffs attached to waist chains and leg irons if they are considered seriously violent or escape-prone. Prisoners in SHU cannot work or go to school. “[They] endure an unprecedented degree of involuntary, enforced idleness,” writes Craig Haney, an expert on the psychological effects of solitary confinement.⁵⁹ “Put simply: prisoners in these units have nothing to *do*.” Another expert, Dr. Stuart Grassian,⁶⁰ said in an interview with the Correctional Association, “The effects of such intense monotony can cause an individual to descend into a mental torpor, a kind of fog in which alertness, attention and concentration all become impaired.”

⁵⁶ Parts of this chapter are based on the Correctional Association’s study and report, *Lockdown New York: Disciplinary Confinement in New York State Prisons*, October 2003.

⁵⁷ See, e.g., Fellner, Jamie, *Cold Storage: Super-Maximum Security Confinement in Virginia*, New York: Human Rights Watch, 1997; Haney, Craig and Mona Lynch, “Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement,” *New York University Review of Law & Social Change*, XXIII, no. 4, 1997; *Madrid v. Gomez*, 899 F. Supp. 1146 (N.D. Cal. 1995) (court rules super-maximum security confinement of mentally ill is unconstitutional as cruel and unusual punishment).

⁵⁸ *Madrid v. Gomez*, 889 F. Supp. At 1265-66 (N.D. Cal. 1995).

⁵⁹ Haney, C. “Infamous Punishment: The Psychological Consequences of Isolation,” *The National Prison Project Journal*, Spring 1993, p. 3-7, 21.

⁶⁰ Psychiatrist Stuart Grassian has provided expert testimony on the psychological effects of disciplinary confinement in numerous state and federal lawsuits. Following the *Eng* litigation in New York, the judge appointed Dr. Grassian to monitor the quality of mental health services in the Attica Special Housing Unit. In the course of his work, Dr. Grassian has evaluated hundreds of inmates who have psychiatrically deteriorated in solitary confinement and has published extensively on his research.

In New York, inmates can be sentenced to 23-hour lockdown for a month, a year, a decade or more, as there is no upper limit to the amount of time that prison officials can impose on inmates who violate rules. Also in New York, if an inmate's prison term expires while he is in the SHU, he is released directly to society, sometimes after years of social isolation.

System-wide, approximately 4,400 inmates were held in 23-hour lockdown in December 2003. Upwards of 20% of inmates in 23-hour disciplinary lockdown were on the mental health caseload, and approximately 11% (some 480 individuals) were diagnosed with a major mental disorder such as schizophrenia.⁶¹ At some prisons we visited, more than 60% of the inmates in the SHU were mental health patients.⁶²

Research has demonstrated that mentally disordered inmates have greater difficulty conforming to strict correctional regimens than their non-mentally ill counterparts and are more likely to accumulate tickets and end up in disciplinary confinement.⁶³ "Offenders who are sent to [these] settings because they have problems adjusting to prison disproportionately are persons who have had mental health problems in the past," noted Hans Toch, who conducted an extensive study of the experiences of inmates with mental illness in the New York State prison system.⁶⁴

The prisoners who end up in disciplinary lockdown are often the system's most troubled inmates, individuals with both psychiatric and behavioral disorders that require a level of attention and care that the prison system does not provide. Commenting on the types of individuals who end up in disciplinary segregation, Dr. Grassian wrote:

There is a notion in the popular mind that the people who end up in solitary confinement are the most ruthless kind of James Cagneys of the prison system. In fact, what you often see there is exactly the antithesis: they are very often the wretched of the earth, people who are mentally ill, illiterate, and cognitively impaired, people with neurological difficulties, people who just really can't manage to contain their behavior at times. The prison system tends to respond to this by punishment. Punishment tends to make their conditions worse and they tend to get into these vicious cycles where they continue to commit this disruptive behavior and they continue to go deeper and deeper into the belly of the prison system and get sicker and sicker.⁶⁵

⁶¹ OMH memo: "Number of Inmates in SHU and SHU 200 on the OMH Caseload by Correctional Facility as of November 30, 2003."

⁶² Some inmates with mental illness in SHUs may not be counted in DOCS' figures because they are not on the mental health caseload. See Appendix 4 for a profile of an inmate with mental illness in lockdown at Southport Correctional Facility, who does not receive mental health treatment.

⁶³ A Bureau of Justice Statistics report found that 62% of state inmates identified as mentally ill had been charged with a rule violation, compared to 52% of inmates not identified as mentally ill. See Ditton, Paula M., *Mental Health and Treatment of Inmates and Probationers*, Bureau of Justice Statistics: U.S. Department of Justice, 1999.

⁶⁴ Toch, H. "The Future of Supermax Confinement," *The Prison Journal*, 81, 2001, 378.

Some superintendents acknowledged that confining inmates with mental illness in a cell for 23 hours a day does little to improve their behavior and can sometimes worsen it. Dr. Grassian elaborated on this phenomenon in an interview with the Correctional Association:

Many of the inmates who end up in the SHU are precisely the group least capable of tolerating such stringent and isolating conditions. They are often individuals with long histories, beginning in childhood, of emotional instability, hyperactivity, impulsivity, or other indications of subtle central nervous system dysfunction. As a result of this dysfunction, such individuals are almost pathologically stimulation seeking and incapable of tolerating stimulus deprivation. When placed in stringent conditions of confinement, they become agitated and paranoid and their emotional state and behavior deteriorates. Many become floridly psychotic or so agitated that they engage in awful, grotesque behaviors. They cover themselves and their cells with feces, they mutilate themselves; they try to kill themselves. And then their prison sentence expires and they are released to the community in a more disorganized and dangerous condition.

Mental health clinicians who work in New York prisons tend to agree. “Being locked in a dark, isolated cell for 23 hours a day isn’t good for anyone,” observed a recently retired unit chief with over thirty years in correctional mental health care. In an interview with the Correctional Association, this retired professional stated:

My feeling is that people with bipolar disorder, schizophrenia, or major depression should not be housed in SHU, period. These are seriously and persistently mentally ill people. SHU is not the place for them. One *day* in solitary confinement can undo some people. Certainly, anyone who is in SHU for an extended period of time is affected by it. We have inmates doing 10 years, 15 years or more in New York. What are we accomplishing?

Certainly, there are some inmates who are so dangerous that they need to be in solitary confinement for their entire sentence, but these cases are rare. In New York, we have nearly 5,000 inmates in SHU, many of whom are receiving no mental health services.

The widespread use of disciplinary confinement for individuals with mental illness raises grave concerns about what will happen when these inmates are eventually released back to the community. Some superintendents recognized the irrationality of this system but felt powerless to do anything to change it. “It’s a flawed system,” said one superintendent. “What are we supposed to do?”

To learn how inmates with mental illness fare in disciplinary confinement, we conducted survey interviews with 162 SHU inmates on the mental health caseload in ten maximum-security prisons.⁶⁶

⁶⁵ Grassian, S and N. Friedman. “Effects of Solitary Deprivation in Psychiatric Seclusion and Solitary Confinement,” *International Journal of Law and Psychiatry*, 8, 1986, 49-65.

⁶⁶ Attica, Clinton, Elmira, Five Points, Great Meadow, Green Haven, Sing Sing, Southport, Sullivan and Wende Correctional Facilities.

Profile of SHU Inmates on the Mental Health Caseload

The ethnic breakdown, age and education level of inmates on the mental health caseload in SHU are similar to that of general population inmates. Over 85% are Black or Hispanic; over 50% are high school dropouts; the average age is 33.

Self-reported data concerning inmates’ psychiatric diagnoses (some inmates reported more than one disorder) indicate that over half have been diagnosed with a major depressive disorder; over one-third with anxiety disorder; 20% with Post Traumatic Stress Disorder; 19% with antisocial personality disorder; 16% with schizophrenia and 12% with bipolar disorder. Attesting to the seriousness of their mental illness, nearly one-third (30%) of the inmates reported previous stays at Central New York Psychiatric Center.

More than half (60%) reported being sentenced to SHU for a violent offense (defined as assault, fighting, weapons possession or committing an unhygienic act), while 40% reported a nonviolent offense (defined as drug use, possession of contraband or disobeying a direct order).

In our sample, the minimum SHU sentence was one month; the maximum sentence was 12 years. Noteworthy is that the average SHU sentence reported by inmates with mental illness in our sample was *six-and-a-half times longer* than that of inmates generally: 38 months compared to the Department’s figure of 5 months for inmates generally.⁶⁷

An inmate we interviewed at Southport, who entered the state system at age 17 on an attempted murder charge, had recently received a ten-year sentence to SHU for fighting with an inmate and assaulting an officer. The assault occurred, he said, when the officer tried to break up the fight. Coherent but withdrawn, he said he was on the mental health caseload, receiving three different types of medication (Depakote, Benadryl and Zyprexa), but did not know his official diagnosis. “I just feel despair,” he said. “I don’t think I can keep my head above water. Ten years in the hole is a long time.”

Profile of SHU inmates on the Mental Health Caseload (n = 162)
Ethnicity:
White: 13%
Hispanic: 27%
Black: 59%
Other: 1%
Median Age: 33
GED or HS Diploma: 44%
Average SHU Sentence: 38 months
Median SHU Sentence: 24 months
Minimum SHU sentence: 1 month
Maximum SHU sentence: 12 years
SHU Charge:
Violent: 60%
Nonviolent: 40%
Prior Psychiatric Admission: 30%

⁶⁷ “Progressive Inmate Movement System contributes to a 28% reduction in SHU time served since ‘97,” *DOCS Today*, New York: New York State Department of Correctional Services, December 2003, p. 5.

Mental Health Services⁶⁸

A Memorandum of Understanding between DOCS and OMH requires that all newly admitted inmates to SHU receive a mental health screening within 24 hours. “It’s basically a down and dirty suicide evaluation,” explained a counselor at Sullivan. Of the 162 inmates in our sample, over two-thirds (68%) reported that they were screened within 24 hours of admission. Approximately one-quarter (23%) said they were screened within 48 to 72 hours, and 9% said they were “never” screened.

OMH staff are required to make daily rounds in the SHU, spending a minimum of one hour per week for every ten inmates, which translates to one minute and 12 seconds of mental health contact on every weekday. The logbooks we reviewed confirmed that OMH meets this meager standard, but many inmates complained that counselors typically “whiz by,” stopping only for inmates who have submitted referrals or whom correction officers identified as in need of services. More than half of the inmates (55%) in our sample reported that they did not have sufficient access to mental health services. Only 35% felt that they could see a therapist if they had an urgent need.

On a positive note, 78% of inmates said they speak with OMH staff in private interview rooms approximately once a month. However, 71% of inmates who receive private mental health consultations reported that, on average, these meetings last less than twenty minutes.⁶⁹ Over 40% said the meetings last less than ten minutes.

Approximately three-quarters of inmates felt that correction officers did not respect their medical confidentiality, either because the officers stood within earshot during cell-side consultations with mental health staff or because inmates believed that the officers did not turn off the audio button in the private interview rooms and eavesdropped on their conversations.

Time Counselors Spend in Private Consultation with SHU Inmates

1 to 10 minutes:	42%
11 to 20 minutes:	29%
21 to 30 minutes:	21%
30+ minutes:	8%

➤ More than half of SHU inmates do not know what mental health medications they are taking.

Eighty-six percent of inmates in our sample were prescribed medication for their mental illness, but more than half (54%) said that the psychiatrist did not explain to them how their medication works, why they were on it or what side effects they might experience. A significant majority (70%) said that they were always or usually medically compliant, while one-fifth reported that they were “never or rarely” compliant, usually because they did not feel that the right medications had been prescribed or because of the

⁶⁸ See Appendix 5 for an evaluation of mental health services for SHU inmates at Sing Sing Correctional Facility by Alan Felix, M.D.

⁶⁹ In November 2003, OMH revised their SHU Services policies. New policies require mental health staff in Level 1 and Level 2 facilities to provide inmates on the mental health caseload in disciplinary housing with a minimum of two private/confidential sessions each month with their primary therapist and a minimum of one private/confidential session with a psychiatrist.

lack of communication with staff. For example, a 42-year-old inmate at Southport with a history of psychiatric illness reported that he had been taking a certain medication, the name of which he could not recall. “But then they started crushing it up before giving it to me so I stopped taking it. I said I wanted to see the psychiatrist, but it’s been over a month and I haven’t seen anyone,” he wrote in a letter to the Correctional Association.

A 28-year-old inmate with mental illness who had served time in the SHU at Upstate and Southport reported that he was not satisfied with his medication because he still hears voices. “The voices tell me to kill myself, that I ain’t shit, that I’m the reason why my appeal was denied last week, and that I need to die because no one loves me or needs me,” he wrote to the Correctional Association. “I need to be put in a facility that has a mental health unit. That’s what the psychiatrist told me. Please come see me and take me out of this place. I’m begging you to help me.”

Had these inmates been in the hospital instead of the SHU, they would have had far greater contact with psychiatric staff and better medication compliance. Without medication, the possibility for mental decompensation and behavioral problems increases significantly.

Deprivation Orders

Prison officials rely on a regimen of increasingly harsh punishments known as deprivation orders to discipline inmates who continue to act out while in punitive confinement. Common deprivation orders include loss of recreation, showers or haircuts. Inmates are mechanically restrained with handcuffs, waist chains and leg irons during recreation in an outdoor cage if they assault another inmate or staff.

A more serious punishment is the addition of time to one’s SHU sentence. Because there is no limit to the length of time inmates can be housed in disciplinary confinement, for inmates with mental illness who have difficulty functioning in lockdown, a sentence to SHU can easily become a kind of quicksand from which the inmate can never quite emerge. “For guys with mental illness, six months of SHU time can turn into 16 years,” a mental health counselor at Sing Sing said.

A striking example is WJ, an inmate we encountered at Wende Correctional Facility who was sentenced to 35 *years* in solitary confinement. Much of his disciplinary time had been accumulated at Southport, where he was housed in the facility’s dungeon-like D-Block and charged with violations ranging from flooding his cell to assaulting staff. A Correctional Association researcher noted after meeting him:

WJ appeared a broken man. Inmates on either side of him reported that he is “totally gone” and refuses to leave his cell for recreation or showers. Decomposing orange peels rotted on the floor under his bed. This and his poor hygiene left a noxious stench in his cell. The first day we met him, WJ was curled on his bed under a blanket. He didn’t move or speak to us when we attempted to engage him. When we returned the second day, WJ was sitting on his bed, motionless and staring into space. He would not lift his head, make eye contact or speak. After several minutes, he muttered: “I want to speak to mental health.” When we communicated this to a deputy

superintendent, he reported that WJ had just returned from an evaluation with an outside psychologist, who considered him a malingerer and not in need of services.

➤ **The majority of inmates with mental illness in SHU receive deprivation orders.**

While the Department asserts that deprivation orders are used sparingly and only in the most extreme cases, our findings suggest otherwise. Over half (55%) of the inmates with mental illness reported receiving deprivation orders while in lockdown. Of those inmates, 62% reported receiving four or more deprivation orders. This finding indicates that there is a core group of inmates who either cannot or will not control their behavior, and to whom DOCS responds by piling punishment on top of punishment. Dr. Grassian explained in an interview with the Correctional Association:

Number of Deprivation Orders Received in SHU	
None:	45%
1 to 3:	21%
4 to 6:	13%
7 to 9:	2%
10 + :	19%

Unfortunately, the prison system has little capacity to understand or cope with such individuals. Instead, these individuals get into a downward spiral of disturbed behavior and punishment and they cannot get out. They just stay in the SHU, and they mentally rot. Some inmates go through a grotesque ‘revolving door’ pattern, remaining in the stringent, punitive environment of SHU until they finally become so ill as to require hospitalization, a setting where they eventually recover just enough to be returned to the SHU, the same toxic environment that caused their psychiatric decompensation in the first place.

➤ **Over a third of inmates reported being put on a restricted diet.**

A particularly pernicious punishment imposed on inmates who have either lost all other privileges or who throw (or *threaten* to throw) bodily fluids is the restricted diet, known by inmates as “the loaf.” Consisting mainly of flour, potatoes, carrots and very little fat, the “loaf” is a dense, binding, tasteless one-pound loaf of bread that is served to inmates three times a day along with a side portion of raw cabbage. After seven consecutive days on the diet, the inmate is given two days off. Although DOCS prohibits imposing the loaf for more than 21 days, attorneys at Prisoners’ Legal Services have identified cases where it was imposed for as many as 56 days. A plaintiff in a lawsuit filed by Prisoners Legal Services challenging the constitutionality of the restricted diet⁷⁰ was fed bread and cabbage for nine months while he was at Southport and lost 65 pounds, according to his attorney.

Over one third of the inmates (34%) in our sample reported being put on the loaf while in SHU. More than half of these inmates said that they were issued the restricted diet for charges other than throwing, including disobeying a direct order. Though the Department asserts that three, one-pound servings of the loaf meet daily nutritional requirements, most inmates do not consume three servings daily because it is unpalatable and hard to digest. Of the inmates in our sample who had been placed on the diet, the majority (59%) reported that they “never or rarely” ate three servings a day, citing

⁷⁰ *Rodriguez v. McGinnis*, et al., 98-CV-6031 (W.D.N.Y).

difficulty to digest it as the primary reason. Some inmates said that correction officers intentionally served the loaf when it was days old, moldy and stale.

In addition, although the restricted diet can only be imposed after a disciplinary hearing and with approval of the superintendent and medical director, a “pre-hearing” diet can be imposed for one week by a sergeant on the unit. Thus, it is highly possible that, even if an inmate is found innocent of charges, he still will have been subjected to a diet of bread and cabbage for seven days.

American Correctional Association standards prohibit using food as punishment.⁷¹ The Federal Bureau of Prisons and many other states have abolished the use of restricted diets. New York, on the other hand, has more than doubled its use of the restricted diet over the past five years, from 626 diets in 1997 to 1,356 diets in 2002.

Psychological Effects of 23-Hour Lockdown

A growing body of research confirms the harmful psychological effects of living in near seclusion.⁷² Since the late 1980s, numerous court decisions have concurred with these research findings. “The record shows, what anyway seems pretty obvious, that isolating a human being from other human beings year after year or even month after month can cause substantial psychological damage, even if the isolation is not total,” wrote the judge in *Davenport v. DeRobertis* (1988), a case involving SHU conditions in Illinois prisons.⁷³ The judge in *Madrid v. Gomez* (1995) wrote that conditions in California’s Pelican Bay “cause mentally ill inmates to seriously deteriorate; other inmates who are otherwise able to psychologically cope with normal prison routines may also begin decompensating in SHU.” According to Dr. Grassian:

The literature, as well as my own observations, has demonstrated that, deprived of a sufficient level of environmental and social stimulation, individuals will soon become incapable of maintaining an adequate state of alertness and attention to the environment. Indeed, even a few days of solitary confinement will predictably shift the electroencephalogram (EEG) pattern towards an abnormal pattern characteristic of stupor and delirium.⁷⁴

On nearly every site visit, and in some lockdown units more than others, we encountered individuals in states of extreme desperation: men weeping in their cells or pacing about like caged animals; men who had smeared feces on their bodies or lit their cells on fire; prisoners who cut their own flesh in a form of self-directed violence known as self-mutilation; inmates who rambled incoherently or expressed paranoid delusions—

⁷¹ See Standard 4-4320, which states: “Written policy precludes the use of food as a disciplinary measure. Food should not be withheld, nor the standard menu varied, as a disciplinary sanction for an individual inmate.” American Correctional Association, *Standards for Adult Correctional Institutions*, 4th Ed., Lanham, MD: American Correctional Association, 2003.

⁷² See Grassian, 1986; Haney, 1993; Human Rights Watch, 1997, 1999, 2003; Kupers, 1999; Toch, 2001.

⁷³ *Davenport v. DeRobertis*, 844 F.2d 1310, 1313 (7th Cir.), cert. denied, (1988).

⁷⁴ Interview with the Correctional Association.

“The COs are poisoning my food,” or “The prison psychologist is drugging me.” Other comments include the following:

- “Objects talk to me,” said a 26-year-old man at Five Points Correctional Facility. The inmate had been in solitary confinement for 18 months and had another 18 months to serve. “Sometimes the radiator comes alive and tries to attack me. At night I get lonely and the door and the radiator and the shadows come alive and try to get me.”
- “I think I see people spying on me at night,” said a 33-year-old man at Southport, serving eight years in disciplinary lockdown.
- “From the corner of my eye, I see things. . . people moving,” a skittish Elmira inmate, aged 37, said to us through the feed-up slot in the metal door of his cell. Sentenced to 3½ years in solitary confinement, he described himself as “a suicidal loner.”
- “Mentally, I think I’ve lost it. I’ve done things here that I’ve never done before,” said a Southport inmate, aged 25, sentenced to ten years in lockdown. “Emotionally, I’m moody, stressed, and arrogant towards people that don’t deserve it. Physically, I feel broken at times. I’ve become a savage, the very thing that Southport breeds.”

Some inmates appeared defensive when asked about the effects of isolation—“I am a *strong* individual. They cannot break me!” said a Southport inmate—or minimized their serious psychiatric histories. Inmates who were double-celled (and thus speaking to us in the presence of a cellmate) sometimes spoke with a certain bravado. A 24-year-old in the S-Block at Mid-State initially joked about how he could “do box time standing on [his] head” and emphasized that he was “not a bug” (prison slang for a person with mental illness). Sentenced to three months in lockdown for fighting, he reported that he takes psychotropic medication “for nerves” but did not know the name of the medication because he was unable to read. He stated that a mental health counselor interviewed him for ten minutes upon admission and asked “the usual silly questions, whether I’ve tried to hurt myself or have been in a mental hospital.” When we asked if he had been hospitalized or tried to hurt himself, he said: “I have mad thoughts about hurting myself. I tell them that and all they do is increase my medication, but it doesn’t do anything for me. I’ve been admitted to mental hospitals all my life. I stabbed myself twice when I was 13.”

➤ **70% of inmates reported difficulty thinking, concentrating or paying attention.**

To ascertain how prolonged seclusion affects one’s cognitive processes, we asked inmates if they had problems thinking, concentrating or paying attention while in SHU. Seventy percent answered affirmatively. For example:

- “When I’m under a lot of stress, my thoughts become very chaotic,” said an inmate at Attica, aged 35, serving a one-year SHU sentence. “I have a very hard time concentrating and remembering what has just been said, and I find it impossible to maintain a solid line of thought. It’s like 20 thoughts are all fighting at the same time.”

- “Sometimes I forget even the simplest things and I am always feeling unloved and lost and lonely and no one can understand,” said a 32-year-old man at Clinton, where he had been in solitary confinement for over two years and twice attempted suicide.
- “If I have to read something, I have to re-read the same paragraph several times over to understand it. It was never like that before SHU time,” said a Southport inmate, aged 25, sentenced to ten years in lockdown.
- “My thoughts wander and my moods drop. My mind gets stuck on things, the loss of my brothers, my sisters, my girl, too many things,” said a 39-year-old prisoner in the SHU at Great Meadow, where he had been for over a year.

While a large body of literature attests to the damaging psychological effects of long-term isolation, there is no empirical research that shows the opposite: that extended segregation produces positive changes in behavior or mental health.

Enforced Idleness

A key problem with disciplinary lockdown in New York is that inmates are basically warehoused. While some states use disciplinary confinement as an opportunity for intervention (see Chapter 8’s discussion of model programs in Louisiana and the Federal Bureau of Prisons), New York provides no meaningful activities in which inmates can engage, no work to perform or programs to attend aside from “cell study,” which consists primarily of workbook exercises.

Not surprisingly, most inmates in our sample reported that they spend much of the time sleeping, as there is no way to tell time and virtually nothing to do. According to Dr. Grassian:

Individuals experiencing such environmental restriction find it difficult to maintain a normal pattern of daytime alertness and nighttime sleep. They often find themselves during the day incapable of resisting their bed—incapable of resisting the paralyzing effect of their stupor—and yet incapable at night of any restful sleep. The lack of meaningful activity is compounded by the diminished opportunity to experience natural daylight. And the individual’s difficulty in maintaining a normal day-night sleep cycle is often far worsened by the constant intrusions on nighttime dark and quiet—steel doors slamming shut, flashlights shining in their face, and so forth.⁷⁵

- **Nearly half of the inmates reported that they “never or rarely” go to recreation.**

Of interest was the number of inmates in lockdown who refuse their one hour of court-mandated recreation, the only opportunity they have to leave their cells and breathe fresh air. For inmates with mental illness, exercise is especially important. “Exercise can be helpful in controlling anxiety, nervousness, manic episodes, and depression,”

⁷⁵ Grassian, S. and Friedman, N. “Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement.” *International Journal of Law and Psychiatry* 8, 1986, 49-65.

according to Correctional Mental Health Care standards.⁷⁶ Psychiatrists who accompanied us on our visits pointed out that refusing recreation can indicate clinical depression, over-medication and/or listlessness due to sensory deprivation. Almost half (49%) of the 162 inmates we interviewed reported that they “never or rarely” go to recreation.

How often do you go to recreation?

Never	27%
Rarely	22%
Sometimes	18%
Usually	10%
Always	23%

“Why should I go?” asked an inmate in the Mid-State SHU who had not left his cell for 35 days. “They just move you from one cage to another and it will stress me out even more.” Some inmates cited the futility of going to recreation in mechanical restraints; others noted the lack of exercise equipment in the rec pens and the extreme cold in northern regions, where temperatures can be below freezing six months out of the year. Because of what the Department cites as “security reasons,” inmates are not permitted to wear gloves or hats in the exercise cages.

Suicide and Self-Mutilation

Suicide. Research shows that disciplinary segregation is correlated with higher rates of suicide. “Perhaps no factor has been more tragically associated with jail and prison suicides than the consistent finding of isolated/segregated housing,” wrote psychologist Ronald Bonner in the winter 2000 *Journal of the American Association of Suicidology*. Between 1998 and April 2004, 34% of prison suicides occurred in disciplinary lockdown although inmates in these units comprise only less than 7% of the total prison population.⁷⁷

- **Over half (53%) of the inmates in our sample reported that they had attempted suicide at least once while incarcerated.**

“It is a well-established fact that inmates serving long-term sentences in SHUs are likely to decompensate,” wrote officials with the New York State Commission of Correction (a government oversight agency) in a sharply critical report after inmate Carlos Diaz hanged himself in his cell at Southport in March 2000. Diaz, who had a history of psychiatric problems, committed suicide after a series of misbehavior reports resulted in his receiving a sentence of 15 years in solitary confinement. The Commission of Correction expressed “significant concern” at the system’s failure to monitor Diaz, who suffered paranoia and hallucinations for years but who, after entering Southport, was determined by mental health staff not to be in need of mental health services. In September 2002, another Southport inmate, 22-year-old Paul Lagoe, was found hanging dead in his cell. Lagoe suffered from bi-polar disorder and had been in and out of

⁷⁶ See Standard M-48 in *Correctional Mental Health Care: Standards & Guidelines for Delivering Services*, 1999, National Commission on Correctional Health Care, 79.

⁷⁷ New York State Department of Correctional Services: *Inmate Suicide Report: 1995-2001 and Inmate Suicides: 2002-April 17, 2004*.

psychiatric hospitals in the community. He had seen a Southport mental health counselor just hours before he killed himself.

A particularly tragic suicide was that of Jessie McCann, only 17 years old at the time of his death in November 2001.⁷⁸ McCann hanged himself with a bed sheet at Downstate Correctional Facility after being put in disciplinary lockdown. Jesse McCann had been in and out of solitary confinement for infractions that his family said were related to his mental illness. A Commission of Correction investigation of his death noted that McCann reported anxiety attacks when he was locked in his cell. The use of solitary confinement “is appalling for someone his age who is struggling with anxiety and depression,” Bryce McCann, the teen’s uncle, told the *Poughkeepsie Journal*.⁷⁹

According to a study of suicide risk factors in New York State prisons conducted by OMH in 2002, 70% of inmates who committed suicide had a history of mental illness. Most of the inmates were on the OMH caseload and 40% had received “a mental health service” within three days of the suicide. Half had made prior suicide attempts, and 40% had prior stays in psychiatric hospitals. Trigger factors included death of a loved one or disruption of a close personal relationship, conflict with other inmates, fear, physical illness, or adverse information such as the denial of parole.

The study’s findings have important implications for inmates in disciplinary lockdown, where many suicides take place and approximately one-fifth of inmates are on the mental health caseload. Departments of Correction in other states have recognized the heightened risk of suicide among inmates with mental illness in isolated confinement and have implemented strategies to divert these inmates from punitive segregation.⁸⁰ In Colorado, cells in the state’s supermax (Colorado State Penitentiary) are equipped with intercoms so that inmates have a way of contacting staff in case of emergencies. Since the prison opened in 1993, there has not been one suicide.⁸¹

Self-Mutilation. Another indication of the pathology bred in total lockdown units in New York is the high rate of self-mutilation, a form of self-directed violence that

⁷⁸ See Appendix 6 for Jennifer Gonnerman’s *Village Voice* article: “For the Mentally Ill, Solitary Confinement Can be a Death Sentence: The Stories of Two Men Who Never Made it Out. Suicide in the Box.”

⁷⁹ Pheiffer, M., “Mental Health Care Faulted in Six Prison Deaths,” *Poughkeepsie Journal*, June 29, 2003.

⁸⁰ Pennsylvania reduced the number of suicides in 23-hour lockdown from 14 in 1995 to 5 in 2000 by diverting inmates with mental illness from administrative segregation. “The policies mandate that psychologists and/or psychiatrists conduct special assessments of mental health inmates when they are committed to restricted housing units to determine whether their misconduct was related to their mental illnesses and what impact close custody might have on their treatment progress. Based on the assessment findings, prison administrators are encouraged to reduce the disciplinary time that special needs inmates would receive for misconduct, and they provide enhanced services and tracking for those inmates with mental illnesses who must be placed in administrative segregation.” Couturier, Lance, “Suicide Prevention in a Large State Department of Corrections,” *Corrections Today*, 63, 5, August 2001, 90-97.

⁸¹ See Appendix 7 for the profile of an inmate who committed suicide in the SHU at Five Points.

typically involves cutting or slashing one's wrists, arms or abdomen, or burning or biting oneself. Clinicians say that people engage in self-mutilation to alleviate feelings of intolerable stress or to counteract "psychological numbness." For instance, an inmate in the SHU at Great Meadow told us that he ground his head in glass and showed us the scar. "I do it in order to feel," he said. A persistent self-cutter at Wende explained, "I cut myself and the bad comes out."

Department figures show that incidents of self-harm rose by 66% between 1995 and 2000. Of the 162 inmates in our sample, 40% reported committing an act of self-harm during their current incarceration. Unthinkable to outside observers, "inflicting self-harm" is an official violation of DOCS policy. Prison officials issue misbehavior reports to inmates who attempt to kill or cut themselves, purportedly to discourage malingering.⁸² Over half (55%) of the inmates in our sample who reported committing an act of self-harm also reported receiving a ticket for it. Dr. Roderick Hall, Ph.D., Director of Mental Health Services at the Florida Department of Correction, seemed astonished when we asked him in an interview whether inmates in Florida receive tickets for self-harm. "Many years ago we gave tickets for self-harm," he said, "but certainly not now. We learned that it is counterproductive."

Malingering

During site visits, it was not unusual to encounter inmates with serious mental illness in disciplinary confinement whose requests for hospitalization and treatment were dismissed by mental health staff as attempts to "malingering." Among these "malingerers" we interviewed were men who had repeatedly attempted suicide, were persistent self-cutters, had multiple psychiatric hospitalizations, or who were so delusional or paranoid that they had to be forcibly extracted from their cells.⁸³

After his first site visit to Attica as the court monitor in the *Eng* litigation, Dr. Grassian sharply criticized mental health staff's handling of an inmate whom they considered a malingerer. The inmate, who was housed in the Attica SHU, had a history of severe mental illness ("depression with suicidal and psychotic features," according to his records) and tried to kill himself on three occasions while confined in the SHU before he succeeded. In a report on the visit, Dr. Grassian commented:

It was shortly after a transfer back to the Attica SHU from CNYPC that he successfully suicided by hanging. Prior to his death, he had once again decompensated; he became fearful and agitated, refused to eat, shave or shower, and threatened to kill himself if he were not given relief. His increasing paranoia, agitation, and suicidality were all ignored; indeed, all of these manifestations

⁸² Rule 123.10, Title 7 New York Correctional Rules and Regulations. In December 2003, DOCS proposed new regulations requiring disciplinary hearing officers to refer inmates charged with self-harm to the Deputy Superintendent of Security, who can dismiss the charge if he or she believes that, due to the inmate's mental state or for any other reason, the disciplinary sanctions would serve no useful purpose.

⁸³ See the following case studies of inmates: RB (p. 26), WJ (p. 52), FB (p. 66), AR (p. 66), DS (p. 66), BH (p. 66), RH (p. 89), JR (p. 92), RY (p. 96) and Al Kirby (p. 107).

of his desperation – even, grotesquely, his ultimate successful suicide – were all characterized by the mental health staff at Attica as “manipulative.”⁸⁴

Commenting generally on mental health staff’s tendency to claim that inmates in SHU are malingering, Dr. Grassian noted in the report:

There was too great a pull towards seeing inmate behavior as manipulative and to uncritically, reflexively, view inmates as “malingering” without any meaningful attempt at psychiatric evaluation—even utterly disregarding the existence of prior records clearly documenting serious psychopathology, and even utterly disregarding the fact that at the very same time that the inmate was being diagnosed as “malingering,” he was simultaneously on high doses of potentially toxic antipsychotic medication.⁸⁵

According to attorneys and psychiatrists familiar with the New York State prison system, the crux of the problem is that neither OMH nor DOCS is willing to take responsibility for inmates with both psychiatric and behavioral disorders. “OMH is willing to intervene only very briefly, at the height of inmates’ mental deterioration, but has been unwilling to take responsibility for their long-term management,” reported Dr. Grassian in an interview with the Correctional Association. “OMH then needs to over-define ‘malingering’ and ‘character problems’ in order to justify—to itself and others—their unwillingness to assume responsibility for the continued management of such inmates, who instead just behaviorally deteriorate in SHU and are punished further. What ultimately is needed, I think, is a broader mandate and mission for OMH—to develop a meaningful long-term residential program for such inmates, if you will, a ‘secure’ Intermediate Care Program.”

⁸⁴ Grassian, Stuart, *First Site Visit to the Attica SHU, Mental Health Care, Eng v. Goord*, Civ 80-385S (W.D. New York, June 1999) (redacted copy).

⁸⁵ Ibid.

VI. TREATMENT FOR DISTURBED/DISRUPTIVE INMATES

The federal lawsuit *Eng v. Goord*,⁸⁶ litigation concerning inadequate mental health care in the Special Housing Unit at Attica Correctional Facility, resulted in the development of a program known as the Special Treatment Program (STP), at Attica and Five Points Correctional Facilities. The goals of the STP are to reduce inpatient psychiatric admissions and disciplinary tickets among inmates with mental illness in 23-hour lockdown and to stabilize inmates' mental health. The first STP was opened in 2001 at Attica with a capacity for 18 inmates. A second STP was opened at Five Points in 2002 with a capacity for 25 inmates.

The core features of the STP are group counseling and the opportunity for a time-cut on one's disciplinary sentence. Inmates spend a minimum of five hours a week in therapeutic groups. The sessions are based on a 12-week "psycho-educational" curriculum that involves discussions about mental health and mental illness and incorporates current events, popular films and homework assignments. Inmates receive significant time-cuts off their disciplinary sentence for participating in the program, complying with their treatment plan and not receiving disciplinary tickets. Time-cuts are determined by a Joint Management Committee of security and mental health staff that meets bi-weekly to monitor inmates' progress.

We visited the STPs at Attica and Five Points and interviewed 27 inmates (11 at Attica and 16 at Five Points) using a structured survey questionnaire. Accompanying us on the visit to Attica's STP was psychiatrist James Gilligan, former Director of Mental Health Services at the Massachusetts Department of Correction.

Inmate Profile

The inmates selected for the STP can best be described as "disturbed/disruptive"⁸⁷—disturbed in that they have a serious psychiatric illness and disruptive in that they have a history of misconduct in the general prison population. A study of the inmates in Attica's STP illustrates the serious nature of their psychiatric and behavioral problems:⁸⁸ two-thirds had a history of suicide attempts or acts of self-harm and more

⁸⁶ *Eng, et al., v. Goord, et al.*, 80-CV-385S, USDC WDNY (1980).

⁸⁷ The term "disturbed/disruptive" was coined by psychologist Hans Toch, Distinguished Professor, SUNY-Albany, in a study of 10,000 inmates in the New York State prison system. Toch, Hans, "The Disturbed Disruptive Inmate. Where Does the Bus Stop?" *Journal of Psychiatry and Law*, Fall 1982, 327-349.

⁸⁸ Way, Bruce B., Robin Nash, Lisa Trapasso, *Attica Special Treatment Program (STP) for Mentally Ill inmates in Special Housing Units*, Preliminary Report, New York: Central New York Psychiatric Center, October 2, 2002, 2.

than half had been admitted to a psychiatric hospital on three or more occasions. STP participants had accumulated an average of 43 disciplinary tickets in the five years prior to joining the STP, and had an average of 2.4 years *remaining* on their SHU sentence when they entered the program.⁸⁹ The majority had been sent to disciplinary lockdown for violent conduct (defined as assault or fighting) in prison.

Mental Health Services

- **STP participants report higher satisfaction with mental health services than non-programmed inmates with mental illness in SHU.**

Overall, we found that inmates in the STP have better access to mental health services than inmates with mental illness in SHUs that do not have an STP.⁹⁰ As the following table illustrates, over half of STP participants feel that they could see a therapist if they had an urgent need, compared to 35% of inmates with mental illness in SHUs without an STP. In addition, more than half of STP inmates described themselves as “equal participants with their therapists” in developing their treatment plans, compared to only 37% of inmates in disciplinary lockdown units without an STP. A greater percentage of STP inmates said that their psychiatrist explained to them how their medication works, and more STP inmates felt that correction officers respected their medical confidentiality than did inmates in disciplinary lockdown without an STP.

Satisfaction Survey (Percent who agree)	Inmates with Mental Illness in SHU with no STP	Inmates with Mental Illness in Attica STP	Inmates with Mental Illness in Five Points STP
I can see a therapist if I have an urgent need.	35%	55%	57%
I was an equal participant with my therapist in developing my treatment plan.	37%	57%	50%
My psychiatrist explained how my medication works and what side effects I might experience.	38%	44%	40%
The groups are a useful part of my treatment.	N/A	50%	86%
The correction officers respect my medical confidentiality.	20%	33%	47%

However, the modest improvements in access to care raise questions about the program’s overall effectiveness. The lower levels of dissatisfaction among inmate participants is not surprising given the richer mental health staffing levels in STPs and regular staff interaction in groups. What *is* surprising is that over 40% of STP inmates said that they could *not* see a therapist if they had an urgent need, that over 50% reported

⁸⁹ This average term far exceeds the average NYS disciplinary confinement sentence of 5 months.

⁹⁰ This finding is based on a comparison of survey responses by inmates with mental illness in Special Housing Units (n=162) conducted as part of this study.

that their psychiatrist did *not* explain to them what medication they were on, and that half of the inmates in the Attica STP said that the therapeutic groups—STP’s key offering—were *not* a useful part of their treatment.

The following section explores these and other program deficiencies.

Treatment in a Punitive Milieu

➤ **The Special Treatment Program is overly restrictive.**

A general problem with STPs is their location in Special Housing Units—prisons within the prison system where inmates are sent as punishment for violating facility rules. This paradigm of punishment undermines the STP’s therapeutic goals. During group and individual therapy sessions, for example, inmates are not only shackled but confined in cages the size and shape of telephone booths to prevent them from touching staff or other inmates. On a basic level, these cages prevent participants from interacting normally with each other, thereby impeding the program’s goal of teaching appropriate social skills. From a psychological perspective, the cages reinforce the notion—in the minds of staff and inmates themselves—that prisoners with mental illness are uniformly violent and cannot control their impulses. “The cages lock a person into the self-identity of violent predator,” said Dr. Gilligan, “the identity that he is so dangerous that he must be locked up like a grizzly bear.”

“How do they expect me to change for the better when they treat me like an animal?” asked an STP participant at Attica. Many inmates we interviewed complained bitterly about being confined in cages during counseling sessions. While some inmates may warrant such restricted movement at one point or another, the uniform use of the cages is unnecessary and counter-therapeutic. It is important to note that cages are not used in maximum-security psychiatric hospitals where individuals deemed mentally ill and dangerous are confined.

Finally, the location of STPs in Special Housing Units goes against empirically established principles of effective treatment programs in correctional settings. Paul Gendreau, a leading researcher in this area, explained how punitive settings obstruct the effectiveness of treatment interventions:

When proponents of sanctions try to justify the use of sanctions as umbrellas under which effective treatment might reside, they minimize the fact that a surround of sanctions can create a miasma in which it is difficult to establish supportive relationships or sustain the predominant use of positive reinforcers vis-à-vis punishers. The offender behavior modification literature is replete with examples of the disastrous consequences that befall programs in which punishment and control are emphasized over all else.⁹¹

⁹¹ Among Gendreau’s principles for effective treatment programs he asserts that services should be intensive, occupying 40% to 70% of the offenders’ time while in the program [STP occupies only 6% of participants’ time] and the program should include positive reinforcers which exceed punishers by at least 4:1. Gendreau, Paul, “The Principles of Effective Intervention with Offenders,” in *Choosing Correctional Options that Work*, ed. Alan T. Harland, California: Sage Publications, 1996, 117-130.

➤ **The repetitive curriculum causes participants to lose interest.**

Although the majority of STP participants will remain in disciplinary housing for more than a year after they enter the STP,⁹² the program's curriculum is limited to a twelve-week cycle. When an inmate completes the program, no other treatment options are available aside from repeating the same curriculum. We interviewed inmates who had been cycled through the STP on three or four occasions, a situation that OMH concluded led to higher rates of absenteeism from group therapy.⁹³

Service Comparison: Attica and Five Points

➤ **Attica's STP received lower satisfaction ratings than Five Points' STP.**

Attica's Special Treatment Program received substantially lower marks in the areas of useful and sufficient therapy than did Five Points' STP. For example, just 30% of STP participants at Attica felt that they receive sufficient therapy, compared to 60% of STP participants at Five Points. In addition, only 50% of Attica inmates reported that the groups are useful, compared to 86% of Five Points' inmates.

The group session we observed at Attica appeared superficial and fragmented. Not only did being placed in cages make it difficult for inmates to hear and see each other during the groups, the bulk of the hour was spent discussing what movie the inmates would rent the next day. Several STP participants reported an over-reliance on movies in lieu of meaningful treatment-oriented discussion. "You don't learn anything; you just watch television," one inmate said. Conversations with staff reinforced our impression that the groups seemed to serve more as a stress-reliever than as a meaningful form of psychological treatment. "It's very hands-off," said a mental health counselor. "The inmates can come here and sleep, or they can come here and 'spin.' They get their time-cut either way."

As an example, the counselor pointed to JM, a balding white man in his mid-30s. JM sat in a cage reading a magazine, despite the handcuffs that made it difficult for him to turn the pages. "He doesn't really like to participate in discussion," the counselor said. "He likes to read *People* and *Time*...he tells us what's going on in the news."

Dr. Gilligan conducted a clinical interview with JM and had serious concerns about his mental state: "JM has an ongoing, unresolved paranoid psychosis. He has a

⁹² A study by DOCS and OMH officials showed that STP inmates have an average of 2.4 years remaining on their disciplinary sentences when they enter the program. Inmates receive up to one day off their disciplinary time for every day they participate in the program. Therefore, the majority of inmates will serve *at least* a year more in disciplinary housing from the time they enter the program. Many will serve more than a year. Clair, Scott, Lisa Trapasso, *Specialized Treatment Program: Attica Correctional Facility*, Quarterly Report, New York: Central New York Psychiatric Center, May 28, 2002-August 16, 2002.

⁹³ *Ibid.* This evaluation report illustrated that a substantial number of inmates admitted to the Special Treatment Program choose not to participate. During the sixth cycle of the program, only half of the inmates attended in more than 50% of the sessions.

chronic suicidal complex. He belongs in a place where there will be more psychiatric help available. The ‘treatment’ he receives here barely scratches the surface.”

When viewed through the lens of mental health treatment, Attica’s STP appeared grossly inadequate. In his evaluation of the program, Dr. Gilligan concluded:

The STP is a wasted opportunity. Therapy groups in cages where inmates have the most superficial or abstract conversations are inadequate. The inmates say it is good—well, it is better than nothing. It helps normalize people but it is superficial, akin to putting band-aids on hemorrhages. The mental health staff are papering over a smoldering volcano while the prison system is endangering public safety by not preparing these very disturbed individuals for release.

In contrast, many inmates at Five Points expressed relief at finally receiving the help they needed to cope with their illness. Despite their lengthy disciplinary records and severe mental illnesses, most men in the program appeared much calmer and more coherent than their peers in SHUs without STPs. One inmate we interviewed had spent several years in the SHU and reported that he had been suicidal and violent before he joined the STP. He told us that the STP helped him gain insight into his illness and control his behavior. Another inmate said that the STP, his first experience with any type of therapy in prison, helped him control his suicidal impulses: “[The STP] is saving my life,” he said. “I’m highly suicidal and they have been able to work with me so that I stop thinking about it. Group therapy is important, but what really helps me is the one-on-one time with the therapist. I’ve never done that before and it’s been instrumental in helping me with my suicidal tendencies.”

A staff researcher documented the following about a prisoner with schizophrenia who reported drastic improvement after joining Five Points’ STP:

The first time that two giant spiders told KM to kill a fellow inmate, he ignored them. KM, a 33-year-old paranoid schizophrenic with a long history of hallucinations, had just arrived in prison and wanted to do his time as peacefully as possible. But then an inmate stabbed KM in the prison yard, carving an eight-inch gash from his earlobe to his Adam’s apple. This inmate was the same individual that KM said his hallucinations had ordered him to kill. “After that,” he explained, “when the spiders told me to hurt someone, I listened.”

In conversation, KM is intelligent and friendly. He is college-educated, interested in aerodynamics and showed me a detailed model airplane he constructed of toilet paper tubes and scotch tape. His disciplinary record paints a different picture: a series of assaults, fights and disruptive behavior – including burning his own cell – that have kept him in SHU for over five years. During this time, the medication he was given did little for his hallucinations, and even less for his feelings of anger and abandonment.

Things started to improve, he says, when he joined the STP at Five Points. For the first time in his life, he said, he has a place where he can talk about his feelings and learn about his mental illness. The insight and understanding he gained helps him manage the hallucinations. “Now, when the spiders come,” he said, “I pretend they’re just cartoons.”

Untreated Inmates

The key problem with the STP is that it has the capacity to treat only 43 of the 480 individuals with serious mental illness in New York's Special Housing Units. During our visit to the STP at Five Points, we interviewed 10 of the 12 prisoners housed in a special cellblock for inmates who had been transferred to the facility to participate in the STP, but who were ultimately deemed inappropriate candidates. Some inmates had been admitted to the program and then terminated; others had never been admitted and were left languishing in the cellblock, which the superintendent referred to as the "STP kick-out" unit. Most inmates cited an *urgent* need for mental health services; some were too ill to even ask for mental health care. A Correctional Association staff member reported the following cases:

- FB understood my questions and provided clear answers, though he mixed up words and had a repetitive speech pattern. He is 48 years old and 260 lbs. He has a congenital heart condition, casts on his hand and foot, and thick purple scars on his neck and stomach from bypass surgery he underwent in prison. He was sentenced to 20 years to life for assault in the first degree and says that he will die in prison. He's serving a five-year SHU sentence and has accumulated "about 100" tickets in the SHU, for which he owes the state \$500. Before he got to Five Points, he was on the restricted diet for making a sexual comment about a female CO. He is a diabetic, and after his blood sugar dropped precipitously, they took him off the restricted diet. At Five Points, he was put back on the loaf but refused to eat it. FB said he "loves" his therapist. He speaks to her privately once a week for half an hour. He is taking medication, has received mental health services in the community and been psychiatrically hospitalized. FB said he "very much" wants to be in the STP, but staff claims that his mental health level is not high enough.
- AR has been in SHU for eight months and has another 11 months on his prison sentence before he is released. He will max out of the SHU and return to the community after a year-and-a-half of 23-hour isolation. AR was previously double-celled in the SHU at Upstate Correctional Facility and was not on the mental health caseload, he said, until he fought with his six-foot tall cellmate and "stomped" him into a coma. He received 24 tickets during the last year-and-a-half in SHU. When asked about mental health services, he stated: "If I wanted to see a mental health staff I'd tell them I'm hanging up. If you don't threaten to hurt yourself, you're not seeing anybody." He added that mental health staff do not conduct regular rounds and he feels that they don't listen to him. AR has been to CNYPC and spent a few weeks at Bellevue Psychiatric hospital when he was 14. He once attempted suicide. He said he wants to be in STP but they tell him he doesn't have a long enough history of mental health problems.
- DS was so disoriented that I had to repeat most of my questions and simplify the language. He said that he liked it better at Southport because he could meet the therapist in private. Although he had been moved to Five Points to attend the STP, he said he did not know what STP was.
- BH, aged 45, was highly delusional. Of the 15 years of his incarceration, he has spent 13 years "in the hole." He suffers from schizophrenia and bipolar disorder and briefly participated in the STP before he was removed from the program. He showed me his arms, covered with scars from self-mutilation, and a five-inch scar on his neck from when he slashed his own throat in a suicide attempt. "The officers rape me and beat me because I know too much," he said. "I hear voices telling me to kill myself." BH spends most of his time writing letters to Ruth Bader Ginsberg, Hillary Clinton, the FBI and the Department of Justice. He believes the officers are after him because of who he knows, and he rarely leaves his cell for showers or recreation. When I asked if he had sought mental health counseling, he stated, "I have no faith in nobody. My mind is constantly on being beaten to death. I've been beaten so much I feel like there's an officer in that shower waiting to press a button to call ten more officers in there to beat me to death."

VII. LEAVING THE SYSTEM: DISCHARGE PLANNING

Each year, approximately 3,000 inmates with mental illness are released from New York State prisons. The majority return to New York City with a two-week supply of medication, a referral to a shelter if they are homeless, and minimal supervision from a parole officer with a caseload of over a hundred ex-prisoners. Throughout our research, OMH staff and discharge planners expressed grave concern over the system's lack of resources to effectively plan for the release of individuals with serious mental illness and for their successful reintegration into the community. A discharge planner at Green Haven commented: "We have men who can't even fill out the paperwork or remember their own birthday who are being released on five or six psych meds alone, with no family, no work history and nowhere to live. How are they going to make it?"

Inadequate Community Housing and Support

Many offenders with mental illness do not fare well on the outside. A study of inmates with mental illness leaving New York State prisons in 1991 revealed that 64% were rearrested within eighteen months.⁹⁴ Attesting to the importance of housing, a University of Pennsylvania study showed that providing supportive housing and services to individuals with mental illness after their release significantly reduces their rate of return to prison.⁹⁵ Unfortunately, many ex-offenders with mental illness do not have housing. In 2000, about half of the prisoners with serious mental illness released from New York State prisons were homeless.⁹⁶ Research shows that prisoners with mental illness are more than twice as likely as other inmates to have been living on the street or in a shelter prior to their arrest (20% compared to 9%).⁹⁷ Our discussions with discharge planners revealed that even inmates who have family on the outside often have nowhere to go because their family is reluctant to take them in. "For a lot of these guys, their family is burned out on them," a mental health worker at Clinton said.

While OMH staff consistently reported a need for more discharge planners in prison, they also emphasized that more community resources were critical. A

⁹⁴ Feder, Lynette, "A Comparison of the Community Adjustment of Mentally Ill Offenders with Those from the General Prison Population (An 18-Month Follow-up)," *Law and Human Behavior*, vol. 15, 1997.

⁹⁵ Cullhane, Dennis, *University of Pennsylvania New York/New York Cost Study*, University of Pennsylvania: Center for Mental Health Policy and Services Research, 2001.

⁹⁶ Smith, Hal, Donald A. Sawyer and Bruce B. Way, "Correctional Mental Health Services in New York: Then and Now," *Psychiatric Quarterly*, vol. 75, No. 1, Spring 2004.

⁹⁷ National Resource Center on Homelessness and Mental Illness, *Get the Facts*, March 17, 2003.

psychologist at Mid-State said: “Discharge planning is poor and so is the follow-up. Linkages between discharge planning in the prison system and parole are getting better, but people still have trouble accessing follow-up care in the community.”

Insufficient Discharge Planners

OMH staff cited the lack of discharge planners in the prisons as a serious deficiency. Although 25 new discharge planner positions were added between 1998 and 2002, most of the mental health staff we spoke with felt that far more were needed. A mental health unit chief explained: “We received a number of new discharge coordinator items a few years ago, but they’re no longer dedicated items. The discharge coordinators have their own caseload to manage, but many are also responsible for inmates in an entire HUB, not just a single prison. More discharge coordinators would allow for more comprehensive planning.”

In addition, staff reported that recent efforts to enhance discharge planning, such as the Community Orientation Re-Entry Program that opened in Sing Sing in 2003 (see description below), do not meet the needs of the population. “Our dream was to open a transitional skills center at CNYPC for every seriously mentally ill inmate leaving the system,” said a former CNYPC psychologist. “Now they’re opening up one at Sing Sing, which is good, but it’s only 31 beds. That’s not nearly enough.”

Delays in Receiving Medicaid and SSI Benefits

Most prisoners with mental illness need Medicaid and SSI benefits in order to obtain medication and treatment in the community upon release. Federal law requires automatic termination of SSI benefits after a person is incarcerated for over a year, so prisoners who need the benefits must complete a lengthy application before they are released. Many inmates will not know whether they have been approved for SSI when they leave prison, and if they are homeless upon release, chances are they will never know if they have been approved. Some inmates turn to public assistance and Medicaid, but in New York, as in other states, it takes a minimum of forty-five days to activate these benefits. In the interim, continuity of care is virtually impossible.⁹⁸

Effective Discharge and Re-entry Programs in Need of Expansion

State officials recently implemented two comprehensive discharge planning programs for inmates with serious mental illness. However, in the course of our research, it became clear that the programs are grossly inadequate in terms of space, staffing and resources to accommodate the large population of inmates with mental illness being released every year. Following are brief descriptions of these programs.

⁹⁸ Abramsky, Sasha, Jamie Fellner, *Ill Equipped: U.S. Prisons and Offenders with Mental Illness*, New York: Human Rights Watch, 2003, 196.

➤ **Community Orientation Re-Entry Program (CORP)**

The Community Orientation Re-Entry Program (CORP) is a new transitional program for inmates with serious mental illness who are within four months of their release date. The CORP unit opened at Sing Sing with 31 beds in the spring of 2003. The unit is expected to serve 100 to 125 inmates each year, providing them concerted discharge planning during the final months of their incarceration. Under the auspices of CORP, the following agencies work together to connect inmates with resources in the community, including supportive housing: Division of Parole; DOCS; OMH; the Osborne Association, a non-profit organization that provides services for people involved in New York's criminal justice system; Project Renewal, a non-profit organization that provides services to homeless individuals and ex-offenders with mental illness or histories of substance abuse; and HALI (Hands Across Long Island), a non-profit organization that provides services to individuals with mental illness.

Staff from the Osborne Association's Safe Landing Project work inside CORP to create discharge plans and aftercare services. Program staff develop transitional plans for each inmate and work with them for at least one year after release. Transitional plans include strategies for finding and sustaining needed mental health treatment in the community, including psychotropic medication; securing the financial means to sustain medical intervention (primarily through Medicaid, especially in the first year after release); rebuilding family ties, including securing a stable residence, reaching out to alienated family members and developing parenting skills; attaining economic self-sufficiency, including post-release vocational training and job placement services or, if appropriate, public assistance or disability payments; and maintaining general health, including evaluation and treatment for illness or chronic conditions, and participating in relapse prevention and substance abuse treatment.

In addition, Safe Landing offers peer support for inmates leaving the system. Inmates are paired with trained peer mentors and encouraged to participate in weekly support and educational groups for former prisoners. Participants also have access to Osborne's drug treatment and job training programs.

CORP participants also have expedited access to community entitlements including: medication grants for prescription psychotropic medications and dedicated community beds funded by the Division of Parole.⁹⁹ Ultimately, the goal of the program is to provide individuals with eighteen months of intensive planning and post-release case management to facilitate their successful transition to the community.

⁹⁹ *Joint Statements of Glenn S. Goord, Commissioner, New York State Department of Correctional Services, and Sharon E. Carpinello, Acting Commissioner, New York State Office of Mental Health, to the Assembly Committees on Correction and Mental Health, Mental Retardation and Developmental Disabilities, on The Disciplinary Confinement and Treatment of Inmates with Serious Mental Illness, January 13, 2004.*

➤ **Project Renewal**

Project Renewal is a New York City-based nonprofit organization that provides a range of services to ex-offenders and individuals who are homeless, suffer from mental illness or have histories of substance abuse. The Parole Support and Treatment Program (PSTP) is a joint effort between Project Renewal, OMH and the Division of Parole. PSTP provides 50 units of transitional, supportive housing in the community and intensive clinical services to newly released parolees who suffer from serious and persistent mental illness and co-occurring substance abuse disorders. During their time in the transitional program, parolees work with the clinical team to secure permanent housing in community residences or city-subsidized apartments. Studies show that homeless individuals with mental illness who receive supportive housing are more than twice as likely to obtain permanent housing within a year, as opposed to those who do not receive transitional assistance.¹⁰⁰

Clearly, these programs are steps in the right direction. However, the 31 program slots available in Sing Sing's CORP unit and the 50 beds available in the Parole Support and Treatment Program are inadequate to accommodate the approximately 3,000 inmates with mental illness who are discharged from New York's prisons each year.

¹⁰⁰ *Criminal Justice/Mental Health Consensus Project*, Council of State Governments, June 2002, 167.

VIII. MODELS FROM OTHER JURISDICTIONS

We identified the following models based on a review of the literature for programs that had been empirically validated and recommendations of experts in the field. In the case of Colorado's San Carlos Correctional Facility, we spent a day touring the institution and interviewing inmates and staff. The collaboration between San Carlos's mental health counselors and correction officers illustrates the valuable role that security staff can play in the treatment and supportive supervision of inmates with mental illness.

With regard to Louisiana's Phoenix Project, we canceled a plan to visit when the program was unexpectedly closed due to budget cuts. We are including a description of it here, however, due to its uniqueness and demonstrated results.¹⁰¹ The Phoenix Project shows what is possible when treatment is emphasized over punishment in handling the system's most difficult-to-manage inmates.

To better understand the Federal Bureau of Prison's use of Dialectal Behavioral Therapy, a new and highly effective form of treatment for inmates with Borderline or Antisocial Personality Disorder,¹⁰² a former project staff member visited the program in Springfield, Missouri and conducted extensive interviews with inmates and staff.

Each of the programs described below has the potential to be replicated in New York State prisons and other correctional facilities.

Colorado DOC: Correction Officers As Case Managers

Inmates in the Colorado prison system who need long-term psychiatric care are sent to San Carlos Correctional Facility, a modern, 255-bed facility about 2½ hours south of Denver. There, inmates participate in a wide range of therapeutic programs and activities, from group and individual psychotherapy to recreation, life skills and substance abuse groups and academic and vocational classes. The staff at San Carlos is comprised of 3 psychiatrists, 3 psychologists, 9 social workers, 26 nurses and 118 correction officers who receive specialized training on how to manage inmates with

¹⁰¹ Tucker, Susan, David Cosio, Lotus Meshreki, "The Phoenix Project: Reducing Recidivism Using a Cognitive-Behavioral Program," *Corrections Compendium*, March 2003, 23-24.

¹⁰² Individuals with Borderline Personality Disorder, a mental illness listed in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), suffer from rapidly shifting emotions, depression, anger, self-hatred and hopelessness. They have high rates of suicide and self-mutilation and are among the most frequent users of inpatient psychiatric services. Anti-Social Personality Disorder, a DSM-IV personality disorder, is described as a pervasive pattern of disregard for and violation of societal norms that begins in childhood or early adolescence and continues into adulthood. It is characterized by callousness, a lack of empathy, manipulative behavior and aggression.

mental illness. It costs about \$110 per day to house a prisoner in San Carlos (two to three times the amount for inmates at other Colorado prisons but significantly less than the \$252 per day for inpatient care at a forensic psychiatric hospital).¹⁰³ The average length of stay is eight months.

We visited San Carlos Correctional Facility in August 2003 and interviewed inmates and staff. The inmates spoke highly of the clinical and correctional staff and the quality of mental health care they receive. Their leading complaint, similar to that of inmates in New York's CNYPC and the ICPs, was that they could not reside permanently at San Carlos while serving their prison sentence but would instead be returned to the general prison population.

A particularly impressive aspect of San Carlos is the collaborative partnership between clinical and correctional staff and the ways in which all staff—correction officers, teachers, psychologists, nurses and social workers—work together to treat inmates with serious mental illness. Unlike most correctional facilities, where a sharp divide exists between clinical and correctional staff, employees at San Carlos “work together in a multi-disciplinary team approach,” said Pat Shiner, public information officer for the Colorado Department of Corrections. Every correction officer, for instance, carries a caseload of three inmates. Officers are expected to converse and interact regularly with inmates, submit written progress notes on their adjustment, attitude and behavior, and serve on clinical treatment teams. They also work with inmates on interpersonal skills and hygiene issues. “The involvement of officers is absolutely essential,” says Shiner. “They are the ones who spend the most time with the inmates. We would be missing an important resource if we only used our correction officers to provide security.”

Likewise, non-security staff including teachers, counselors and clinicians perform traditionally security-related tasks. A psychologist, for example, might participate in a facility search for contraband; the librarian not only checks out books but pat frisks inmates when they leave the library and escorts them to their housing unit. Shiner reports that this type of job-crossover maximizes the resources of a limited number of staff and results in more attention paid to the inmates. “It is not unusual to find 200 ‘inmate contacts’ (consultations) per month in an inmate’s mental health records,” a staff psychologist told us. The involvement and observations of many different staff members ensure that individuals do not fall through the cracks, said Shiner, and reduce the bias that can come with a single clinical perspective.

All staff receive training in both security and clinical issues. “Whether they are officers, nurses or kitchen staff, everyone here is working in a prison with inmates and we all need to be trained—not just the officers—so that we’re aware of and can respond to the situations that arise in this environment,” a nurse explained. Training in security-related issues makes civilian staff aware of corrections protocols, which makes them better able to assist officers. Likewise, officers receive training on suicide prevention,

¹⁰³ Bowers, Karen, “The Committed,” *Westword*, July 25, 1996.

CPR, first aid, and the symptomatology of mental illness, preparing them to assist in the treatment and rehabilitation of inmates on their caseload.

Louisiana DOC: Treatment for Disturbed/Disruptive Inmates

Prior to its closing, Louisiana's Phoenix Project provided enhanced mental health services to inmates in disciplinary confinement and a time-cut off their disciplinary sentence in return for participation and good behavior. While similar to New York's Special Treatment Program, the Phoenix Project was more intensive and less restrictive.

According to Dr. Susan Tucker, clinical director of the Mental Health Department at the Clinical Treatment Unit in Keithville, Louisiana, where she developed and launched the Phoenix Project in 2001, inmates learned behavior modification skills in order to successfully reintegrate into the general prison population. The program consisted of approximately six months of group and individual therapy while the inmates resided in disciplinary housing and six months of after-care services once the prisoners returned to general population.

Prior to participating in the Phoenix Project, most of the inmates had served multiple and lengthy sentences in disciplinary confinement and were diagnosed with Antisocial Personality Disorder. Participation was voluntary, and each inmate had to sign a contract agreeing to follow program rules. Upon admission, counselors helped inmates develop treatment plans with realistic goals. "For many of the inmates, the number one problem they needed to address was dealing with their anger," reported Dr. Tucker. "By the end of the program, most had developed skills to talk about and deal with their anger instead of lashing out. We made sure that the participants not only understood these skills but were able to demonstrate them in their interactions with staff and other inmates."

Phoenix Project inmates resided in a secure unit and progressed through three treatment levels, spending a minimum of 45 days on each. As they moved from Level I (the most restrictive level) to Level III, they earned additional commissary, visiting privileges and out-of-cell time. While Level I inmates were only permitted to leave their cells for treatment groups and two hours of recreation a day, Level III inmates could participate in academic and vocational programs with general population inmates.

Inmates at all levels received four to five hours of group therapy *daily*, without being confined in cages or shackles. (In New York, inmates in the comparable Special Treatment Program receive one to two hours a day of group therapy in individual cages.) According to Dr. Tucker, there were no fights or assaults on the unit during the two years that the program was offered. "We emphasized to everyone that the program was about respect and a commitment to refrain from violence. Developing a sense of trust is important in treating this population," she added. "I think that by allowing the men to participate in therapy without restraints or handcuffs communicated that we trusted them, and that respect goes both ways."

After successfully completing the six-month program, inmates returned to general population regardless of how much time remained on their disciplinary sentence. (In comparison, inmates in New York's Special Treatment Program recycle repeatedly through the 12-week curriculum and receive incremental reductions on their disciplinary sentence.) After returning to general population, program graduates attended twice-weekly aftercare groups for six months with Phoenix Project inmates and staff.

While correction officers provided security, it was mental health staff who ran the program. "We consulted with correction staff as needed," said Dr. Tucker, "but mental health staff had the final say, even when it came to transferring patients off the unit." The correction officers who worked on the unit were required to receive forty hours of training. "I taught them about the major psychiatric diagnoses and how mental illness manifests. We showed them the *Stanford Prison Experiment*¹⁰⁴ and talked about what it means to be a correction officer and how working with inmates affects them."

An evaluation of the program showed positive results.¹⁰⁵ Program graduates matched with a control group in disciplinary confinement revealed significant reductions in rule violations, indicating that even among a prison system's most persistent offenders, change is possible in the context of a well-designed treatment program.

Federal Bureau of Prisons: Reducing Self-Injury and Violence

Dialectical Behavioral Therapy (DBT) is a new form of treatment with demonstrated success in reducing violence, suicide and self-injury among behaviorally-disordered inmates, particularly those with Borderline Personality Disorder and Antisocial Personality Disorder. Historically, treatment for these disorders has been difficult; traditional therapeutic approaches have been considered "marginally effective at best."¹⁰⁶ Recently, however, the Joint Commission on Accreditation of Healthcare Organizations recognized DBT as the only empirically effective treatment for individuals with Antisocial and Borderline Personality Disorder.

DBT involves use of cognitive-behavioral techniques but with close attention to the development and influence of the therapeutic relationship. Patient-therapist collaboration is fostered through the therapist's empathic understanding of the patient's behaviors, experiences and reactions to these experiences. According to DBT practitioners, by not emphasizing patient validation throughout treatment, many

¹⁰⁴ A 1971 psychological study conducted at Stanford University that simulated prison life by randomly assigning college students to the roles of correction officer and inmate. The study ended prematurely, after only six days, when the student-correction officers exhibited sadistic behaviors and the student-inmates displayed signs of extreme stress.

¹⁰⁵ Tucker, Susan, David Cosio, Lotus Meshreki, "The Phoenix Project: Reducing Recidivism Using a Cognitive-Behavioral Program," *Corrections Compendium*, March 2003, 23-24.

¹⁰⁶ McCann, Robin A., Elissa M. Ball, Andre Ivanoff, *DBT with an Inpatient Forensic Population: The CMHIP Forensic Model*, Association for Advancement of Behavioral Therapy, 2000, 450-451.

psychotherapists effectively blame the patient, which undermines the therapeutic process.¹⁰⁷

The program consists of individual and structured group therapy, during which offenders document their behaviors and identify precipitating events, alternative solutions and prevention plans. Group sessions focus on such topics as distress tolerance, emotion regulation, “mindfulness” and interpersonal effectiveness. Proficiencies are tested through written assignments, effectiveness of skill utilization, and an oral examination with the treatment team.

Over the past several years, DBT programs have opened in approximately 30 prisons and forensic facilities throughout the country. In 2001, the Federal Bureau of Prisons started a DBT program at the U.S. Medical Center in Springfield, Missouri to target self-injurious behavior and suicide attempts among a notoriously treatment-resistant group of inmates.

“We accepted the worst self-mutilators in the federal system,” said Program Coordinator Dr. Georgina Ashlock. “The inmates we initially accepted had a combined total of 1,192 incident reports over the course of their incarceration and numerous incidents of self-harm. During the first year of the program we saw their rate of incident reports go down, and no incidents of serious self-harm.”

The approximately 40 inmates now in the program live in the general prison population and attend DBT groups two to four times per week in addition to receiving brief individual therapy sessions and meeting with the team to review their progress. They are taught to stop self-destructive and violent behavior, improve decision-making and communication skills and learn self-awareness. “The emphasis in DBT is not on simply rewarding good behavior and punishing bad behavior. It’s about teaching inmates to understand their actions and giving them new skills to develop healthier responses and coping strategies,” Dr. Ashlock explained.

U.S. Medical Center’s Warden, Bill Hedrick, has been an ardent supporter of DBT since the program’s inception. His experience as warden at U.S.P. Marion, a federal supermax where inmates are locked down 23-hours a day, convinced him that intensive treatment for the system’s most difficult to manage inmates was critical. “There was a revolving door between our penitentiaries and the hospital among inmates with personality disorders. They were clogging up the disciplinary housing units because of their behavior, getting infraction after infraction. We would transfer them to the hospital, and they would get better, but only because of the change of environment. And once they were sent back to the penitentiary, they would decompensate. I knew we needed to break this cycle.”

Dr. Ashlock and Warden Hedrick said that correction officers, nurses, and mental health staff initially opposed the program. “People don’t like personality-disordered

¹⁰⁷ Linehan, M. *Cognitive-Behavioral Treatment of Borderline Personality Disorder*, 1993, New York, NY: Guilford Press.

inmates,” said Dr. Ashlock. Some staff felt that the program would take time and resources away from other mental health services and were skeptical that DBT would work. “We had a lot of meetings, explaining to staff exactly what we were going to do,” Warden Hedrick said. In addition, Dr. Ashlock made space on their website for staff to post concerns and ask questions about the program.

“The message we tried to communicate,” said Warden Hedrick, “is that there is an economic payoff as well as a ‘staff sanity’ benefit in meeting this problem head on. It’s better than ignoring it and watching our costs continue to go up.” Treatment programs which target self-injurious, aggressive, and suicidal behavior also improve the safety and security of institutions by reducing staff contact with blood and bodily fluids, assaults on staff and inmates, and the frequency of running to emergencies and physically restraining inmates, all activities which often result in injuries to staff.

The warden gave an example of a DBT success story—an inmate with repeated psychiatric hospitalizations. He was, said Hedrick, “the type of person that if he didn’t get his way, he would hurt himself. He would puncture himself in the stomach and then stick things in the wound once he got sewn up. He did this for years and had drug-seeking behaviors on top of that. But once he got into the program, he turned completely around. He gained insight—that it’s not a good thing to cut yourself and stick things in the wounds. He hasn’t hurt himself in over two years.”

IX. RECOMMENDATIONS

Reducing the number of individuals with mental illness behind bars is the first and perhaps most important step to reforming mental health care in the New York State prison system. A well-funded network of community-based treatment and supportive housing is essential in this regard. Studies have shown that supportive housing for individuals with mental illness saves money through decreased use of emergency health care services and reduced arrest and recidivism rates.¹⁰⁸ Since 1995, New York State Governor George E. Pataki has increased community treatment beds by 60%. In his 2004-05 budget, the Governor wisely included an additional 5,000 beds for community-based housing. We fully support this proposal.

As long as New York State prisons continue to house a substantial number of individuals with mental illness, it is critical to provide the resources necessary to treat them. The high-quality care we observed at Central New York Psychiatric Center and in the Intermediate Care Programs shows what is possible when sufficient resources are provided. Governor Pataki's 2004-05 budget recognizes the need for increased staff and treatment programs for inmates with mental illness. The Governor has called for the addition of 66 full-time clinicians, 87 beds in Intermediate Care Programs, 75 beds in the Special Treatment Program and the creation of two Behavioral Health Units with 102 beds to divert prisoners with serious mental illness from 23-hour disciplinary lockdown. We endorse these proposals and also make the following recommendations:

1. INPATIENT CAPACITY

- **Expand Central New York Psychiatric Center to its full 350-bed capacity.** The New York State prison system currently has one of the lowest inpatient bed-per-inmate ratios in the country¹⁰⁹ and a high patient return rate to the psychiatric hospital: 65% of inmates discharged from the hospital decompensate in prison and are re-hospitalized within a year. Staffing and expanding Central New York Psychiatric Center from 206 beds to its full 350-bed capacity would allow more inmates to be admitted and to stay longer, thereby maximizing their potential for long-term recovery.
- **Expand the Intermediate Care Program (ICP) and place new units in medium-security prisons.** With 3,200 inmates suffering from a major mental disorder and only 534 ICP beds, the Governor's proposal for another 87 beds is

¹⁰⁸ Cullhane, Dennis, *University of Pennsylvania New York/New York Cost Study*, University of Pennsylvania: Center for Mental Health Policy and Services Research, 2001.

¹⁰⁹ Smith, Hal, *NYS OMH Task Force on the Future of Forensic Services: Report of the Subcommittee on Prison Mental Health Services*, New York: January 31, 1997.

insufficient. Moreover, any new units that are built should be located in medium-security prisons so that inmates with lower security classifications can be more appropriately housed in a less restrictive environment.

- **Provide more beds for prisoners with serious mental illness who are currently housed in 23-hour lockdown.** As of December 2003, there were 480 inmates with serious mental illness confined in Special Housing Units. The Governor's proposal for 102 beds in Behavioral Health Units and an additional 75 beds in Special Treatment Programs are steps in the right direction. However, in light of the 480 inmates in need, significantly more beds should be added.
- **Correct deficiencies in the Special Treatment Program (STP).** In the new STPs proposed by the Governor, the counter-therapeutic "bird cages" used to confine inmates during counseling sessions should be eliminated. Patients in secure psychiatric facilities with histories of violent behavior are not shackled and confined in cages during group therapy, or at any other time unless they exhibit seriously dangerous behavior. In addition, the 12-week STP curriculum should be expanded to accommodate the many inmates who stay in the program longer, and Dialectical Behavioral Therapy should be considered as a treatment modality in STPs given its demonstrated success with disturbed/disruptive inmates. Finally, inmates should be able to have (or earn) more than two hours a day out of their cells.

2. DISCIPLINARY LOCKDOWN

- **Enact legislation that prohibits confining inmates with mental illness in 23-hour lockdown.** Research has shown and the courts have confirmed that 23-hour lockdown is inappropriate and inhumane for individuals suffering from mental illness. Lawsuits in a growing number of states have forced Departments of Correction to provide more humane housing for inmates with mental illness and to keep them out of isolated segregation. New York policymakers should pursue remedies on their own, before current litigation mandates those remedies and millions of taxpayer dollars are spent on protracted litigation. The Governor and the Legislature should endorse Bill A-8849 introduced by Assemblymember Jeffrion Aubry, Chair of the Corrections Committee, which prohibits housing inmates with serious mental illness in 23-hour lockdown and establishes standards for alternative therapeutic housing.
- **Restrict the use of disciplinary lockdown to inmates who commit the most serious offenses.** The National Institute of Corrections asserts that 23-hour lockdown is inappropriate for the "nuisance inmate." Given the psychological damage that isolated confinement is known to cause, DOCS should limit the use of long-term disciplinary lockdown to the most serious cases.
- **Provide anger management, self-help and educational programs through Closed-Circuit TV (CCTV).** The chronic idleness experienced by inmates in 23-

hour lockdown exacerbates mental illness, stress and depression. Moreover, simply confining inmates in their cells wastes a vital opportunity for therapeutic intervention. DOCS should use the existing technology for CCTV in the S-Blocks and Upstate Correctional Facility to provide programs for inmates in disciplinary confinement.

- **Provide intercoms in cells so inmates can contact staff in cases of emergency.** The majority of inmates we interviewed expressed little confidence that staff would arrive promptly in cases of emergency. Given the higher rate of suicide in lockdown, the isolation of many inmates behind thick metal doors and the documented instances of neglect, DOCS would be wise to equip all cells in 23-hour lockdown with intercoms. The Colorado Department of Corrections provides intercoms in the cells of its central supermax prison (Colorado State Penitentiary). Since the facility opened in 1993, there have been no suicides.
- **End the routine practice of extending inmates' time in lockdown for violating rules.** For inmates with serious mental illness who have difficulty controlling their behavior, a six-month sentence to SHU can easily turn into a sentence of several years or more, as DOCS extends inmates' time in SHU for continued misbehavior. At one SHU we visited, a prisoner with mental illness had his sentence to lockdown extended to 35 years for repeated rule violations. Given the harmful psychological effects of solitary confinement, DOCS should extend SHU sentences only in the most egregious cases. It should identify incentives to promote rule-abiding behavior rather than simply extending one's time in lockdown.
- **Provide incentives to outdoor recreation.** The National Commission of Correctional Health Care states that recreation is especially important to inmates with mental illness in that it reduces stress and helps control anxiety, nervousness, manic episodes and depression. Sadly, nearly one-half of the inmates with mental illness in our study reported that they "never or rarely" go to recreation—the one opportunity they have to leave their cells and breathe fresh air. The Department should encourage inmates to attend recreation by providing exercise equipment such as chin-up bars or basketballs in rec cages, and permit inmates to wear gloves and hats during winter.

3. STAFFING AND TRAINING

- **Increase the number of clinical staff and fill system-wide vacancies.** Over the past decade, increases in mental health staff have not kept pace with the burgeoning mental health caseload in New York's prisons. The addition of 66 full-time clinicians to staff the new units proposed by the Governor is a necessary and positive step. However, more staff are needed to fill system-wide vacancies. As of November 2002, approximately 20% of mental health positions were vacant system-wide, including 35% of psychiatrists, 25% of psychologists and 11% of nurses.

- **Recruit more Spanish-speaking mental health staff.** The facilities with the highest concentration of Spanish-dominant inmates (located in the Clinton and Wende hubs) have the fewest number of Spanish-speaking mental health staff. Correction officers or other inmates are used as translators, a practice that violates confidentiality, puts inmates at risk and discourages prisoners from seeking help.
- **Increase training for correction officers.** Correction officers uniformly reported that the mental health training they receive in the Academy is insufficient, and that they are rarely able to participate in annual in-service training due to staffing shortages in the prisons. Research indicates that many correction officers are highly motivated to obtain additional training in working with inmates with mental illness. DOCS and OMH should ensure that all line staff, particularly officers who work in residential mental health treatment programs, receive the clinical training they need to safely and effectively supervise the inmates in their care.
- **Improve communication between correctional line staff and clinical staff.** A common frustration among correction officers was the clinical staff's lack of interest in their observations. During our site visits, it was not uncommon for correction officers to lead us to inmates who had mentally deteriorated and to ask us to contact mental health staff since their efforts had failed. Mental health staff should seek out officers' opinions and actively listen and respond when officers share their observations.
- **Include correction officers on treatment teams.** Correction officers who have been trained to work in mental health units should have input into treatment teams (also known as case management committees).

4. QUALITY ASSURANCE AND OVERSIGHT

- **Create a permanent, independent oversight board comprised of psychiatrists, psychologists and correctional experts to monitor conditions in mental health units and disciplinary lockdown.** The oversight board should be authorized and required by the legislature to make regular, unannounced inspections, investigate complaints, evaluate compliance with directives and report findings and recommendations annually to the legislature and the public. Inmates with mental illness are the most vulnerable and marginalized individuals in the prison system; mandatory oversight of their care by outside experts is critical.
- **Increase monitoring by legislators and judges.** New York's prisons are public institutions that consume over two billion dollars of taxpayer money annually. Their operations should be more open to public scrutiny. New York State legislators, specifically members of the Assembly's Committee on Corrections and the Senate's Committee on Crime, Crime Victims and Corrections, as well as

New York State judges, should make better use of their statutory authority to inspect prisons and speak confidentially with correction officers and inmates.

- **Review all inmate suicide reports published by the New York State Commission of Correction and implement Commission recommendations.** The Commission of Correction (a government oversight agency) investigates all inmate suicides and issues detailed reports of findings and recommendations. The Commission's carefully considered recommendations often go unheeded, however, because no entity monitors or requires their implementation. An independent oversight board and/or the Governor's Director of Criminal Justice should review all reports published by the Commission and hold DOCS and OMH accountable for making necessary reforms.
- **Require nurses to conduct evening rounds in the cellblocks of maximum-security prisons and other areas where inmates with mental illness are concentrated.** Regular rounds by nurses can help identify neglected inmates and ensure better access to care.
- **Create positions for Inmate Program Assistants to serve as "buddies" to inmates on the mental health caseload.** Using Inmate Program Assistants to aid special needs inmates is a low-cost way to enhance both support for vulnerable prisoners and oversight of their care and treatment.

5. SUICIDE PREVENTION AND CRISIS TREATMENT

- **Institute a suicide prevention program in every 23-hour lockdown unit.** Between 1998 and April 2004, 34% of prison suicides occurred in disciplinary lockdown although inmates in these units comprise only less than 7% of the total prison population.¹¹⁰ A properly administered suicide prevention program could mean the difference between life and death.
- **Enhance services in Residential Crisis Treatment Programs.** The majority of RCTPs we visited were empty or under-utilized. OMH should increase staff in these units so that more intensive services, including therapeutic groups and individual counseling, can be provided.
- **Prohibit the practice of disciplining inmates in mental distress or psychosis with tickets and deprivation orders.** Our research identified instances where inmates on suicide watch were punished with the restricted diet of bread and raw cabbage, and prisoners who cut themselves were issued tickets for "committing self-harm." DOCS should prohibit such punitive measures and train security staff in appropriate responses to inmates who engage in this behavior. Punishing psychotic and/or suicidal inmates with deprivation orders, more time in lockdown and a diet of bread and raw cabbage is misguided and cruel.

¹¹⁰ New York State Department of Correctional Services: *Inmate Suicide Report: 1995-2001* and *Inmate Suicides: 2002-April 17, 2004*.

- **Decrease the time inmates spend in observation cells.** Suicidal inmates can be held for days at a time in barren, sometimes dungeon-like observation cells where they receive minimal mental health services before they are transferred to the hospital or back to general population. Mental health staff should limit time in observation cells to no more than 48 hours.
- **Make more use of dorm beds in mental health satellite units and give mental health staff discretion over use of these beds.** Although it is not official policy, suicidal inmates are often held in stark observation cells even when dorm beds are available and more therapeutically appropriate.

6. TREATMENT AND MEDICATION

- **Offer psychotherapeutic groups and classes on such topics as anger management, medication compliance and self-care to inmates in general population.** Aside from monthly appointments with mental health staff, few if any supports exist for inmates with mental illness in the general prison population. Groups facilitated by mental health staff should be offered to general population inmates. The Georgia Department of Corrections found that this practice decreased use of costly psychotropic medication.
- **Implement Dialectical Behavioral Therapy (DBT) for difficult to manage inmates.** DBT is a new and empirically proven program to reduce self-injurious and violent behavior among inmates with both psychiatric and behavioral disorders.
- **Enhance patient education.** Many inmates reported that they did not know what medications they were on, why they were taking them or the potential side effects. Prisoners who are prescribed psychotropic medications should receive verbal and written information about their use and effect in their preferred language.
- **Monitor medication more closely.** Psychotropic medication typically requires adjustment before proper dosage levels and appropriate combinations are achieved. Mental health staff should provide more monitoring, oversight and consultation to inmates on psychiatric medication.

7. STIGMA AND CONFIDENTIALITY

- **Re-design medication delivery procedures to enhance confidentiality.** Facilities should avoid medication delivery procedures that blatantly violate confidentiality, such as announcing “Psych Meds!” over the loudspeaker.
- **Educate inmates about mental illness.** Our research found a significant level of misinformation about mental illness among general population inmates, as well as mistrust of mental health staff and suspicions about medication. Mental health

staff should obtain free pamphlets and videos from pharmaceutical companies and provide information about mental illness and its treatment to any inmate who requests it. These materials can be made available in orientation for new inmates and in prison health care clinics and mental health units.

- **Arrange for members of the Inmate Liaison Committee to meet on a regular basis with mental health staff.** When Sullivan Correctional Facility instituted monthly meetings between the Inmate Liaison Committee and health care staff, medical grievances decreased by 50%. Such meetings afford inmates and staff an opportunity to better understand each other's concerns, to resolve issues and filter the relevant information back to general population prisoners.

8. DISCHARGE PLANNING

- **Expand the Community Orientation and Re-Entry Program (CORP).** Every year, approximately 3,000 inmates with mental illness are discharged from New York State prisons. CORP is a new and innovative program operated by DOCS, OMH, the Division of Parole and community-based providers to provide intensive discharge planning and aftercare services to inmates with serious mental illness. The 31-bed program should be significantly expanded to serve the thousands of inmates on the mental health caseload who are released to society each year.
- **Increase the number of discharge planners.** Mental health staff consistently reported that more discharge planners are needed throughout the system, particularly in maximum-security prisons.
- **Ensure that critical benefits such as SSI and Medicaid begin on the day of release.** Inmates should leave prison with Medicaid cards in hand to avoid lapses in medication, which can easily lead to mental deterioration.

X. APPENDICES

1. EXCERPT OF A LETTER FROM AN INMATE ENTERING PRISON

THE MENTAL HEALTH SYSTEM WITHIN DOWNSTATE IS A BIG PROBLEM BECAUSE YOU HAVE A COMPETENT AND COMMITTED MENTAL HEALTH STAFF WHO PROVIDE SERVICES TO THE INMATES A FEW TIMES A WEEK AND AN OVERBEARING AND UNCARING STAFF OF C.O.'S WHO ~~SEE~~ OVERSEE YOU ALL OF THE TIME. BECAUSE OF MY DIAGNOSIS I WAS GROUPED IN WITH THE MENTAL OBSERVATION UNITS SO I WAS WITH SOME REALLY SICK PEOPLE AND I SAW SOME REALLY BAD TREATMENT IN THE 2 MONTHS I WAS THERE. UPON ARRIVAL YOU STAY LOCKED IN YOUR CELL FOR A WEEK WITH NO RECREATION-THAT'S WHEN I WROTE YOU. THAT'S FOR ALL INMATES NOT JUST ME. ANYWAY, AFTER THAT FIRST WEEK ~~AND~~ I SAW A PSYCHIATRIST WHO CONTINUED MY PRESCRIPTION FOR RESPARADAC, AND TRAZADONE AND ONCE A WEEK I WOULD SEE THE SOCIAL WORKER TO

DISCUSS MY STATE OF MIND. THEY WERE CONCERNED AND SEEMED DEDICATED TO PROVIDING QUALITY CARE. THE THING THAT MADDENED ME THE MOST WAS THAT THOSE OF US WHO REQUIRE MENTAL HEALTH SERVICES HAD TO STAY IN RECEPTION FOR 2 TO 3 MONTHS WHEN OTHERS ONLY SPENT 2 WEEKS AT DOWNSTATE. BECAUSE, I WAS TOLD, THAT THERE ARE ONLY A HANDFUL OF PRISONS WITH MENTAL HEALTH FACILITIES. THE PROBLEM WHICH ARISES AT DOWNSTATE IS THAT YOU HAVE CERTAIN INMATES WHO BELONG IN HOSPITALS NOT PRISONS AND THE C.O.'S DONT KNOW HOW TO DEAL WITH THEM. THE C.O'S ARE VERBALLY ABUSIVE ALOT OF THE TIME AND IF YOUR ACTING STRANGELY EVEN MORE SO.

~~DISCUSS~~ ARTHUR KILL SO FAR HAS BEEN MUCH BETTER. THE C.O'S ARE PETTY IN THIER RULES AND REGULATIONS BUT THEY ARE NOT ABUSIVE - AT LEAST THEY HAVNT BEEN YET - AS FAR AS THE MENTAL HEALTH SERVICES I HAVE SO FAR ONLY SEEN A DOCTOR ONCE TO RE-UP MY MEDICATION AND UPON ARRIVAL I SAW A SOCIAL WORKER. THEY WANT TO MAKE SURE YOU GET THE PROPER MEDS AND MAKE SURE YOUR NOT CONTEMPLATING SUICIDE - THEN THATS ALL YOU SEE OF THEM - THERE IS NO ONGOING THERAPY WHICH BOTHERS ME ALOT - I ASKED FOR REGULAR THERAPY SESSIONS BUT WAS TOLD THAT THE SOCIAL WORKER WOULD TALK TO ME ONCE A MONTH.

2. GREAT MEADOW CORRECTIONAL FACILITY- GAIL ALLEN, M.D.¹¹¹

On December 6, 2002, I accompanied the Correctional Association to Great Meadow to view its mental health services. Areas toured included the Residential Substance Abuse Treatment, the Special Housing Unit, the Intermediate Care Program (ICP), and general population blocks A and B. Meetings were held with the superintendent, his administrative staff and the Inmate Liaison Committee. The mental health staff was prohibited from meeting with us due to current litigation. Informal and structured interviews were conducted with individual inmates.

Reflecting on the visit as a whole, I was struck by how deeply disturbed and sick many of these men are. The incidence of mental illness throughout the prison was alarming.

For example, on B6, one man was floridly psychotic and paranoid. The tension in this inmate was palpable, as he spoke incoherently of homicidal fantasies or memories. Another inmate on the same general population cellblock was visibly agitated, guarded, and potentially explosive. He talked to himself and appeared to be actively hallucinating while muttering violent threats. He apparently had had an outbreak in his printing class and was singled out by his teacher as “troubled.” Although he initially hesitated to speak with me, he gradually engaged and confided that he hated printing class because he was illiterate. He was interested in school and also said he would be willing to talk with a counselor, especially in Spanish. He complained he had not been feeling well physically and expressed a desire for a medical work-up and HIV testing.

A third man was delusional and grandiose. Another inmate was housed in an observation cell after cutting his throat. He claimed he had been off his meds and had been asking for help for several weeks before making the suicide attempt. He felt the staff had been unresponsive compared to his other experiences upstate. A review of his chart showed a two-week span between entries and a well-documented horrendous history of sexual abuse, depression, violence, self-mutilation, and repeated efforts to kill himself.

The CO in charge of the area had been there for nine years and seemed sensitive to the men’s needs. He informed us that their length of stay varied from several days to several months and they were allowed out of their cells only three times a week for showers.

The fact that so much pathology surfaced in the brief time of our visit suggests that we saw but the “tip of the iceberg.” It engenders sympathy for the officers faced with the task of containing this population. That they resort to and perhaps overuse SHU and keeplock sentences or keep men heavily medicated in their cells is understandable but hardly optimal. It has been observed that “normal” persons subjected to solitary confinement and nutritional deprivation deteriorate in those circumstances. Needless to say, there is a greater toll on the mentally disturbed.

¹¹¹ Gail Allen, M.D., a recently retired psychiatrist who practiced at St. Luke’s-Roosevelt Hospital in Manhattan, serves on the Correctional Association’s Board of Directors.

So what can be done if substantial resources – time, energy, personnel, money – are spent pursuing strategies that are counterproductive and actually aggravate the mental illness in the facility? Quite simply, the men such as those described above should not be in general population or in long-term observation cells. They need more intensive treatment. They should be hospitalized, stabilized, medicated, and subsequently transferred and maintained in a therapeutic environment.

The ICP, with its vocational activities and groups, is such a setting, but admission is restricted to the more manageable and docile inmates. This program and the dormitory of the Residential Crisis Treatment Program should be enriched, expanded and better utilized, suggesting implications for the size of the Central New York Psychiatric Center (CNYPC).

One man I interviewed in general population (PT) illustrates what's possible. PT stated he had been given more than ten tickets for fighting and assaults and had been to CNYPC twice for extended periods, seven-month and sixteen-month stays. Schizophrenic and violence prone, he had nonetheless been treated and medicated at CNYPC to the point that he was able to function in the open environment of the ICP.

According to the administrative staff, approximately two to three men per month are now sent to CNYPC and another two to three are waiting for entry into the ICP at any one time.

Temporary transfers to CNYPC should be made more often, and if doing so is limited by capacity, CNYPC should be expanded.

When the men return from the hospital, they should not be put in SHU where whatever stability they've achieved may be undone. They should be referred to the Residential Crisis Treatment Program or the ICP or to a "step down" unit of less austere cells and modified activity, mirroring the hospital atmosphere in which they recovered.

Although Great Meadow will never be "a hospital," other steps could be taken to make it more generally therapeutic.

1. There should be an intensive training program given for all COs and staff throughout the institution so that the staff will be better able to identify and understand symptoms of mental illness and respond in more appropriate ways.
2. Disturbed inmates should not be penalized for untidiness or minor infractions. Positive reinforcement such as praise and rewards should be employed more frequently in place of punishment. Groups on hygiene and daily living skills should be increased.
3. Inmate requests for help should be treated seriously and with respect, not ignored or dismissed as manipulative (a problem cited by several men we interviewed, who also

spoke of a case where an inmate was ridiculed and called “Cyclops” by the guards and who subsequently fatally set himself on fire). Officers who persist in name-calling or engage in other sadistic behavior should be reprimanded and ultimately screened out if they fail to change their approach. It was reported, for example, that Officer R----- provoked an inmate who had been off his medication. The man “snapped,” resulting in a violent fracas.

4. The prison population should also be educated about mental illness so they, too, can be more sensitive to those with psychiatric problems. The compassion shown by many of the men towards their disturbed colleagues was impressive. Since money and staffing present potential obstacles to structuring a more supportive environment, a group of peer counselors or a buddy system might be established, a recommendation of the ILC that I think has merit. We suggested that a representative from the ICP serve on the ILC and the Administration was receptive to the idea.
5. Spanish-speaking professionals or counselors should be actively recruited given the large number of Latino prisoners.
6. Medication should be more closely monitored. Patients should not be overmedicated or rendered totally dysfunctional. Meds should be dispensed so that at least a portion of the day can be spent in activities. Side effects should be minimized through the use of counter-acting meds or the newer anti-psychotic drugs so that inmates feel less inclined to stop their medication. When an inmate refuses to take his meds, he should be seen at least once a week for signs of decompensation and for exploring his reason for noncompliance. In some instances, intra-muscular medication should be considered.
7. The issue of idleness was raised during the prior visit and noted again. The men are in dire need of more educational and vocational groups and activities. There are links between boredom, despair and negative behavior. Conversely, people who are learning and feeling productive are less likely to act out.

A therapeutic community can reduce the incidence of violence and promote the healing necessary for many inmates to return safely to the outside. Expanding CNYPC and the Intermediate Care Programs would be costly but ultimately a cost-saving endeavor; many of the other measures could be implemented with little expense.

3. CASE STUDY- NANCY DUGGAN, PH.D.¹¹²

In August of 2002, RH wrote the Correctional Association a letter from Southport. "I am scared of everyone and everything," he wrote. "I wonder about killing myself all the time." At that time, he was serving a SHU sentence of 15 months for disobeying a direct order, creating a disturbance, assault and threats. He was scheduled to complete his sentence on February 16, 2003. He reported getting more than 10 deprivation orders while in the SHU. While in the SHU, he reported that he was receiving anti-depressant and anti-anxiety medications as well as limited contact with mental health staff. He was seen in his cell by a mental health staff person once a month and spoke privately with a clinician every 6 weeks. In January 2003, he cut his right hand and wrist and was sent to an observation cell.

A review of his mental health records suggests that RH's early life was chaotic and traumatic. As a child, he was shuttled between foster care, group homes, and an uncle who sexually abused him. RH reports that he was psychiatrically hospitalized at age 7, the first of several hospitalizations in his childhood and teenage years. He dropped out of school in 10th grade, was frequently homeless, and worked as a male prostitute to survive. He joined a street gang, the Bloods, which he subsequently tried to leave. He has spent most of his late adolescence and adult life in prison.

RH was a problematic inmate when he first entered the correctional system and has continued to be, intermittently, for two long periods of incarceration. He has had frequent altercations with inmates and staff. His behavior has led to frequent disciplinary actions and extensive periods of time in the SHU. When in the SHU, he reported experiencing auditory and visual hallucinations, paranoia and suicidal ideation. He engaged in several episodes of self-mutilation. Early in his prison career, he was diagnosed with psychotic symptoms that led to several hospitalizations and varying diagnoses including schizophrenia, schizo-affective disorder, unspecified psychosis, post-traumatic stress disorder, anxiety and depression. When mental health personnel believed he was psychotic or suicidal, he was placed in an observation cell or hospitalized. In the hospital, he would immediately stabilize, socialize with other inmates, and seemed to enjoy the amenities of hospital life. When mental health diagnosed him as being predominantly a borderline personality disorder, an antisocial personality disorder, or an adjustment disorder, his treatment tended to be minimal and his behaviors often led to extensive periods of solitary confinement. Mental health staff sometimes treated him in the SHU for psychiatric symptoms with medication and limited contact with mental health staff, about 15 minutes a month. At other times, he has been seen as simply manipulative. One psychiatrist wrote: "He's a smooth-talking individual with a steady flow of requests and excuses...seeking release of the normal stress of jail and the boredom of incarceration by medication-seeking. Medication is denied."

Clearly, there was a lack of continuity in care. There did not appear to be any particular clinician who was familiar with this man or his history. He has seen many

¹¹² Nancy Duggan, Ph.D. is a forensic and clinical psychologist and a former clinician with Montefiore Hospital's Mental Unit at Rikers Island.

different clinicians briefly. In addition, there was a disconnect between his mental health records and his disciplinary and medical records. His disciplinary and medical records shed light on some of the situational reasons for his maladaptive behaviors, which are not clear from his mental health records. In his disciplinary and medical records, we learned that one reason RH has spent so much time in disciplinary confinement is because he has been attacked by members of the Bloods, his former gang. Though RH quit the Bloods when he was a young man, current members of the gang have threatened to kill him for his defection. RH has been attacked several times in the prison yard; at one point on his way to court, his face and body were slashed several times. It would appear that some of his behavior was designed to help him find refuge from assaultive inmates.

These issues were mentioned only twice in his mental health records (“Patient has frequent arguments with COs and inmates”), but glossed over without much comment. Even though mental health staff would usually interview RH just after he arrived in SHU, they either did not ask him about or did not record the precipitating events that brought him there. In one screening, a clinician noted a recent razor slash on RH’s face, but did not report how it happened or its possible impact on his behavior or reported psychological symptoms. The mental health staff seemed reluctant to get involved with any issues that seem “prison-related” rather than “psychological.” RH’s behavioral issues are left to correction officers to handle.

While real situational stressors can explain some of RH’s behaviors, there are also deeper and more complex issues going on with RH that cause him to get him into trouble. DOCS staff picks up on RH’s apparent self-destructive impulse – his tendency to invite trouble and put himself almost deliberately in harm’s way. In one meeting with a clinician at Auburn, he revealed the name of the uncle who sexually abused him as a child and admitted a previous suicide attempt prior to incarceration, for which he was hospitalized. Even while acknowledging very real traumatic events from his past, RH confessed to having sometimes faked psychiatric symptoms. “I did a lot of manipulative stuff,” RH was quoted as saying. “I even cut my arms to get attention. I also claimed I was hearing voices, which was not true.” In reviewing his records, RH sometimes seems to fit a category of inmate that psychologist Hans Toch characterizes as “disturbed-disruptive,” i.e. inmates who are emotionally disturbed and demonstrate frequent behavior problems.

Inmates like RH present a real dilemma for mental health and for corrections. Mental health staff tend to view inmates like RH as manipulative and attention seeking, which is not entirely untrue. The services provided by mental health staff tend to be crisis-oriented; their interventions are designed to stabilize troubled inmates so they can cope with institutional living. Once the inmate is stabilized, mental health staff usually disengage from care until the next crisis. Consequently, inmates like RH, who are seen as manipulative and as primarily behavior problems, are treated with extensive SHU time, which often exacerbates their pre-existing problems. When he is unable to cope with the conditions in SHU and exhibits psychiatric symptoms, mental health staff is called in to address the symptoms.

RH's early history and his dysfunctional adaptation through two incarcerations suggest that he also has some significant deficits in coping, which could benefit from an intervention that focuses on his maladaptive behavior patterns and his inability to cope with stress. Traditional mental health tools such as therapy would very likely be ineffective with RH, and there are not the resources to do that kind of treatment with inmates even if it were recommended. However, there is a great need for innovative approaches that can help inmates like RH develop more effective coping. For instance, Hans Toch, Ph.D., author of *Maladaptive Behavior in Confinement*, has documented various approaches to working with chronically maladaptive inmates that lower the rates of disciplinary infractions, staff assaults and SHU time. Dialectic Behavioral Therapy (DBT) has also proven effective with inmates such as RH. Without such treatment interventions, which require collaboration between corrections and mental health staff, inmates like RH will continue to pose an ongoing problem for both DOCS and OMH staff, and ultimately society when they are released.

4. PROFILE OF AN UNTREATED INMATE¹¹³

JR is a 30-year-old African American man who has been in prison for 11 years. For six of those years he has lived in solitary confinement. We first met JR in Southport Correctional Facility, a freestanding disciplinary lockdown correctional facility for 780 inmates. The cellblock was relatively quiet when we arrived.

We stopped outside JR's cell because his disheveled appearance and the barrenness of his living quarters caught our attention. His cell lacked the typical (though illegal) wall adornments, such as family pictures or pin-ups, and there were no books, magazines, or papers on his desk. His black plastic glasses were broken in places and missing an eyepiece; they hung lopsided across his nose. His t-shirt was stained. His expression was expectant and somewhat fearful.

JR's responses to our questions were repetitive and highly disorganized, some unintelligibly so. When told that the Correctional Association was located on 15th Street in Manhattan, he responded like a proud first grader, "I know 15th Street! I know 125th Street, 138th Street, 42nd Street..." When asked how long he had been in SHU, he responded, "Oh, fifty days, a hundred days, a hundred fifty days, massive days" In fact, JR had served more continuous SHU time than he could probably count: 2,067 days.

Inmates in nearby cells, listening to our odd conversation, began to snicker. "He's crazy!" they shouted. "He's a bug! Help him!" Some prisoners began to tease him. "Whore Street!" they shouted, causing Jamie to spring to attention like a soldier. "Whore Street Representative!" he barked in response. This was repeated several times to the great amusement of the inmates on the tier. Later, an older inmate on the block said that JR gets mocked every day. "Guys here have nothing to do," he explained. "He's their TV."

JR entered prison in 1992, was screened by mental health staff and found not in need of services. Five years transpired before mental health staff saw him again, when JR was sent to the SHU for assaulting an officer. Over the next two years, mental health staff saw him eight times. The picture that emerges from his records shows an individual experiencing increasing difficulty coping with the isolation of the SHU environment. When mental health staff first screened JR upon arrival in SHU, they found him naked in his cell, wearing "nothing but his glasses." The screening social worker wrote that he appeared "lucid and coherent," but based on "his appearance and the fact that he assaulted an officer, patient will be evaluated for service need." Despite that observation, JR was not seen again until three months later. At that time, he was found to be healthy and not in need of mental health services.

One year later, JR began exposing himself to nurses and masturbating in front of female officers. He received several tickets for this behavior and additional SHU time, and was interviewed by the then-Unit Chief at Attica. Her report of that interview is the only clinical write-up on JR throughout his incarceration. She wrote in part:

¹¹³ Written by staff researcher Gregory Warner.

Patient has no psych history and after 7½ years in prison this is the first time he exhibits this behavior. Patient claims he has SHU [time] till 2001 and thinks he won't be able to handle it.

Alert, excited. No evidence of hallucinations. No delusions. Coherent. Organized...Patient made several sexual remarks to this writer and interview was ended. Patient seems to be acting out as a means to get out of SHU. Diagnosis: Antisocial Personality Disorder.¹¹⁴

JR quieted down for a while, then resumed exposing himself to female staff. He was transferred to the SHU at Wende, another maximum-security prison, and finally to Southport in April 1999, where he was screened once, found not in need services, and never seen again. There his official mental health file ends.

What happened to JR between April of 1999 and May of 2002, when we first met him? Since the medical file had no answers, we turned to JR's sister, his closest relative. She has corresponded by mail with JR since he was incarcerated, and she stated that about five years ago (when JR first arrived in SHU), his letters started becoming strange – rambling, confused, disturbing, inappropriate, and repetitive – sometimes 5 or 10 letters saying exactly the same thing (see letter on next page). When she visited him in 2000, she was shocked at the change. “He wasn't himself,” she said. “Only at the end of the interview, he touched my hand, and I started crying. I thought, maybe he actually knows who I am.”

¹¹⁴ Toch: “Mental health staff gain most freedom by asserting that typical infractors are of no interest to clinical professionals in that they at worst have a character defect [like Antisocial Personality Disorder] that is unresponsive to therapeutic administrations.”

A Letter from JR to his Sister

Dear mickel

How are you today fine I hope. Have you ever been on a yacht to me a yacht is a very big boat with a Jacuzzi on it. A yacht has a Jacuzzi on it. With bubbles on it. You can watch television and play nintendo all day eating MandM and Snicker's as the ho's strip down to there panties and high heels with their boob's showing. Shaking it for the fellas. Or you into shopping most people or into shopping that is the best! Shopping Games and Gambling, and Clubbing & Parties and Toy's and Theme Park's & Ride's. You watch alot of TV cartoon's and Music is Good. Alot of people or into Restaurant's most people go to a restaurant like mcdonald's and Buger king. Pizza Hut R.B.S. The whaffle House is alot better then the coffee house. Send some money \$155.00 for candy. Alot of people or into music to me music is

Good music Movies Cartoon's Tv Dance
Rap & R&B Or You into Bicycles &
motorcycles to me Adventure's And
Journeys Im Taking All charities &
Gift's Send Some money for Soap
Shampoo Lotion Stamp's And candy \$155.00
Tell Sheila or Pam or nicole to
Send Some money And A Picture or
Come up Here to see me. Im Going
Shopping When I come home Im
Going Shopping. When I come home
Im Going Shopping You or into
Game's and Gambling and
Clubbing & Parties and Toy's and
Theme Park's & Ride's You watch alot
of Tv cartoon's and Movies. And
Dance Rap and R,B to me Music
is The Best Alot of people Go to A
Restaurant like mcdonald's and Buger
King that is were the Friend's And
family Goes is shopping that is the
Best Shopping I love You. Please
Send Some money \$155.00 Peuce.

5. SING SING CORRECTIONAL FACILITY- ALAN FELIX, M.D.¹¹⁵

My visit to Sing Sing on January 7, 2003 began with a meeting with members of the Inmate Liaison Committee. They expressed diverse opinions about the quality of mental health services in the prison. Most felt the response to psychiatric emergencies was prompt. However, one committee member called the observation cells “appalling” while another inmate found his 10-day treatment in observation “okay.” While some felt that counselors were not available enough for non-urgent concerns (taking up to three months to see someone) one inmate reported that the quality of counseling he received was “great.”

Overall, the committee seemed to feel that abuse of mentally ill prisoners by the COs occurred, but infrequently. There was general agreement that COs needed to speak more respectfully to the mentally ill and that they would benefit from improved training. The committee recommended that the ICP be expanded and that mental health counselor visits to general population increase.

Next, I visited the SHU, where I spoke with three inmates, each receiving psychiatric treatment. Inmate AC reported that he was soon to be homeless but had little knowledge of the shelter system. He believed he was close to release and felt anxious about where he would go and how he would receive his medications for bipolar disorder. He was unaware of the vouchers that are available to pay for his medications.

A second inmate, TK, reported that he was on anti-psychotic and antidepressant medications, and that he was in “the box” for 14 months. I was unable to elicit why he was there for so long. I did have the opportunity to interview more extensively and review the chart of a third inmate, RY.

RY reported a long history of mental illness and appeared overtly manic and psychotic. He was agitated; his speech was pressured, he had a flight of ideas and believed that he could feel “the power” in his body. His explanation for why he was in the SHU was the following. He had been to the medical clinic when he was placed in a holding cell. He began to shout that he wanted to use the bathroom or return to his cell. He felt he was left there too long. Officers approached him, telling him to keep his hands in his pockets. He believes that he was cooperating, yet he was “beaten up” and taken to the SHU for creating a disturbance.

I reviewed RY’s prison medical record with the goal of assessing his treatment and the events leading up to his placement into the SHU. During September and October 2002, RY seemed to be rapid cycling, alternating between mania and depression in the course of his bipolar disorder. He was described as delusional at times, made threats of self-harm, and actually self-inflicted some lacerations at one point. The attempts to treat him with atypical anti-psychotic medications and Depakote, a mood stabilizer, seem appropriate.

¹¹⁵ Alan Felix, M.D. is an Associate Clinical Professor of Psychiatry at Columbia University.

In November 2002, RY showed his doctor a cup of pills he did not take. Despite the fact that he voluntarily disclosed this, a nurse wrote: “Patient tried to rationalize his reasons for hoarding meds but was reality oriented by writer who pointed out that his decision was his own and manipulative.” Medications were discontinued. Subsequent notes indicated that the staff was revising their diagnosis of RY from “paranoid schizophrenic” to “BPD,” which in the context of the notes, I took to indicate “Borderline Personality Disorder.”

By mid-November, RY was described as loud and hyperactive, with an “alteration in thought process—reality orient is needed.” What I believe was needed at that point (ideally, before this point was reached) was a more aggressive regimen of mood stabilizers and antipsychotic medications. Stopping meds only exacerbated his symptoms and this seemed to stem from a misdiagnosis and belief that he was being “manipulative.” There was an understandable concern about self-inflicted injury, but careful monitoring of meds would seem to have been a more appropriate response than stopping them.

Only after RY appeared increasingly manic and was placed in an observation cell was he placed on Zydys, a rapidly dissolving form of Olanzapine, an atypical anti-psychotic medication.

For unclear reasons, the staff began to indicate that RY should be returned to general population. This seems inappropriate and the rationale for this is poorly documented, although one psychiatrist’s note reads, “Loud talking—marked, sudden changes, probability of feigning or malingering although secondary gain is not apparent.” To me, these symptoms, without any apparent secondary gain, indicate continued mania, not malingering. Further staff observations (“delusional, irritable, non-stop talking, grandiose”) support this.

The last note written while RY was in the observation cell was dated 11/27. In a subsequent psychiatrist’s note, it is clear that the psychiatrist is unaware that RY had been transferred to general population. It struck me as disturbing that this decision was reached without the psychiatrist’s knowledge, particularly for a patient so unstable.

Not surprisingly, RY ended up in the SHU on 12/7/02. There are no notes documenting what occurred between RY’s departure from the observation cell and his screening in the SHU on 12/9. However, one could easily draw the conclusion that RY’s mania was a contributing, if not central, factor in the events leading to his placement in the SHU.

My last stop in Sing-Sing was a visit to the ICP. I was impressed with the unit and its director. I am also pleased to know that a new unit is being planned that will help mentally ill inmates prepare for their release. However, it is unfortunate that the new unit will occupy half the space of the ICP. This is especially unfortunate because the existing ICP probably serves only a fraction of the chronic mentally inmates in Sing Sing. In other words, this seems to be a case of robbing Peter to pay Paul.

While at the ICP, I asked its director about RY. He was very familiar with him and informed me that RY had been removed from the ICP due to his inability to participate in the groups and effectively utilize the program. At times, RY's behavior was disruptive to the program and he was therefore placed back into general population.

During our wrap-up meeting with the superintendent, I brought up the lack of appropriate services for difficult-to-treat individuals like RY. Placing them in general population because they are too ill for the ICP is illogical. This lack of proper care is likely to be a frequent factor for the use of the SHU to contain the behavior of mentally ill inmates. The prison administration is understandably frustrated by this situation, but seems to throw up its hands rather than seek out innovative programs, such as Dialectic Behavior Therapy (DBT). FECS, for example, an agency that provides LINK services, has a forensic DBT program.

Perhaps more importantly, I think it is vital that the prison staff, including mental health providers, not mistake the symptoms and behaviors that result from mental illness for "manipulative" behavior that warrants punishment. Isolating mentally ill inmates and withholding necessary treatments will only make their symptoms worse.

Overall, I found the attitudes and approaches of the prison staff towards those with mental illness to be sensitive and appropriate. However, there seem to be exceptions that might be ameliorated through better training of COs and expanded mental health services. In particular, the prison does not have a program for inmates too disturbed to take advantage of the ICP. Based on epidemiological studies of prison populations, I believe that a significant number of inmates would fall into this category and suffer as a result of this gap in services.

6. SUICIDE IN THE BOX

Suicide in the Box

by Jennifer Gonnerman

(Reprinted from the *Village Voice* December 17 - 23, 2003)



Elsie Butler visits her son's grave at least twice a day.
(Photo: Jay Muhlin)

On any given day, about 5,000 of New York State's 65,000 inmates are on 23-hour lockdown. Some are left in their own cells; others are taken to a "Special Housing Unit"; still others are moved to a high-tech supermax prison. These forms of solitary confinement go by various names: "keeplock," "the box," "the hole," "disciplinary lockdown," "the SHU." None of these words, however, come close to describing the harrowing nature of these prisons-within-a-prison. Imagine spending all day every day trapped in a 70-square-foot room, surrounded by only a toilet, a sink, and a cot. Time slows to a near halt. The passage of minutes is marked by the drip of the faucet, the jingle of keys on a guard's waistband, the screams of other inmates, the scraping of a food tray through a slot in the door.

Punishment here takes on a new, more extreme form. It's not just boredom and monotony, the usual banes of prison life. For mentally ill prisoners, life in the box can quickly become an invisible torture as their minds fill with delusions. And there is no limit to the number of months—or even years—a prisoner can be locked up this way. Solitary confinement is the penalty for a wide range of transgressions, everything from failing a drug test, to refusing to obey an order, to assaulting a guard. Between 1997 and 2000, New York State opened 10 new facilities specifically to hold inmates in 23-hour lockdown.

Assemblyman Jeffrion Aubry of Queens has proposed a bill that would keep mentally ill inmates out of the box. The Correctional Association, a prison watchdog group, recently released a report titled "Lockdown New York." The report contained two especially disturbing facts: Almost a fifth of the inmates in solitary confinement are suffering from mental illness. And of the 48 state prisoners who killed themselves between 1998 and 2001, more than half—25—died in disciplinary housing.

All of this attention to the needs of mentally ill prisoners comes too late for Jesse McCann and James Butler. They never knew each other, but there are disturbing parallels

between their life stories. Both end the same way: Each young man left prison in the back of an ambulance after hanging himself while confined to 23-hour lockdown.

SIX MONTHS IN THE BOX: JAMES'S STORY

On the afternoon of June 3, 2000, James Butler tied a bedsheet around the ceiling vent in his prison cell, looped the sheet into a noose, and stuck his head inside. At the time, he was locked in Fishkill prison's "Special Housing Unit," which everyone calls "the box." Several years earlier, James had been diagnosed with manic-depressive illness. He hanged himself after being in the box for nearly 200 days in a row.

He first entered the prison system in 1997 for selling drugs. In 1999, he was assigned to a work-release program. Six months later, he was back in prison—for assaulting an ex-girlfriend and going AWOL from the program. After an administrative hearing, he was sent straight to the box. Soon he was hearing voices; he said they belonged to other prisoners who were plotting to kill him.

James died at age 36, leaving behind four sisters and his mother, Elsie. On a recent Sunday, she sat on a leather sofa in her Poughkeepsie home, surrounded by paperwork—letters and cards from her son, scrawled notes about the calls she made to the prison on his behalf, the State Commission of Correction report investigating his death.

Elsie, a 62-year-old social worker, still calls her son by his pet name, Pumpkin. When she talks about his death, it seems like barely any time has passed at all.

Elsie Butler: I had five children—four girls and one son. James was the next to youngest. He was loving, sweet. He wanted to become a scuba diver. He had these little flappers, and he'd flap around on the floor in a tight bathing suit. He'd be on the floor in the living room, and he'd just flap, flap, flap all over the place. Diving on the rugs. He had the goggles on.

I was like a mother hen. Wherever I went, all five of these little people were with me. I kept my kids when I was separated from my husband. Raised them all by myself. I didn't have a car. I didn't get child support. I didn't get anything. I just prayed a lot. It wasn't easy for me. I was working two jobs and went to school.



James Butler, 1963-2000

When James got to 16, I don't know what was with my baby. He would be taking things. He would take a little pair of sunglasses. Or he'd take little stuff from Kmart, the dime store. I'd say, "Why did you take that? You have money." He'd say, "I don't know." "You don't have to do that, Pumpkin."

He did very poorly in school. They said Pumpkin had some issues. He was slow. And they wanted to give him medication. But by me being a young mother, I said, "No, no, I'm not going to let you give my baby medication." I thought I was protecting my child. Now I wish I had.

From 16 up until he died, that child was in and out of jail. He'd walk out of the house and get in trouble. No high crimes. He had a problem with cocaine. I had a VCR; it took me a long time before I noticed the darn thing was gone. I even found food missing out of my refrigerator. I had this coat, and I kept looking for it, but I couldn't find it. Then I said, "Pumpkin is taking stuff out of the house." I took my keys from him.

He couldn't find work, and he'd sit here and cry like a baby. I'd been talking to him about going to get some help. But I think he was more ashamed than anything. He'd say, "I ain't going. I ain't going. Ain't nothing wrong with me."

Once he tried to stab himself in the stomach with a butcher knife. My daughter called me on the phone and said, "I think Pumpkin is losing his mind." We called the police. The police came down and took him to Saint Francis Hospital. He stayed there for a while.

I think he did two and a half years in prison. From there he went to work release. He was working through a temp agency, doing some work making cabinets. He didn't get into any trouble. He was supposed to be in this house at 11 p.m.; he slept on the couch.

I thought he had made it. I really did. He said, "I work every day. I go to my [parole] board in December. And I'm not going back there. I know what I'm going to do. I'm going to church. I'm getting my life together." He was on the right foot. He was doing really great. We were very happy. And people that knew him said, "I can't believe Pumpkin goes to work every day!"

Two weeks before Thanksgiving, he had a confrontation with a lady friend. He went back into Fishkill Correctional Facility. They were saying he was AWOL. He couldn't call because he was in the box. He told me they gave him medication that made him sleep all the time. When he'd come down for a visit, you could tell he had just woken up because

he still had sleep in his eyes. He was real depressed. He said he couldn't take it, to be confined in this little box. It was horrible.

He weighed 240 and he was 6-4. I could tell something was wrong with him because he used to love to eat, and now he picked at his food. He'd eat the popcorn and maybe half a sandwich, but he didn't really want it. He started to lose weight.

When he'd come out on those visits, he'd say he was all right, but he wasn't all right. His eyes were red. He'd tell me he cried all night. He was nervous. He was rubbing his hands. He seemed like he was scared. Sometimes he'd just put his head down and say, "I can't take this."

I'd get two or three letters from him a week. He talked about his life being threatened by other inmates. I'd go see him every Sunday until he sent me a letter telling me don't come, because he said somebody was going to hurt me. He said somebody was going to follow me home. Whether this was factual or he was hallucinating—I don't know. To keep him from being all worried, I said I'll stay out until you tell me to come in.

I spoke to the supervisor, but nobody paid any attention to me. It fell on closed ears. I talked to quite a few people. I was pleading for his safety, pleading with them, "Just move him, so I can re-establish a relationship with him. So I can visit him, so he can talk to me."

One day I came home around three or four, around late afternoon. I saw the machine blinking. I just pushed the button; it was the operator telling me to call the prison. Father Licata from the correctional facility said there had been a terrible tragedy with my son. I didn't know what a tragedy was. Did he get cut? Did he get stabbed? He told me my son was dead, and I just screamed.

I had a white chair in my bedroom. I was balled up in that chair for about three months, and I didn't move. I was in like the fetus position. I'd get up, take a shower, change my clothes. I only ate because it was necessary or I would've died. I have diabetes. And I dried up to a size 10. I wear a size 12 now, but I was so skinny then that I had to get new clothes.

I go to the graveyard every day. In the wintertime, when they have the worst snow, I carve a path to his grave so that I can get there. I don't care if it's raining or sleeting or hailing, I go every day. That's one of the ways that I find a little peace. Sometimes I go five times a day, three times a day, two times a day. At least two times. I go in the morning, and then I go back in the afternoon.

I've been praying for the last four years that somebody listen to me. That somebody else besides myself know what this child has gone through. I'm tired of crying. I'm tired of

holding my head down. If I don't speak my peace now, I'll never have the opportunity again.

I brought a lawsuit because I knew I had to get the word out some kind of way, so that the correctional facility and their staff be more attentive with the mental health inmates in their care. I know it won't help my son. But for the other mothers, fathers, sisters, brothers who have a similar situation as myself—my hope is that they not have to spend their Christmas at the cemetery crying over a grave site where their child is buried.

DEAD AT 17: JESSE'S STORY



Jesse McCann, 1983-2001

Jesse McCann's 50th day in state prison began when he woke up in a standard cell at Downstate Correctional Facility. It ended in the box, when he fastened a bedsheet to the window frame, knotted it into a circle, and hanged himself. The date was March 16, 2001. His 18th birthday was two weeks away.

Since childhood, Jesse had been in and out of psychiatric hospitals. One doctor said he had "oppositional defiant disorder"; another diagnosed him with "intermittent explosive disorder." He was arrested for burglary at 16, then picked up for grand larceny at 17. While in Ulster County Jail, he attacked a guard and was convicted of assault. He was sentenced to up to three and half years in state prison.

Fifteen days after Jesse arrived at Downstate, in Dutchess County, he got into a fight with an inmate and was sentenced to 30 days of 23-hour lockdown. Soon after this punishment ended, he got into another fight, this time with a guard. Jesse was sent to the prison's "Special Housing Unit." Eighty-five minutes later, an officer discovered him hanging from his cell window.

Jesse left behind a mother, a father, and two brothers. His father, Guy McCann, lives in a modest second-floor apartment in Kingston, 20 miles north of Poughkeepsie. Jesse's high school picture and his faded Yankees cap hang on a wall in the living room. On a recent afternoon, 50-year-old Guy sat at the kitchen table, his fingers circling a cup of coffee, and told the story of his son's short life.



Guy McCann thinks his son might have had the same disease he has.

(Photo: Jay Muhlin)

Guy McCann: Jesse was very, very intelligent. Never studied. Straight A's. It was so easy for him. The teachers loved him. When Jesse was three, he could name every state in the country. And before he hit five, he could spell every state. He knew every president. Scholastically, life came easy to him. Emotionally, life was a death trap.

I knew he had a chemical imbalance from the time he was a baby. Jesse and I both had seizures when we were children. He had seizures ever since he was six months, and it went on until he was around four or five.

He was combative and confrontational. He'd go out on the street, and someone would say something at him, and he was ready to throw hands. And in school he had behavioral problems. He grabbed a picture off the principal's wall one day and smashed it on his desk.

When I'd get on his case about something he did, his face would turn red. You could see the color change right in front of you because he was so light. He would blow up. He would either throw something or run out the door or become confrontational himself. I would ignore him while he ran his mouth. Then, about five minutes later, he would apologize. And we'd talk, and then he was OK. That was the only way to handle him.

I have what they call tuberous sclerosis; I have on-the-brain tumors. What that does is, involuntarily, your emotions can fly. And with age and maturity, you learn to control that. Jesse was never diagnosed. But his eyebrows and his eyelashes are two different colors, and that's a sign of tuberous sclerosis. I was only diagnosed with this three years ago; if I had known this years ago, I think things might've been different today. Jesse might still be alive.

Jesse was eight when his mother split. That's when his behavior really started escalating. He would run away. Just a lot of anger and not knowing how to deal with it. He started hanging out with the wrong crowd. It started off with stealing from stores. He was very street smart; he picked up on how to get over.

The first hospital he went to was Benedictine. I think that's when he was 10. He went for a weekend stay there. We had him in Family House three times. Family House is like a respite for teenagers. Then he went to Four Winds [psychiatric hospital] for substance abuse and erratic behavior. Then he went to Rockland Children's Psychiatric Center. He was there twice.

Jesse was 150 pounds, 5 feet 7, and built like a rock. He got his GED when he was 16. He took the entrance exam to Ulster Community College when he was 16, and they were going to accept him.

One night I went to bed at 10, and Jesse ended up hanging out with two guys he hadn't hung out with in a long time. The three of them were walking around drinking. They ended up at a trailer that was empty. One guy went over and pried open the window and started taking stuff. Jesse told me he wanted to leave, but he didn't want to be a punk, so he stayed there. They stole baseball caps, costume jewelry, Nintendo games—junk.

They gave him probation on that and let him go. He was 16. He walked out of court, walked down the street, and bumped into a couple of his brother's friends. They went down to Kingston Plaza, and they were looking for money to buy some weed. One of the kids saw a truck running by the pizza place—it was a pizza delivery guy—and saw a wallet sitting there. Jesse kept watch, and the kid went over and grabbed the wallet. There was 26 dollars in there.

The cops came. They found the wallet in Jesse's back pocket, and it had three credit cards in it. Because of the amount of the credit cards, it was grand larceny. There's his second felony. They threw him in jail.

I saw him twice a week. I'd go up on Saturday, and I'd go up during the week. The more depressed he got, the more he acted out, the more lockdown he got. At least six months of the time, he was in solitary confinement. They put him in this little room all by himself. Honestly, the isolation killed him. He was becoming more distant from the world. He didn't know how to read the situation. His anger was increasing. He told me, "Dad, I can't handle this anymore. I just wish I would die." I thought he was feeling sorry for himself. I just tried to stay strong for him.

More than one guard came up to me and said, "Get your son out of here. He's not right for prison; he's not a criminal." But I didn't know what to do. I had no way to get him out of there. Being poor and being in the situation I was in—a single dad trying to make ends meet—I couldn't afford a lawyer.

I called the judge. I called the assistant DA. I called the DA. I spoke to them, and I explained that the kid needs rehabilitation, not incarceration. I said, "I'm not asking him to be on the street; I'm asking you to get him some help." They just wouldn't hear it.

I get a phone call on Friday at 4:30. Brrring. "Hello." "Hi, is this Mr. McCann?" "Yes it is." I don't remember the guy's name. Reverend So-and-so from New York State Department of Corrections. "OK, what can I do for you?" "I'm sorry to tell you but your son died at 11-something Friday morning."

I cursed the guy out. I thought it was one of my friends being a jackass. I went crazy. "What the hell are you doing?" I couldn't believe that somebody would actually call me. I mean, somebody dies in 'Nam, and somebody shows up at your door with a flag. My little boy dies, I get a phone call.

I just sat here in the house for three days. I was just so depressed. I didn't know if I should get angry, or crawl in a hole and die. I didn't know where my emotions were going. I had no clue. I mean, I didn't really admit my emotions to myself for four months.

I just don't want to see this continue. My son is already dead, but it doesn't mean other people have to die the same way. Because I went through this personally, I hope that I can help other people not go through it.

7. PROFILE OF AN INMATE SUICIDE

Al Kirby was in the OMH Level 1 wing of the Five Points SHU on the day of our visit in August 2002. He was sprawled on a stained mattress, bone-thin, wearing only a pair of boxer shorts. Excrement was smeared on the windows and walls of his cell. His face was covered with scabs; he appeared disoriented and bewildered during our interview.

Al Kirby had significantly decompensated since December 2001 when we first interviewed him in the Green Haven SHU. There, a correction officer had taken an interest in helping him. The Green Haven officer got him to shower several times a week and helped him obtain a pair of orthopedic shoes from the doctor. “He’s got a lot of issues, a lot of fears,” said the officer. “He wouldn’t take a shower because he said he couldn’t stand up. So I got him a chair he could use in the shower, and he took a shower, and everything was fine. And when he was out of the cell, we cleaned it.”

In addition to other strange behaviors, Kirby was known to hoard feces in potato chip bags under his bed. The officer reported that Kirby was not on the mental health caseload at Green Haven, “but he should be.” The problem was that Kirby was afraid of mental health staff and refused to speak with them.

“Al Kirby does suffer from a mental illness,” an OMH counselor at Green Haven told us, “but he does not necessarily need mental health services. He is extremely violent toward OMH staff. He refuses to shower and bathe. After one month here, we had to do a cell extraction because the odor coming from his cell was putrid. He was hoarding feces. He says he has allergies to food, but he rejected a medical diet. He says he will only drink purified water. He wants orthopedic shoes. This is typical jailhouse behavior.”

“Primarily because of a decent CO,” the counselor continued, “He hasn’t thrown feces once in twelve months. He’s calmed down quite a bit.”

OMH transferred Kirby to Five Points Correctional Facility so that he could participate in the Special Treatment Program. He began to decompensate almost immediately and “acted-out.” He never made it into the program. For various rules violations, he was put on the “restricted diet”—three daily servings of bread and raw cabbage. On the day of our visit, Kirby had been on the waiting list for transfer to CNYPC for six months.

In our final meeting with Five Points’ Superintendent that day, he expressed frustration at managing Kirby. “We clean his cell every day,” he said. “A nurse comes to see him every day.” Before we left the prison, we were informed that plans were underway to send him back to the psychiatric hospital.

On March 24, 2003 Al Kirby committed suicide in the SHU at Five Points. In its death investigation and report, the State Commission of Correction (a government oversight agency) described his obviously deteriorated behavior: “Inmate Kirby would

continue to behave in the same manner with refusing to eat, smearing his cell with feces and food and continuing to be non-communicative.” On the day of his death, he smeared his window with feces before hanging himself with a bed sheet. Only ten days earlier, Kirby had been sent to the Residential Crisis Treatment Program at Five Points, but he was never transferred to the hospital for more intensive treatment. Instead, he was sent back to his cell in disciplinary confinement. Correction officers refused to be interviewed by Commission staff about the circumstances surrounding Kirby’s death.

The Commission’s report had two main recommendations to OMH:

1. “Conduct an inquiry as to why inmate Kirby was not considered for re-admission to Central New York Psychiatric Center considering his obvious decompensation while housed in the Special Housing Unit...”
2. “Conduct a quality assurance review as to why a court order was not pursued for forced medications when the need was consistently identified by OMH clinical staff.”¹¹⁶

Illustrating the propensity of DOCS to punish inmates with mental illness instead of treating the clinical origins of their “acting-out” behavior, Commissioner Glenn S. Goord selected Al Kirby as one of ten inmates profiled in a November 2000 policy paper justifying the use of disciplinary confinement in New York State prisons. Goord wrote: “To understand the need for SHUs one needs to know the profile of the types of offenders who are sent to them.” Al Kirby was described as follows:

Al Kirby (93-A-6135) received nearly 10 years for attacking two officers with a shank as they entered his cell to remove him. One officer was cut on the arm and the second in the abdomen. This inmate has nine serious prior misbehavior reports ranging from multiple unhygienic acts to weapons possession, assaults on staff, flooding his cell and refusing to obey direct orders. He is serving a Queens County sentence of 15 years to life for murder.¹¹⁷

While some of Al Kirby’s actions were undeniably violent, they also reflect his extreme fear and paranoia, symptoms of the serious mental illness from which he suffered. However, even an inmate as ill as Al Kirby managed to make significant strides toward recovery solely because of the intervention of an attentive correction officer. One wonders what would have been possible had he received long-term, intensive mental health care in a secure treatment unit, instead of being sentenced to nearly a decade in disciplinary confinement.

¹¹⁶ Lamy, Frederick C., *In the Matter of the Death of Al Kirby, an inmate of the Five Points CF: Final Report of the New York State Commission of Correction*. New York: New York State Commission of Correction, September 2003.

¹¹⁷ Goord, Glen S., *Commissioner’s Policy Paper: On Prison Safety and Programming*, New York State Department of Correctional Services, November 2000, 4.

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